

**Report to Governor Maggie Hassan:
November 7, 2013**

**Review of Implementation Preparedness,
New Hampshire Medicaid Care Management Program**

**Submitted By:
The Governor's Commission on Medicaid Care Management**

**Pursuant To:
Executive Order 2013 - 05
An order establishing the Governor's commission to review and advise
on the implementation of New Hampshire's Medicaid care management
program**

Table of Contents:

Commission Membership	3
Review Process	4
Commission Findings and Recommendation #1 and #2	6
Meetings of the Commission	9
Appendix 1, Concerns And Priorities Reviewed By The Commission	10
Appendix 2, Review Summary	11

The Governor's Commission on Medicaid Care Management

Commission Membership

Mary Vallier-Kaplan, Chair; former Vice President of the New Hampshire Endowment for Health

Donald Shumway, Vice Chair; President and CEO of Crotched Mountain Rehabilitation Center and former Commissioner of the Department of Health and Human Services

Thomas Bunnell, policy consultant for NH Voices for Health

Susan Fox, Associate Director at the UNH Institute on Disability and a parent of a child with developmental disabilities

Wendy Gladstone, MD, pediatrician at Dartmouth-Hitchcock Medical Center's Child Advocacy and Protection Program

Yvonne Goldsberry, Ph.D, MPH, Vice President of Population Health and Clinical Integration at Cheshire Medical Center/Dartmouth-Hitchcock-Keene

Catherine McDowell, founder of Coos Family Health and currently consultant with McDowell Project Management (resigned September 2013)

Douglas McNutt, Associate State Director for Advocacy, AARP NH

Gustavo Moral, President of Independent Services Network

Kenneth Norton, Executive Director of NAMI New Hampshire

Jo Porter, MPH, Deputy Director of the NH Institute for Health Policy and Practice.

Commissioner Nicholas Toumpas of the Department of Health and Human Services (ex-officio member of the Commission).

Twelve Commissioners were appointed by the Governor. They bring expertise in areas such as; managed care and payment reform models of care, Medicaid public policy, elderly affairs, children's health, public health, mental health, developmental disabilities and adult health care services.

Staff members from both the Governor's office and the Department of Health and Human Services provide consultation to the Commission upon request.

Review Process:

This Commission report is issued after eight months of review of the New Hampshire Medicaid Care Management Program and in anticipation of the imminent implementation of this major change in the policy and operations of our critical health safety net. We wish to begin by recognizing the prudence of “external review” as shown by Governor Hassan in regard to complex change that affects so many citizens of the State and relies on such major commitment by the public.

The Commission on Medicaid Care Management has held eight meetings, listened to twenty four hours of testimony from sixteen experts, taken hundreds of comments and questions from the public, reviewed dozens of documents, and submitted two initial recommendations to Governor Hassan. The Commission’s work was carried out in accordance with the Executive Order 2013 – 05, reflecting the following goals:

- Assuring the implementation of Medicaid care management in accordance with Senate Bill 147-FN (Chapter 125, Laws of 2011) and the State’s contracts with three managed care organizations;
- Assuring that implementation achieves goals of improving access to eligible populations, quality and appropriateness of care and cost effectiveness.
- Assuring that implementation reflect the best practices of managed care models and payment methods;

Priority consideration was placed on the most immediate and urgent tasks occurring in the initial implementation of Medicaid Care Management, such as the review of network formation, enrollment processes, and the use of best practices in respect to the acute care services of Step I. Consumer protection, safety net provider stability, and operating performance and efficiency were reviewed throughout.

With “Go-Live” for Step 1 the Commission will reset its priorities and focus. Likely ongoing efforts will reflect consideration of the availability of high quality patient centered medical homes as well as the provision of best practices in behavior health. Additional considerations are likely to include: assurance of patient’s rights protections; the evaluation of Step 1 implementation at periodic points in the coming months, particularly in relation to enrollment and provider networks. Review of evaluation data has been made a recommendation, yielding an opportunity for publicly engagement, intended to assure the best results for enrollees as well as essential providers.

At this time we have also started the review of Step 2, i.e. the long term supports and services provision to New Hampshire’s Medicaid enrollees. This review has begun with the presentation of DHHS planning timeframes. Substantial upcoming work of the Commission will be focused in this area. Ongoing public testimony will be sought.

The Commission’s work is based on establishing “open” communication among all stakeholders. Based on the testimony and questions received and in anticipation of inevitable challenges for all involved, the Commission is working to build non-partisan

engagement, stakeholder knowledge and readiness and, through transparent public review, assure necessary public engagement and dialogue.

