

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

MINUTES

September 4, 2014

1:00 – 4:00pm

**Granite State Independent Living
21 Chenell Drive, Concord, NH 228-9680**

Welcome and Introductions

The meeting was called to order by Commissioner Mary Vallier-Kaplan, Chair, at 1:05pm. Present in addition to Commissioner Vallier-Kaplan were Commissioners Nicholas Toumpas, Roberta Berner, Doug McNutt, Tom Bunnell, Gustavo Moral, Wendy Gladstone, Jo Porter, and Susan Fox. Also in attendance were Kathy Sgambati and Brittany Weaver from the Office of the Governor.

Absent: Commissioners Donald Shumway, Yvonne Goldsberry, and Ken Norton

Commissioner Vallier-Kaplan welcomed everyone and thanked Granite State Independent Living (GSIL) for hosting the meeting. The Commission acknowledged and publically thanked Katja Fox from the Department of Health and Human Services (DHHS) for her work and support as liaison during the formative years of the Commission. Marilee Nihan, Deputy Commissioner of DHHS, will assume this role.

Commissioner Vallier-Kaplan explained how the agenda is structured for DHHS to provide a general update on the MCM program, provide updates since the last meeting, and respond to key issues that have been raised in person or via mail/email. The second half will consist of a panel of Step 1 providers to discuss their experiences, reflections, and lessons learned from the launch of MCM. A public listening session will be held at the end of the meeting. Commissioner Vallier-Kaplan reminded the public that individual, personal issues related to MCM should first be presented to the individual's MCO and then to DHHS. The Commission is tasked with listening to primarily systemic issues; therefore, this process is what will occur if individual issues are raised directly to the Commission.

Commissioner Vallier-Kaplan invited the Commissioners and the public to introduce themselves, and asked for those within the public who are representing others, e.g. consultants or attorneys, to identify who they are representing.

Minutes of the August 7, 2014 Meeting

There are no corrections to the minutes of the August 7, 2014 meeting. Upon a motion duly made and seconded, the minutes of the August 7, 2014 meeting of the Commission are approved.

Previous MCM Commission minutes, handouts, and recommendations are posted on the website for DHHS and the Governor's Office if one is interested in more details.

DHHS MCM Update

Commissioner Vallier-Kaplan introduced Commissioner Toumpas for an update on MCM implementation. Commissioner Toumpas introduced a presentation that will be updated and refined each

month to provide a standard MCM update. Slides of today's presentation are posted on the DHHS website. Today's presentation will contain a monthly enrollment update, a review of the key indicator report that is posted on the Commission's website, and a review of key operational issues that DHHS is monitoring.

Commissioner Toumpas explained how the MCM program has been underway since December 2013 and underscored the principles of the program, including whole person management and care coordination, increasing the quality of care, payment reform opportunities, budget predictability, and purchasing for results and delivery system integrated. These principles are essential to achieving better health and better outcomes. Leading up to the launch of MCM, Medicaid enrollments were tapering off. DHHS saw a total enrollment increase of 11,000 between January and May 2014 as a result of new modified adjusted gross income (MAGI) rules. The new enrollees consist primarily of children, parent caregivers, and pregnant women. Medicaid caseload growth has since stabilized. On July 1, 2014, DHHS began determining eligibility for the New Hampshire Health Protection Program (NHHPP). These individuals were enrolled in fee-for-service Medicaid beginning August 15, 2014 and will transition into managed care organizations (MCOs) beginning September 1, 2014. To date, DHHS has enrolled 13,000 individuals in the NHHPP. The projections for this program are approximately 50,000 enrolled over a 7 year period with approximately 30,000 enrolled in the first two years. It is important to recognize that individuals have up to 60 days to select an MCO; therefore, the MCO enrollment numbers for the NHHPP population represent those who remain in fee for service Medicaid while they make a plan selection.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on MCM enrollment numbers. None recorded.

Commissioner Toumpas reviewed the Key Performance Indicator Report released by DHHS, which is part of the overall Medicaid quality program. The quality perspectives are based upon health care services, consumer experience, and business operations. This report will continue to be updated. A website dedicated to quality within the Medicaid program that can be queried will be available in the late Fall. The Key Performance Indicators Report is a tool that DHHS uses to monitor program performance. During the last MCMC, meeting a user guide was discussed. This information has been integrated into the report itself. For each measure collected, the user guide describes what this measure means and why it matters. The metrics in the report include:

1. Access & Use of Care
2. Customer Experience of Care
3. Provider Service Experience
4. Utilization Management
5. Grievance & Appeals
6. Preventative Care
7. Chronic Medical Care
8. Behavioral Health Care
9. Substance Use Disorder Care
10. General

