

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

MINUTES

November 6, 2014

1:00 – 4:00pm

**White Mountain Community College
220 Riverside Drive, Berlin, NH 03570**

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 Donald Shumway, Nicholas Toumpas, Douglas McNutt, Roberta Berner, Yvonne Goldsberry, Gustavo Moral, Tom Bunnell, Kenneth Norton, and Susan Fox. Also in attendance were Kathy Sgambati from the Office of the Governor and Representative Wayne Moynihan of Coos County.

Absent: Commissioners Wendy Gladstone and Jo Porter.

Commissioner Vallier-Kaplan welcomed everyone and thanked the White Mountain Community College for hosting the meeting and providing the means to stream the meeting live for those who could not attend in person. Those attending online had the ability to email comments and questions to Commissioner Shumway.

Commissioner Vallier-Kaplan explained that the first half of the meeting typically contains feedback received since the last meeting, updates and new issues, new implementations, etc. Commissioner Toumpas will review current MCM enrollment, feedback on the Key Performance Indicators Report and notable results, responses to issues raised in past meetings, and the timeline for Step 2 of the MCM program. After the break, the meeting will move into the area of education and discussion, and will contain a provider outreach panel with representatives from both Well Sense Health Plan and New Hampshire Healthy Families. The Commission will then review its updated recommended principles developed to guide DHHS' work as it moves forward into Step 2 MCM implementation. These principles were posted on the Commission's website with the meeting agenda and were shared in hard copy during meeting. Questions and time for a public listening session will follow. Attendees were encouraged to focus on higher-level questions and common issues, as opposed to individual concerns that should be raised first to an individual's MCO and then to DHHS. As a reminder, the Commission is a body

appointed by Governor Hassan and is charged with providing feedback to the Governor as the MCM program is planned and implemented. This is a voluntary group chosen by the Governor's office to provide this service to the public.

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.

Commissioner Shumway reviewed correspondence sent to the Commission since the October meeting. Letters about systemic issues can be sent to don.shumway@crotchedmountain.org in between meetings. These letters are then maintained in a larger list and distributed to DHHS. These issues are acknowledged immediately by DHHS and filtered to the appropriate area within the Department to address the issue. These issues are also sent to the Governor's office, and DHHS and the Commission meets with the office regularly to mutually update the Governor's staff on these issues. In the time since October's meeting, the Commission received several concerns regarding transportation services. Transportation services have been a primary agenda item during recent meetings, and this latest correspondence has provided content on the experience of individuals impacted by transportation issues and their particular needs. Therefore, transportation services will be added as a routine agenda item for each future Commission meeting.

Minutes of the October 2, 2014 Meeting

There are no corrections to the minutes of the October 2, 2014 meeting. Upon a motion duly made and seconded, the minutes of the October 2, 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 you are 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. The presentation will begin with a review of monthly enrollment for the MCM program, both Step 1 and the New Hampshire Health Protection Program (NHHPP), then briefly review the Key Program Indicator (KPI) report, and spend most time focusing on

Step 2 MCM timeline and concepts. The high level concepts for Choices for Independence Waiver (CFI) and Nursing Facility (NF) services only will be presented. The Developmental Disabilities (DD) Waiver, In Home Supports (IHS) Waiver, and Acquired Brain Disorders (ABD) Waiver services will not be presented. The design concepts for integrating these three waiver services in Step 2 MCM continue to be worked on by the Department, and the BDS Quality Council is providing formal feedback as well. Because the BDS Quality Council has not yet finalized its formal feedback, these design concepts are not being presented today. Susan Lombard from DHHS/BEAS will speak about the CFI and NF services design concepts from a high-level view that focuses on answering key questions DHHS has received regarding Step 2 MCM. This will be a phased discussion. DHHS will be having stakeholder engagement sessions beginning in December, and a more detailed presentation that will provide details on each concept and look at them over a 3 year period will be presented. This detailed presentation is not being shared today, however, will be shared with stakeholders in advance of each session in December.

