

Governor's Commission

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

**MINUTES
October 8, 2015
Legislative Office Building
Concord, NH**

Welcome and Introduction

The meeting is called to order by Commissioner Don Shumway at 1:10 pm. Commissioner Mary Vallier-Kaplan is unable to attend. Present in addition to Commissioner Donald Shumway is Nicholas Toumpas, Doug McNutt, Dr. Wendy Gladstone, Thomas Bunnell, Jo Porter, Yvonne Goldsberry, Susan Fox and Ken Norton.

Commissioner Shumway welcomes everyone and states that it is a small group today and asks the Commissioners and public to introduce themselves. Commissioner Shumway recognized Commissioner Ken Norton, Executive Director of NAMI NH and congratulates him for being awarded the Champions award at Riverbend Recognition ceremony. Commissioner Shumway states that he serves as the President and Chief Executive of Crotchet Mountain Foundation and has announced his retirement in mid-January. It is his intention to continue with the MCM Commission. He states that he will not be taking a position in the future that would be a conflict of interest.

Commissioner Shumway states that the next meeting on November 13th will be in Atkinson at Community Crossroads. This is a setting where the ServiceLink has joined with the area agency providing an opportunity to continue with the how community services under Step 2 are organized.

Commissioner Shumway thanks the Commissioners and MCAC members for joining with the Department last month for an extra meeting to hear about Medicaid Quality management that was presented last month by Mr. Andrew Chalsma, Director of Data Analytics and Dr. Doris Lotz, Chief Medical Officer of DHHS.

Commissioner Shumway references the minutes from the September 10, 2015 meeting. A motion is made to approve the minutes and seconded. The minutes of the September 10, 2015 meeting of the Commission are approved.

Commissioner Shumway references the Commission's Second Recommendation, dated November 7, 2013 which was a month before Medicaid Managed Care went live in the State. The Commission approved its second recommendation to assure upon the implementation of Medicaid Care Management that if there was identification of any major problem that there would be rapid remediation and that it would be secured by an independent review and public transparency of the first seven (7) months of operations. It went on to say that the consensus that we had reached with the Department was around a public reporting of information, ranging from the basic facts of the enrollment for MCM recipients, auto enrollment, network adequacy, right on through quality improvement information which developed over time to the monthly, quarterly and annual reporting that would be present in relation to public engagement regarding the MCM program. We wanted an opportunity for continuous learning. The Department on its end had to look at reporting that had to be done and organized in a way to efficiently carry out quality measurements. As envisioned in the recommendation, you can see monthly key indicator reporting that has been brought before the Commission and also the Medicaid Quality Management systems that are

available in what is an extraordinary amount of public information. The webpage and its customization of reporting of operations data is remarkable.

It seems that it is time to restate the recommendation to the Governor and the public.

Commissioner Shumway also wants to make sure that everyone knows the collaboration and the partnership effort that has been involved in this. The NH Endowment for Health and its support of the Urban Institute, UNH including the Institute for Health Policy and Practice, the IOD collectively has brought a much better analytical and maintenance capability in the long term. Also Commissioner Shumway wants to note that the legislature when it established the policy to move to managed care, stated in its authorizing statute the contract for managed care model that the Department shall ensure no reduction in quality of care of services provided to enrollees in the managed care model and shall exercise due diligence to maintain or increase the quality of level of care provided. This is ambitious at a time of declining resources but what is most important is that the Department has approached this legislative charge with a transparency and an aggressive dedication to the public information around the quality of care for Medicaid managed care. The best guarantee of quality of care is the public's knowledge of the policy of quality of care. The Department has carried out this mission of public information in a very helpful manner and the Commission would like to inform the Governor the data reporting that was recommended in 2013 was well managed and the public initiative is engaging and is going to be useful as we move from Step 1 to Step 2. Commissioner Shumway states that he has drafted for the Commissions consideration an update to the recommendation and asks the Commissioners to review this document over the next month, review it with others and then provide comments at the November meeting.

Commissioner Shumway asks the Commission and Public if there are any questions.

There are no questions.