Commissioner Toumpas reviewed each domain and its associated notable results. Of note, within access and use of care, 21% of transportation requests were not approved or delivered. DHHS is reviewing this metric on an individual MCO basis. Also, over half of emergency department (ED) visits per 1,000 members were potentially treatable in a primary care setting. This is not the intent of the program; therefore, DHHS is working closely with the MCOs to determine why this is occurring. In addition, pharmacy claims are not being paid as quickly as the contract standard requires; therefore, this is being closely monitored. Call center hold times are trending upward this summer due to the Meridian Health Plan transition and enrolling members into the other two MCOs. The overall number of grievances is

increasing over time, and 57% of the grievances in the first quarter were related to transportation. Members discharged from New Hampshire Hospital (NHH) are not meeting the standard for receiving a follow-up visit within 7 days. This is a significant performance and quality metric to be improved. Overall, the data represents things that have been raised by the public to date.

Commissioner Gladstone noted a high number of patients seeing pediatricians under MCM, and asked if this is because children enrolled in Medicaid are more or less likely to see a family practitioner. Commissioner Toumpas noted that this report represents one quarter worth of data from the beginning of program. This represents the transition of the existing Medicaid population into an MCO. Therefore, DHHS suspects that a number of things were occurring during this transition to skew the data. Commissioner Gladstone expressed concern about pediatric facilities that will not take more Medicaid members and instead direct members to community health centers. She also expressed concern about the use of the emergency departments (ED) and calls being properly managed. Most primary care offices have nurses who answer phones after hours and typically direct patients to the ED. DHHS should look further into the data to determine if these patients visiting the ED are being directed there or going themselves.

Commissioner Porter noted how the report references where the benchmark being used is the contract standard and asked if there is a fee-for-service (FFS) benchmark that could be used instead. An example is ED use. DHHS could benchmark based upon the average ED use over the last year of FFS Medicaid, if possible.

Commissioner Vallier-Kaplan noted that it will be important to disseminate this information broadly. For example, those that oversee the quality program at the Community Mental Health Centers (CMHCs) could benefit from this information. Commissioner Toumpas agreed and explained how this system is in place to share data and look for patterns in an automated way. While this is a handful of indicators, as the program moves forward additional indicators will be added, as will new ways to analyze the data.

Commissioner Toumpas provided an update on current key issues. DHHS reviewed whether each MCO has been applying the medical necessity standard appropriately. DHHS requested ad hoc data to scope the nature of this issue. MCO "A" provided data from April to July and indicated that 9% or 97 out of 1,112 of service authorizations have been denied. The MCO indicated that 50 of 97 denials were because the authorization came in after the service had already been provided. About 35 others were denied because the medical necessity standard was not applied properly; therefore, DHHS and the MCO went back and corrected these denials. DHHS recognized this as an issue to ensure appropriate guidance was given to MCOs for habilitative or rehabilitative services. Data from MCO A represents all of their service authorizations, not just for children. MCO "B" provided data from December to July, but only for children. Roughly 6.5% or 106 out of 1,633 of MCO "B" service authorizations were denied. Interestingly, a significant amount of these denials were from one provider. DHHS and the MCO went back to that provider and to ensure that they were providing the appropriate information.

Commissioner Toumpas explained how DHHS reviewed RSA171-A and consulted with the Attorney General's office on the statute. DHHS did not seek a formal opinion from AGs office, but reviewed its interpretation of the statute in a meeting. The AGs office approved of DHHS' observations. The statute provides DHHS with the ability to apply utilization management techniques for these State Plan therapy services in Step 1 of MCM. Commissioner Toumpas also noted the focus area of pharmacy authorizations. DHHS is requesting data from both MCOs and is currently analyzing over 8,000 rows of data. DHHS is reviewing this data to ensure appropriate fidelity to the State and MCOs preferred drug lists (PDLs). Also, DHHS is monitoring crossover claims payments due to providers from Meridian Health Plan since the MCO transitioned out of the market. Detailed information about this transition has already been shared. The transition was successful and fairly seamless for members, but monitoring will continue.

DHHS NHHPP Update

Commissioner Toumpas provided an update on the implementation of the NHHPP. Enrollment in the program began on July 1, 2014. HIPP cost effectiveness began on August 1, 2014. Coverage under FFS Medicaid began on August 15, 2014 and subsequent MCM coverage began on September 1, 2014. DHHS holds a daily conference call with management staff on this implementation, including on the Labor Day holiday. DHHS also conducted readiness reviews with both MCOs on August 13-15, 2014 and found no readiness concerns. This is a complex program for providers, therefore DHHS has been hosting provider forums regarding the NHHPP throughout the State and they have been very well received. In addition, the NHHPP fee schedule has been posted to the Xerox website and communications to potentially eligible individuals is ongoing, with approximately 38,000 letters sent in the past week.