Commissioner Toumpas explained the MCM program began on December 1, 2013, and has been underway for 11 months. The principles of the program include whole person management and care coordination, increasing the quality of care, payment reform opportunities, budget predictability, purchasing for results, and delivery system integration. As of November 1, 2014, 137,030 people were enrolled in the MCM program. Well Sense Health Plan has 74, 331 members, and New Hampshire Healthy Families (NHHF) has 62, 699 members. In May 2014, DHHS saw an increase in this enrollment based upon the modified adjusted gross income (MAGI) rule changes. Roughly 70% of the Medicaid population is low income women and children, who are clearly reflected in the health plans' enrollment numbers. Since January 2014 until the present, there has been an increase of 10% in low income children, and increase of 27% in parent caregivers, and an increase of 21% in the number of pregnant women who have enrolled in the program.

Commissioner Toumpas described the New Hampshire Health Protection Program began in August 2014, which reflects an additional enrollment increase in the program. As of November 4, 2014, 22,208 individuals were enrolled in the NHHPP. Over 9,000 of these clients are new to DHHS and have not had health insurance in the past, while over 7,100 are new to the NHHPP and have been clients in the past. When an individual is deemed eligible for the NHHPP, they have 60 days to select a plan. Currently, 8,807 are enrolled in Well Sense Health Plan and 7,901 are enrolled in NHHF. The remaining 4,739 are covered under Fee for Service Medicaid as they are within the 60 day plan selection period.

Commissioner Toumpas explained that enrollment in the HIPP program as part of the NHHPP is a lengthy process. Fifty-six (56) individuals are currently enrolled in the HIPP program with 705 applications of individuals potentially eligible for HIPP under further analysis. In general, DHHS projected an increase of 50,000 people in the NHHPP over the course of five years. DHHS has achieved over 22,000 in just four months. This shows the success of the program and the need demonstrated by those who now have access to health insurance. This number will increase as open enrollment begins for the individual mandate as part of the Affordable Care Act that begins on November 15, 2014.

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

Commissioner Bunnell asked about the mandatory HIPP enrollment number of 56 individuals. The current understanding is that this program requires a cost effectiveness analysis process that needs to happen before individuals enroll. Of the 705 individuals who are potentially eligible, have they been enrolled in Fee for Service (FFS) as they wait? Commissioner Toumpas answered yes; they are in the Medicaid FFS program as they wait for HIPP eligibility determination.

Commissioner Toumpas reviewed the Key Performance Indicator (KPI) report released by DHHS, which is part of the overall Medicaid quality program. The report is a standard document that DHHS uses to monitor performance of the MCM program and is posted on the DHHS website. Each month the report will follow the same format, building off baseline data from the first few months of the program. The KPI report has also shown data that result in DHHS action to make improvements. If something is troubling, DHHS will act upon it. There is a user guide embedded in document as a tool for those who review the report. The metrics contained within 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

For each major domain, Commissioner Toumpas reviewed the notable results. The first domain focuses on access and use of care. 25.6% of August transportation requested rides were not approved or not delivered. While this may represent an appropriate utilization, DHHS has determined that the measure does not provide all the necessary information to draw data-based conclusions about transportation requests. Therefore, DHHS is reviewing this measure with changes anticipated in early 2015. Rides that are not delivered will be categorized if the ride was cancelled by the member, by the provider, if the member failed to show up for transportation, or if the provider failed to show up. Clean provider claims are being paid accurately and within contract standards. A clean claim means it was submitted without errors and DHHS was able to process it. DHHS also noticed that the trend in answering provider calls within 30 seconds is downward, indicating a rising number of calls. This is something that DHHS will continue to monitor.

Commissioner Toumpas followed-up on seven specific issues raised by the Commission in October. DHHS plans to publically report out on the final KPI report in January 2015. The November KPI report been revised to refer to providers as Mental Health Practitioners, the term used in the national follow-up appointment measure. Currently, DHHS uses a combination of national standards as well as best practice benchmarks, and is working to incorporate comparators into the KPI report in early 2015. Also, as it relates to quality and care transitions, DHHS suggests that the Commission invite the MCOs to speak about their quality strategies in a future meeting.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the Key Performance Indicator (KPI) Report.

Commissioner Fox asked about transportation information not being approved nor delivered, and if there is a way to collect this data separately. Commissioner Toumpas explained that currently DHHS does not have this level of data for transportation services in order to know why a service was not provided. This issue is broader than transportation. DHHS is currently seeing this issue in two other areas within Step 1 MCM: service authorizations for therapies and prior authorizations for prescription drugs. DHHS is spending a full day with both MCOs to review real-life situations and cases that have had issues in these three areas to identify systemic problems vs. mistakes. As this happens, this will trigger additional data that needs to be pulled to answer these questions. DHHS acknowledges that the KPI is a living document that needs to adjust to new data that is collected to effectively monitor the MCM program.