DHHS MCM Update

Commissioner Toumpas opens by reviewing the agenda and states that he will follow up on open items from the last meeting specifically around the Step 2 Information Sessions and some of the key themes. He explains he will quickly review the monthly enrollment numbers, go through the Premium Assistance Program update, Step 2 update, at a high level the Waiver timelines with more to come later in the session, the quarterly MCM Quality Reporting Plan and Behavioral Health Network update. Commissioner Toumpas states that there were four (4) main themes from the Step 2 Information Sessions which included prior authorizations as they relate to out of network/medical necessity, non-emergent transportation, continuity of care, and guardianship. He explains initiatives taking place around each of these items. There are FAQ's as a result of these sessions which are posted on the Departments webpage.

Monthly Enrollment Update

Commissioner Toumpas states that the Care Management program has been in place for 23 months. As of October 1, 2015, there were 163,779 individuals enrolled in the MCM program. This is the traditional Medicaid population along with the NH Health Protection Program population. There are 17,191 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 88,971 members enrolled and New Hampshire Healthy Families has 74,808 members enrolled. Commissioner Toumpas opens the meeting up for questions from the Commission. There are no questions.

NHHPP Update

Commissioner Toumpas states that there are 42,707 recipients enrolled in NHHPP as of September 4, 2015. This number has leveled off and where we thought it would be. The rest of the information is in the slide deck but he explains he will not review it as it is the same information from past meetings.

Commissioner Toumpas asks the Commission if there are any questions. There are no questions.

Commissioner Toumpas then updates the Commission on the Premium Assistance Program (PAP). Under the NHHPP we were to establish a Bridge program to keep people into the Managed Care Program until January 1, 2016 until they would transition the one of the Qualified Health Plans in the marketplace. As of this point a Heads Up letter went out at the beginning of October and we plan enrollment as of November 3, 2015. WellSense members that have not selected by December are auto-assigned and New Hampshire Health Families members will be auto-assigned to Centene/Ambetter. Coverage begins on January 2016. There is a lot of work operationally to get systems and other components set up. This is led by Ms. Deborah Fournier. Commissioner Toumpas then asks the Commission and the public if there are any questions. There are not questions.

Commissioner Toumpas begins his update on Step 2 by announcing the enrollment date of November 1, 2015 for Step 2, Phase 1. He reminds everyone that Step 2 has four (4) phases. Phase 1 is the voluntary population now becoming mandatory. Phase 2 is the Choices for Independence Program (CFI), Phase 3 is the nursing facility services and Phase 4 is the other three waivers which is the Developmentally Disabled Waiver (DD), the Acquired Brain Disorder (ABD) Waiver, and the In Home Supports (IHS) Waiver. He explains that what he is announcing today is the timeline and go live date for Phase 1 of Step 2 which is the mandatory population. The Department is issuing a press release today and has notified the plans and the Medical Care Advisory Committee (MCAC) and now here to the MCM Commission. What this means is as follows, effective on November 1st enrollment letters will go out to these individuals. The Department did this to coincide with other activities such as annual open enrollment for the Affordable Care Act, the annual open enrollment for the Medicaid Care Management (MCM) program, enrollment for PAP and now Step 2, Phase 1. Letters will be going out and individuals will have 60 days to enroll. We are targeting 85% self-selection. For those that do not self-select at the beginning of January 2016 will be auto enrolled. There will be time in January 2016 for the MCOs and recipients to get to know each other as coverage will not begin until February 1, 2016. The Department is working with the individual case managers to have a greater collaboration. The Department will also be transferring the medical claims information to the MCOs. We have held operational and readiness reviews with each MCO to make sure they are ready to handle this complex population. The target population is approximately 9,900 individuals. In addition we have been working on a High Touch projects and continued Education and Training. There is a handout on High Touch Readiness and Training and Education Plan as part of the materials in the Commissioners Packets.

Commissioner Toumpas opens the meeting up for questions.

Commissioner Shumway begins by stating the dual eligible in nursing facilities will now be required to enroll in managed care, children with special health care needs and others.

Commissioner Toumpas identifies the groups including Foster Care Adoption, in this group an overwhelming number of individuals have already opted in to managed care, SSI child with the same thing that an overwhelming number in the program have already opted in, Katie Beckett category with the numbers reversed with a little less than 500 have opted in and a little less than 800 opted out of the

program, the Special Medical Services category (SMS) about 900 have opted in and 200 have opted out. The Medicare dual eligibles, less than 65 years old, significant number about 6,000 who have opted in and about 3,000 have opted out. The Medicare dual eligibles over 65 about 2,700 opted in and 4,500 opted out of the program. This is a breakdown by eligibility category. We have had a decent amount of participation in all four (4) of the waiver program, but the nursing facilities there were about 1,100 that have opted in and about 2,800 have opted out of the program.

