

Governor's Commission

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

**MINUTES**

**May 14, 2015**

**New Hampshire Hospital Association, 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, Nicholas Toumpas, Roberta Berner, Yvonne Goldsberry, Thomas Bunnell, Wendy Gladstone, MD, and Gus Moral. Commissioner Vallier-Kaplan welcomes everyone and states four (4) commissioners could not make the meeting today. Commissioner Vallier-Kaplan informs the attendees that Ms. Robin Preston from CMS was unable to attend the meeting as of late Monday. The Commission will try to reschedule the meeting with Ms. Preston or another representative from CMS in the near future. Commissioner Vallier-Kaplan thanks Deputy Commissioner Marilee Nihan, Ms. Kathleen Sgambati, and Commissioner Nick Toumpas for the effort made to schedule the meeting with Ms. Preston. Commissioner Vallier-Kaplan then 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. This includes the March 2015 issue brief from the Kaiser Commission on Medicaid and the Uninsured entitled, "Awaiting New Medicaid Managed Care Rules: Key Issues to Watch". CMS is slated to issue a Notice of Proposed Rulemaking (NPRM), revising and updating the current regulations for Medicaid Managed Care. This issue brief focuses on key issues to watch related to states' MCO programs. Commissioner Vallier-Kaplan refers to the issue brief as important and easy to read. The Commission was hoping that Ms. Preston would have been able to address this today.

Commissioner Vallier-Kaplan reviews updates since the last meeting. She states that she had a conversation relative to SB 7, which requires a joint health care reform oversight committee to provide greater oversight, policy direction, and recommendations for legislation regarding implementation of managed care and the New Hampshire Health Protection Plan. Proposals came out of the Senate to change the entity responsible for oversight of Medicaid Managed Care. Commissioner Vallier-Kaplan engaged with individuals to make sure they knew what the MCM Commission is responsible for and what appeared to be duplication. Commissioner Vallier-Kaplan's understanding is that the bill didn't go anywhere.

Commissioner Vallier-Kaplan references minutes from the April 9<sup>th</sup> meeting. A motion is made to approve the minutes and seconded and the minutes of the April 9, 2015 meeting of the Commission are approved.

**DHHS MCM Update**

Commissioner Toumpas opens by stating that Lorene Reagan will provide an update for Step 2 mandatory enrollment. He states that he will present his standard MCM update. The presentation focuses on enrollment updates, the Key Program Indicator (KPI) report, and general Q&A from the Commission and the public. The MCM program began on December 1, 2013 and has been underway for 17 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 May 2015, there were 158,105 people enrolled in the MCM program. The 18,994 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. This number is trending down a little bit. The growth rate of the New Hampshire Health Protection Program has stabilized. It is still growing but not at the pace it was before. In terms of MCM program enrollment by plan, Well Sense has 85,523 members enrolled and New Hampshire Healthy Families has 72,582 members enrolled. At some point we will remove the Meridian line. 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 the program.

Commissioner Toumpas asks if there are any questions from the Commissioners or the public. There were no questions.

### **NHHPP Update**

Commissioner Toumpas states that there are 39,635 recipients enrolled in NHHPP as of May 12, 2015 and 18,342 are new to the Department. These are clearly people that were uninsured and now they are enrolled into the program. There are 19,605 new to the NHHPP but have been clients in the past. The medically frail category is a relatively small number. Of these, 423 have standard Medicaid. The HIPP program, which is the program for those that have access to employer insurance and it is deemed cost effective for them to be in the program, remains relatively small. The Lewin group projected that this number would be much higher but it far less than their estimate. Currently, 18,919 are enrolled in Well Sense Health Plan and 16,817 are enrolled in NHHF. The remaining 3,381 are in Fee for Service as they have not yet enrolled in a plan. So there is still growth in NHHPP but not as fast as it was. Within the next week enrollment will probably reach 40,000. Commissioner Toumpas states that a map of the State is updates as major milestones are reached. The map shows the number of people enrolled by county and what percentage of people are represented in that county. He states that numbers are town by town so if anyone would like to use this information, they can do so. This could help policy makers make decisions. He states that CMS has approved the 1115 waiver to transition from the Bridge program to the Premium Assistance Program effective January 1, 2016. NHHPP population will then move into the marketplace. He remarks that his colleague, Ms. Deborah Fournier will answer any detailed questions in this area as she will present later in the agenda.

Commissioner Toumpas opens the meeting to the Commissioners and public for comments and/or questions on MCM enrollment numbers. There were no questions.