DHHS Step 2 MCM Timeline Update

Commissioner Toumpas provided the updated timeline for Step 2 MCM and high-level design concepts. Step 2 MCM originally had three phases: (I) mandatory enrollment, (II) the Choices for Independence (CFI) Waiver and Nursing Facility (NF) services, and (III) the Developmental Disabilities (DD) waiver, Acquired Brain Disorders (ABD) waiver, and In-Home Supports (IHS) waiver services. A key change is that Phase I and II are begin combined into one phase. There was concern expressed that mandatory enrollment beginning before CFI waiver and NF services would require members to make two choices in a short period of time. Therefore, these phases have been combined. Commissioner Toumpas explained Step 2 MCM will be phased-in with a gradual approach. There will be minimal change in certain areas in the first year to increase continuity, especially with nursing home providers as it relates to their budget cycles. Design considerations of managed long term services and supports, including provider contracting and payment, will evolve over time.

Commissioner Toumpas introduced the new timeline that combines Phases I and II, which has enrollment into MCM opening on July 1, 2015, with coverage for those new enrollees and nursing home/CFI coverage for all enrolled individuals beginning on September 1, 2015. On July 1, 2015, DHHS will require all populations to select a health plan for their medical services, CFI waiver services, and NF services. On September 1, 2015, coverage with the health plan begins. The stakeholder input process will continue through December 2014. Initial stakeholder engagement and input was completed in October 2014, but additional forums will be held to elicit stakeholder feedback on the Step 2 Design Considerations in November and December for 2014. The submission of a waiver, MCO contract work, and other operations will occur between now and the start of the program. This also allows DHHS to explore the operational issues still occurring in Step 1 to further stabilize the program before adding additional members to the system.

Commissioner Toumpas explained the Department has reviewed the vision, principles, and guidance recommended by the MCM Commission for implementing a Managed Long Term Services and Supports Program (MLTSS) and focus on promoting health, wellness, independence, and self-sufficiency. The Department has conducted a detailed crosswalk of its actions taken and/or planned for Step 2 to each of the MCM Commission's recommended principles and principle implementation guidance. This crosswalk will evolve over time and be shared publically as the Department plans for and implements Step 2 MCM. The Department is mindful of these recommended principles and plans to continue to crosswalk all of its

actions to these principles. The example provided underscores to the Commission that DHHS has taken this seriously.

Commissioner Toumpas reviewed key questions heard thus far in the stakeholder engagement process with respect to Step 2 MCM that DHHS will address in its key concepts:

1. Who will determine eligibility for the CFI Waiver and Nursing Facility services?
2. How will CFI Waiver and Nursing Facility services be authorized, and by whom?
3. Who will manage the care for people receiving either CFI Waiver or Nursing Facility services?
4. How will existing service providers operate as part of the health plan's provider network? How will payment rates be determined?
5. Will I be allowed to manage my own budget for CFI Waiver services?

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the Step 2 MCM timeline.

Commissioner McNutt asked about the waiver process that DHHS is considering. Commissioner Toumpas explained that developing an 1915(b) waiver is the likely path that DHHS will take, however there are different stakeholder engagement and public processes involved with the development of a waiver, and DHHS will use the more rigorous stakeholder process for an 1115 waiver even if it submits an 1915(b) waiver.

Commissioner Toumpas introduced Susan Lombard from the Bureau of Elderly and Adults Services (BEAS) to introduce the draft design considerations that address these key questions. These draft design concepts were developed after BEAS held 12 stakeholder sessions from late summer to October 2014. In response, DHHS drafted design considerations to answer the questions raised and discussed during these sessions. First, the Department will continue to determine eligibility for CFI waiver and NF services both clinically and financially. Currently, DHHS has a process where acute, preventive, and all types of more mainstream medical services are provided in one system either through one system: a health plan if enrolled in MCM, or FFS if not enrolled. In many cases, these services are not managed. The person navigates what services are best to help them maintain their health. On the long term care side, BEAS authorizes each service that a person will receive through the CFI waiver program, from personal care, meals, nurse visits, etc. The waiver participant has a case manager who identifies providers and renders services. Currently, there is not a connection between these types of care; recipients do not have the benefit of having all services managed through a whole person approach. The seven case management