Commissioner Shumway asks if there were issues identified in the readiness reviews that have been remediated.

Commissioner Toumpas responds that there were a number of issues. The Department gave various examples to the MCOs to see how they would respond including secret shoppers to make sure they understood the complex needs of this population. When we go live there will be a team that meets on a daily basis for the first month to resolve issues that are identified, much like we did when we went live with Managed Care. We want to make sure we are collecting the data to look for trends.

Commissioner Shumway remarks that the process will be most effective if issues are brought to the MCOs and have each MCO use their resources to make sure they capture that concern. The contract requires each MCO to have a New Hampshire based person who focuses on the complex care clients.

Commissioner Toumpas states that by giving the full 60 days for the enrollment process and then an additional 30 days it will allow the plans and clients to work with one another earlier in the process. One area of complexity is that many of the clients coming in have third party insurance which can be confusing. We want to make sure there is a solid understanding of this.

Commissioner Shumway comments that during Step 1 there was a contact sheet that the Department developed and he asks if this will be done again.

Commissioner Toumpas responds that when the Department briefed the Governor's Office it was agreed that the Department would do more frequent checkpoints with the Commission as this is being rolled out and that we would consult with the Governor's Office. When we go live we will have a representative of the Governor's Office to sit in the daily team meetings so they understand what is going on.

Commissioner Tom Bunnell asks for the vulnerable populations many of them have already opted in with the MCOs giving them the experience with this group but is there an expectation that for those that have opted out and are now coming in, are their needs more complex?

Commissioner Toumpas states that this is what the Department is expecting and that some of those needs will be more complex, however the plans have already had the opportunity over the past several months to provide medical services to these individuals with complex needs and they have not lost those individuals. They have stayed with the MCOs. We have also made sure we double down with the readiness reviews to make sure that the plans truly understand this population. The High Touch project is designed to address this complex population.

Ms. Deborah Scheetz explains that there is a document in the packet that outlines the high touch readiness review that was done in May and the results of that, as well as the scheduled October and November readiness reviews that the Department is just beginning to work with the MCOs on. These are not use case scenarios but secret shopper scenarios to see what we have learned in October and November. There is also a High Touch readiness project with a brief description that the Department is working on with Ms. Sandy Hunt in the lead. This is to provide the MCOs with greater information around some of the clients identified by case management agencies that might be at some level of increased risk.

All materials will be posted on the MCM Commission website.

Commissioner Toumpas states that the Department has been very deliberate with this complex population to be as vigilant as we can to be ready. With the team of people working on this for months and when we set up the SWAT team we will quickly be able to respond to the issues.

Commissioner Toumpas opens the meeting up for questions.

Question from the Ms. Kay Affhalter: How will this impact clients served by Area Agencies?

Commissioner Toumpas responds that clients serviced by the Area Agencies will have their medical services, prescription drugs and behavioral health services managed through this process. The Waivered services that are received in the Area Agencies by private providers that provide these services will not part of this transition. These services will get folded in at a date that is not defined yet.

Question from Ms. Kay Affhalter whom introduces herself as a home health provider. How the people with ABD Waiver are be impacted?

Commissioner Toumpas states that those individuals that are already served by Area Agencies will be include for their medical only.

Question from Ms. Kay Affhalter: How will this impact the budgets of those within the Area Agencies?

Commissioner Toumpas: Again there is not impact.

Question from Ms. Denise Colby: You stated that letters will be sent out to the families, I know that letters have gone out for PAP but is this going to happen quickly and who will be on the SWAT team?

Commissioner Toumpas responds that yes the letters will go out soon and the SWAT team will be made up of individuals internal to the Department, customer services, systems, policy, legal and rules, MCO operations individuals.

Mr. Clyde Terry states that he has two questions one in relation to consumers and one in relation to providers. He explains that he has a number of consumers that opted out two years ago because while GSIL provides their personal care and we are contracted with both plans, their primary care physicians are only contracted with one of the plans. Last time he spoke with one of these consumers in the summer that situation has remained the same. So now that they are mandated to come in how will the Department work with these individuals so that there is a continuity of care?

