

Governor's Commission

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

**MINUTES  
August 13, 2015  
Legislative Office Building  
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 Nicholas Toumpas, Roberta Berner, Thomas Bunnell, Gus Moral, Jo Porter, Yvonne Goldsberry, Susan Fox, Ken Norton and Doug McNutt. Commissioner Don Shumway and Commissioner Wendy Gladstone, MD are on the phone. Commissioner Vallier-Kaplan welcomes all and asks 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 Department's website.

Commissioner Vallier-Kaplan references the minutes from the July 9, 2015 meeting. Commissioner Gus Moral identified one correction and a motion is made to approve the minutes and seconded. The minutes of the July 9, 2015 meeting of the Commission are approved.

Commissioner Vallier-Kaplan acknowledges the receipt of a letter from the New Hampshire Behavioral Health Association. Commissioner Vallier-Kaplan also received an email from the NH Oral Health Coalition in reference to the CMS prioritization of an oral health PIP for managed Medicaid programs. This was passed onto the Commissioner's Office and the Medicaid Director of Dental Services. Commissioner Vallier-Kaplan reported she attended one of the DHHS Step 2 information meetings in Keene in July.

**DHHS MCM Update**

Commissioner Toumpas opens by reviewing the agenda and states that he will follow up on open items from the last meeting. He also explains that the key indicator quality section is not on the agenda this month as the report is being reformatted and will be reviewed at the September meeting. He then reviews the follow-up items from last month's meeting which include the nursing home census, PAP 90 day retroactive coverage and the PAP benefit package. He describes the Alternative Benefit Plan (ABP) and the ten (10) essential health benefits along with the wrap services.

Commissioner Toumpas asks the Commission members if this format is helpful reporting on follow-up items. The Commissioners answer yes.

Question from Clyde Terry, GSI : When you describe the Essential Health Benefits, could you tell us what they are?

Commissioner Toumpas reviews the benefits to include prescription drug, rehabilitative and habilitative services, laboratory services, hospitalization, ambulatory patient services, maternity and newborn care, mental health and substance use disorder services, preventive and wellness services, chronic disease management, emergency services, and pediatric services.

Question from public: Is consumer directed personal care included in these benefits?

Commissioner Toumpas states that he will check on this and will provide follow-up at the next meeting.

Question: Will there be a deductible for PAP participants?

Commissioner Toumpas responds that there will be limited deductibles.

Question from Commissioner Bunnell: Can anyone at any time be directed as medically frail?

Commissioner Toumpas explains that this is self-attestation and that a recipient can attest to being medically frail at any time.

### **Monthly Enrollment Update**

As of August 1, 2015, there were 162,128 individuals enrolled in the MCM program. This is a steady progression up and includes both traditional Medicaid and NHHPP. There are 17,219 enrolled in Medicaid but not enrolled in MCM which 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 88,071 members enrolled and New Hampshire Healthy Families has 74,057 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 41,866 recipients enrolled in NHHPP as of July 31, 2015, and 20,748 are new to the Department. These are people that were uninsured and now they are enrolled into the program. There are 10,574 new to the NHHPP but have been clients in the past. In the Medically Frail category there are 2,262 in the ABP and 421 of Medically Frail in standard Medicaid. There are 310 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 20,448 enrolled in WellSense Health Plan and 17,973 are enrolled in NHHF. There are 2,852 are in Fee for Service/not yet enrolled in a plan. Distribution by county reveals that the northern part of the state has the highest number of enrollees. A map by county is posted on the Departments website.

A Commissioner Bunnell comment that it appears that enrollment in NHHPP has slowed down and wonders why.

Commissioner Toumpas responds that the number of uninsured has come down dramatically but there are still about 5,000 individuals that remain uninsured because they have made the decision not to enroll. These individuals are still receiving services at the Community Health Centers. If they enroll the number in NHHPP could go over 50,000. Enrollment is not required to receive services at a Community Health Center.

Commissioner Bunnell asks a follow-up question: Could it be that the individuals that are eligible but not enrolled are harder to reach and that is why they have not enrolled?

Commissioner Toumpas states that this is not his take on it. You cannot make someone enroll. But there will be follow-up on this issue.

Commissioner Gus Moral asks if this is also the situation with HIPP?