agencies operating in New Hampshire provide case management services for people in the CFI waiver program. In Step 2, all CFI waiver service providers currently enrolled and meeting criteria will be offered a contract in Year 1 of Step 2. The reimbursement rates for CFI services will equal the Department's current fee schedule in Year 1. Another question raised by stakeholders was the ability for consumer-directed budgeting for CFI waiver services. In Step 2, the Department will develop a consumer-directed and managed long term services and supports option with stakeholder input. The Department will then request approval for this new service from the Centers for Medicare & Medicaid Services (CMS).

Ms. Lombard then reviewed the key questions with respect to NF services. Eligibility for the CFI waiver and NF services is the same; therefore The Department will continue to determine eligibility for NF services. In Year 1, the health plans will authorize coverage of NF services based upon criteria approved by the Department. Current service authorizations will be honored by health plans, unless the client's condition changes. The Department will approve any reduction in services recommended by health plan during the first year. The administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply. Also in Year 1, the health plans will coordinate the integration of medical care and NF services using a whole person approach under the direction of the Department. In Year 1, health plans will offer contracts to all NF that are currently licensed, Medicaid enrolled, and meet applicable requirements from the National Committee for Quality Assurance, but payments will continue to be calculated by the Department under an acuity-based payment model. This has been a key question raised by NF providers. The Department as met with NF providers multiple times to date and plan to do so as further planning continues.

To date, The Department has scheduled five public sessions in December when it will present further detail for discussion. The feedback received throughout this period will be used as DHHS continues to develop the design concepts. Another round of public sessions will be scheduled for early 2015. The five scheduled sessions are as follows:

- December 1 in the Brown Building Auditorium at 1:30
- December 2 at the Keene Public Library at 1:30
- December 8 at the Genesis Health Center in Lebanon at 1:00
- December 10 at the Littleton Area Senior Center at 12:45
- December 16 in the Brown Building Auditorium at 1:30

Information will be posted in advance of these meetings on the Department's Medicaid Care Management, Step 2 website: <http://www.dhhs.nh.gov/ombp/caremgmt/step2.htm>. Stakeholders can also send e-mail concerning Step 2, Phase I, to the Bureau of Elderly and Adult Services at: beasmcmstep2@dhhs.state.nh.us.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the Step 2 MCM update.

Commissioner Moral asked if any reduction in services will be approved by the health plans after the first year. DHHS will do this approval for the first year, and Year 1 is the focus of today's meeting. DHHS will explore how this is handled in the subsequent years. DHHS expects to work with the plans on authorization policies. Commissioner Toumpas added that because of timing, we are taking a very substantive discussion and shrinking it to fit the time allotted in today's meeting. This type of information will be presented in December at greater length. Year 1 is a starting point for discussion. Some things will change in the subsequent years, while some will not. The Governor's office is still reviewing the Step 2 design materials developed to date; therefore, DHHS is not prepared to comment on design considerations beyond Year 1.

Commissioner Goldsberry commented that given that health plans may contract with existing care management agencies, which does not appear to be a requirement, there is concern around the same issues in Step 1 in terms of network adequacy and enrolling primary care providers that people who have certain providers would not continue to if they did not contract with an MCO. This could be a similar issue that should be considered.

Commissioner Fox similarly stated that because the MCOs may provide care management services or contract to do so, there should be thoughts about when a private care management company would be used over an MCO. What are the criteria for deciding how this occurs? This area requires more discussion. This also raises issues with conflict free case management. Commissioner Toumpas explained that in December this concept will still be a draft for stakeholder input and these will be points will be raised for discussion. DHHS wanted to present these considerations to open up the floor for proactive questions that will stimulate the discussion at stakeholder forums in December. This will enable a dialogue for subject matter experts, the MCOs, and stakeholders to contribute to. This is intentional language to allow for further discussion.