The Premium Assistance Program is the third phase of the NHHPP. DHHS has a target submission date for the Premium Assistance 1115 Waiver of December 1, 2014, per SB 413 requirements. It is essential that DHHS receives CMS waiver approval by March 1, 2015. The transition of this population from an MCO to a qualified health plan (QHP) on the marketplace is targeted for January 1, 2016.

Unrelated to the Premium Assistance 1115 Waiver, DHHS submitted its Building Capacity for Transformation 1115 Waiver application to CMS at end of May 2014. Since that time, DHHS continues to have discussion with CMS on the transformations and initiatives included in the application.

Commissioner McNutt Doug asked how the decision making process works for determining the medically frail population identified within the NHHPP. Commissioner Toumpas explained this is a self-declaration and how DHHS maintains a set of questions that are asked if someone declares they have a certain number of issues categorizing them as medically frail. Lorene Reagan of DHHS will describe this further during the next section of the meeting.

Commissioner Tom Bunnell asked about the HIPP cost effectiveness program within the NHHPP. There were 601 of the 13,000 individuals enrolled identified as potentially HIPP eligible. How is this number relative to what was anticipated? Commissioner Toumpas explained that this number is lower. The first segment of the population that signed up was on the lower end of the economic spectrum; therefore, DHHS expects the HIPP numbers to increase. DHHS will report out on these enrollment numbers each month so that the Commission can monitor these types of changes.

Commissioner Fox asked a clarifying questions about the two 1115 waivers discussed. Does either of these waivers address the mandatory enrollment scoped as Phase I of Step 2 and targeted for January 1, 2015? Commissioner Toumpas explained that none of these 1115 waivers are related to Step 2 of MCM. There will be another waiver developed at part of Step 2, which may be an 1115 waiver or a 1915(b) waiver. DHHS is currently exploring the potential options to requiring mandatory enrollment into MCM.

Commissioner Vallier-Kaplan congratulated DHHS for its successful launch of the NHHPP on August 15, 2014 and recognized how much additional work this program required of DHHS on top of its daily operations.

Public Comments and Questions on MCM Implementation Update by DHHS

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions.

Cathy Spinney; parent and advocate: The update on RSA 171-A and steps taken were not clear. Commissioner Toumpas explained how DHHS reviewed the statute, formulated a position, explained its opinion to the AGs office, and AGs office agreed with the opinion. DHHS and the AGs office reviewed issues regarding utilization management techniques and the applicability of the statute to these services. DHHS' review focused only on Step 1 State Plan services, and not on Step 2 MCM services. The statute provides DHHS with the ability to do utilization. This is an opinion of DHHS sanctioned by the AGs office. DHHS is willing to speak to anyone individually about this interpretation of the statute if they contact DHHS directly.

Parent & Advocate, ABLE NH – Thank you for presenting the quality indicators. I am wondering about person centered management as we are hearing a lot about the whole person approach. How will the whole person approach be measured in terms of quality indicators, e.g. medical, psychosocial, support, spiritual, etc? Particularly, how will this be measured in Step 2? Commissioner Toumpas answered both portions of the question. First, there are over 170 pages of quality indicators on the DHHS website for the current program. For Step 2, DHHS will be developing additional quality measures, especially to measure the developmentally disabled (DD) population. MCM is just a building block for the whole person approach to DHHS is implementing. Health care needs are one piece of assessing an individual. You also need to consider their social determinants, e.g. housing, transportation, socialization, community, etc. All of these social determinants are part of a related effort that DHHS is executing that relates to MCM. This is a great observation; we need to be able to provide the linkage to these social factors in the overall care plan and it is the long term goal of DHHS to do so.

Chris Dornin, writer for The New Hampshire Challenge, Inc, asked if DHHS can track whether the MCOs are “cherry-picking” the least expensive patients. Commissioner Toumpas explained how it is up to the individual to choose which MCO they enroll in. MCOs are not picking individuals, but rather individuals have the choice. Therefore it is not possible for the MCOs to “cherry pick”.

DHHS MCM Step 2 Stakeholder Meetings Update

Commissioner Vallier-Kaplan introduced Lorene Reagan, DHHS, to provide an update on the ongoing Step 2 stakeholder forums. To remind or inform those who haven't attended, the 120-day stakeholder input process period began on July 15, 2014 and will end on November 15, 2014. The first half of the time period is being used to solicit input on Step 2 planning for Phase I, Phase II, and Phase III of the program. DHHS has reached out to over 200 people to date via 8 BEAS forums to solicit input on CFI waiver services integration, nursing facility services integration, and the mandatory enrollment process. Also on the DD side, DHHS has engaged over 200 individuals in 8 BDS forums. BDS has 8 additional forums scheduled before the end of September. During the forums, the following three questions are being asked and discussed:

1. What works for you now in terms of how your Medicaid services are provided and what should be continued?
2. What are the “lessons learned” during Step1 implementation that we should consider for Step 2 planning and implementation?
3. What do you think should be included in a Step 2 Quality Strategy? What are the most important things that should be measured to make sure that the MCM Program is working well?