Commissioner Toumpas refers to 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

Commissioner Toumpas explains that for this month the Department is including a chart, as well as the commentary for those areas he is reporting on. He reviews three areas, highlighting those areas with changes from the month before. The first area Commissioner Toumpas addresses under Access and Use of Care is inpatient hospital utilization for ambulatory care sensitive conditions for adult Medicaid members. Inpatient hospital utilization for ambulatory care sensitive conditions for adults has decreased and meets the pre-MCM benchmark. The next area of discussion under Provider Service Experience is the pharmacy claims processed in less than one second. Processing pharmacy claims in less than one second is an important part of a good pharmacist experience of service. The MCM contract standard for this measure is 95%. This measure describes the number of pharmacy claims accurately processed within one second as a paid or denied claim, divided by the total number of pharmacy claims, as a percentage. Pharmacy claims are being processed below contract standards for timeliness. This is attributable to one MCO who is actively engaged in processes understanding and improving. As part of their research they determined that while they are not meeting the standard, all their claims were processed in less than 12 seconds. The Department will continue to monitor improvement efforts for this measure. This does include the NH Health Protection population is included in these numbers. Commissioner Toumpas then discusses the data related to grievances. There is a small increase in the number of grievances. The appeals remain around where they were. The Department wants to make sure that the information on how and where to file a grievance gets out to members. This measure does include the NHHPP populations. Commissioner Toumpas opens the meeting to Commissioners and the public for questions.

Commissioner Wendy Gladstone, MD asks if the children's data for inpatient utilization for specialized conditions is not included because it hasn't changed.

Commissioner Toumpas responds that he went through the report with Dr. Lotz and highlighted all of the benchmarks with positive changes. If there was no noticeable change it was not included in the presentation.

Commissioner Gladstone asks: What the significance of the 12 seconds vs 1 second?

Commissioner Toumpas states that the standard has changed recently. It went from three (3) seconds to one (1) second. When a claim comes in from the pharmacy it is being processed within 1 second or 3 seconds. This is the processing of the claim and not authorization. The pharmacy is sending something in and they are waiting for it to payment.

Commissioner Mary Vallier-Kaplan states that for the lay people in the room it is hard to understand the significance of this.

Question: In last month's minutes for prior authorization it stated that there was a glitch in the pharmacy data. I'm assuming that because this is not here there is no resolution to this.

Commissioner Toumpas responds that work is being done on this. This is related to the pharmacy authorization. The Department is working with the Community Mental Health Centers, MCOs and the Legislature to come up with a response to this. This is regarding the prior authorization process.

Commissioner Gladstone states that the Commission has have been looking at this for a year and it is still at 40%.

Commissioner Mary Vallier-Kaplan asks Commissioner Toumpas if he will report back to the Commission when this is resolved.

Commissioner Toumpas responds that he will do that. More informative data should be available and analyzed by Jun3 2015.

Question from Commissioner Roberta Berner: In the previous report as of January 2016 NHHPP population will be brought into the marketplace. The ending of the assistor funding ends Dec. 31<sup>st</sup> 2015. Will this be a glitch in enrolling in PAP?

Answer from Ms. Deborah Fournier: No, while more assistance is always better, the responsibility of enrolling beneficiaries in PAP is with the Medicaid Department. The FFM does not have the capacity or capability to support this particular effort. Shoppers must shop through the Department's platform for the most part. The Department and our partners such as SericeLink can help us facilitate, as well as our enrollment broker.

Commissioner Vallier-Kaplan states that at previous meetings transportation was an issue and this seems to be stable now. In the last report it was exclusively clients either cancelled or postponed. Commissioner Vallier-Kaplan wants to get this information out to all that are concerned about it and is not sure who's responsibility that is, the Commissions or the Departments. This will be a follow-up item.

Commissioner Vallier-Kaplan asks the Commission and the public if there are any other questions regarding the Key Indicator Report. The full report is posted to the Governor's webpage and the DHHS webpage.

Question from Ms. Kathleen Sgambati: Is the grievance data broken out by grievance area?

Commissioner Toumpas responds that he will have to check on that. The increase in grievances is small but what is important is that the MCOs are looking at this and taking it to heart.

Commissioner Mary Vallier – Kaplan states that even if the numbers are small, if they are all about the same thing than this makes a difference.