Public Comments and Questions on MCM Implementation Update by DHHS

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

Public comment; not identified – The MCOs can make suggestions for reduction in care to the waiver programs. Can the MCO recommend a reduction in care for a person receiving waiver services? For Year 1 of Step 2, the MCO will have to go through DHHS but can make a suggestion. These reductions need to be approved by DHHS. DHHS needs to identify what level of involvement the MCOs will have had with the person before they start making care recommendations. Also, when funding is taken away from this program, where does it go? In the CFI waiver program, there are no set budgets. There are individual services authorized on a provider basis; therefore, DHHS will not be reducing a set budget. A change in amount of services is a more accurate description, which relates to DHHS' overall budget.

John Poirier, New Hampshire Health Care Association – When will DHHS have draft of this prior to the December meetings, e.g. how far in advance? Commissioner Toumpas added that the Governor and her staff are reviewing this and DHHS will not release details until it is agreed upon by the Governor. DHHS intends for this to be as early as possible before December, but cannot confirm a date.

Commissioner Toumpas reiterated that email address for BEAS is live right now (beasmcmstep2@dhhs.state.nh.us) and encouraged the public to submit questions in advance of the December stakeholder sessions so that they may be raised and addressed.

Clyde E. Terry, Granite State Independent Living – Commissioner Toumpas referred to economic self-sufficiency as a principle for Step 2. As BEAS moves forward, it needs to keep this in mind and may need to make policy changes to enable employment services for those in the CFI waiver program. Employment will promote an individual to be healthier and provide savings for the MCOs. We should not to lose sight of this in Step 2. To summarize, the recommendation is that as program planning continues, BEAS should look at making policy changes that would support and encourage employment supports.

DHHS NHHPP Update

Commissioner Toumpas explained that the Premium Assistance Program for the NHHPP population. This phase will transition the NHHPP population from managed care coverage to Qualified Health Plans on FFM beginning on January 1, 2016 (per SB 413) if approved by CMS. Public hearings and the comment

period for the Premium Assistance 1115 Waiver just concluded on October 31, 2014. The final waiver application was submitted to the Fiscal Committee for its November 10 meeting. Assuming Fiscal approval, DHHS will file this waiver with CMS as quickly as possible. The waiver must be approved by CMS by March 31, 2015, per SB 413 for the NHHPP program to continue past December 31, 2015.

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. CMS is now requiring all states to demonstrate how delivery and payment systems will change with new Federal funding DHHS is working to reformulate waiver requests and will hold public information sessions in December.

Commissioner Vallier-Kaplan thanked Commissioner Toumpas for this update and acknowledged the amount of work done that DHHS has over the past months to ensure the NHHPP's success.

DHHS MCM Step 2 Readiness Review Process Update

Commissioner Vallier-Kaplan introduced Lisabritt Solsky, Deputy Medicaid Director within DHHS, to provide an update on the Department's readiness review process. Ms. Solsky explained that readiness review is a comprehensive assessment by DHHS of the MCO's readiness to commence provision of coverage to Medicaid enrollees. Readiness reviews focus on people, process, and technology necessary to support the business functions for contract compliance. DHHS typically uses a dynamic team of subject matter experts which includes representation from CMS Regional and Central Offices. It is important to recognize that readiness review is a collaborative exercise designed to reveal what is working as envisioned and where there are areas for improvement such that process improvement can occur.

As it relates to the process, readiness tools are shared with the MCOs in advance to assure they are prepared to present all the necessary information and demonstrations in an efficient and comprehensive way. This collaborative approach is taken so that the MCOs are comfortable with the material and are therefore able to address issues that arise during the review. There are multiple components in doing readiness review. The most time consuming is document review, which is typically completed before an onsite visit and includes member and provider facing materials, marketing materials, policies, and anything else being associated with the MCM logo, in which DHHS needs to agree with content and tone.

Ms. Solsky described the work that DHHS does in the form of live system demonstrations. The MCO demonstrates their system capabilities, in a test environment, to load member demographics accurately, to retrieve member information by call center staff, to process claims correctly, record outreach efforts, and more. To assess the consumer experience, DHHS creates use case scenarios that cover the most common types of member or provider concerns and then runs the scenarios as a role play with appropriate staff with responsibility for the particular need. These are real-life cases and examples may include arranging transportation, looking for a provider, crisis caller, benefit inquiry, and complex high-need member in need of care coordination and/or case management.

