

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

**MINUTES  
July 9, 2015  
Upper Valley Senior Center  
Lebanon, NH**

**Welcome and Introduction**

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 1:35 pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Nicholas Toumpas, Roberta Berner, Thomas Bunnell, Gus Moral, Jo Porter, Yvonne Goldsberry and Susan Fox. Commissioner Doug McNutt and Wendy Gladstone, MD, are not in attendance. Commissioner Vallier-Kaplan thanks Commissioner Berner for arranging for the meeting to take place at the Upper Valley Senior Center and welcomes everyone. Commissioner Vallier-Kaplan states that the meeting has a different structure this month. The Commission subgroups will meet for the last hour of the session. This will be the first time the subgroups are meeting.

Commissioner Vallier-Kaplan states that the materials and the minutes from the meeting will be posted on the Governor's website and the Department's website. She states that the agenda is usually available the Monday before the meeting so that those interested in reviewing it.

Commissioner Vallier-Kaplan references the minutes from the June 11, 2015 meeting. Two changes were identified and corrected. A motion is made to approve the minutes and seconded and the minutes of the May 14, 2015 meeting of the Commission are approved.

Commissioner Vallier-Kaplan then invites the Commissioners and the public to introduce them.

Commissioner Vallier-Kaplan acknowledges the receipt of a letter regarding the community mental health centers and their status under Managed Care that was sent by the New Hampshire Behavioral Health Association.

Commissioner Vallier-Kaplan introduces Commission Nick Toumpas to present the Department of Health and Human Services update.

Commissioner Toumpas introduces Ms. Deborah Scheetz and Ms. Sandy Hunt as new additions to the Department staff and welcomes them as part of the Step 2 team.

**DHHS MCM Update**

Commissioner Toumpas opens by stating that his update is a standard agenda item. The presentation focuses on enrollment updates for Step 1, the Key Program Indicator (KPI) report, and general Q&A from the Commission and the public. The Key indicator report will be kept at a high level. Then there will be a review of Step 2 activities and a Waiver update. The meeting will then be opened up for a Q&A. The Commissioner states that there are follow-up items from the last meeting that he will address first. In terms of answering questions related to the Key Indicator Report, the Commissioner states that Dr. Doris Lotz and Mr. Andrew Chalsma will attend the September meeting to present quality data, specifically HEDIS, CAHPS and the new Medicaid Quality Indicator System website. He also informs the

Commissioner that the SUD key indicator will be included in the newly re-designed Key Indicator Report that is anticipated to be ready in September. Commissioner Toumpas then responds to the request from last month's meeting to break the pharmacy service requests out by behavioral health versus non-behavioral health. He states that there are very few pharmacy appeals and there is no indication of adverse clinical outcomes related to pharmacy claims. The Department will follow and trend this data with the expectation that as providers become more familiar with the individual health plans formularies, denials will decrease. Commissioner Toumpas then responds to the follow-up around who can choose a health plan for a foster child. He states that this response has two parts. For foster children whose parents still retain their legal rights to the child, they are asked to choose the health plan. If parents do not choose a plan, they go through auto enrollment. For foster children whose parents do not have legal rights, DCYF is the legal guardian and chooses the plan. This is done in conjunction with the DCYF worker and the foster parents. The Department chooses a plan with everyone's input. If foster parents are in the process of legally adopting the child, then the nurses will outright ask which plan they would like the child to be in. At the last MCM Commission meeting, Commissioner Jo Porter asked if the Step 2 training and education sessions will be made available to the MCM Commission. Some of these sessions are online at the NHCarePath webpage at: <http://client.millennium-im.com/nhcarepath.org/training.org>

Commissioner Toumpas then responds to the question from last month's meeting regarding nursing home geographic distribution. He states that the Department is working on getting the information on the census of nursing homes by geographic distribution in the state and will have it for the next meeting.

Commissioner Toumpas opens the meeting up for questions.

Question from public: Will Vermont Nursing Homes be included in Step 2?

Response from Commissioner Toumpas; No, Vermont Nursing Homes will not be included.