Commissioner Toumpas explains that the Department is in the process of augmenting the team and will be bringing at least one or two people in to lead the Step 2 implementation. Basically the Department has been working in a number of areas including Step 2 and PAP where staff that are responsible for operational areas have been given the responsibility of carrying out the implementation of these initiatives. The Department is recruiting individuals that have the knowledge to lead these initiatives and this will be their full time job. We will be making an offer within one to two weeks.

## Step 2 Update

Ms. Lorene Reagan begins with an update of where the Department is today operationally with Step 2. Step 2 now has four (4) phases. The first phase of Step 2 is mandatory enrollment. Medicaid recipients who were optional now are mandatory. Phase 2 of Step 2 is the integration of Choices for Independence (CFI) waiver services into the program. Phase 3 is nursing facility services into the program and phase 4 is developmental disabilities waiver services, acquired brain disorder waiver services, and in home supports waiver services and several other smaller but important programs into the Care Management program.

Ms. Reagan then discusses the timeline from the beginning. She reviews the timeline starting with the signing of SB 147 in June of 2011 and moves through each phase with MCM medical services for most Medicaid recipients beginning December 1, 2012. Selection period begins for clients who were voluntary/opted out to choose their plan starting July 1, 2015 with medical coverage beginning on September 1, 2015. On January 1, 2016 MCO coverage begins for CFI waiver services and on July 1, 2016 MCO coverage begins for DCYF services and Nursing Facility services.

The next slide shows the total MCM eligible long term care population by opt out status. Ms. Reagan states that on the bottom of the bar graph in blue shows that about half of the individuals in these programs are already enrolled with an MCO for medical care. Fewer are from nursing facilities because people have dual eligibility and have previously had the option to opt out. There are some in the blue group that had the ability to opt out and didn't. In the red on the bar graph is the number of people that will be enrolling into the program on July 1, 2015. The Department recognizes completely how important it is to think about the complexity of this population. The Department knows that children with Katie Beckett are enrolling on July 1, 2015 and some of the providers for this population are not enrolled with MCOs yet. We also know how important continuity of care is making sure of coordination of benefits. We know that there are people coming in on July 1<sup>st</sup> that have private insurance, Medicare and Medicaid. What does that mean for people coming into the plan and complexity that will add? We also have to make sure that we have done all that we can do in terms educating the health plans about the complexities of these individuals families and guardians and work on education and outreach around these issues. We have worked with stakeholders over the past months to understand what are the lessons learned in Step 1 of the program and as we continue with our training we are using all of this information to avoid similar challenges in Step 2.

The Department is focusing today on readiness and education and training. We have done numerous trainings between the Department and the health plans on disability competence and person centered planning, Department eligibility and data systems and State and Federal regulations. There are two (2) initiatives that the Department has conducted over the past months that address the need for the Health Plans to better understand individuals' needs. One is an exercise where each of the health plans was required to pick ten (10) current members that they are serving for medical care, 5 CFI and 5 nursing facility. The plans were invited into the Department to see how the Departments systems currently work. The plans were then asked to connect with the CFI case management agencies and providers in CFI and nursing facilities to discuss these 5 members and to start the dialogue to answer the question what is this like for you. We understand what happens on the state level but what is it like for you at the provider level. The plans sought out the members or guardians and visited with each individual at the place of their residence. They talked to them and reviewed their plans of care. They then came back and presented a formal presentation to the Department on things they learned. They saw the positive supports that currently surround individuals on waivers and heard about their unmet needs. This exercise started in March and ended last week. Also last week the Department invited five (5) experts, two (2) receiving CFI waiver services, one (1) individual on the ABD and 2 Developmental Disability waiver services. They spent two hours sharing their stories. One individual brought in his service dog and one brought in his

paintings. They shared their experiences and service needs and why these services are so important to them. This was a successful event. The Department will build on these trainings issues and is interested in hearing from others.

Ms. Reagan then discusses what else is happening as we move forward with Step 2. She states that Ms. Fournier will also be presenting in this section. The Department is working on the contract with Managed Care Organizations. There will be no detail here today but the contract addresses continuity of care services during transition, emphasis on supports home and community based care services, care coordination, significant emphasis on special needs and long term supports and grievances and appeals. There is very robust strategy in development and oversight of quality will be with the EQRO and a report will be generated. The Department will also continue with our stakeholder engagement for LTSS.

We are now moving into the phase of readiness review for mandatory open enrollment, same as the readiness review that was undertaken prior to step 1 in December 2013. We have dates to go to the plans and make sure they are ready. We will be looking at networks, care coordination, member services, and scenarios for readiness, data system and conduct a walk-through.