Lorene Reagan explained how DHHS is hearing how the DD population likes the structure of the area agency system and it is important to maintain. Regarding the Choices for Independence waiver and nursing facility services, DHHS is hearing concern around how rates will be set and how this process will continue in the future. There have also been conversations around the prior authorization process, what works well and what needs improvement, and how this will look in LTSS system. Similar to the previous

public comment, there have been discussions around the quality strategy for Step 2 and how to ensure a whole person centered approach and its principles are implemented and measured, specifically for LTSS.

Lorene Reagan asked for the Commissioners who have attended one or more forums to share their thoughts and feedback. Commissioner Vallier-Kaplan encouraged the Commissioners to attend both a BEAS and BDS forum, as the discussions are different and informative.

Commissioners Fox and Moral attended a recent BDS forum and thought it was very well done. They credited DHHS on their approach, citing it as very positive and that the public seemed comfortable voicing opinions. There were no surprises in the things being heard, including the level of anxiety/concern around service payments and how this will translate to the utilization of services. There is a certain level of anticipation that this will occur when LTSS is transitioned in MCM as the providers rely on the payments to maintain their businesses.

Commissioner McNutt attended 2 forums and explained how it was helpful for DHHS to pose 3 questions for participants to consider. There were a lot of questions about eligibility, but DHHS was clear that it will remain within the Department. There were also questions raised about who would be involved in care planning, concerns around rate setting, and questions about the prior authorization process. Overall it was an open conversation in which people could discuss issues freely, while the format forced people to figure out what they like about the system first, and then identify what they don't want to lose.

Lorene Reagan followed up on an earlier question from the Commission regarding how a person can indicate that they are medically frail within the NHHPP. During the application process, when individual completes screening for eligibility, individuals can indicate that they need assistance with daily personal care activities. This is the main criterion to identifying as medically frail. The person then selects the most appropriate plan to them to meet their needs, either under the alternative benefit package (ABP) in the NHHPP or standard Medicaid DHHS has documentation to describe this process in detail and can provide it to anyone who has further questions about the process.

Public Comments and Questions on MCM Step 2 Stakeholder Meetings

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions. None recorded.

Commissioner Vallier-Kaplan announced a meeting break until 2:30pm.

Panel: Building on Step 1 & Medicaid Expansion: LTSS Provider Preparation for Step 2

Commissioner Vallier-Kaplan introduced Commissioner Bunnell who moderated the panel. On the panel was Steve Ahnen, President of the New Hampshire Hospital Association, Clyde E. Terry, Chief Executive Officer of Granite State Independent Living, and Karen Boudreau, MD, Chief Medical Officer for Well Sense Health Plan. Each panelist had been asked to share insights and perspectives about what had been needed for systems change and success in the context of Step 1 MCM. The intent of the panel discussion was to provide an opportunity for thoughtful and reflective conversation about how this systems change will translate into Step 2 MCM.

Steve Ahnen: It is an honor to meet with everyone today. The implementation of MCM was a long time coming in New Hampshire. There were many opportunities for us (hospitals) as we began to think about new partnerships with multiple health plans but also partnerships with the State, beneficiaries, and patients. Our goal is to ensure that every patient gets the right care at the right place every time with the highest level of quality. MCM is an opportunity to engage with the Medicaid program in a new way as the system itself transformed from FFS Medicaid to value and outcomes-based care. As we began the

process, the hospital community created a number of task forces and workgroups. These groups were structured around financials, billing, admissions, etc. so we could begin to understand what the issues were for these components of hospital systems. We answered questions like how to identify those who are eligible and how to deal with information flow back and forth between all three parties. Early on, we identified issues by plan and by if they were systemic issues that were large in scope. Instead of dealing with these issues individually, we convened groups of members with all parties to problem solve together. Resolving these issues together and across the system was important because other hospitals, while they were not facing the same issue at the time, were likely to experience it in the future. This ability to bring everyone to the table is important, as insight and context is lost if this is not the case. It is also important to establish a partnership between providers, the MCO, and State. While there have been some bumps in the road that we have smoothed out and some problems are still being worked through, the ability to have these relationships in place has helped. While there will be different requirements for each MCO, these can be identified to seek consistency and streamlining from the beginning of implementation. Setting up task forces and workgroups early on was very important for us as this created feedback loops. Overall, establishing and maintaining open lines of communication and providing constructive feedback during tenuous times was a key driver of success in Step 1 MCM.