Commissioner Toumpas continues explaining that the MCM program began on December 1, 2013 and has been underway for 20 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, Step 2 update, Wavier update and MCO contract update. He will then open the meeting up for Q&A regarding these numbers.

### **Monthly Enrollment Update**

As of July 1, 2015, there were 161,224 people enrolled in the MCM program. This is both traditional Medicaid and NHHPP. Overall MCM enrollment grew 1.6%. Unlike prior months growth was in both the NHHPP (3.4%) and standard Medicaid (1.1%). Standard Medicaid increased as a result of a combination of overall enrollment growth and the continued small but steady growth in the percent of members in MCM. The budget has contemplated a decrease and not an increase in enrollment numbers.

The 17,594 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 87,408 members enrolled and New Hampshire Healthy Families has 73,816 members enrolled. Low income pregnant women and children 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.

## **NHHPP Update**

Commissioner Toumpas states that there are 41,404 recipients enrolled in NHHPP as of July 7, 2015, and 20,433 are new to the Department. These are people that were uninsured and now they are enrolled into the program. There are 10,410 new to the NHHPP but have been clients in the past. In the Medically Frail category there are 2,230 in the ABP and 435 of Medically Frail in standard Medicaid. There are 333 enrolled in 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. This number was projected to be much higher but it far less than the estimate of 12,000 people. There are 20,217 enrolled in WellSense Health Plan and 17,853 are enrolled in NHHF. There are 2,753 are in Fee for Service/not yet enrolled in a plan.

Question from Commissioner Tom Bunnell: Has approval been obtained from CMS on the PAP waiver and is there 90 day retroactive coverage included in the waiver?

CMS has approved the waiver and the ninety (90) day retroactive coverage was included in the waiver that was approved. A conditional approval of waiving retroactive coverage was included in the special terms and conditions of the waiver. The approval will be predicated on CMS receiving data that confirms what was told to CMS.

## **Key Indicator Report**

Commissioner Toumpas refers to the Key Performance Indicator (KPI) report released by DHHS, which is part of the overall Medicaid quality program. The Commissioner states that the Department will continue to keep this report updated but there will be changes in the way the report is presented to the MCM Commission. Commissioner Toumpas reviews two slides in the Key Indicator Report. The first refers to the slide on Routine Medical Service Authorization Processing Rate (Figure 4-2). He explains that the dotted red line shows what our standard of service is supposed to be and the blue line indicates where we are on a quarter to quarter basis. He explains that the numbers show that in the last quarter the standard service authorization processing timeframes showed a slight decrease. This is attributable to one MCO who experienced office closures as a result of winter storms in February. This triggers a corrective action plan with the MCO.

Commissioner Toumpas then presents the slide on the Pharmacy Claims Processed in Less than One Second (Figure 3-2). Pharmacy claims are being processed below contract standards for timely processing in 1 second. This is attributable to one MCO. Further data analysis of the MCO's operations has shown 99.8% of May pharmacy claims have been processed within 3 seconds and a small number of claims are skewing the average. We were above the standard and then the standard has changed. A small number of claims are skewing the average. This is being monitored by the MCO and the pharmacist.

Commissioner Vallier-Kaplan states that these are the only two indicators that raise the red flag so we are not looking at all of them.

Commissioner Toumpas states that two variables came up that the Department wanted to point out. The entire report is posted on the website. If it wasn't highlighted here then there was no major change.

Mr. Roland Lamy asks if he can refer back to the New Hampshire Health Protection Program. He states that one of the concerns he has is that providers are not clear that if the patient is under the NHHPP are they covered under the Medicaid benefit package and when they move to marketplace under Premium Assistance Program will they get the commercial insurance benefit package? He asks, because there are services, an example is mental health that is not covered under the traditional commercial benefit

package. So we are not clear whether or not the mix of patients that we have receiving services today will be able to get the same services post conversion.

Commissioner Toumpas responds that it is his belief that we are obligated to provide the benefits by CMS and if it is not offered then we will need to do a wrap around. We will confirm and bring back to the next meeting.