Ms. Reagan introduces Ms. Deb Fournier who discusses the 1115 (b) waiver to move those that were voluntary opt in to mandatory. The waiver is almost finalized. There is a remaining appendix that is being finalized as we speak. The state has shared the remainder of the draft application with CMS and the Department is trying to front load as much information as possible. Until CMS can see the complete picture we cannot finalize the application without it being complete. A reminder that the application is very narrow in scope and it isn't seeking any other design changes and is not seeking any other authority in the managed care system that doesn't exist today. Its sole purpose is to obtain the legal authority to mandate enrollment. Ms. Fournier opens the meeting up for questions.

Question from public: How long do you think it will take for the actuarial analysis to be complete and once complete, how long will it take to insert it and submit it to CMS?

Ms. Fournier responds that she is not sure but for sure but is optimistic that this work will be finalized within the next 30 days to start the process.

Follow-up question: Assuming it is 30 days that will bring it to the middle of June. Do you anticipate that you will be able to get an answer to start the new program from CMS in two (2) weeks?

Ms. Fournier: We are working with CMS and frontloading as much information as we can. This is pretty straight forward but I can't answer to what their timeline is. We are frontloading to take all of the questions outside of the equation before the final submission.

Commissioner Toumpas adds that we are working closely with CMS like we did with the Premium Assistance waiver so that when we submit the document there are no surprises. The Department is doing everything possible to know what CMS's issues are so that when we submit there will be no surprises. We will be doing things in parallel with the expectation that we will get that approval, however we cannot enroll individual's e into the program until CMS approves the waiver.

Commissioner Don Shumway thanks both Ms. Reagan and Ms. Fournier and asks the question: In Step 2 for network adequacy, will you do a review like you did in Step 1 for the high complex population?

Ms. Reagan responds that much of the network is the same. So we will be looking at that and then there are also some individuals are providers are not connected to an MCO network.

Commissioner Shumway states that not all providers able to serve complex populations and will they be able to serve this population with the same access and quality of care.

Ms. Reagan restates Commissioner Shumway's response. There may be one hundred (100) providers and they could serve X number of people but they may not handle that same number of people due to the complex needs of this population. That is a good question and I will find out.

Commissioner Shumway asks: Has there been a data review of the service categories of the population of those that are coming in as mandatory population?

Ms. Regan: Yes, a data review has been done of the people who are coming into mandatory enrollment. We have received data of those providers that have not currently enrolled and shared that information with the health plans as a first step to have them reach out directly to those providers. It doesn't answer the question regarding the increased complexity of this group but it will be important to discuss this with the providers and let them know that they are the primary care provider for this person and it will be important for us to come to an agreement on a contract to continue the services for that recipient.

Commissioner Shumway asks: Is there a network readiness review after implementation for example after Sept 1, such as nursing facility readiness or for a certain population that has shifted into a less controlled atmosphere of the arrangement for transportation such as for a wheelchair van? This will be an adjustment. Pre authorization for medications is another area for readiness review.

Ms. Reagan: Yes, this readiness plan includes things that will be different. Some systems and putting training, education and processes in place such as transportation, pharmacy needs including step therapy, coordination of benefits, developing trainings and readiness materials to address the complexity of the situation. We are also interested in hearing about any other of these high level areas that we may be missing.

Commissioner Shumway: MCOs have to provide complex care that they have not seen yet and we have not seen it yet. I am not looking for literal answers as much as an understanding of what we may have to prepare for focusing on grievances and make sure we are helpful.

Ms. Reagan: Yes, this is a huge priority for us.

Commissioner Yvonne Gladstone: During Step 1 roll out there were two sets of information provided to us, one was the readiness reviews for the MCOs and a separate section of readiness review for the providers. There was also a third track from consumer/client perspective.

Ms. Reagan: We are using the same format for this readiness review with additions.

Commissioner: This would be good to hear about going forward.

Question from the public: The population of children with special health care needs complex conditions and a lot of those children and their families depend on specialist in the region who specialize and take care of children with these rare conditions. They tend to use Children's Hospital. I wondered about looking at the usage patterns of those children in terms of the specialty centers in New England including Boston's Children's and wondering if they will have access to those specialists?

