

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

MINUTES

September 5, 2013
1:00 – 4:00pm
Richards Free Library
58 North Main Street, Newport, NH

Welcome and Introductions

The meeting was called to order by Commissioner Vallier-Kaplan, Chair at 1:05pm. Present in addition to Commissioner Vallier-Kaplan were Commissioners Donald Shumway, Vice Chair, Gustavo Moral, Jo Porter, Tom Bunnell, Ken Norton, Doug McNutt, Sue Fox, Wendy Gladstone, Catherine McDowell and Nicholas Toumpas.

Absent: Commissioner Yvonne Goldsberry

Commissioner Vallier-Kaplan thanked Senator Odell and Andrea Thorpe, Director of the Richards Free Library for hosting this meeting. She welcomed everyone and invited the Commissioners and the non-commission members to introduce themselves.

Commissioner Vallier-Kaplan reviewed the agenda, and the CMS construct that the Commission is using to guide the work. Today's areas of focus are, behavioral health and medical home which are issues related to benefit design and specialized services and populations. Today's agenda also includes the proposed draft of the second recommendation to the Governor.

Updates

Commissioner Vallier-Kaplan stated that since the last Commission meeting, the department announced the "Go-Live" date of December 1, 2013. She introduced Commissioner Nick Toumpas for updates from the department.

Commissioner Toumpas reported that the department has made the formal target of December 1, 2013 as the "Go-Live" date and this has initiated a series of activities. "Go-Live" is the date that they will begin providing services under the managed care program. Next week enrollment packets will go out to Medicaid clients and the Call Center will be ready. They have set up a "situation room" as a convenient meeting area for addressing issues quickly. This week they begin the first of several readiness reviews for each MCO. The reviewing team includes department senior staff, subject matter experts, and regional and central office members of CMS. The first review includes contract requirements, and all member facing materials and activities. Corrective actions will be issued to the MCO's where necessary. The

importance of clear communication with clients due to the significance of these changes will be stressed.

In parallel with this review, the Call Center will begin – 1- 888-901-4199.

In response to questions from the audience, Commissioner Toumpas stated that the department has contracted with an external firm to handle the surge of calls possible at the beginning. Commissioner Vallair-Kaplan advised all to go to the web site, www.governor.nh.gov to see the time line for “Go-Live” activities provided by the department at a previous meeting from the perspective of the client and the provider.

Commissioner Bunnell asked for clarification on the claims processing transition of the MMIS across vendors. Commissioner Toumpas reviewed the issue of the national provider identifier causing people to have to re-enroll. This has caused significant numbers of claims to be “in suspense”. Those providers have had to request contingency payments. In addition, the department has reviewed plans created by Xerox to customize the system (built for fee for service) for the managed care model.

Provider Relations and Outreach Strategies

Commissioner Shumway stated that the updates by Commissioner Toumpas are critical and reminded everyone that all department and MCO information is available on the department web site. The department is conducting in person and webinar trainings for providers beginning on September 11. Commissioner Shumway introduced Aaron Brace, Senior Vice President, NH Healthy Families (Centene). As one of the MCO’s, he provided part two of the Commission’s review of provider outreach and training from the perspective of an MCO.

Mr. Brace reviewed the company background and the provider relations team. He stated that provider relations and their outreach strategy, applies to every provider contracted under the network. Partnerships are the key, from the point of time when the patient enters the system to the moment the claim is submitted. Provider partners will get the tools and knowledge they need. They are stressing a localized approach with candid, unfiltered conversations with everyone.

Mr. Brace introduced Maria Scott, Provider Relations Manager, Centene. Ms. Scott reviewed the provider relations strategy including provider orientations, “Open Mic” sessions and relationship management (see power point). Provider orientation includes individual meetings, group workshops, webinars, summit calls and telephonic orientation. The provider manual and billing manual are available on line. Provider registration begins November 1, 2013.

In response to a question from Commissioner Porter, Mr. Brace stated that there are 4 areas of focus for addressing provider concerns during orientation. 1. Verifying eligibility – e.g. among the three MCO’s; 2. Claims submissions set up on an electronic clearinghouse (although manual claims are accepted); 3. Prior authorization requirements; 4. Appointment waiting time and notification after a member goes to the ER.

Commissioner Vallier-Kaplan asked for clarification on Centene's role in transferring this information from the administrators to the clinical providers. Mr. Brace replied that they encourage all members of all practices to participate in orientation. All the resources are on line, including the provider manual.

In response to a question from Commissioner Vallier-Kaplan, Ms. Scott replied that a forum with the three MCO's to work toward the standardization of processes, is being discussed. Commissioner Toumpas stated that the department management team is also working with the MCO's to define the areas that are unique and specific to each and what administrative processes could be standard with all. Commissioner Norton advised that standards towards efficiencies in billing mechanisms would help with the lag in reimbursements.