Commissioner Questions “On The Table” at this time:

- The ability to fully absorb expanded populations and Marketplace enrollment.
- Strategies for developing efficiencies across MCOs eg billing processes.
- State Innovation Model grant proposal concept and implementation plans.
- Review of CMS guidelines for step 2 process, timeline, and communications.
- Process for monitoring evaluation data.
- Changing to be more prevention focused (incl. PCMH) both within the health care delivery system as well as for people who use services. How will public health be measured?
- How the interface between community care and inpatient services for people with severe mental illness will be managed.
- What is the role of tele-health in the provision of services and in the provision of consultation?
- Shortage of some health professionals (eg. Primary Care, Child Psychiatry etc).
- MCO's moving the 10 year behavioral health plan forward.
- Complying with the American with Disabilities Act/Olmstead Decision. What key performance indicators will be utilized to measure and assure accountability?
- Performance indicators to measure and to promote integration between primary care and behavioral health care.
- Treatment for substance use disorders is an Essential Health Benefit (EHB) under the Affordable Care Act. When will NH move ahead with Medicaid coverage for Substance Use Disorder treatment?
- Monitoring patient grievances
- Given the provider network changes inherent in a contracted MCO model, how can we ensure best practice care coordination and service integration for enrollees?
- Other “special population services” and their planning process.
- What is the scope and construct of the 1115 Waiver, and how will it alter implementation?
- Review process for financial/cost data.

The Commission has found:

1. The Department of Health and Human Services should be commended for its diligence and skill in preparing for the implementation of Medicaid Care Management. In the face of rapid change at all levels, the leadership and staff of the Department has consistently reflected excellent commitment to successful implementation through seeking public engagement and dialog, the establishment of appropriate policies, and working towards the protection of vulnerable citizens. This planning is consistent with the statutory requirements of Senate Bill 147-FN (Chapter 125, Laws of 2011). In particular the Commission believes that the Network Adequacy, the Enrollment Process, and the Care Management Quality Strategy has been thorough and thoughtful and each reflect approaches that address the major areas of concern in managed care models.
2. The expansion of the Medicaid program must occur so as to provide a more efficient, effective, and more cost effective health care system in meeting the needs of New Hampshire's citizens into the coming decade of major change. As such, the Commission issued to the Governor Recommendation #1:

The Governor's Commission On Medicaid Care Management Hereby Recommends That Medicaid Expansion Be Implemented In New Hampshire Due To Its Necessity In Ensuring The Successful Transition From A Medicaid Fee For Service System To A More Efficient, More Effective, And More Cost-Effective Medicaid Care Management System In The Granite State.

The Commission recommended, with urgency, that Medicaid expansion be approved by the State to assure the fiscal stability of New Hampshire's Medicaid Care Management system.

"In the unanimous opinion of the Commission, failure to proceed with the expansion jeopardizes the entire care management initiative and the ability of the Department of Health and Human Services to carry out its legislative mandate in this regard."

It is the Commission's belief that the three managed care companies hired by the state would operate with greater efficiency by utilizing a larger enrollment base and thereby lowering administrative costs.

3. The Commission has acknowledged that, as with all changes, ongoing implementation is very complex. Transparent operations and responsive accountability are vital to assuring effective and efficient results. Therefore the Commission issues to the Governor, Recommendation #2:

Governor's Commission on Medicaid Care Management

Recommendation #2

A Recommendation To Assure, Upon The Implementation Of Medicaid Care Management, The Identification Of Any Major Problems And To Assure Their Rapid Remediation. This Assurance Is Secured With Independent Review And Through Public Transparency, Of The First Seven Months Of Operations.

November 7, 2013

The Governor's Commission On Medicaid Care Management Hereby Recommends That The Governor Request From The Department Of Health And Human Services (DHHS) Systematic Public Reporting Of Information That Tracks Implementation Concerns, As Consistent With DHHS Data Collection Process And Other Reporting Requirements Associated with Medicaid Care Management.

Beginning With The Initial Implementation Of Medicaid Care Management And Through June 30, 2014, The Commission Recommends That The Governor Request That DHHS Establish Public Information Reporting On A Key Set of Issues Which Have Been Identified During Commission Meetings As Those That Are Priorities For Successful Public Benefit of Medicaid Care Management. The Commission Recommends That The Reporting Be Completed On a Timely Basis, Published As Frequently As Monthly When Applicable.

The Concerns To Be Addressed In Reports Include:

- **Status of Enrollment In Medicaid Care Management - Key Metrics That Allow for Monitoring on Enrollment To Include:**
 - **The Number Of Recipients Who Have Enrolled In The Program,**
 - **The Number Of The Voluntary Population Who Have Chosen To Opt Out,**
 - **The Number Who Have Selected A Health Plan,**
 - **The Number Who Have Been Automatically Enrolled,**
 - **The Number Electing to Change The Plan Selection After Initial Enrollment, and**
 - **The Reasons for Plan Selection Change.**

- **Enrollee Satisfaction - Key Issues To Be Assessed That Gauge Enrollee Satisfaction Include:**
 - **Concerns Raised During Calls And Other Contacts With DHHS and MCOs Reflecting Concerns And Barriers In Enrollment Processes,**
 - **Assessment of Network Adequacy and Provider Coverage Across MCOs,**
 - **Service Authorization Tracking by MCOs, Including Types of Authorizations and Disposition of Requests for Authorizations.**
 - **Additionally, Other Major Problems That Come to DHHS' Attention**

- **Provider Concerns - Key Issues To Be Assessed Regarding Provider Concerns Include:**
- **Reflecting Concerns And Barriers In Enrollment Processes,**

- **Assessment of Network Adequacy and Provider Coverage Across MCOs,**
- **Service Authorization Tracking by MCO's Including Types of Authorizations and Disposition of Requests for Authorizations,**
- **Issues in Claims Payment Processes.**
- **Other Major Problems That Come to DHHS' Attention**

The Commission Also Recommends And Endorses That The Regularly Published Reports Of DHHS Provide Information About Medicaid Care Management Progress And Include:

- **The DHHS Dashboard**
 - **Frequency: Monthly**
- **The Monitoring Access To Care Report**
 - **Frequency: Quarterly**
- **The NH Medicaid Annual Report**
 - **Frequency: Annually**

This Information Should Be Submitted To The Governor, Health And Human Services Oversight Committee Of The NH General Court, The Governor's Commission On Medicaid Care Management, The Medical Care Advisory Committee, And Posted On The DHHS Website.