Clyde Terry: GSIL is a non-profit organization that operates statewide and has been providing personal care services to individuals with disabilities within the State Plan for 30 years. GSIL is an outgrowth from a time 34 years ago when individuals with disabilities had few options. The desire was to create an option within the Medicaid program so that those with physical disabilities had ability to self-direct or manage their own care and live in the community and be full, equal citizens. Other states, including IA, IL, MN, and OR have reached out to learn about this model. GSIL is learning a lot about MCM while maintaining putting the consumer first. For example, GSIL has learned a lot about contracting. We have been relying on State rules for a long time, but now there is a new level of requirements and the need to negotiate how to provide services. Current contracted services lack a long term care focus and instead focused on acute care settings. We communicated with the MCOs to find alternative vehicles to be able to provide these services. This took time, but it worked. Providers need to be in a position to provide services the day the program begins. It took a lot of work to do this for Step 1 and will require the same for Step 2, including a lot of education and training on how to follow contracts. GSIL invested time, energy, and effort to implement Step 1, include changes to IT, increased staff time, and credentialing. This resulted in new expenses. Also, the finance office had to build three new systems to be able to track finances in the organization based upon program changes. In terms of challenges, the lack of understanding of each other's services was noticed. There were multiple systems for each MCO and different State regulations. We learned that partnerships needed to be built and that values needed to be shared. The investment into long term care is something that needs to be done together to achieve better outcomes. There needs to be an agreement on fixes to ensure that quality support is provided. There was also a lot of discussion about opportunities. The improvement of outcomes for consumers will not happen quickly in the long term care setting. The advantages to breaking down social isolation, offering employment, and involving the community to support mental health are values and outcomes that are systemic in nature. This is what GSIL has been involved in for 30 years. We need to be innovative in this changing the long term care world and its economy. GSIL has recommendations for doing this, including network readiness that includes provider capacity. We need to ensure that providers are ready, including their IT capabilities. MCOs must share risk within this model and roles need to be clarified, particularly for those who run a consumer-directed model. There also needs to be a clear expectation of long term financial goals for the investment into long term care services, workforce, and insurance. This could take 5-7 years but we will result in a better and healthier state. All of us are only an accident or illness away from experiencing a disability. While some can economically support this, we need to do right by the citizens of New Hampshire and bring improvements to the system.

Karen Boudreau, WellSense: Echoes agreement with Steve and Clyde. There is huge promise in these programs and opportunities to work together to improve lives and health care system over the long haul. I am excited to be part of this. I joined Well Sense in May 2012 and was previously a family physician for 30 years. Working together to achieve improvements in this system is important, and New Hampshire can learn together in the process. Learning from each other and having providers raise issues along the way has allowed for this progress in implementing Step 1 and working towards Step 2. In general, health plans are not fast moving organizations and they do not make quick turns. This is because health plans are highly regulated. Well Sense, for example, works with the State to follow its program in detail and meet its expectations. In addition, we have to be licensed and meeting NCQA accreditation, including HEDIS measures, and follow contract obligations and accreditation criteria. So before an MCO can make a turn in anything, it has to check each of these sources. Therefore, a policy change can take 90 days at a minimum to implement. To focus on Step 2, the biggest shift in focus is to move to a prospective process. State plans are often prospective e.g. prior authorizations for pharmacy. Shifting the focus of an MCO to proactivity is significant. Asking permission for things that providers are not used to asking for and the consumer adjustment are also significant. It is also important to note that while MCOs have processes in place to apply criteria consistently, individual considerations can be taken into account in this process where needed. In general, moving to a proactive focus is a big shift. This is about ensuring that MCOs have enough information to apply new polices and understand them. This will take communication from current providers to MCOs and from MCOs back to the providers. For contracting, often times and especially when working with smaller organizations who have not had the need to have this level of formality, education is important. Well Sense built a whole LTSS network in Massachusetts, which included providers who did not have these types of contracts in place. We worked together on job descriptions and other components, and there was a dedication to learning and understanding on both sides. This is just an example of how collaboration and conversations that assume the best intentions need to continue in New Hampshire as we move into Step 2.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions.

Commissioner Fox asked about the credentialing process that Clyde Terry spoke to. Karen Boudreau explained how a part of the MCOs quality assurance process is the credentialing of providers. For LTSS, for example, MCOs need to ensure that providers are not on sanctioned lists or involved in anything that would not let the provider provide care. This process occurs every 2 years and the specifics within the process depend on the type of provider. In some cases, for example, if a facility gets credentialed, that facility will then credential its employees, as opposed to every employee within the facility being credentialed individually.