Comment from Commissioner Don Shumway: Recently CMS has released 600 pages of proposed regulations. With these regulations they are trying to improve mental health benefits to show more parity to the other benefits in the Medicaid program. One example is that they are going to cover inpatient psychiatric hospital day. This is an indicator that the marketplace will take on the parity characteristics to improve benefits including SUD. Comments are due at the end of this month and encourage CMS to get even more serious regarding mental health and substance abuse areas. This would provide tremendous benefits to the NH Medicaid program in fact even in covering some days at New Hampshire Hospital and community hospitals. This could be really valuable.

Comment from the Public: What is interesting is that for Adult Day Centers, Wellsense and NHHF are denying, dementia and Alzheimer's claims even though they fall under mental. This is a problem.

Commissioner Shumway notes that Commissioner Norton is documenting this. Commissioner Toumpas also will follow-up.

Commissioner Ken Norton states that he would like to note a couple of things, one is that Ms. Michelle Merritt is here and did a briefing that many advocates signed onto that was submitted to CMS on parity last month. NAMI also did a parity report that came out in April and is available online and has good information and this morning there was a call with the New Hampshire Insurance Commission on parity and a number of advocates including New Futures, and the SUD Provider Association participated in order to be sure that the plans in the marketplace have parity.

Ms. Michelle Merritt has a follow-up on Commissioner Norton's comment: New Hampshire Insurance Department is holding a network adequacy meeting tomorrow July 10<sup>th</sup> from 1-2:30 PM in the Brown building to discuss what the health plans will look like on the private marketplace. If anyone has concerns about the network they should attend. In regards to Commissioner Shumway's comment, New Futures is in the process of drafting secondary comments because there are two sets of proposed rules from CMS regarding parity and mental health and Managed Care. New Futures is drafting a letter and if anyone is interested in signing onto that letter Ms. Merritt states she will be happy to submit it to the Commission.

## **Step 2 Update**

Commissioner Toumpas opens up by reviewing the Step 2 timeline. He states that in June 2011 the SB 147 mandated Managed Care for the Medicaid population. The expectation initially was that all populations would go into Managed Care day one. The Department pushed back and said we needed to do this in a couple of phases. Step 1 of the program includes all State Plan medical services, prescription drug and behavioral health services. Step 2 includes four (4) different phases. The Step 1 was all the medical services, Step 2 involves members that opted out of the program and adding them to the program is Phase 1. Phase 2 is adding services CFI. Phase 3 is nursing facility services and Phase 4 is DD, ABD and In Home Supports (HIS). There was also a Step 3 which was the Medicaid Expansion now known as the New Hampshire Health Protection Program which happened before Step 2. As SB 147 was going through Medicaid Expansion was mandatory but that changed with the Supreme Court ruling giving the states the option. Commissioner walks through the timeline. In June 2011 SB 147 was signed into law. We were supposed to begin the program in July 2012 but did not begin until December 1<sup>st</sup> 2012. In order to add the additional people into the program it requires approval from the Federal Government. The 1915 (b) waiver was submitted on June 18, 2015. The remaining people not in managed care right now are about 10,000 people. The 1915 (b) waiver was resubmitted through informal Request for Additional information to include additional technical information on June 25, 2015. This did not stop the clock with CMS. The Department is in active discussions with CMS. The target date was September 1<sup>st</sup> for enrollment into the program. We will not begin any enrollment until we get approval by CMS on this waiver and the managed care contracts are approved through Governor and Executive Council. The Department received thoughtful feedback on the waiver from several entities and is developing a response. The timeline that was projected to begin enrollment in July with coverage beginning in September is not valid. Because we will not moving forward until we have approval by the Federal government. Education will continue but the Department will stop short of sending out the enrollment packet.

Commissioner Toumpas opens the meeting up to the Commissioners and the audience for questions.

Commissioner Don Shumway asks if the Medicaid enrollees can be assured that they will have the same opportunities to learn about the program as others in the past.

Commissioner Toumpas states that the purpose of the Client and Provider Information Sessions that are going on right now are meant to do that. We spoke to the Governor's Office and it has been made it clear that enrollees will have 60 days to choose instead of 30 days. We will need to do an amendment to the waiver in order to do this. Because we are moving to more time we do not believe CMS will have a problem with this. They will also have 90 days to change plans.