Rationale:

The Commission finds that the Department has reflected vigilance in carrying out its mission in all aspects of planning within a complex and evolving political and practice environment and a difficult to predict future of the Medicaid program.

The Commission believes that transparent communication, via critical data and reports, based on efficient reporting and analysis, is vital to the effective implementation of Medicaid Care Management. The release of these reports, consistent with the Department and the MCO reporting schedules will allow continuous improvement of quality, satisfaction, and efficiency. Transparency builds a shared understanding and commitment to success among all stakeholders.

The Commission recommends an ongoing commitment to early identification and correction of any concerns as key to adherence to the requirements of Senate Bill 147-FN (Chapter 125, Laws of 2011) and fulfillment of the Federal compliance requirements of the Medicaid program.

The Commission hopes that this reporting structure, which includes CMS required, State contracted "external review" as supplemented and reinforced by additional, independent reviews that are in process, will assure a high degree of understanding of our public's health and health management in New Hampshire. We commend the Department for its commitment to a collaborative quality improvement process.

The Governor's Commission on Medicaid Care Management recommends that Medicaid Care Management reporting be formalized, comprehensive, and publicly engaging in New Hampshire in order to ensure that the Medicaid care management initiative is well implemented and will succeed in our State.

Meetings of the Commission

The public is invited through widely circulated announcements. Recommendations and minutes from the Commission meetings and related materials including dates and locations for upcoming meetings can be found at www.governor.nh.gov under Medicaid Managed Care Commission.

Meeting agendas are maintained in a fashion in which public comments are invited periodically throughout and also upon the conclusion of the structured agenda. Commissioners have and will continue to visit varying locations and groups. More than 50 members of the public attended each meeting.

The Commission would like to express our appreciation to speakers who have provided formal presentations to the Commission including:

Commissioner Nick Toumpas, DHHS
Lisabritt Solsky, Deputy Director, Office of Medicaid Business and Policy, DHHS
Mary Ann Cooney, Associate Commissioner, DHHS
Carol Sideris, Director of Client Services, DHHS
Susanne Cassidey, Product Implementation Director, Well Sense Health Plan
Christopher Ware, Director of Customer Care Center, Well Sense Health Plan
Christine Shannon, Bureau Chief, Planning and Research, OMBP, DHHS
Maya Glover, Senior Management Analyst, OMBP, DHHS
Aaron Brace, Senior Vice President, NH Healthy Families (Centene)
Maria Scott, Provider Relations Manager, Centene
Dr. Carl Cooley, Center for Medical Home Improvement/Crotched Mountain, Greenfield, NH
Dr. Don Caruso, Dartmouth Hitchcock Clinic and Cheshire Medical Center, Keene, NH
Dr. Doris Lotz, Medicaid Medical Director, DHHS
Bill Gunn, Capital Region Health Center
Steve Arneault, Center for Life Management
Erik Riera, Bureau of Behavioral Health

And appreciation is extended to the public for offering their helpful comments.

Appendix 1

Concerns And Priorities Reviewed By The Commission

The following list of concerns is used by the Commission for the purpose of organizing review and recommendation. The list includes both generic aspects of Medicaid Managed Care that affect all enrollees as well as specific programs or populations. This list follows the construct for technical assistance outlined by the federal Center for Medicaid and Medicare Services (CMS).

Managed Care Program Planning and Procurement

- State Law Managed Care Directives and Authorities
- Rate Setting and Risk Adjustment
- MCO Contracting and Purchasing
- Stakeholder Engagement

Access, Quality and MCO Financial Monitoring and Oversight

- Operating Standards and Controls
- Measuring Provider Network Adequacy and Performance
- Quality Measurement, Reporting and Improvement
- MCO Financial Oversight
- Monitoring and Enforcing MCO Compliance with Contract Provisions
- Ensuring Program Integrity and Preventing Fraud and Abuse in MCO's and Networks

Beneficiary Enrollment, Education and Rights

- Beneficiary Education/Information
- Contracting with Enrollment Brokers
- Developing and Implementing Auto-Enrollment/Auto-Assignment Strategies
- Managing Grievances and Appeals

Data

- Evaluating Population Experience for Performance Measurement
- Developing or Implementing Information Technology and Systems
- Encounter Data Collection and Validation

Benefit Design and Specialized Services and Populations

- Medical Homes
- Behavioral Health Services
- Behavioral and Physical Health Integration
- Other, i.e. DME, Transportation, Pharmacy

Managed Long-Term Services and Supports

- Dual Eligibles and Managed Care
- Step Two Services Integration With Step One
- Developmental Disabilities Service Delivery
- Older Adult Service Delivery

Appendix 2:

Review Summary, (As Excerpted From Minutes)

MAY 1, 2013

Commissioner Shumway reviewed the Commission meeting structure and responsibilities. The commission will dedicate itself to listening to the public, bringing information to all attendees, and providing review and recommendation on implementation of New Hampshire's managed care program.