Ms. Reagan states there is an omission here. The Department has our own readiness. We look at departmental readiness and readiness for MCOs. We have developed a High Touch Readiness approach which we are ready to roll out with individuals we know are accessing specialists. For children with Special Medical Services and individuals receiving waiver services we have developed materials and have a separate plan for those that we feel will need more assistance in selecting a plan. This will be data driven and we will be reaching out to area agencies, case managers, CFI waiver case managers, special medical services and DCYF to provide information to address this population specifically. The question about Children's Hospital is the same as when we rolled out Step 1 and what the health plans are using right now. Evaluating whether resources exist within the network, make the decision of whether or not

care will continue in a network arrangement or whether a family will be asked to transition to an MCO network.

Follow-up response from public: I am concerned about the process of evaluating a pediatric pulmonologist since they are not all the same. These specialists are high quality with the greatest experience with these rare conditions and families need to be able to continue their care with these providers.

Ms. Reagan responds that she cannot talk about the specifics of the contract but there is very strong continuity of care language and the processes in place now will continue. Many children in Step 1 have continued to get services from those providers we have talked about.

Question from the public: How were the five people chosen for the expert panel? Were targeted questions asked of groups of people to use information as data? Were they asked specific questions so this can be used for data?

Ms. Reagan: No, there was no data collected. Ms. Reagan stated that she chose two (2) individuals, Ms. Susan Lombard chose one (1) and another colleague chose the other two (2). This was very successful. We asked if they would like to tell their stories and asked them if they would like the MCOs to understand their needs and priorities.

Response from public: In the North Country our needs are different and a lot of times groups come in Concord and south of Concord and a lot of times what works for those areas doesn't work for North Country.

Ms. Reagan acknowledged this and responds that the individuals were from various areas of the State, including Laconia, but not from up North.

Ms. Reagan states that the issue of transportation was highlighted as one individual didn't have a ride and got a ride for one of the other presenters. She asked him how would he have gotten to Concord to tell his story if he didn't get a ride. He stated that he would not have been able to come because had no transportation.

Ms. Reagan mentions that one of the speakers lived in a nursing home and left on many occasions. She quoted him as saying that he ran away and therefore it was decided that it was time for him to live in the community. He was assisted by Money Follows the Person (MFP) program and is now living in the community.

Question from the public: Families are starting to prepare for Step 2. In the Nashua region there are about 8% of families that may qualify as complex. They have already begun to make list of the physicians they are using and are starting to make calls. If you are looking at a heads up letter and you are looking a list you might want to compare it to the list that various agencies have in their regions. The other item is coordination of benefits and in the last four (4) days we have taken eleven (11) calls that that has been referred to client services. So if there is any information to be able to communicate, it will be helpful.

Ms. Reagan responds: The Department will work with the plans to identify people that will need assistance. To make direct connections with them.

The question was asked about Options counseling for these families.

Ms. Reagan states that the Department has enrollment support and there is also a need for direct connections.

Commissioner Don Shumway asks with pre enrollment will there be personal support? He also states that the heads up needs to be resourceful and sharp.

Ms. Reagan responds that it will be as personal as we can make it. For some, they are already doing this. We are highlighting issues and reaching out. But our capacity to understand each individual situation is limited. We are using Service Link and partners through Balancing Incentive Program (BIP) to reach out. These individual cases can be complex. There could be a need for coordination of benefits though Medicare, Medicaid, private insurance and military insurance, at that point it is so complex it will be important to contact a plan to make the best choice under the circumstances. We have a network of professionals but our capacity to reach out to each individual is limited.

Mr. John Poirier of the NH Health care Association commented on the man that ran away from the nursing home. People who live and work at nursing homes would take offense to this portrayal of the scenario. We as policy makers need to be sensitive how we speak of these situations.

Ms. Reagan apologizes to Mr. Poirier and Commissioner Mary Vallier-Kaplan. thanks Mr. Poirier for speaking up.

Question from the public: We are asking for CMS to approve the waiver for Step 2 and at the same time CMS is putting out new guidelines for MCOs. It seems that the cart is before the horse and it seems like the timetable is a little skewed.

Ms. Fournier responds: The rules are draft rules and out for comment. To the extent that CMS has issued guidance, those regulations are in draft and not even published yet. They will need to have a public comment period. We are doing everything to comply with this in the 1915 (c) waiver. This will take a better part of a year.

Commissioner Mary Vallier-Kaplan thanks Ms. Reagan and Ms. Fournier and asks Lorene to come back

Medicaid Expansion Status Review:

Commissioner Mary Vallier-Kaplan then discusses the revised and updated recommendation that the Commission has reauthorization of the New Hampshire Health Protection Program (NHHPP), which was distributed last night to the Commission.