Question from the public: You talk about educational process and how does this work for people who are 80, 90 and 100 years old?

Commissioner Toumpas: This is one reason to extend the timeline. We must work with families, providers and those that can inform people of their choices.

Question from public: Who is monitoring the CFI providers that enroll?

Commissioner Toumpas: The Department is monitoring these providers.

Commissioner Vallier-Kaplan states that she received a letter from a provider having challenges getting credentialed with an MCO. They were referred to the Department for follow-up. This is relative to Step 1.

The 1915 (c) waiver is the Choices for Independence Waiver. The Department is finalizing the draft and is targeting public notice and comment period for some time in August. We will be going through a rigorous public comment period. The 1915 (c) waiver is more of a narrative than the 1915 (b) waiver that

is more of a checklist. We continue to work with CMS and consultants on the waivers. There is a 30 day public comment period and the Department plans to hold public hearings across the state. The target date for CFI is January 1, 2016. This date has not changed like the date of the mandatory population waiting for the 1915 (b) waiver to be approved. The 1915 (c) Waiver will have to be approved by CMS and an amendment to the MCO contract will also have to be approved before the CFI services are moved into care management. The rates for the CFI providers are not in the contract that is currently going forward for approval. This will have to be an amendment.

Commissioner Toumpas opens the meeting up for questions.

Commissioner Mary Vallier-Kaplan asks Commissioner Toumpas if he can remind everyone where the dates for the public hearings will be posted on the Webpage.

Commissioner Toumpas explains they will be on the DHHS webpage under MCM, What's New. We will be doing some active outreach.

Commissioner Toumpas then gives an update on the 1115 Transformation Waiver. He states that the waiver remains pending with CMS. The Department continues to work with CMS on approval of the application, which we hope occurs in the fall. The focus of this Waiver is on mental health and substance abuse, as well as integrated care. It is a demonstration waiver. It is not a waiver that will fund services that are already being funded by the State. This is for demonstration waiver which is an opportunity to innovate change and transform services.

Commissioner Toumpas updates the Commission and the public on MCO contract activities. This is the contract with the Managed Care Organizations. At the June 24<sup>th</sup> meeting of the Governor and Executive Council did a contract extension for a short period of time between DHHS and the two MCOs. The Department did this because the current contract with the MCOs expired on June 30<sup>th</sup>. If we did not do this we would not have a contract in place with the MCOs on July 1<sup>st</sup> and the Department would not be able to pay them. The extension continues the Care Management program as is while the Department and the MCOs continue to negotiate. There are no changes in rates or terms. It only extends the time. The idea is that the Department and the MCOs get a contract in place by the end of July and if agreement is not met by the then, the 120 day period will include phase out of managed care. The Department remains confident that we will have a contract signed by July 31<sup>st</sup>. This requires the Department and the MCOs to agree to a broader amendment which will bring it to June 2017. This is a two (2) year amendment. This introduces terms and conditions for Step 2 Phases 1 and 2. The extension was necessary because the existing contract ended at the end of June and the Commission received a letter from the Behavioral Health Association and the DuPont Group basically indicating that the CMHCs and the MCOs were at an impasse in terms of negotiating agreements. The Department wanted to have time to continue to work with them to get to an agreement to avoid terminating the program. So the next piece of this is the CMHC, the Community Mental Health System not just the centers. There a number of factors that requires the Department to strategically review the Community Mental Health System. A report is done every few years regarding the viability and stability of the Mental Health Center. This report was issued to each individual CMHC. Nancy Kane from Harvard did a report that indicates that certain CMHCs are financially unstable and the system as a whole is not financially strong. The Commissioner acknowledges that a part of that is the Department and the State in terms of what it is that we pay for mental health services. This is one part of it. We also have the Community Mental Health Agreement (CMHA) Independent Reviewer report released in June which indicates that CMHCs are challenged to meet the term of that agreement and there is a number of implications to that. The mental health area demographics are changing. There are more children. Other providers now are in the mental health care market, notably FQHCs. Without mental health services we do not have a viable mental health network.