In response to a question by Commissioner Moral, Mr. Brace affirmed their readiness to serve specific populations.

In response to questions from the audience, Mr. Brace stated that their contract with the State outlines every area of obligation for compliance and they monitor all compliance areas through the policies, procedures and workflows. Commissioner Toumpas stated that both State and Federal compliance criteria are part of the Department readiness review. The conversation with MCO's and providers is a journey that will include both corrective actions, and new ideas to improve the program.

Commissioner Fox asked when the network provider list will be available for clients. Commissioner Toumpas replied that the MCO's have been encouraged to sign up key players in every area with the broadest reach possible. The provider list will need to be available in order to do enrollment.

Commissioner Toumpas replied to a question from Rep. Harding, stating that network adequacy for the three MCO's is for Medicaid clients and is completely separate from the ACA "marketplace". The overlap in the timing of these two announcements is unfortunate and confusing for many. The Department is striving to be sure all their messages are very crisp and clear.

Medical Homes, Nationally and in New Hampshire

Commissioner Vallier-Kaplan introduced Dr. Carl Cooley, Center for Medical Home Improvement/Crotched Mountain and Dr. Don Caruso, Dartmouth Hitchcock, Keene, NH to report on the concept and execution of the Patient Centered Medical Home in New Hampshire.

Dr. Cooley reviewed the history of the Center for Medical Home Improvement in NH. (see power point). The Primary care setting is the only entity with the time and resources to coordinate every aspect of care. A community based medical practice was designed around the way the providers delivered care. The Patient Centered Medical Home focuses on populations

of patients, is patient outcome based and measures results. There is still a need for a robust definition of a Medical Home. Medicaid patients are a small but diverse population with very high needs and a high proportion of the costs. The Medical Home environment could provide care coordinators, and other professionals in addition to their doctor, in one location. Complimentary payment reforms are critical. At the October MCM Commission Meeting, Dr. Cooley will present the Patient Centered Medical Home in relation to mental and behavioral health and at the November MCM Commission Meeting, integrating services with complex needs patients. Dr. Cooley then introduced Dr. Don Caruso, to report on his experience with the Patient Centered Medical Home in Keene, NH.

Dr. Caruso described the Medical Home in Keene, NH, recently chosen by the Robert Wood Johnson Foundation to be part of a national learning collaborative, one of two in the Northeast (see power point). The Patient Centered Medical Home involves the patient and their family, the physician and RN. Around that group there is a team that includes; behavior health specialist, a nutritionist, anti-coagulation nurse, diabetes nurse, and chronic disease nurse. In addition there are community mentors, RN care coordinators and registries for chronic disease management. Primary care is critical for integration of the medical health care system and the public health system. They are now involved in pilot programs with Anthem, Cigna, and Harvard Pilgrim.

In response to questions, Dr. Caruso replied that more complex mental health issues could be addressed in the Medical Home with the partnership of a clinical psychologist to educate the primary care doctors and in conjunction with a Community Mental Health Center. The inclusion of substance abuse in the Medical Home, similarly, depends on what's available in the community and reaching out to them to bring those experts into the practice. They have a smoking cessation program in place now.

In response to questions from the audience, Mr. Brace stated that the MCO contract states that each beneficiary has a Medical Home and they support the infrastructure for these functions. Dr. Cooley replied that net savings are generated through this model.

Commissioner Shumway stated that the October and November meetings will explore this topic more deeply and that the commission will work with the Department on their aspirations for the Patient Centered Medical Home and will consider a future recommendation to the Governor in this area.

DHHS MCM Quality Strategy – Overall Strategy, with Behavioral Health Integration

Commissioner Norton reported that the Department is working with each MCO on quality performance plans. Today's presentation by Dr. Doris Lotz, Medicaid Medical Director, is the first in a series on Quality Strategy.

Dr. Lotz introduced the DHHS Medicaid Quality Strategy (see power point). Current quality activities include; CMS Medicaid Care Management "Quality Strategy", External Quality Review,

CMS Adult Medicaid Quality Grant and State Innovations Grant. Future quality assurance programs are planned for; health and healthcare services, consumer experience, business operations and integration with national initiatives. There are over 450 quality measures in the MCO contracts, comparing MCO's to each other and to national standards in all aspects of care. The MCO's participate in Quality Incentive Programs and Performance Improvement Projects. There are accountability standards in the MCO contracts. The focus of the quality strategy is around the patient care.

The External Quality Review Organization (EQRO) is Health Services Advisory Group. The external review is required by CMS for all states with managed care programs to ensure accurate, reliable, free from bias, standards compliant data collection and analysis and that the MCO structure, operations and provision of health services are consistent with current professional knowledge.