Commissioner Toumpas responds no, that the low numbers of individuals enrolled in the HIPP program are related to individuals not having cost effective coverage from their employer.

### **MCO Contract Update**

Commissioner Toumpas gives an update on the MCO contract. The Department provided a contract to Governor and Council (G&C) on July 24<sup>th</sup> and asked G&C to table this until the August 4<sup>th</sup> meeting allowing for public review. G&C approved a two (2) year amendment to MCM program. This extends the terms through July 30, 2017. This requires mandatory participation for populations that can opt out now to enroll. This is phase 1 of Step 2 with a target date of September 1, 2015. It also includes the CFI waiver services effective January 1, 2016 contingent upon CMS approval which is phase 2 of Step 2. The contract also establishes a date for inclusion of nursing home services, effective July 1, 2016 which is phase 3 of Step 2. Dates to include Developmental Disability (DD), Acquired Brain Disorder (ABD) and In Home Supports (IHS) into MCM have not been established yet. The 1915 (b) waiver was approved yesterday with an effective date of September 1, 2015. However, the Department is working with three different groups on readiness. These include the two MCOs, key providers to make sure they understand the components of the program and the Department's readiness. We are in the process of doing this now which is a significant amount of work. The Department will send out enrollment notices to approximately 10,000 individuals and they will have 60 days to choose a plan. The issue of most concern has been around mental health. Because the MCOs and the CMHCs could not come to agreement, the CMHC's will be in a managed FFS model. The Department will pay a per member per month to the MCOs and they will be responsible for coordination of physical and mental health services. The CMHCs will be reimbursed at the NH Medicaid fee schedule rate. This allows the whole person approach to be maintained. This is not a long term solution. The Department is trying to work on an MOU with the MCOs and we will continue to work on folding these services back into care management. The Department wants to restart the discussion and have an effective date. G&C wants to check in with the Department by November 1, 2015 and we will provide that update.

Commissioner Moral asks how the transition will occur with at the services and the medications that are provided now that are unlimited? He also asked about the prescription drug formularies and that he heard that the MCOs will be able to use their own formularies.

Commissioner Toumpas responds that there is a six (6) month continuity of care provision. Once that occurs, it will be turned over to the MCOs. So whatever someone had prior to cutting over will be maintained for 6 months

Question from Commissioner Tom Bunnell: What is the process and timeline for approval from CMS on the contracts?

Commissioner Toumpas explains that CMS is reviewing the contracts now and if they have questions they will come back to us. This is standard practice so there is nothing out of the ordinary that is occurring right now with CMS.

Commissioner Bunnell asks a follow-up question regarding whether or not there is any formal process for the public to have input on the contract?

Commissioner Toumpas responds that there is not any formal process because CMS will only come back to the Department if there is something that is out of compliance with what CMS wants. We will not go back and change the contract now. There are a number of amendments that need to take place in the future where changes could be made.

Commissioner Bunnell asks when the contracts are effective.

Commissioner Toumpas states they are effective September 1, 2015.

Commissioner Bunnell asks if the contracts will be published once they are approved.

Commissioner Toumpas explains there will be notification.

Commissioner Yvonne Goldsberry does not understand the payment process for the CMHCs.

Commissioner Toumpas explains that prior to November 1, 2014 we were in a FFS environment with the MCOs. One plan has been effective since November 1, 2014 to present day. They are on a capitated arrangement which was negotiated between the MCO and the CMHCs. The other MCO used the same model and was effective as of April 2015. They have a similar capitated arrangement. We are paying the MCOs a capitated amount that includes care management and care coordination and the capitated amount for all the services that are provided in Step 1. This includes the behavioral health services that are Medicaid. In order to maintain that whole person orientation and have somebody looking and coordinating the care of everyone, we took that amount and peeled off the amount that would be around the care management coordination, as well as processing the claims. So we will pay the MCOs that amount and not include any of the service dollars associated with the services provided by the CMHCs. The CMHCs will continue to invoice the MCOs for that and give that to us. So now the MCOs have the encounter data in real time for what is being done and then the Department will reimburse the CMHCs for the services that are provided. This is not long term strategy and is an interim solution. We had a number of challenges. The Department needed to have a contract with the MCOs by July 31, 2015. If we did not have a meeting of the minds then the Department had a 90 day period to phase out the program. We would have had to take everything that we have done over the past 21 months and roll it back to a complete FFS program. With the exception of the Bridge program that would have continued to the end of the year. We believe that this would have caused chaos for clients, providers, advocates and everyone. CMS would not have given approval without having the ability to have the CMHCs in the network. There was a question as to why the Department could not extend the amendment until November 1<sup>st</sup>. Because the rates certified by CMS are until November 1<sup>st</sup> this would not have worked. We would have been required to go back to CMS to submit the rates again. This is complex but we needed to come up with a way to move the program forward while still staying true to the whole person orientation.