Commissioner McNutt asked about how we can put this information and education together now for these providers. Karen Boudreau explained how there are provider relations teams at each MCO that do this. In preparation for each step of program, they have countless types of training programs available, including information on the website, onsite trainings, webinars, etc. Some of these topics are very complicated; therefore, MCOs and providers often have to work back and forth, and will do so until not necessary for Step 2. Note, however, one aspect that MCOs cannot work directly with providers on is billing.

Commissioner Moral asked if credentialing is done by the MCO or an outside entity. Karen Boudreau explained how it depends on the provider type. For physicians, there is an organization that holds onto the credentialing documents. The MCO can work with this organization to confirm that the provider is up-to-date and accurate. For other types of providers, the MCO may have a credentialing requirement that, for example, a surgical center needs to be certified by CMS. An MCO could accept this but also verify it. Also, if the state licenses a facility and does a site visit, an MCO could accept this.

Commissioner Moral asked if the MCOs could send providers a boilerplate contract so that they can review it in advance and be prepared to negotiate terms. Karen Boudreau agreed that this could occur, and noted that what goes into the boilerplate depends on what the MCO has worked out with the State in terms of what providers need to deliver during Step 2. This is currently unknown. In terms of negotiation, there is always negotiation about language and about programs. For example, an important feature of the NHHPP is a statewide fee schedule. This was an important piece of the program to get the program underway quickly. If this requirement is not part of the program, then there would have been a negotiation on rates with individual providers. Commissioner Moral reiterated the importance for providers to have this in advance to review. There is, however, a risk of providing the language too early as it may include things that are not final and therefore not relevant to negotiate.

Commissioner Toumpas added that what is occurring right now with substance use disorder (SUD) providers within the NHHPP is a great example of lessons learned that those in LTSS community can use, especially for credentialing and being enrolled as a Medicaid provider and an MCO provider. One suggestion is to utilize this provider network as a group for a future panel. Also, thinking about the long term, this landscape is shifting. For the NHHPP, when we get to the Premium Assistance Program, it will not just be two MCOs and DHHS. There may be five other carriers on the marketplace. It will be important to look at this broader landscape when deciding things like credentialing and information technology infrastructure needs.

Public Comments and Questions on Building on Step 1 & Medicaid Expansion: LTSS Provider Preparation for Step 2

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions.

Public comment; not identified – If DHHS does not have all the information about the program for these two MCOs to be able to provide boilerplate contract language, how does it know that they will meet all of our needs? How can the public know if the MCOs are able to meet consumer needs if the State hasn't given them the information that they need? Karen Boudreau responded that we have to trust each other in good faith to build a program that can work for both consumers and the State. Faith may be hard to have because there have been issues with Step 1 that are being resolved. However, big picture, these issues were not as big as they could have been. We recognize that for individuals, they could be big issues. Therefore, we are asking consumers to meet the MCOs half way and work together. MCOs have confidence, they want it to work and understand the public's anxiety. Commissioner Toumpas added that these questions are precisely part of the development of the Step 2 straw person, concept, and design. This will be something to react to for consumers and to present to the MCOs. This will demonstrate how the State conceives it will work for each of the components of the program. This stakeholder and planning process is in place to get to the place for contracts. We are not there yet. Public engagement throughout the process will matter, but nobody has the answer right now as to what the program will look like, and therefore cannot develop contracts or boilerplate language for providers to review.

Public comment; not identified – Karen Boudreau mentioned minor bumps in the road that could have been bigger, and also mentioned how it often takes 90 days for an MCO policy change. As a family member of child with a disability, it is unsettling to sit back and say that we are comfortable waiting 90 days for particular services. Waiting 90 days for some of these services can be devastating to families. Karen Boudreau provided two perspectives. First, changing a policy is a formal process and the MCO tries to make sure they are as right as possible because to change it again requires more time. Also, an MCO has the ability to consider individual information of a person when a need arises. We need to marry these two at the same time. While policy changing is a broad stroke, we have means to address individual needs.

Data Report Update

Commissioner Vallier-Kaplan introduced Commissioner Porter to discuss the Horn Report and asked for further questions from last month's meeting. Note that this report was developed based upon conversations with only 36 people and is not a full census.

Commissioner Moral reviewed the report and mentioned a reference to transportation in the body of the report on the bottom of page 13. This reference indicated that participants would like to know more about transportation reimbursement. This did not make it into the recommendations that the Commission sent to the Governor, however it is valuable to raise.

Commissioner Vallier-Kaplan explained how Commissioner Porter is the liaison for data reporting and asked her how this data gets used. Specifically, how do findings of the Horn Report can get implemented into Step 1 as improvements and into Step 2. Commissioner Porter noted, for example, that consumers asked for more information to make selections between the two MCOs during the focus groups and that DHHS is currently working to implement this.