A new web portal with the ability to analyze large amounts of data with better technology will be constructed using funds from the CMS Adult Medicaid Quality Grant. This will allow user directed extracted reports. They are committed to being transparent. The goal is to have this available in the fall of 2014.

In response to a question about the EQRO, Dr. Lotz stated that NH chose to use an external organization. The contract with them was signed in April (funded by a 75/25% match by CMS) and their work has begun. They have offices throughout the country and are working in 23 states and have staff dedicated to NH.

Commissioner Vallier-Kaplan advised that this document from the department will be posted on the Commission website www.governor.nh.gov.

Draft Recommendation #2

Commissioner Shumway introduced the second recommendation (draft) to the Governor. The Commission is asking for a requirement of reporting post "Go-Live" as follows:

The Commission recommends that the Governor request from the Department of Health and Human Services, public reporting no later than 45 days after the completion of each quarter during FY 14 and FY 15, post "Go-Live", in a detailed report identifying changes and problems in client access, quality of client care, customer satisfaction and appeals, and the financial performance under New Hampshire's Medicaid Care Management Program.

Specific review should also include the following:

- 1. Evidence of the protection of client rights under the Medicaid program*
- 2. Critical indicators pursuant to the Department's quality management system.*
- 3. Changes in utilization of care.*
- 4. A financial analysis of claims, program expense, and expenditure reductions.*

In addition, plans for remediation of concerns shall be noted.

Commissioner Shumway continued by stating that at this time, we're asking for the Commissioner's views on endorsing this draft recommendation. If this endorsement is established, we will form a subcommittee, including representation from the department, to complete the recommendation and bring it to the October 3rd meeting for a vote. Commissioner Shumway asked for comments.

Commissioner Toumpas stated that the department has significant reporting obligations already to CMS, the legislature, the external quality review organization and the internal DHHS monitoring of the program. This may be a duplicate of what they already need to do and quarterly reporting may not be possible due to the need to collect data for a year. If there's a gap in reporting, this could be useful.

Commissioner Shumway suggested aligning efforts to find the gaps and prioritize so that we can be assured that all is working well. One example of a possible gap would be; are client rights and protections covered in the quality assessments?

Commissioner Vallier-Kaplan stated that there is interest in creating a release to the public about how things are going. This Commission is a tool to do that reporting to the public in a pro-active, preventive way. We could create a structure through the Governor's office showing the impact it's having and places where work is being done on improvements.

Commissioner Porter asked for clarification on the role of the Commission in this request. Commissioner Shumway replied that the sub-committee can work on ways to accomplish what the Executive Order requires; *"...to review the Medicaid care management program's performance data in the form of reports and/or summaries provided to or by the Department of Health and Human Services to assess the needs for future changes to the program and recommend such changes to the Governor..."*, by structuring an underlying receipt of data.

Commissioner Fox stated that the value is for us to think about key areas of reporting and the Commission's role. We might consider a task force to identify these areas. Commissioner McNutt stated that the Commission needs to respect the work of the department. Commissioner Norton said that it will be a challenge to put all this information in a form that the public can understand. Commissioner McDowell stated that it would be helpful to know what the external review organization has done elsewhere. Commissioner Moral asked if the audience is the Governor or others.

Upon a motion duly made and seconded, it was unanimously:

VOTED: to form a sub-committee (off line) to explore the Draft Recommendation

Commissioner Vallier-Kaplan reviewed the schedule of meetings. October 5 will be at the Legislative Office Building – note the new time – 9am – 12 noon. A six month summary report to the Governor will be prepared prior to "Go-Live".

Commissioner Vallier-Kaplan asked if there were any final comments or questions from the public.

Richard Cohen, Executive Director, Disabilities Rights Center, stated that he would like an agenda at a future meeting to present the question of whether or not the long term care services for developmentally disabled individuals should be under the MCO's.

Commissioner Shumway thanked Mr. Cohen for participating in the meeting and stated that there are already scheduled points in the Commission's work where vulnerable individuals are considered. On November 3rd, the third part of the Medical Home presentation will include the integration of area agency supports in Medical/Health Homes. At this time, Step 1 related capacities are the first priority. The Commission is also following the SIM process and what it's suggesting for Step 2. Step 2 deliberation will soon be scheduled.

Commissioner Vallier-Kaplan presented the draft minutes of the August 1, 2013 meeting for review. Upon a motion duly made and seconded, it was unanimously:

VOTED: to approve the minutes of the August 1, 2013 meeting of the Commission as presented.

The next meeting of the Governor's Commission on Medicaid Care Management will take place on Thursday, October 3 from 9am – 12 noon at the Legislative Office Building.

Commissioner Vallier-Kaplan adjourned the meeting at 4:20pm.

Minutes approved on October 3, 2013