Commissioner Ken Norton congratulates the Department and the MCOs on negotiating a contract. Commissioner Toumpas thanks Commissioner Norton on behalf of the Department and states that it is something needed to move forward.

Commissioner Norton asks if there is a dollar value to the contract.

Commissioner Toumpas explains that the Department did not cut money or services. The rate was negotiated between the MCOs and the CMHCs. When the health plans reviewed the data they stated they could not sustain the current situation. The Department is not part of these negotiations.

Question: When does the FFS model start with the CMHCs? Commissioner Toumpas responds that he is not sure because there needs to be a conversation with the MCOs and the CMHCs.

Commissioner Norton references the MCM Commission meeting last month in Lebanon. He refers to the Kane Report that indicates that certain CMHCs are financially unstable and the system as a whole is not financially strong. The proposed FFS model is tied to the 2012-2013 rates not the 2008 rates and the fragility of the mental health centers is not tied to the 2012-2013 rates.

Commissioner Toumpas expresses his continued concern regarding the fragility of the system and that although there has been an improvement in the stability of the centers, it is not sustainable.

Commissioner Norton states that he does not understand what the incentive is of the MCOs to go back to FFS. Commissioner Toumpas tables the discussion.

Commissioner Yvonne Goldsberry remarks that as more utilization information is shared, there will be a better sense of where the dollars are going.

Commissioner Norton comments that he is encouraged that the Department is looking at how the MCM interacts with the mental health settlement.

The expectation is that the CMHCs are the focal point to build capacity and infrastructure for a more robust level of services once the capabilities are in place. The Department must work with mental health centers to make sure the agreement is being met. The Department has more control with the interim step of paying FFS.

Commissioner Norton asks if there would be more quality indicators regarding mental health centers. Commissioner Toumpas responds, yes that there are more indicators being added.

Commissioner Bunnell is concerned that that the contract provision to use the MCOs own PDL has tripped up some early concerns. He suggested that this issue be on the Commission's agenda at an upcoming meeting.

Commissioner Ken Norton responds that the CMHCs will not come under the PDL.

Commissioner Mary Vallier-Kaplan references the proposed CMS Managed Care rules and asks if they will be a problem for our contract because CMS may be using them before they are adopted.

Commissioner Toumpas responds that there is an expectation but it would be highly unlikely for CMS to use this standard. The Department is in the process of doing a gap analysis between what we currently have in place and what is proposed. The Department will be happy to share that analysis. There was a comment that moving to FFS would be a step backwards. The move to a capitated rate has been positive. Payment reform was a thoughtful process and there is disappointment that we do not have time to get the bugs out. Moving back to FFS will impact patient care. Hopefully in September more information will be shared.

Question from Clyde Terry, GSIL: We would like to help our consumers with mandatory enrollment. When can we make this help available?

Commissioner Toumpas responds that the Department will not move forward without the three readiness review points.

Ms. Kathleen Sgambati asks what the timeframe is for the readiness review.

Commissioner Toumpas states that it will be done quickly there is not timeline set. He stated it will not be done before September 1<sup>st</sup>.

Question: If the date for mandatory enrollment is pushed off, will everything else be pushed off?

Commissioner Toumpas responds not necessarily.

## **Waiver**

## **Update**

The 1115 Transformation waiver remains with CMS. The Department is optimistic that there will be something in place by fall. This decision lies with the Secretary of Health and Human Services because it is an 1115 waiver.

Commissioner Toumpas updates the Commission on the 1915 (b) waiver and that it was approved on August 12<sup>th</sup> with an effective date of September 1<sup>st</sup>. As discussed earlier, this will not move forward until readiness is met. The 1915 (c) waiver is still in draft form and being finalized. The Department is continuing to get technical assistance from CMS and CMS consultants. There will be a required 30 day public notice and comment period and multiple hearings.