Another important component of readiness that was very important in launching Step 1 of the MCM program is network adequacy. DHHS has several rules in its assessment of network adequacy. Network adequacy is assessed based on New Hampshire Insurance Department (NHID) regulations. CMS has been excited about this approach of analyzing by zip code the number of members they were likely to have in their plan. DHHS then asks who the MCOs' providers are in these areas and if distance meets NHID regulations. This process is working to ensure adequacy within the provider network being constructed by MCOs. This assessment is a theoretical determination of whether there are enough providers of a certain type to meet the needs of membership of a certain size. It is not a proxy for access or disruption. For the first readiness review within Step 1, the MCOs had to demonstrate that their networks could assure compliance with NHID standards for 80% of their anticipated membership. Each MCO was to assume 50% of the potential mandatory enrollment and 25% of the voluntary enrollment. DHHS issued member counts by zip code. For the second readiness review within Step 1, the MCOs had to demonstrate that 90% of the membership (again 50% of the mandatorics, 25% of the voluntaries) would meet the NHID standards. The high assumption of membership per MCO assured that each MCO had excess capacity since 150% of the potential membership was being matched to providers. For the NHHPP, DHHS could not issue a member count by zip code because DHHS did not know who these folks would be, from what zip code or how quickly they would enroll. However, having essentially demonstrated excess capacity in Step 1 provided a high-level of assurance of the adequacy of the existing network for most care. For substance use disorder (SUD) providers, DHHS created a new standard. For the NHHPP, ongoing monitoring of the network is a key component as we learn more about the membership.

For the first phase of Step 2 in terms of network adequacy, many of the tools and approaches to Step 1 network adequacy are exportable to Step 2, particularly because DHHS knows who the members are and where they are. Still, Step 2 readiness will be different than Step 1. Care and creativity will be taken to assure acceptable levels of competency in managing the Step 2 populations with particular attention being

paid to assessing the flexibility of policies and procedures to not rely wholesale on a medical model but to look at the whole person. Use case scenarios will be used again, likely with some real members, where DHHS will test both the people and processes for this competency. With the actual readiness reviews for Step 2 being about a half a year away, there is plenty of time to develop more of the details, tools, scenarios and the like. Dates for readiness review are not concrete, but as they are scheduled DHHS is can present to the Commission to review any new tools, scenarios, etc. that are relevant. DHHS and the MCOs have been meeting weekly to provide insight and discussion regarding all aspects of current LTSS, both what works and where there is opportunity for improvement and innovation, and MCOs are also developing relationships with some LTSS providers and stakeholders to date.

Public Comments and Questions on MCM Step 2 Readiness Review Process Update

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

Commissioner Goldsberry mentioned how readiness review includes consumer experience, and asked if/how provider experience will be reviewed, as this was an issue in Step 1. Ms. Solsky explained how the Department will spend time separate and apart from network adequacy to evaluate if providers know who to contact at the MCOs, if they understand the grievance process, if they understand how to look up preferred drug lists (PDL), if they can do eligibility checks, etc. DHHS regularly spends time with provider relations representatives at both MCOs to keep this line of communication open.

Commissioner McNutt asked about network adequacy and how DHHS could rely on other models that are out there, e.g. not just looking at network as it looks today, but the state's network to provide other services. Ms. Solsky thanked the Commissioner for his comment and identified this as something that DHHS will look into as the readiness review process moves forward.

Commissioner Bunnell cited recent press from CMS that indicates its plans to issue new federal rules that are designed to strengthen access within MCM and network adequacy. Does DHHS have insight into what these new standards may be and how its current approach will adapt to this? DHHS does not have any formal insight into these federal rules, yet CMS has not signaled to the State that it should require significant changes to its approach.

Commissioner Vallier-Kaplan announced a meeting break until 3:00pm.

MCM Step 2 Provider Education Panel

Commissioner Vallier-Kaplan introduced Betsy Hippensteel from DHHS to discuss how providers will be communicated with in Step 2. Beginning next week, all providers will be emailed via State MMIS email blasts with a Step 2 heading. This communication will also be posted on the DHHS website, eStudio which is currently used for BEAS provider notices, and mailed in some instances. The Step 2 website for providers will include all news updates, links to relevant DHHS documents, a brief description of the health plans with links to their websites, a calendar of scheduled provider trainings, conference calls, and webinars from completed provider trainings.