Commissioner Toumpas refers to the Continuity of Care document that is in the packet. We are working with agencies to provide counseling for them. These individuals will need to choose a plan that has the provider that they want.

Mr. Clyde Terry asks if the readiness review includes a billing assessment to make sure that providers will be reimbursed timely.

Commissioner Toumpas states that we have looked at the systems side but for the medical services provider are already billing so there will not be changes.

Mr. Clyde Terry responds that he is referring to one of the programs within the State Plan services where there have been coding issues that have taken a lot of in house fixes on the part of the plan. He then goes

on to ask if the Department has looked at how some of the antiquated systems have been streamlined as part of the readiness review.

Commissioner Toumpas states that this question will be documented.

Question from the public: Do you have a date for when the letters will drop for enrollment?

Ms. Deborah Scheetz explains that on October 30th the names and addresses will be pulled from the system and the letters will be sent immediately all at the same time.

Commissioner Toumpas updates the Commission at a high level on the Waivers. He refers to the graph in the slide deck entitled “DHHS Waiver Update, October 2015”. The 1115 (a) Waiver for Premium Assistance has already been approved; the 1915 (b) Waiver to mandate MCM has also been approved. The Department intends to submit the 1915 (c) Choices for Independence Waiver which we will discuss more about later. Before we go live with the 1915 (c) Waiver services and Nursing Facility services the Department needs to go back and make an amendment to both the 1915(b) and (c) Waiver.

Ms. Deborah Scheetz states that when looking at the graph everything above the line is what needs to happen to bring the CFI Waivered services into the health plans domain for delivery. Below the line is the ongoing Waiver work that the Department needs to do relative to our Waivers because we have renewals coming up. Ms. Scheetz wants to call attention to the Commission members understanding for the renewal schedule, as well as for the new Waiver we are awaiting pending approval. This new Waiver is the Transformation Waiver that the Commissioner spoke of. A question that the Commissioner and some of my colleagues hear often is about the timeline and because it is pushed forward would there be additional Waiver amendments for DD, ABD and IHS and how will that work relative to renewals. One response is that it depends on how quickly things roll out in our readiness. We may be doing a combination of renewals and amendments at the same time moving forward. This has been an interest of the Commissioners in regards to the Waiver work that needs to be done to enable the Care Management Program. Ms. Deborah Scheetz explains the graph to the Commission.

Commissioner Toumpas states that Waivers need to be modified and approved by CMS to expand health plan services to include long term services and supports. This is where the combo waiver the 1915 (b) and 1915 (c) need to be done and approved by CMS before we expand CFI/NF coverage to Care Management. The 1115 Waiver for Premium Assistance has already been approved. Other Waivers that need renewals are the IHS, DD, ABD and CFI Waiver renewals that would have to be done irrespective of this. Once the date for DD/ABD/IHS Waiver are included, the Department will consider and set dates for necessary Waiver amendments. The 1115 Transformation Waiver is pending CMS approval. We know they are looking at it but this is one of the Waivers that unlike the other Waivers is at the discretion of the Secretary of CMS. We are developing the CFI Waiver which expands health plan services to include CFI Long Term Services & Supports (LTSS). We are going through an internal review and there are a number of things we have to do internally. We have not set a date for when we will release that Waiver which will require extensive public process.

Question from public: So there are two Waiver components related to CFI that have to be done before the CFI services can move forward. This is the singular CFI Waiver and the combined Waiver.

Ms. Deborah Scheetz responds: Yes, the Department will have to do a Waiver modification to the 1915 (b) to enable managed care. We will have to do a modification or amendment to the 1915 (c) CFI to enable managed care for the CFI Services. Then we must provide a combo b/c Waiver. For some people who understand Waivers, there is also something called a 1932 (a) State Plan. This is not a Waiver but

also must be done. These are all on the calendar and part of the Department's approach and we are fully aware of the Waiver work that needs to be done and the plan amendment work that needs to be done.

Commissioner Toumpas states that the 1915 (c) Waivers will go through a rigorous public process and once we have a target date to release it, we will develop a process to get public comments and then submit to CMS.