Commissioner Doug McNutt comments that the CFI waiver is being brought into Step 2 before Nursing Facility (NF). If the timelines are pushed back the hope is that the CFI and NF waivers would come into line at the same time.

Commissioner Toumpas responds that it depends on readiness and our readiness depends on the perception of the client.

Commissioner Mary Vallier-Kaplan asks if there are any conditions attached to the 1915 (b) waiver and could the waiver be posted?

There are no conditions to the waiver and it will be posted on the Department's website.

Review of Commission Step 2 Work plans:

Commissioner Mary Vallier-Kaplan opens the meeting after the break and explains the Commission met after the Lebanon meeting and broke into two workgroups. The one question that has surfaced is that now that the waiver has passed and we know we are moving forward with Step 2, Phase 1, does that make a difference with the priorities of the Commission. The two areas of focus currently are consumer protection and effective operations and payment systems.

Commissioner Gus Moral thanks Commissioner Toumpas for commenting in the letter to CMS about consumer protections. He reviews the recommended priority issues the workgroup developed during the July 9, 2015 meeting. These include:

- Accessible and understandable information for clients rights and responsibilities
- User friendly problem solving system.

Desired Outcomes

1. Establish a process whereby:
  - a. Information , in addition to being easily accessible and widely distributed by a variety of means
  - b. Is understandable and educational
  - c. Above items, a and b, are measurable
  - d. Above items become part of the existing reporting system

2. A problem resolution system that establishes
  - a. Adequate training in problem resolution for managed care employees
  - b. The ways in which a complaint can be registered and resolved and the means to do so are clearly communicated to and understood by patients.
  - c. A process whereby all complaints are recorded and are measurable
  - d. A process that leads to prevention, a decrease in that area of complaint, and an increase in patient satisfaction
  - e. A process that included a conflict-free Ombudsman

Kathleen Sgambati asks if people recalled the meeting where the DRC said how low the grievance rate is. The families said it was their lack of time and effort to complete the process so the group focused on simplifying the process.

Commissioner Mary Vallier-Kaplan asks the other Commissioners if they have any thoughts around this?

Commissioner Vallier-Kaplan states the one objective of this workgroup is to determine if one priority is more important than the other and will this rise to making a recommendation to the Governor.

Commissioner Moral states the conflict free Ombudsman which was referenced in Commissioner Toumpas's letter is a key element.

Commissioner Vallier-Kaplan asks if there are lessons learned from Step 1? Consumer protection is an important element to have up front.

Commissioner Moral will provide the handout of these priorities from the Consumer Protection work group.

Commissioner Yvonne Goldsberry gives a summary of the work that the Effective Operations and Payment Systems workgroup completed at the July 9<sup>th</sup> meeting. She states that there was list of issues that were placed in nine buckets that were identified for Step 2. They looked at whether they alligned with the principles and lumped these into three categories. These areas include:

1. Streamline Prior Authorization
  - a. Increase efficiency; improve timeliness and access to necessary health services and prescription medications.
2. Strengthening MCO standards and reporting requirements
  - a. Clear and standardized definitions for service models and the associated reporting requirements can support the development of a strong integrated health delivery system. The workgroup views this as an opportunity to increase efficiencies and support a successful launch of Step II.
3. Payment Systems should support goals and essential elements of the program, including home and community based care.

Commissioner Goldsberry states that these are the three highest priorities and it is premature to determine which one is the top priority.

Commissioner Vallier-Kaplan opens the meeting up for questions.

There are no questions.

Commissioner Vallier-Kaplan states that the two groups will continue to meet.

### **Long Term Supports**

Commissioner Susan Fox gives an introduction on CFI. She states that it is very timely to work in LTSS because CFI is the first program to transition into Care Management. The 1915( c) waiver will be submitted soon. CFI begins at age 18 years. Individuals must be clinically and financially eligible. Individuals must be eligible for nursing facility care. This program serves a lot of individuals 18 and over that can live at home. Most of the funding match comes from the County with a wide range of services. Many providers are both State Plan and CFI providers. Some of these are large but most of these are small Mom and Pop operations. Many individuals receive services from both SPA and CFI Waiver. This is good timing to be discussing this in order to set the stage for the next several months.