This first meeting is occurring within 30 days of the Executive Order and has been posted under the public notice requirements. This is a nonpartisan, public access process. Meetings will be held in a variety of locations around the state and meeting structure will include public input. Those who want to attend and need special assistance will be accommodated. Advanced notice of special accommodation is requested when possible.

Today we will begin to develop a sense of specific subjects to examine. The priorities of these subjects may change as we begin listening sessions and as managed care moves forward in implementation. At many upcoming meetings, Commissioner Toumpas or other members of the department will present status updates and introduce topics. This commission will strive to bring a good sense of the whole to the public and will consider other initiatives and advisory groups that also have public input. These include: The Medicaid Advisory Committee; State Innovation Model Grant; Care Management; Balanced Incentive Program; 1115 Waiver.

All members should be ready to choose and lead a specific topic and produce a draft written document with reviews and recommendations to the Governor. Commissioner McNutt noted that this is a way of taking advantage of the wide range of skills and expertise present in the members of this group. Commissioner Vallier-Kaplan remarked that many other organizations have been eager and generous in offering assistance and support. Commissioner Toumpas suggested that the department set up a link from the DHHS Medicaid Care Management web page to a separate page for this commission.

Public comment was requested and occurred on an ongoing basis.

Commissioner Vallier-Kaplan invited Commissioner Toumpas to provide an update on Medicaid Care Management. Commissioner Toumpas reported that there are many moving parts but January 2014 is the date for implementation of the Affordable Care Act with or without Medicaid Expansion. Per request of attendees, goals of managed care were described: better health for the people we serve, better

outcomes and better coordination. We want to support the continuity of care with appropriate planning and assure that everyone has a primary care provider or a medical home. We aim for shared decision making in determining what will improve health. In achieving greater efficiencies we're focusing on: increased primary care access; better transitions; fewer hospital readmissions; reduced emergency room visits; reduction in duplication of testing and integration of public health and prevention. In response to a question by Commissioner Shumway, Commissioner Toumpas reported that there are reports on the website of 12 forums held around the state last summer. These forums were designed to help people understand what Medicaid is and what it is not. Personalized examples helped reduce their anxiety. We are developing a series of communications that will be sent out to every Medicaid beneficiary. The first will be a broad level communication to each beneficiary. The second will be targeted to specific individuals with a more successive level of detail. We're working with all the agencies so that they can be prepared to answer client's questions related to these materials.

The department has contracted with three managed care organizations; Centene, Meridian, and Well Sense. Their task is to contract with providers including; hospitals, health centers, community mental health centers, primary care practices and specialty care organizations. At this time, they have not achieved a level of adequate network providers.

CMS looks at rates one year at a time and won't approve more than that. We are now in the process of "refreshing the rates" for July 2013 – June 2014. These rates were presented to the MCO's last week.

1 – rates are based on our data and efficiencies achieved. There is a 2.9M general fund efficiency, not 15M

2 - rate structure for mental health services needs to look at the population being served by all services, not only mental health centers.

3 – rates are based on an eligibility category

An updated contract will go to the Governor and Executive Council in June.

The implementation is in three phases. Step 1 includes State Plan Services, Step 2, (1 year later) Long Term Care Services and waivers, Step 3, Medicaid expansion.

The state needs to declare whether or not it's moving into the optional Medicaid expansion or not. We estimate an additional 50,000 beneficiaries and half of those would be new beneficiaries. We need the Managed Care Organizations up and running and operational before we start Medicaid expansion. January 2014 is the earliest possible date for Medicaid expansion to begin. When two out of three MCO's have achieved substantial network adequacy, we can start a series of activities (systems, call centers, protocols, manuals) needed to assure our readiness.

In response to questions from Commissioners, Commissioner Toumpas reported that network adequacy is defined in the contract which can be found on the

department website. At this time, we're working with Step 1 only. Each Managed Care Organization has to demonstrate state wide adequacy but the time and distance parameters are different in different regions. In response to Commissioner Norton's question about substance abuse and behavioral health, Commissioner Toumpas said that there is no current Medicaid benefit for substance abuse services. A policy level decision will have to be made as to what the benefit package under Medicaid expansion will be. An analysis of the different eligibility groups is in process. Commissioner Bunnell asked how the challenge to succeed without the Medicaid expansion, or the challenge to have Medicaid expansion without the Managed Care Organization will be addressed. Commissioner Toumpas replied that if we estimate that we would gain 50,000 people newly covered by Medicaid Expansion, we can assume that many of those people are already "in the system" through hospital emergency rooms or other services. To be eligible for Medicaid they will need to have a primary care doctor or a medical home. The Lewin report will be completed soon. The Managed Care Organizations have the responsibility of determining the designation of the standards of a medical home. We want greater emphasis on wellness and we want to move away from separate internal discussions on how it plays out for real integration of public health and wellness. We are working on how to strengthen the systems and integrate areas such as housing and transportation.