Commissioner Toumpas then discusses contract amendment next steps. The primary goals of this agreement is to exercise a two year extension option, continue with Step 1 services, bring the voluntary population into managed care subject to the approval of the 1915 (b) waiver, bring the CFI services into MCM and address the impasse between CMHCs and the MCOs. The Department is targeting July 22<sup>nd</sup> to bring the broader amendment to the Governor and Council (G&C) meeting. The intent is to have it tabled to make it open for public review and have G&C act on the amendment at the August 5<sup>th</sup> meeting. The new contract terms would be effective on September 1, 2015.

Commissioner Toumpas opens the meeting to the Commission and then to the public.

Commissioner Mary Vallier-Kaplan explains that the questions should be relative to the contract update. Commissioner Susan Fox asks if the extension that G&C just approved extend the current arrangement between the CMHCs and the MCOs.

Commissioner Toumpas states that it keeps everything the same. There are no changes. The Department stipulates that there will be a 120 day phase down period if agreement is not met. The exception on this is the New Hampshire Health Protection Program. The agreement would stay in place until the end of the calendar year because the Bridge program is required to stay in place until the end of the calendar year. At that point these individuals would transition into the Premium Assistance Program (PAP).

Commissioner Tom Bunnell asks about the terms of the current extension and if agreement is not met between the Department and the MCOs. Will a new agreement have to be drafted and approved by G&C? Would there need to be a new amendment to extend the extension?

Commissioner Toumpas states that the intent is not for us to go back to G&C. The extension will continue. But if there is an impasse then that is a different conversation that we would need to have.

Commissioner Gus Morrell asks if the issues are focused on the mental health centers. Commissioner Toumpas states that no there are other issues. This is the biggest issue but not the only issue.

Commissioner Ken Norton has a question relative to the financial status of the CMHCs relative to the Kane report. It states that there was no improvement since 2008 but it was my understanding that the generally during the past year under managed care that the financial status of the mental health centers has improved. Commissioner Toumpas states that he is speaking from the system standpoint. The Kane report points out challenges in the system. Ms. Kane grouped the ten mental health centers into three tiers, top, middle and bottom. There were four mental health centers that served more than 50% of the population and their financials were favorable. The middle and lower tiers were less so. It is tough to say if there are areas where improvements has been made but the Department is looking at the trend line from 2008 until the end of 2014 and the system is very fragile. Commissioner Toumpas explains that this question should be directed to the CMHCs. He states that he has data but that the question should be directed to Mr. Lamy and again the Department and policy makers bear this burden because of the amount of money that is allocated through the budget.

Follow-up by Commissioner Norton: The viability of the mental health centers is connected to workforce development and the recruitment of psychiatrists. This has to do with rates but when a mental health center loses a psychiatrist they are not able to bill and they have to spend tremendous amounts of money to recruit and that is no fault of their own.

Commissioner Toumpas comments that he agrees because the issue of work force is not just with the mental health centers but also on the Developmental Disability side of things, Home and Community

Based care side, and a number of other areas where there is a challenge. The Department belongs to an organization called NESCO. This is New England States Medicaid Collaborative Organization. Ms. Katherine Powers from Region 1 of the Substance Abuse Mental Health Services Association (SAMSA) met with us last year and one of the themes we discussed was workforce development. There was a session two weeks ago in Vermont and the entire session was on workforce. This meeting focused particularly around mental health and substance abuse. This is a real significant issue and this is a key issue because if the workforce isn't there it is hard to generate revenue. But we must look at the entire system because each mental health center tried to individually recruit we may lose people from one location to another location not adding to the workforce but shifting instead. So the issue you are raising is critical and on my management team we are trying to escalate this. Commissioner Toumpas states that he wants to designate someone from the Department to be the focal point to coordinate all efforts around workforce development. There are things we can do, it will cost money but there are things we can do. I do not think it is an option, I think it is something that we absolutely have to do.