Commissioner Vallier-Kaplan opens up the meeting for questions.

There are no questions

### **Nursing Facility Principles**

John Poirier, Executive Director of the NH Health Care Association presents a map of the Nursing Homes in New Hampshire by County. Included in the handout is a spreadsheet with the name of the nursing home, the city, member type and bed count. There are currently 4,400 Medicaid residents in nursing facilities in NH. This number has steadily been declining. Of the 4,400 approximately 30% of these individuals are in county facilities. Of that 30%, 80% of the beds are filled. The other 70% are in private nursing facilities and of that 56% are Medicaid.

The NH Health Care Association and NH Association of Counties continue their presentation from the June 11<sup>th</sup> meeting to discuss the important principles of LTCSS in Step 2.

#### **Principles to Govern LTC Managed Care**

- Quality of care is paramount. The transition to MMC should not directly or inadvertently impair the quality of care or quality of life experienced by long term care recipients and nursing home residents.
- DHHS should continue to be the rate setter for facility based care for at least the first year. If rate is negotiated with the MCOs, then it needs to transition over at least 4 years for stability o providers.
- Any rebalancing of the care delivery system should not be funded at the further expense of nursing homes.
- The NF's must understand the difference between the MCOs.
- Individuals should not be moved out of facilities if they do not want to.
- For all major functions, appeals, etc. there should be standardized processes between MCOs.
- Previously approved capital cost that have been included in reimbursement rates should continue to be recognized and compensated in any revised reimbursement formula, and the system should recognize the need for further capital improvement to aging facilities and continue to provide an atypical rate for special populations.
- The reimbursement formulas applied to any class of LTC services should be neutral to type or form of ownership. No form of ownership should be advantaged or disadvantaged by state policy. There is an understanding that all payments need to be rolled into one rate under managed care. However, pro-share and MQIP need to be included.

The LTC provider community, private and county is willing to partner with DHHS and MCOs to develop a workable plan however, it was stated that managed care is not perceived as a value added service for their residents. What is the benefit for the resident and what are the additional burdens? The perception is that the additional burden is added steps which take time from them.

In the midst of all of this CMS has sent out a 400 page proposed rule increasing the standards for LTC providers. The NFs will have to see how this rule intersects with the Department's changes.

The Commission was thanked for their time.

Commissioner Vallier-Kaplan opened the meeting up for questions.

Question: On the Nursing Home by County, Northwest to Southwest document handout, what are the definitions of the categories, County-based facility, not-for-profit, private, and non-CMS?

Response: Private is for profit, not for profit is a 501 (c ) (3), County is county based, and a non- CMS are facilities that do not accept funding from public payers.

Commissioner Tom Bunnell thanked Mr. Poirier for providing the bed count, occupancy numbers.

Comment by Commissioner Berner: The County is a large source of funding for the nursing facilities but as a whole it does not cover the full cost of care. The Medicaid funding varies by county. This information could be provided to the Commission.

Commissioner Toumpas states that there is a work group with the Counties and the Department that currently meets that encompasses more than just financing. But The Department cannot look at financing until we look at the entire process. The Department is currently leading a Lean project to map out the process. There is an approach with options. The Department will attend the annual meeting in November with the Counties to present the option.

Commissioner Susan Fox responds that this Lean project is important and she would like to be updated on the process.

Commissioner Toumpas: At least for the first year the Department will set the rates and then once the rate is set for per diem there will only be blended rate. This new rate will require a rule change, and statute change.

Commissioner Doug McNutt : The NF rates are complex but there are also three lines for CFI. Will there be a capitated rate to the MCOs that they will negotiate?

Commissioner Toumpas states that the Department is working through this right now.

Commissioner Mary Vallier-Kaplan asks if there are any more questions.

There are no further questions and.

Commissioner Vallier-Kaplan thanks all for attending

Next month's meeting is September 10<sup>th</sup> at the Legislative Office Building in Concord. Commissioner Meeting adjourned at 4:00PM.

## **Follow-Up Items**

The following items were noted during the August MCMC Meeting:

Question: Is consumer directed personal care part included in these essential benefits?

1. Presentation and discussion about new contract's allowance for MCO's to use their own prescription drug formulary.