The Managed Care Organization rates are based on twenty eligibility categories. We provide the rates and the Managed Care Organizations negotiate with the providers. In response to a question by Commissioner Porter regarding authority of the department and the Managed Care Organizations, Commissioner Toumpas replied that some of these areas are defined in the readiness review but there will be changes in the department organization because some areas will be added and some will be shifted to the Managed Care Organizations.

We are not establishing a new Medicaid rate structure but are "refreshing the rates" we pay to the Managed Care Organizations. The contract requires the MCO's to work with providers to look at payment reform. Commissioner Toumpas will bring an update on the department's draft quality manual. Commissioner Vallier-Kaplan thanked Commissioner Toumpas and said that the roll of this commission relative to Medicaid expansion is to discuss it in relation to Medicaid Care Management.

Framework for Establishing Priorities:

Commissioner Vallier-Kaplan led the discussion on a framework for sorting the themes of Medicaid Managed Care. We are using a version of the CMS technical assistance center and will build off this. The work plan will be an ongoing, changing process but this prioritizing will give us a place to begin. The Commissioners sorted the topics in three groups; most important, most urgent, most actionable (low hanging fruit). See chart below for results.

Topic Headings	Red Most Important	Green Most Urgent	Yellow Most Actionable
Managed Care Program Planning And Procurement		4	9
Access, Quality and MCO Financial Monitoring and Oversight	10	2	
Beneficiary Enrollment, Education And Rights	1	7	15
Data	1	9	6
Benefit Design and Specialized Services and Populations	9	7	2
Managed Long-Term Services and Supports	11	2	1

Public input to the process was noted.

Commission members remarked that information from other initiatives of the department and updates on the current status of these areas would be helpful and might affect the ranking of these topics. Commissioner Kaplan assured all that the department will provide updates so we can sequence our input and align our efforts with current projects and goals. Commissioner Vallier-Kaplan reminded everyone that our charge is to provide our recommendations to the Governor. This is an opportunity for a thought process that can provide reflections grounded in a broad and integrated perspective with the best interest of the public in mind. We will be grounded in data, best practices, standards and we will also be able to say when “we don’t know”.

Commissioner Shumway stated that the Governor’s charge began with listening. We need to be certain that all voices are heard now and as the process moves forward. We will establish a set of formal reviews in specific areas, take the temperature of the stakeholders, move certain areas up to the front and put the spot light on some areas that need extra work.

Concluding comments: Commissioner Goldsberry stated that we are the stewards of the voice of quality. Based on data and best practice, we can work on two tracks. 1) Create an ongoing monitoring process 2) be the voice of innovation for things that are not yet completed. Commissioner Bunnell said that mental health and long term care will continue to be hot spots but we need to continue to listen and be informed

in these areas. Commissioner McNutt commented that there is a lot of value in bringing a seemingly disparate group such as this together. It doesn't happen very often. Commissioner Moral stated that there is a commonality on what the key issues are. Commissioner Shumway said that a meeting evaluation tool will be set up through an email process. He and Commissioner Vallier-Kaplan will develop a proposal for the next couple of meetings based on the priorities this group has chosen. Commissioner Toumpas stated that the department will bring a high level road map of the next year or two and consider how this commission can help the department. He will provide updates in specific areas when he knows the focus of the next meeting.

MAY 22, 2013

Medicaid Expansion, DSH (Disproportionate Share Hospitals) payment and implementation of ACA (Affordable Care Act)

Commissioner Bunnell reported that the three arenas are interrelated and impact the implementation of Medicaid Care Management. DSH update: There is some possibility that some of the uncompensated care funds lost during the last budget cycle may be restored by the legislature during this cycle. If this occurs, there is also an increased likelihood that those hospital systems impacted by the previous cuts will join the Medicaid care management system. Note however, that DSH reimbursement begins to decrease to states as ACA is implemented. Regarding Medicaid expansion, hospitals are now treating many uninsured, uncompensated patients. There will be a reduction in such uncompensated care costs if we choose Medicaid expansion as there will be improved coverage of health services for more low income, working people especially for primary care. Review of Medicaid Expansion ensued. It was determined that the original RFP, MCO proposals, and contracts assumed that Medicaid Expansion would occur and that it would provide an efficiency of scale and diverse recipients that would allow the Medicaid program to work as a functioning system. Expansion was part of the business model of all parties and is necessary for the MCO business plans and the network formation.

Commissioner Bunnell brought forward a recommendation to the Governor for consideration by the Commission to authorize Medicaid expansion as essential to the implementation of Medicaid Care Management. Discussion by the Commissioners noted the expectation of Medicaid expansion as tied into the MCO contracts; achieving adequacy by the MCO's; benefit design and eligibility categories.

Commissioner Norton moved to approve the recommendation to the Governor, Commissioner McNutt seconded. It was unanimously:

VOTED to approve the following recommendation:

“The Governor’s Commission on Medicaid Care Management hereby recommends that Medicaid expansion be authorized in New Hampshire in order to ensure that the Medicaid Care Management initiative is implemented and can succeed in the Granite State.

We recommend the implementation of Medicaid expansion to ensure the successful transition from a Medicaid fee for service system to a more efficient, more effective, and more cost-effective system of Medicaid Care Management in and for our state. A failure to approve and implement Medicaid expansion imperils this pragmatic and compelling opportunity”.