Commissioner Susan Fox references the CMCH System slide and references the fourth bullet down regarding how the mental health environment is changing and how there are other types of providers offering mental health services including the FQHCs. She states that in her mind the core mission of the CMHCs are caring for people with severe and persistent mental illness and that this population is not served in the primary care environment and the FQHCs. She states that it is concerning to her as she looks at this impasse and the letter they received from the Behavioral Health Network which claims that they were asked to take a 30% rate cut. This seems impossible when you think that the mental health centers are already fragile and serving the most needy population. This will not be resolved with other providers coming in. To her the CMHC is there for a very specific purpose. Their coordination is very different than providing therapy or medication management. These services are important but that is a small part of their business. Commissioner Fox agrees that we have to look at what the private, community mental health system looks like going forward but a rate cut is not going to solve the issue.

Commissioner Toumpas states that he will not get into the contract negotiations. It is not the Department's contract to negotiate. It is between the CMHCs and the Health Plans. If they cannot come to an agreement then it becomes the Department's problem and we will need to act.

Commissioner Tom Bunnell asks a question relative to the overall contracting process that went through G&C on June 24<sup>th</sup>. If the Department cannot come to an agreement what would the impact be on client care over that 120 days and beyond and does the Department have the capacity internally given the number of positions the Department has lost over the past year to manage Medicaid once again and what budget implications does this have?

Commissioner Toumpas explains that this is a viable question and that scenario would be extremely difficult. Within 120 days the Department would have to take everything we have done in Care Management and move it back to Fee for Service where we were before. Any of the integration of care, quality measures and all of the positive things we have seen would eventually go away. We would have to look at the resources we let go of when we went into the managed care environment. It is challenging when you look at where we are in the budget process. The Department just received guidance from Administrative Services regarding the continuing resolution with regards to the next 6 months. The Department is working through that with the understanding that any changes we make will have to go to fiscal and G&C. A plan would have to be put together to move dollars around to make this happen. It is on the radar screen but it is not something that I am hoping we have to do.

Commissioner Yvonne Goldsberry asks if the Commissioner can review the timeline for NHHPP.

Commissioner Toumpas states that if this scenario came to pass, the Department would have to phase down managed care for the traditional population. The contract revision that just went to G&C has that NHHPP will continue until the calendar year to allow for an orderly transition into the marketplace.

Commissioner Jo Porter asks Commissioner Toumpas to explain the detail behind the bullet that states the Department will bring CFI services into MCM as it relates to the contract around network adequacy, rate setting and the things that will impact the work of the Commission. What does this contract stipulate for the CFI services knowing that there is still work to be done on the 1915 (c) waiver.

Commissioner Toumpas states that the contract amendment sets the stage to do the first two phases of step 2. One key thing that is not in there is the rates. The Department is continuing to work with the actuary and the budget that was vetoed by the Governor called for a rate increase for CFI services. How this translate into this environment Commissioner Toumpas states he will not get into the detail at this point.

Commissioner Roberta Berner comments that she is thinking ahead in regards to rolling in the CFI services. Does the Department have something similar to the Kane report for CFI providers?

Commissioner Toumpas explains that doing a report on a defined set of entities such as ten (10) community mental health centers, FQHCs, critical and non-critical access hospitals that are in the system is doable. But there are over 200 CFI providers and to do a report on this provider type would be difficult to do. We will keep it in mind but not sure we could do this for all those providers.

Commissioner Don Shumway: Comment to the public. There are two important sets of changes that will affect the senior oriented programs that will be coming up over the next 3-4 weeks. The first being the contract and CFI related terms and the other is the 1915 (c) waiver and it's early August public hearing. It is important for folks to understand the terms and attend the forums and get ready from an organizational point of view. The next 3-4 weeks and the immediate days after are going to be critical to the Senior Care organizations.

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

Question from Mr. Roland Lamy: I appreciate all the hard work the Commission does on behalf of NH's vulnerable citizens. He states that he would like to clarify a couple of points that were made in regards to the mental health system.

Commissioner Vallier-Kaplan asks Mr. Lamy to introduce himself again. He explains that he is the Executive Director of the NH Community Behavioral Health Association.