In addition, provider forums will be held both in person and via webinar and be posted on the website. Transcripts will be made available for each forum. Some Step 2 providers have no experience with MCM, so the first forum will target those with limited MCM experience. DHHS is working on each provider type within Step 2, building profiles for them that highlight what they do, the services they bill for, specific questions they ask, etc. This is something that DHHS is doing differently than Step 1, to target each individual provider type. During training sessions for each training group, DHHS will review aspects such as eligibility, checking plan enrollment in MMIS, claims submission and payment, prior authorization for services, grievances and appeals, provider resources, etc. DHHS will also distribute a quick reference guide handout to all providers, as an easy, quick tool to know who to contact, when, and where. Also, during at least the first six weeks after program start, DHHS and the MCOs will hold conference calls for as long as there is a need.

Commissioner Vallier-Kaplan introduced Provider Relations representatives from both New Hampshire Healthy Families and Well Sense Health Plan.

Karen Kimball, New Hampshire Healthy Families, Director of Long Term Care Supports and Services, has worked in this system for almost 30 years. One of the lessons most clear is that the way we achieve positive outcomes for those we serve by building strong, collaborative, durable relationships. NHHF understands this message and wants to work hard with the provider community to build these relationships. NHHF is partnering with DHHS to host upcoming provider forums. NHHF is also actively engaged in meeting with providers and understanding specific needs and supports required for Step 2 providers. As we move into Step 2, some of the supports available to providers will be orientations, scalable to what the provider feels will work best for them. Providers are already reaching out to NHHF requesting this type of communication and to begin working together. Webinar sessions can engage

multiple providers at any one time. In these sessions, NHHF will discuss the whole person approach and integration of medical management, which is one of the primary goals of Step 2. NHHF also has provider relations staff dedicated to Step 2 providers, as value added programs and services on the provider website will differ for Step 2 providers. These providers are best positioned to tell them what these programs would be so that NHHF can design programs and services that are specifically useful to these populations. Staff will go out after go-live to work through live issues, as done during Step 1. NHHF also has a secure portal for providers to do things such as Product/Benefit Information, Eligibility verification, Individual Care Gaps and Plans, Secure Messaging, Claims Submission, Provider Self Service, and Authorization requests and verification. This is used successfully now and should transition well into Step 2. NHHF staffs dedicated provider relations specialists to serve as a liaison between primary contacts for providers, operates a call center and interactive voice response (IVR) system, as well as provides written materials. NHHF is open to creating additional written materials if providers request as necessary, and adapting any of its resources to better fit Step 2 providers' needs.

Laura Pizza Plum, Regional Manager, Provider Relations, Well Sense Health Plan, discussed Well Sense Health Plan's provider relations team that serves as the primary liaison between the Step 2 provider community and the MCO. This team uses a multi-faceted communication approach that includes Provider Welcome/Introduction letters for new providers, a Welcome kit that contains a welcome letter, quick reference guide and all materials needed to do business with the MCO, hosting Provider Forums that focus on comprehensive education on MCO operations, staff Provider Relations Consultants that visit provider offices, maintain a Website that includes a Provider Manual, medical, reimbursement, prior authorization and claims policies and procedures, distributes Quarterly Provider Newsletters, and hosts Monthly meetings with key providers as requested. Well Sense Health Plan's new provider training strategy for Step 2 providers will review working with the MCO as well as benefit differences. This training and subsequent communications will include information for providers on issues such as Enrollment, ID Cards, Eligibility & Benefits, Claims Submission, Policies & Procedures, Prior Authorizations, Access & Availability, Appeals & Grievances, Plan Contacts, Provider Manual, Provider Web Site and Portal, and Interacting with Vendors. It is important to note that each of Well Sense Health Plan's sub-contractors (vendors) follow the same training model and will work as closely with Step 2 providers.

Commissioner Vallier-Kaplan explained that the feedback received and experiences learned from Step 1 is we cannot do "too much" to help providers get ready. The Commission is seeing from DHHS and the MCOs a lot of advance thinking and wanted to show this to the public today. Commissioner

Vallier-Kaplan then opened the meeting to the Commissioners and the public for comments and/or questions on provider education.

Public; not identified – As a provider, the fact that DHHS and the MCOs are thinking ahead towards this is reassuring. With regards to the MMIS email blast, DHHS needs to ensure that the two MCOs have a complete email list before doing so, and needs to ensure that this information is solicited ahead of time.