Commissioner Kaplan appointed a subcommittee to complete the recommendation transmittal document and provide background documentation to the commission as soon as possible.

Introduction to SIM Grant – Doug McNutt

Commissioner McNutt invited all to refer to the handout, DHHS State Health Care Innovation Model: Stakeholder Session, May 19, 2013. New Hampshire is one of the few states testing models for long term care. Long term care includes Medicare recipients, the developmentally disabled population, and covers children and adults. This is a significant initiative that brings the opportunity for more rigor and discipline and will be a key piece for step 2 of MCM. Commissioner Shumway added that this Commission will follow the SIM process and will welcome education from the department on issues and events as they emerge.

Listening Opportunities

Commissioner McDowell, Vallier-Kaplan, and Shumway reported on listening opportunities that they attended in the North Country and a second listening opportunity with stakeholders from the developmental disabilities community in Concord. Commissioner Fox reported that she will attend the next meeting of the DHHS Committee on Long Term Care where they will discuss long term care in step 2 of MCM. All commissioners are encouraged to seek out and respond to similar opportunities to meet with and listen to anyone or any group that would like to meet. Commissioners Vallier-Kaplan and Shumway will participate whenever possible.

Commission Work Plan

Commissioner Shumway led a discussion on the commission work plan. Work will begin in the areas of priority as selected by commission members, in each of the six sections. Next step will be to outline areas of review for each commissioner and coordinate timing with the department. Each area of review will be tested in the following areas: consumer protection; critical safety net providers and stable and efficient quality systems of care.

DHHS Medicaid Care Management Implementation Work Plan

Milestones and Critical Steps to Achieve Implementation

Commissioner Toumpas introduced Lisabritt Solsky, Deputy Director, Office of Medicaid Business and Policy, who presented a report on the MCM Timeline (handout). Ms. Solsky reviewed the Medicaid Care Management Timeline saying that the clock starts when two MCO's meet "substantial network development" for 80% of potential members and allows 150 days to the "go live" date. The review included details on initial outreach; enrollment packet, readiness review; provider communication; call centers; enrollment options; plan selection; provider preparedness; auto assignment; plan switch options and notice of decision. Subsequent discussion with commissioners focused on best ways to manage disruption in service during the transition. In response to questions, Commissioner Toumpas stated that the Medical Care Advisory Committee is reviewing the materials. Commissioners Norton and McNutt are members of the MCAC.

Implementation Issues that DHHS most wants Commission to address

Commissioner Toumpas stated that the department will provide a timeline of milestones coming up in the next year so the commission work can be coordinated with that timeline.

Other Updates

DHHS Plans and Requirements for Grievance and Appeals

Due to the time constraints, Commissioner Vallier-Kaplan assured members that the DHHS Plans and Requirements for Grievance and Appeals will be taken up at a later meeting.

JUNE 6, 2013

How the MCO's will Demonstrate a Substantial Network of Providers

Commissioner Vallier-Kaplan introduced Ms. Lisabritt Solsky, Deputy Director, Office of Medicaid Business and Policy. Ms Solsky reported on the department's process to verify the Managed Care Organizations (MCO's) substantial network development (SND). The review included background on guidance from the department and the insurance regulations; network adequacy to trigger first step of sending "heads up letter"; mental health services as specialty services; two parts to readiness review ; comparison of network adequacy to current utilization patterns; and mitigating disruption. In response to questions from commissioners, Ms. Solsky replied that the best intelligence is being applied to improve plan selection. MCO's are to work with providers to assure readiness for greater volume and disruption will be monitored through the call center and customer satisfaction outreach. Mental health services are discretely measured within the SND. Ms. Solsky reviewed the summary of each practice area and the plan for allowing exceptions. Substance abuse disorders are not in the current contract and will need work on benefit design, rates and providers to deliver the services. Recognizing the time limitations, Ms. Solsky suggested that additional questions be submitted to Mr. Jeffrey Meyers, Director, Intergovernmental Affairs, DHHS. Commissioner Porter will compile questions and submit to Mr. Meyers.

Questions from the public:

Are the insurance department standards adequate for the mental health population? How would volume capacity be measured? How do you define PCP? Is the insurance department standard adequate for the mental health population?

Updates

Representative Harding reported that the Primary Workforce Commission has scheduled a Roundtable on June 27 to discuss the Primary Care Providers workforce. The behavior health providers are considered PCP's. The Primary Care workforce should stay on this commission's agenda.

Commission Recommendation on Medicaid Expansion

Commissioner Shumway reported that the Commission Recommendation on Medicaid Expansion, approved at the May 22 meeting, was finalized by Commissioners Bunnell, and Porter and submitted to Governor Hassan on May 31, 2013.

Medical Care Advisory Committee (MCAC)

Commissioner McNutt, Chair of MCAC, reported that MCAC receives significant updates on MCM questions each month including updates on the Medicaid Management Information System (MMIS) which is in the process of conversion. Commissioner McNutt will share the update document with this commission.