Commissioner Toumpas then reviews the Quality Management Program and provides links. He explains the quarterly reporting structure moving forward. In March 2016 the EQRO will do a technical report, side-by-side MCO comparison, MCM contract compliance and data integrity activities. In July there will be a general MCM operations report, network adequacy and access report, biannual focus group and special projects. In October reporting will include HEDIS, CAHPS, Behavioral Health Satisfaction Survey and NCQA ranking. In December the MCO will do their annual reports, performance Improvements projects, Consumer and Provider Advisory Board, Provider Survey and MCO Quality Assurance and Improvement Plans.

Commissioner Toumpas then updates the Commission on the Behavioral Health Network. The department is meeting with a delegation from the mental health centers and has been working with them on a weekly basis as of September 10, 2015. A proposed MOU has been established that delineates a process for moving forward with a report due to Governor Hassan on November 1, 2015. The focus is on Care Management Savings Rate, Enrollment Rate of Dual Eligibles and Commitment on CMHCs.

1915 (c) Waiver Update

Ms. Deborah Scheetz opens by reviewing the Waiver components Appendix A-E. See slide deck entitled Choices for Independence 1915 (c) Waiver Amendment Update, October 8, 2015. She wants to look at them and determine what can be improved and what can be done to enable Managed Care. She explains that there will no longer be a requirement for a CFI redetermination home visit for every participant. Instead of completing a Medical Eligibility Assessment (MEA) for each person, the required clinical information may be obtained from documentation already available in MDS or OASIS systems, or from a DHHS clinical assessment form that will be simplified version of the MEA. Ms. Scheetz then reviews the new and modified benefits. The new benefits include vehicle modifications and in-home evaluations by Department-approved professionals for Environmental Accessibility Adaptions/Vehicle Modifications. Audits that were completed by CMS for modifications showed they were not being done properly and did not address participant's needs. Modified benefits include changing the description of approved service for personal care to include transportation to non-medical services and updating descriptions and provider qualifications for services to assure compliance with CMS regulations. This means we are looking at one rate and one procedure code. Adult Medical Day (AMD) will be provided through State Plan through the same providers at the same rates. DHHS will update the Administrative Rule and make the service available for waiver and non-wavier participants. There has been a lot of feedback on this. Adult In Home Care (AIHC) will be eliminated because it duplicates Homemaking and Personal Care Services for which payment rates are more competitive. There will also be updates on Quality Improvement Strategy to better align with March 2014 MS guidelines, as well as some of the things we are seeing with our quality waiver. Ms. Deborah Scheetz then answers questions in regards to who is submitting the waiver. She discusses that the waiver will be submitted when it is ready. There is an operational build with this waiver. There is work to do on the Ombudsman position. Ms. Scheetz then discusses that there will be a robust stakeholder engagement plan that encourages listening to concerns to either incorporate ideas or explain why points are not practical/feasible. The MCM Commission, MCAC and the public will be informed of the comment period and schedule. The Department will need to find a way to rapidly report and respond to these comments. The Department is receiving technical assistance from Camille Dobson, Deputy Executive Director, and National Association of States United for Aging and Disabilities. If

something is not in the waiver it may show up in the contract. The projected go live date will depend on the Department's and the MCO's readiness. There will always be a FFS program due to the spend down population.

Commissioner Gladstone asks if pediatric providers that receive Katie Beckett (KB) funds will be impacted so their patients won't have to be hospitalized.

Ms. Deb Scheetz responds that if you are referring to KB funds then these are actually handled through the IHS waiver not the CFI Waiver.

Commissioner McNutt states that this will expand the portfolio of help.

Commissioner Tom Bunnell thanks the team and the Commissioner for a robust public process and he states he is looking forward to seeing the final product when the Department is ready.

Commissioner Shumway adjourns for a 15 minute break.