Mr. Lamy proceeds to reference Commissioner Fox's comment regarding ongoing services in light of the impasse that the mental health centers and the health plans are at. Mr. Lamy explains that it is important to note that the CMHC's have an ongoing relationship with one MCO and we have a second one that is under termination. There was an attempt to notify the mental health centers of lowering rates 25%-30% and given that this decrease would bankrupt the system and eliminate one third of their workforce, the centers responded and voluntarily discontinued working with that MCO and under some circumstances under breach to terminate the contract. State law provides for extension of services for 60 days beyond any termination date. The earliest we would have problems is the end of August. The termination is in effect with one of the MCOs. The second point Mr. Lamy makes is relative to alternative providers. He states that FQHC's and CMHC's have a great relationship and they are partners. They do not provide the same services. The providers by and large in the FQHC's are the CMHC providers. The CMHCs are located at the FQHCs. Mr. Lamy references the comment made by the expert reviewer stating that the CMHCs were challenged to provide services in terms of the settlement. To his knowledge they have not

been asked to provide services with the exception of one instance. Mr. Lamy states that they will review the expert reviewers report and make a formal response. At this point they have not been asked to provide services. The last point that Mr. Lamy makes is that he agrees the system is fragile because about 85% of revenue is based on State and Federal funds. So when there are cuts to these funds it affects the workforce and the financial stability of the system. It is simple to figure out how this happens. The Managed Care program to Commissioner Norton's comment has drastically improved the outcomes of patients and drastically improved the financials of the CMHC system since November. There is a new payment system in place. He states they have changed the conversation regarding how mental health care is delivered. The CMHCs have drastically improved the outcomes and financial payment reform process and the new model improved financial results. Mr. Lamy is hopeful that commitment to payment reform continues but receiving notice of a 30% reduction is a non-starter. This is estimated at 50 million dollar cut over the biennium. He states they are optimistic about trying to resolve the problem and the commitment to payment reform because this is leading to better patient care and better patient outcomes.

Commissioner Gus Morales has a follow-up question. Are you still in negotiation with this entity or are you at the end of the road.

Mr. Lamy states that it is a tough question to answer. They have been conducting negotiations in the commercial world for a long time. Usually when payers and providers are within a narrow window there is an opportunity to solve the problem. The 30% reduction in rates has stalled the conversations and it has been about four (4) weeks since we have had any dialogues. There is only so much money allocated through the data book and it has caused the impasse. The payment reform process is closely tied to the rate or data book that you hear about as part of this program. Minor fluctuations were contemplated but a 30% reduction has flat lined the negotiations at this point.

Commissioner Tom Bunnell asked if the Medicaid Data book that Mr. Lamy referred comes from the Department so can the Department play a role in helping to resolve the dispute.

Commissioner Toumpas states that he will be honest that he will not talk about a contract in a public forum. He states that the Department plays no role in their negotiations. This is not the forum for this discussion. The Data book is actuarially sound and must pass CMS muster. The Commissioner states he will not talk about this in a public forum.

Question from the public: An employee of Silverthorne Adult Day Care thanks the Commission for what they do. She states that it is a tough job. She states that providers also have a tough job. She explains that she loves the idea of taking care of the elderly and they deserve to get the right care at the right time and providers also have the right to get paid for the care they give. She thinks that the elderly in this state need to be thought of more. Sometimes the older people don't have the ability to come out. So on their behalf she wants to say that Managed care needs a lot of work. It is not working well. She states that she will sit down with anyone to go over the transportation issues. For the health plans to say that mental health, Alzheimer's and dementia are not a medical diagnosis in order to deny Adult Day services is sinful in her eyes. This is what is happening to the elders in this state.

Comment from the public: My mother has Alzheimer's and it is impossible for elders to get respite care.

Comment from the public: It would be helpful at these forums for those of us that are not familiar with the terminology to have a list of acronyms. Also want to say that we often come with come with our complaints but we do appreciate all of the work that you do.