House Subcommittee on Long Term Care

Commissioner Moral reported that the last meeting of the House Subcommittee included an impressive presentation from Well Sense. They have a good rating from the National Committee on Quality Assurance, focus on local staff, diversity and demonstrated a person centered approach. They will need to focus on existing supports in New Hampshire and increase collaboration to maximize what we have.

Other Updates

Representative Harding invited the members of the commission to attend presentations by all three MCO's at upcoming meetings on June 11 and June 25. See the general court calendar for specifics.

The Department will have updates on SIM (State Health Care Innovation Model) prior to the July 11 meeting of this Commission.

Ms. Kathy Sgambati reported that the Governor's office has had meetings with area agencies and parents to alleviate misunderstandings. Input from the developmental disabilities community will help shape things going forward. Ms. Sgambati is working with the department to develop a communication system for all populations and suggested that this Commission play a role in provider readiness.

Next Steps /Draft Agenda for July Meeting on Enrollment

Commissioner Shumway reminded all the Commissioners that they will have an opportunity to bring agenda items forward and take the lead on recommendations. He thanked Commissioner Bunnell for leading the work on the first recommendation to the Governor. Discussion included various methods of listening sessions, the benefit of the Department timeline, and the possibility of creating a list of touchstones to guide decisions.

Stakeholder engagement is a priority and an area to work in over the next month.

Commissioners Fox, Moral, Shumway and Vallier-Kaplan will begin development of the stakeholder conversations for presentation at the July 11 meeting. They will consider the CMS stakeholder input process, our role as the "process describers", both step 1 and step 2 populations, previous public listening sessions, and foundation levels of understanding managed care. CSNI has provided a good example by bringing Bob Gettings to speak to a large audience.

Beneficiary enrollment will also be on the July agenda. We will ask the department to do a presentation on the enrollment process. Commissioner Porter volunteered to help organize this and to integrate the data component of enrollment. Mr. Jeff Meyes will assist with MCO participation for this meeting.

Three areas of focus to date are: 1) conversation around network development 2) outline of a plan of stakeholder involvement 3) enrollment, data involvement and informed choice making

Discussion toward future agenda items included: mental health coverage adequacy, integration of enrollment and services for individuals with developmental disabilities (step 1 and step 2).

Public Comment

Consider having some discussion on how MCO's are planning to manage behavior health in step 1 and how behavior and physical health will be integrated. It would be valuable to pursue concerns on network measurements now, in order to have that information later when the contracts are reviewed.

JULY 11, 2013

Network Development

Commissioner Vallier-Kaplan invited Commissioner Porter to report on discussions since the June 6 meeting on network development. Commissioner Porter stated that the issues of sufficient coverage and organizational capacity were discussed and documented for later development. There is no recommendation at this time. Commissioner Shumway referred all to the DHHS document, "Monitoring Access to Care in New Hampshire's Medicaid Program". This document is updated quarterly and posted on the department website. It provides a baseline and a way to look back and track progress as we move forward, assuring that those who need service have access. Chapters 4 and 5 were excerpted for the Commissioners.

Commissioner Toumpas reported that there has been significant progress in developing network adequacy. When two out of the three Managed Care Organizations (MCO's) have demonstrated substantial network development, implementation of the department's time line will begin. Progress has been made in the area of hospital contracts. As of today, the majority of acute care hospitals have signed contracts or have agreements in place to sign soon. Commissioner Toumpas said that they expect an additional 4 – 5 month process leading to implementation.

In response to a question from the public regarding the definition of network adequacy, Commissioner Toumpas replied that there are components in the

contract that require each MCO to establish a network of providers (based on distance and time) that will serve 80% of the population by county. After review of the data submitted by the MCO's, the department must be satisfied that there is substantial network development by 2 of the MCO's.

1115 Waiver

Commissioner Toumpas described the 1115 Waiver as an opportunity to innovate. The department will strive to demonstrate to the federal government, a cost savings through innovative methods of expanding the population served over a 5 year period. There are three drivers to the 1115 Waiver:

- 1) Mandating additional people into the Medicaid program
- 2) State Innovation Model (SIM)
- 3) Hospitals innovations to bring additional federal dollars into the state

The department is also examining "cost not otherwise matchable" to identify healthcare related costs at all three levels of government.

In working toward transforming the Medicaid system, the department is focused on increasing primary care, medical homes and home health. Initiatives toward this include Medicaid Care Management, SIM grant and the Balancing Incentives Program. To group all of these efforts together under the authority of the 1115 Waiver would expand health care to the populations not served today. The 1115 Waiver includes a disciplined approach to public opportunity for education and input. Commissioner Vallier-Kaplan concluded by saying that the 1115 Waiver would remain part of the agenda for the Commission.

Medicaid Expansion Commission Organizational Meeting

Commissioner McNutt gave a report from the first meeting of the Medicaid Expansion Commission. The commission includes six legislators and 3 members of the public. James Varnum, former President of the Mary Hitchcock Memorial Hospital, is the chair. They will be looking at studies related to Medicaid expansion and the experience of other states with the goal of completing their fact finding by the end of September with a recommendation to the Governor by October 15. There will be one or two sessions for public input by mid-August. The meetings are open to the public and are held in the Legislative Office Building, rooms 210-211. In response to questions from the public regarding the process after the recommendation is made to the Governor, it was stated that when the report is issued, the Governor could call a special session of the House and Senate.