Commissioner Tom Bunnell reads the letter that the Commission drafted to the Governor to recommend extension of New Hampshire Medicaid Expansion. Commissioner Mary Vallier-Kaplan states that all absent Commissioner sent their support in writing.

Commissioner Shumway states he would like to add the experience of his organization. About 10% of uninsured are now covered and they have seen now that almost everyone is usually showing up with some sort of insurance. This has led to reduction in accounts receivable from 100 days to 70 days. This makes Managed Care as a whole work. The same time we are going through the transition which includes costs associated with systems changes, contacts, etc. this e cash from NHHPP has gotten us through that period. It is important for the health care delivery system. This is the most stunning success that has ever occurred in the State and the Department has ever seen.

Commissioner Tom Bunnell states that enrolling 40, 000 people in the past nine (9) months is incredible and he thanks Commissioner Toumpas and his staff for making it such a success.

**Commissioner Vallier-Kaplan states that the Governor's Commissioner on Medicaid Care Management hereby recommends that Medicaid expansion be continued in New Hampshire due to**

**its positive impact on the health of our citizens, our health care system and our economy. This recommendation will be given to Governor Hassan. Commissioner Vallier-Kaplan asks for a motion to approve it was seconded and approved by the Commission.**

Ms. Kathleen Sgambati asks that once the Governor accepts the proposal, if the commission would send it to decision makers.

Commissioner Mary Vallier-Kaplan states that as soon as the Commission gets approval they will send it out.

Commissioner Mary Vallier Kaplan announces a break for fifteen (15) minutes.

Commissioner Mary Vallier Kaplan opens up after the break to discuss Step 2 priorities and the work the Commission has done between meetings. Commissioner Shumway has developed a process to provide structure to the role of the Commission regarding Step 2 readiness. There was a conference call with the Commissioners on May 6, 2015. Commissioner Shumway's structure outlines the steps of the process. There are four domains which include 1) assure adequate network of providers, 2) provider community based services, 3) establish upfront consumer protections, and 4) assure effective operations and payment systems. The idea is that within the four domains, the Commission will break into groups reviewing the domains and work as a team to incorporate the principles into the domains that have already been identified. The goal is to restate the bullets that have already been identified and instead of disconnected bullets look at the bullets as a whole. How would they be rewritten to be more integrated? Each group should come forward with steps that should be taken and use the commission agendas in the upcoming months for the next year through July 2016 when nursing facilities move into step 2. The Commission will form into groups, restate the domain particularly in reference to the principles, and create a work plan. There are four groups but two issues - data and communications – impact all 4 domains. The Commission needs to look at the data to stand up the program and communicate well to this population, as there is a lot of emotion around this change. Since the conference call on May 6<sup>th</sup>, the Commissioners picked a first and second choice as to what subgroup they wanted to work on. The list of subgroup teams was handed out to the Commissioners at the meeting. Commissioner Vallier-Kaplan comments that she would like to have workgroups conduct virtual meetings in between MCM Commission meetings.

Commissioner Don Shumway stresses that he would like the commissioners to restate the essential questions in the particular area, identify key conversations the Commission should undertake and what agenda items they would like to see, identify what DHHS support is needed and work as a combined group to have a work plan in place for the next six (6) months.

Commissioner Mary Vallier-Kaplan asks the Commissioner's if they have any questions. No questions from the Commission.

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

Question from Mr. Clyde Terry, Independent Living: Mr. Terry states that the information regarding operationalizing Step 2 is important and needs to be shared as soon as possible. This could have a significant impact on organizations that need to support this change. Systems may need to be changed and for personal care attendants it could be a payment and coding issue. Also, for the Provider Community Based Services workgroup, it will be important to include employment services so that people can have a high quality of life.

Commissioner Mary Vallier-Kaplan agrees and responds that the Commission will address these issues.

No other questions from the public. Meeting adjourned.

Next meeting is on June 11<sup>th</sup> at the Merrimack County Nursing Home.

### **Follow-Up Items**

The following items were noted during the May MCMC Meeting:

- Commissioner Vallier-Kaplan would like an update on the pharmacy denials including the more detailed drill down data. Ms. Kathleen Sgambati would like to see grievance data broken out by grievance area
- The Commission would like to know if the providers will be able serve the same number of individuals due to the complexity of their situations. Has the Department identified this as an issue and if so has it been addressed?
- Has there been a data review of the service categories of the population of those that are coming in as mandatory population?