Question from the public: When do you propose that the new Medicaid Care Management rules will be incorporated into the new contract and whether or not CMS has to approve the contents of the CMS contract?

Commissioner Toumpas states that CMS must approve our contracts. But these are notice of proposed rules. Currently the Department is doing a gap analysis to see what we already have in place versus the

notice of proposed rules. We have Department staff working on this and analyzing the detail to determine what this means for the State. The Department will also be sending in comments to CMS. These are due on July 27<sup>th</sup>.

Question from the public: Is it going to help if we put pressure on the Governor and our representatives to approve our budget?

Commissioner Toumpas: Again, development of the budget is challenging. We present what it is that we need to the legislature and if they give us less it is our obligation to make sure we let them know what the ramifications of that will be.

Question from Public: Is the amendment going to be for two years? The first two phases are contemplated in the contract but not the third which is due to go live July 2016 so will this be articulated in an additional amendment?

Commissioner Toumpas explains that the contract contemplates the phases and the target dates but before this can be implemented there are two things that need to happen. One is that we need the Federal approval and we need to develop the rate structure and the approach for CFI, Nursing Facility and DD. This is not in any one of the contracts right now. On an annual basis we will need to go back to the Federal Government to get the rates because these are only approved one year at a time. There are three or possibly four amendments that will be done between now and July 30, 2017. One will be before the end of this calendar year for the CFI rates and some other terms and conditions and another one that will be required to move nursing facility services into care management as well as refreshing the rates for the last year of the contract for 2017. The Department will also be required to do something similar when we get into the next three waivers, DD, ABD and In Home Supports that focus on children.

Question from the Public: The speaker states that she is not part of any group. She is someone who is affected by Medicaid. She states that nobody touched upon the medical recipients that are not elderly or others. She states her family has been through three insurance companies since managed care began. Her son was diagnosed at birth with a disorder that has caused him to have many surgeries with many complications. He has been followed at Boston Children's Hospital and she continues that when she called to make an appointment at Boston Children's she was told that the insurance company does not work with that hospital. She explains that the Department needs to consider this other group of people when negotiating with the insurance companies because recipients like her are at stand still because they cannot see their doctors anymore and there is no place to turn.

Commissioner Toumpas asks if her child is enrolled with in one of the Managed Care Organization currently.

The speaker states that her child is in Medicaid but has not opted into a Managed Care company. She has connected with one of the managed care companies but not believes they have not been very well educated. Commissioner Toumpas states the he will give her his card for follow-up.

Comment from the public: People need to talk to their legislators about this situation. There is not enough revenue in this state. The Governor vetoed the budget because it is cutting revenues for this year and the next year after that. We cannot afford that to happen so we have to fight that battle. The other things are more ideological. Some disapprove by way of Obamacare and NHHPP is part of that. And the finance committee does not believe substance abuse treatment works. This is in the House of Representatives. The Senate is better. This is a political fight between parties that New Hampshire is in the middle of.

Commissioner Mary Vallier-Kaplan closes this part of the meeting. She thanks everyone for attending and explains that the Commission is going to break up into two workgroups to work on two of the priority

areas regarding the Commission's planning. The public is welcome to stay and observe the process if you wish. The Commissioners have been sent materials by email prior to this meeting for the subgroup.

Next month's meeting is August 13<sup>th</sup> at the Legislative Office Building in Concord. Commissioner Vallier-Kaplan thanks everyone for attending and in particular Commissioner Roberta Berner for hosting the meeting today.

Meeting adjourned at 3:30PM.

### **Follow-Up Items**

The following items were noted during the July MCMC Meeting:

1. Commissioner Toumpas states that the Department is working on getting the information on the census of nursing homes by geographic distribution in the state and will have it for the next meeting.
2. Commission Toumpas will confirm that the PAP waiver includes the 90 day retroactive coverage
3. Under PAP will recipients receive the commercial insurance benefit package, or the Medicaid benefit package? Commissioner Toumpas responds that it is his belief that are obligated to provide the Medicaid benefits by CMS and if it is not offered by the Commercial plan then we will need to do a wrap around. He stated that he will confirm this and bring back to the next meeting.