Commission Next Step: Commissioner Vallier-Kaplan explained how as this group is transitioning into the implementation of Step 2, the Commission will be preparing its next report to the Governor this Fall. It will focus on Step 1 Implementation and plans and principles for Step 2 implementation. Commissioners Fox and McNutt proposed where the Commission should go and what it should do as it relates to Step 2. From time to time, the Commission has developed a formal recommendation to present to the Governor. We believe that we should do the same for developing a set of principles for Step 2 of MCM and the implementation of MLTSS. The Governor met with the Commission in April and laid out principles that she believed should be part of MLTSS. The Commission will review these and make sure they align with recommendations that come out of the Commission. Also, the Commission has looked at reports from Truven to CMS about the implementation of MLTSS published in May 2013 that focus on providers and transitioning nontraditional providers into this new MCM world. The plan is to lay out best practices from Step 1, lay out SIM principles, and review input gained from stakeholders through this process. As a Commission, they came into being as Step 1 was already being implemented. The group is now in a position to be a functioning Commission at the beginning of Step 2. Therefore, we need to agree on a set of principles moving forward. The Commission will develop a first draft and discuss it during the next meeting in October with the hope of having a final draft available for approval no later than November. If the Commission formally meets in between scheduled times, notice will be posted. However, several Commissioners may work alone on this draft and those types of sessions will not be public.

Public Listening Session and Next Steps

Commissioner Vallier-Kaplan opens the meeting for public comments and questions.

Commissioner Vallier-Kaplan mentioned how at the last meeting, the Community Support Network, Inc network submitted a letter. As of this meeting, a written response has been sent back from the Commission. Also, there is a meeting of the New Hampshire Care Path on September 26th that is open to the public and the LTSS community is encouraged to attend.

Public comment; Disability Rights Center – One focus area that DHHS is looking at is service authorizations for therapies. This is a consistent call coming into the Disability Rights Center. In the presentation, for MCO “B”, those denials are for children only. For MCO “A”, was there a sense for how many denials relate to children? Commissioner Toumpas explained that MCO “A” did not break this out. It was an ad hoc report that was requested. We can go back and do additional analysis of the data to see if

it can be broken out into children. Also, Commissioner Toumpas notes that if there are specific, personal issues, individuals should contact the MCOs and/or DHHS directly. Sometimes having this information on a real time basis is key. DHHS monitors calls into its Client Services Center and on the provider side. This real time feedback needs to be picked up and not withheld until DHHS receives this data. There should not be any fear in terms of making this call to the MCO or DHHS, whether it is related to service authorizations or anything else. This is a massive change, so having this real time feedback on any issue is important in order to be able to make improvements. Karen Boudreau added that the most important thing about the MCO process is that there is an appeal process and it is important that consumers are aware of and use it.

Commissioner Toumpas explained how this issue around children's therapies has been reported, is systemic, and the data shows that some of these denials have been because the MCO misapplied the policy. DHHS is looking at how to fix this policy, for both rehabilitative and habilitative therapies. The claims in which the MCO misapplied the policy were corrected and the MCO needed to demonstrate that they made this change. Also, DHHS has reference material regarding the administrative appeals process that occurs within the Department and can provide it to anyone who wishes to learn more.

Kathryn Kindopp, Director, Maplewood County Nursing Home: We have discussed the nursing facility concerns around rate setting for Step 2. Is it possible to make a recommendation to DHHS that nothing be changed for the 72 nursing homes operating in the State? Can DHHS use the same rate methodology for a period of 2 years after Step 2 implementation so that tension can be released? A big rate change is going to impact nursing facilities tremendously. There is not much time left and we have already set budgets. Commissioner Toumpas advised the public to make this recommendation directly to the Department. The reason that a response has not yet been provided to these questions is because DHHS is currently designing the Step 2 program. There are two tracks. The first track is the stakeholder forums taking place now, and second track will contain the concept and the role of the MCOs, providers, and DHHS. This is when the discussion around rates can occur. We are not there yet. The dimensions to set up rates and contracts are details that have not yet been determined. Commissioner Toumpas urged the public to make recommendations directly to DHHS for part of the Step 2 concept design.

Commissioner Vallier-Kaplan explained that Steve Woods, Director and Administrator of Rockingham County Long Term Care Services, submitted a letter on behalf of the Nursing Home Affiliates that was then forwarded to DHHS and to the Governor's office. Steve Woods explained in person how the nursing homes want to be partners with the MCOs and agree with the values of MCM; however, the process needs to slow down. Having date certain is very ominous. Rate setting, provider credentialing, IT infrastructure, and contracts are all big components, and we are very concerned that they are not prepared to accomplish this within the current timeframe. Steve Woods asked the Commission to urge the Governor to delay Step 2 MCM and to do it right. John Poirier, New Hampshire Health Care Association, indicated plans to send a similar letter to DHHS for review and consideration as well.