Commissioner Shumway reconvenes the meeting at 3:15 PM. and states that the Commission Workgroups will give an update. He explains that the work of the groups has already begun and will get more important as the LTSS are rolled into managed care. He then turns the meeting over to Ms. Deborah Scheetz who reviews the work of the Consumer Protections and Safeguards for Step 2 group, including the Ombudsman. Ms. Scheetz reviews the DHHS considerations in implementing Step 2. This includes stakeholder engagement, alignment of payment structures with MLTSS program goals, comprehensive and integrated service package, enhanced provision of Home and Community Based Services, adequate planning and transition strategies, support for consumers, person centered processes, qualified providers, participant protections and quality. Ms. Scheetz then goes on to introduce the members of the Commission Consumer Protection Subgroup. These members include Commissioner Gus Moral, Commissioner Ken Norton, and Ms. Kathy Sgambati from the Governor's Office. Ms. Scheetz then reviews the priorities of the Commission subgroup which include how information will be accessible, widely distributed, understandable on the Resolution system. There will be education and outreach to enrollees on grievance & appeal rights, the State fair hearing process, and rights and responsibilities. She then goes on to explain the Resolution System in more detail. Ms. Scheetz continues that complaints should include items that do not rise to a level of grievance and allow the participant "not to give up." The CMS LTSS Proposed Rules Beneficiary Support System and explains that the proposed scope of services for the LTSS beneficiary supports may include what has traditionally been considered "ombudsman" services. Ms. Scheetz continues to discuss the 1915(c) CFI Waiver Amendment Safeguards which includes Choice Counseling and Education, Continuity of Care, options to switch plans, robust incident and complaint reporting, appeals process and services, and Ombudsmen which will be an independent resource to help participants understand rights, responsibilities and how to navigate a dispute with the managed care plan or the State. Key elements in expanding the system include a complaint process, a document that outlines the complaint, appeal, and State Hearing process and consumer rights known as the "What you Need to Know" document, the 1915 (c) Waiver Amendment, Appendix G, and the Ombudsman position.

Commissioner Doug McNutt comments that what is happening is encouraging and is looking forward to hearing more about Consumer protections in the future.

Commissioner Shumway then introduces the Operations and Payment Systems team to include Commissioner Yvonne Goldsberry and Commissioner Tom Bunnell. Commissioner Goldsberry states that the team is working with Ms. Deb Scheetz on the status of Prior Authorization issues around Step 1. They are also looking at the take always from Step 1, asking the Department to share data information on Prior

Authorization's (PA), looking at oversight of the PA process and how it is being staffed in relation to Step 2, share plans to ensure PA concerns can be shared early on. Commissioner Goldsberry continues that the team is prioritizing the PA process.

Commissioner Shumway then reviews with the Commission and public all of the materials in the packet and states they will be on the Governor's website.

The Network Adequacy subgroup then gives an update. Members of this group include Commissioner Porter and Commissioner Gladstone. The major areas this subgroup is working on with Ms. Deb Scheetz includes an in depth review of the waiver, what the current provider network looks like now under the waivers, what is the criteria to show an adequate network, overview of the process for care coordination and assessment of provider satisfaction. They also are looking at the Step 1 population and challenges in the transitional phase for those with complex conditions to identify these challenges early on.

Commissioner Doug McNutt states that there are a couple of states that establish criteria for network adequacy.

Ms. Deb Scheetz responds that she will discuss this with Ms. Camille Dobson and reflect the discussion back to Department and the Commission.

Meeting open for questions from the Commissioners.

Question from Commissioner Sue Fox: Will Choice Counseling and Education be a billable service?
Response from Ms. Deb Scheetz: This is in their contract right now.

Commissioner Ken Norton thanks Ms. Deb Scheetz for being well prepared.

Commissioner Shumway opens the meeting up to the public for questions.

Question from public: Will APS be included in the Consumer Protection Model?
Response from Ms. Scheetz; Yes, if you have a sentinel event there must be a clean and rapid handoff.

Comment from the public. For CFI providers that work with clients with dual diagnosis. We are managing these cases but have safety concerns for our case managers.

Question from Mr. Clyde Terry: For the provider that provides a service and is pending an appeal will they be reimbursed for that service.
Response: That is a very good question. We will follow-up on this.

Commissioner Don Shumway thanks the Commissioners and the public and adjourns the meeting at 3:45PM.

Follow-Up Items

The following items were noted during the October MCM Commission Meeting:

1. Follow-up to a question from Mr. Clyde Terry from GSIL Services. There have been billing issues revolving around coding that have required in house fixes. As part of the readiness review will the Department look at how these antiquated systems have been streamlined to resolve these issues?

2. Commissioner Doug McNutt referenced a couple of states that have established criteria for network adequacy. Ms. Deb Scheetz responds that she will discuss this with Ms. Camille Dobson and reflect the discussion back to Department and the Commission.
3. Question from Mr. Clyde Terry: For the provider that provides a service and is pending an appeal will they be reimbursed for that service?