Principles for MCM Step 2 Developed by the Commission

Commissioner Vallier-Kaplan introduced Commissioner Fox to discuss the updated set of Step 2 MCM principles developed as the Commission's benchmark that defines what is most important in their role to move into the next phases of MCM. Commissioner Fox indicated that a small change has been made under implementation guidance under payment structure to ensure the providers have education and support to implement new billing and payment process for service delivery.

Commissioner Fox opened the meeting for any further discussion on the principles and asked if, following the discussion, the Commission would be comfortable with voting on making it a recommendation to the Governor. The Commission has made several formal recommendations to the Governor to date, so this Step 2 principles document would be added.

Commissioner Shumway provided written comments submitted online by Commissioner Gladstone to assure that certain language be more inclusive of children. Commissioner Fox will make these changes.

Commissioner McNutt asked if was appropriate to move for a vote. Commissioner Vallier-Kaplan added that unlike other recommendations, these principles have not been shared yet with the Governor but will still be submitted. Commissioner Bunnell complimented the diligent and thoughtful work that has gone into these principles. It is important to clarify that these are not principles for DHHS but for the Commission, although there is evidence that DHHS has reviewed them with its crosswalk presentation today. Upon a motion duly made and seconded, the Step 2 MCM principles will be submitted as a recommendation to the Governor.

Public Listening Session and Next Steps

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

Public comment; not identified, provided electronically – When the updated Step 2 timeline was up, the right hand date arrow pointed to the September 1, 2015 go-live point. The question is how this date has been arrived at. Commissioner Toumpas said that once someone enrolls, they will have 60 days to select an MCO, therefore this date is 60 days past the enrollment start date of July 1, 2015. Those individuals already in Medicaid would also have the opportunity to enroll in one of the MCOs and have 60 days to do so.

Public comment; not identified – Are all the individuals who were able to opt out of Step 1 going to be included in the enrollment date of July 1, 2015? Yes, this is correct. Second, how was the September 1, 2015, date arrived at given that there is still so much work to do and CMS approval for a new waiver takes about a year. Commissioner Toumpas said that an 1915 waiver does not have the same level of complexity of an 1115 waiver, so this timeframe is feasible. This is the current timeline and plan that is being worked towards. There are dependencies between contacts, G&C, legislature, committee, and the Federal government that could add additional time, but this is the plan that is believed to be reasonable for CFI waiver services, NF services, and mandatory enrollment.

Public comment; not identified – As MCM evolves, is there any expectation on part of the state that two payments/shares currently made to NFs will not continue to be available and paid? Commissioner Toumpas explained that yes, these payments to NFs will continue going forward. The issue is that how these will get paid will change. DHHS is working on this now and briefed the County Commissioners recently, along with private NFs to give them insight. DHHS cannot make separate payments outside of capitation payments made outside of MCM rates, this needs to be blended. DHHS will be coming back to the County Commissioners as well as private NFs to review its approach to making this one payment. The intent is to look at the amounts being paid beginning July 2015 and adapt so these payments keep NFs whole for what they would have received through separate payments. DHHS needs to change this due to federal law, which will require a statute change on behalf of the legislature. Second, the reimbursement that is paid for services in addition to these two payments is acuity-based. These calculations will always be made by a state agency or an MCO. In Year 1 of Step 2, DHHS will continue to make these payments. DHHS cannot comment on Year 2 and beyond.

John Poirier, New Hampshire Health Care Association – There has to be transparency within this NF payment process so that providers and taxpayers who are impacted by this have a high level of confidence

that these numbers are being incorporated into the rates. DHHS has assured the county nursing homes that this will happen and has committed to transparency throughout the process.

Commissioner Vallier-Kaplan adjourned the meeting at 4:00pm. The next meeting will be held in Concord on December 4, 2014.

Follow-Up Items

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

- DHHS to include an update on Step 1 transportation services issues/progress during each future MCMC meeting presentation
- DHHS to present Step 2 MCM design concepts for Years 2-3 of the program at December's MCMC meeting
- DHHS to review and consider making it a requirement vs. an option for MCOs to contract with existing/private care management agencies/companies
- DHHS/BEAS to consider making policy changes that would support and encourage employment supports for CFI waiver enrollees in Step 2
- DHHS to review other models and/or state networks as it reviews the MCOs for network adequacy
- DHHS to remain committed to transparency as it develops and/or changes Nursing Facility reimbursement processes during Step 2