Chris Dornin, writer for The New Hampshire Challenge, Inc, noted that it seems that readers will not know what the plan for Step 2 is when they go to the voting booth. Will the plan for Step 2 be ready by early November? Commissioner Toumpas explained that for the DD population, this plan will not be developed as this is Phase III of the program without an explicit target date. The first focus is Phase I, including mandatory enrollment, CFI waiver services, and nursing facility services. Commissioner Vallier-Kaplan added that the goal is to have a completed and agreed upon set of Commission principles by this timeframe in November.

Public comment; not identified – Part of conversation is around the appeals process and dealing with denials with children. Some things do not fall into denials, like utilization review. As a parent, I called Commissioner Toumpas on Tuesday at noon and received a call back in 3 hours. My call was channeled

into the MCO within the week and the process was quick. I am a fortunate mom and an advocate who can be at these meetings to know the proper channels. I publically thank Commissioner Toumpas for being available to help, but there is a gap for family members that are not as savvy as those who know and can be here or access materials. Commissioner Vallier-Kaplan agreed that DHHS puts out a lot of information, but if clients cannot recall it or know how to use it, it is not helpful. She encouraged all of the organizations present at the meeting to help facilitate this knowledge for their members.

Public comment; ABLE NH – Something evidenced by the current FFS Medicaid system and area agency system is all kinds of buckets of money are needed to get services for a child. Services and funding is very silo'ed. This is not cost effective. Governor Hassan speaks of her own situation with her own child and references this as well. How can you ensure that the medical piece is matching with the psychosocial piece and that they all come together? The MCOs do not seem to be the answer for psychosocial supports. I am hoping that this is included in the Commission's guiding principles for Step 2 MCM and MLTSS, because when you look at person-centered care you must look at all these different components. This is not happening currently, which indicates that we are not ready to move to Step 2.

Bruce Moorehead, Nursing Home Administrator, Hillsborough County Nursing Home – The open enrolment period will end for those dually eligible on December 31, 2014. After that date, they will be assigned an MCO by the state. Is this accurate? Commissioner Toumpas agreed that is the target date (January 1, 2014 for Phase I) and that to do so will require a waiver. There are a number of steps that need to happen first. Bruce questions how this can occur if the Commission's principles are not complete until November. Commissioner McNutt clarified that the principles discussed today will primarily focus on Phase II-III of Step 2. The principles will not be defining, but rather redefining. Providing a cohesive set of information based upon what has been discussed and reviewed to date. This is not necessarily new information.

Kathryn Kindopp, Director, Maplewood County Nursing Home – What is the impact for residents in nursing homes if Step 2 Phase II goes through? Nothing negative will happen to a nursing home resident. Federal and State regulations mandate that a certain level of care must be given to the resident. If the Medical Director says the resident needs a specialized service or a referral elsewhere, the resident will receive this. If this service cannot be preauthorized, we are facing a medical order and a delay in treatment. If we delay this service, it is a survey and compliance issue that will be paid out of pocket. County nursing homes do accept residents that cannot afford and pay out of pocket to be compliant. Also, we are still facing transportation issues because they send out residents to hospitals with services that nursing homes can't provide. We need more staff training, a budget in place, and clear prior authorizations. This cannot be added to our Medicaid rate and negotiated. The Medicaid rate is only half of what it costs to provide services. How can we possibly add one more expense to our Medicaid rate? There is not a strong level of understanding by DHHS. Residents won't suffer, but long term care providers will suffer. If our Medicaid rates decrease, the county budget would be better but the nursing homes' will not and the nursing home will not survive. So, nursing home residents stand to lose a lot if we do not focus on this. We are not be reimbursed for what we provide, and are facing even less reimbursement through MCM and it will not work.

Commissioner Vallier-Kaplan adjourned the meeting at 4:30pm. The next meeting of the MCMC will be held at the Legislative Office Building in Concord, NH on October 2, 2014.

Follow-Up Items

The following items were noted as follow-up items during the September MCMC Meeting:

1. The report out on the exact number of transportation service providers/contractors maintained by New Hampshire Healthy Families

2. Details on how the findings of the Horn Report are being implemented into Step 1 MCM and will be considered during Step 2 planning and design
3. A further review of the Key Performance Indicator Report data to determine if patients visiting the ED are being directed there by after-hours nurses or going themselves; review if fewer pediatricians are taking Medicaid patients therefore resulting in higher utilization of family physicians.
4. Plan to share Quality Indicators with relevant providers.
5. Explicit description of DHHS' consultation and results from the Attorney General's office on RSA171-A interpretation and application
6. A draft set of principles for Step 2 MCM and implementing MLTSS from the Commission
7. Response to nursing home provider concerns re: feasibility of their ability to implement a quality program given Jan and April 2015 target implementation dates and current status of DHHS plans for Step 2