State Innovation Model (SIM)

Commissioner McNutt gave a report on the June 27, 2013 meeting of the SIM committee. In response to questions from the Commissioners, Commissioner McNutt stated that there are people from the mental health community on the SIM

grant team. Commissioner Toumpas added that long term care cuts across the entire life spectrum and includes mental health and children with behavior health issues. It's not only considering Medicaid but looks at the entire system of payment and delivery toward reform. Commissioner McNutt noted that there will be a public outreach program for SIM and any program has to advance community based care. This is a planning vehicle for step 2 of MCM and could lead to the possibility of an implementation grant. There are many reports available on the DHHS web site.

Enrollment – DHHS Process

Mary Ann Cooney, Associate Commissioner, DHHS reported that the enrollment process is being designed and managed by the Division of Client Services. There is no wrong door for entry and the “call center” is the central engine for assistance. Prevention, quality and outcomes will be emphasized for each enrollee. All the MCO's are on board with the importance of client assistance. Ms. Cooney introduced Carol Sideris, Director of Client Services, DHHS. Ms. Sideris reviewed the enrollment process and department readiness through communication, consistent messaging and member experience to date (see handout). In response to questions, Ms. Cooney stated that it is the vision of the department to have a more mobile workforce with eligibility workers in various locations.

To clarify, Commissioner Toumpas explained that this first step of the enrollment process is designed for people who are already enrolled in Medicaid. If Medicaid expansion is approved, there will be a new and different level of communication needed to reach a group of people that they don't work with now.

Commissioner Goldsberry asked how people find out if they are auto assigned to a plan. Ms. Sideris explained that they will first receive a letter from the department advising them of the plan they've been enrolled in. They will then have 90 days to change plans if they choose to and can change plans again if necessary.

Commissioner Fox asked what providers are being trained to assist people. Considerable discussion ensued as to many community providers needing to help their clients in this process. Commissioner Porter stated that a coordinated provider education plan is needed to understand the breadth of our community partners. Deb Fournier noted that the call center has contracted with a vendor to assist in the managing the volume of calls expected during enrollment.

Enrollment – MCO Process

Susanne Cassidy, Product Implementation Director, Well Sense Health Plan introduced Christopher Ware, Director of Customer Care Center. Mr. Ware presented an overview of the Member Experience in step 1 and noted that the step 1 enrollment design will be the building block for step 2 and Medicaid expansion. He reviewed enrollment and outreach, the welcome kit, ID card packet, PCP assignments, welcome member call, post enrollment, staff orientation and training, member advisory board, town hall meetings and the member web site.

Commissioner Porter asked if there is coordination and oversight for all the communication going out to the clients from the department and three MCO's. Is there a cap on the level of communications and consideration for the timing of mailings? What happens if the client is auto assigned and their first contact is the Welcome call from the Plan? Mr. Ware replied that Well Sense is working closely with the department and all pre enrollment material is approved by the department. The first communication to the client will come from the department. Well Sense will inform the clients of their rights, their access to benefits, and the options to change plans over time.

Mr. Whitney stated that a number of people that are going to come through under Medicaid expansion are under active medical care now but are not in the current Medicaid system and this assignment may disrupt the care that they're already receiving. We will have to address this continuity of care pro actively.

Commissioner Toumpas replied that in step 1 of care management, we will reference the claim history of existing Medicaid clients for continuity of service. If Medicaid expansion is approved, there will need to be another process for people who are not currently in the system.

In response to questions on marketing Commissioner Toumpas replied that the MCO's cannot market directly to the individuals until they're enrolled. Pre enrollment materials on managed care in general are approved by the department. Ms. Fournier reminded everyone that there are federal protections for Medicaid beneficiaries and these have been worked into DHHS materials. Commissioner Shumway suggested that the next meeting of the commission include a report from the department on the plan for Community Partner Engagement.

Upcoming Recommendation Discussions

Commissioner Shumway suggested that upcoming meetings address the possible need for an active process upon start-up of indentifying areas of priority concerns and the remediation of those concerns. Priority concerns include; consumer protection in necessary health access and quality, stability of safety net providers, operating performance and efficiency. He asked all the commissioners to consider areas where they want to work toward building recommendations to the Governor. Upcoming meetings will also include presentations from Meridian and Centene.

Questions from the Commissioners

Commissioner Fox raised the issues of provider engagement and consumer education and decision making assistance. Commissioner Shumway replied that the department has provided a structure that is CMS compliant and set up the potential for community partner engagement. He asked Commissioner Fox to compile a list of questions and work with the department to structure their presentation.

Commissioner Gladstone asked how we would address provider satisfaction. Commissioner Vallier-Kaplan reminded all that if Medicaid expansion is approved, there will need to be additional enrollment plans for that population.

Commissioner Shumway replied to Ms. Sgambati's questions about provider readiness by stating that the meetings of this commission should continue to move to various locations around the state and asked all commissioners to offer locations in their areas.

Questions from Non Commission Members

In response to questions from the public, Commissioner Toumpas stated that the department is conducting a self-assessment of their capabilities and what will be needed for the change from the fee for service model to managed care. We can learn from the 47 other states who have made this change. It's very valuable and appropriate to have these issues and concerns raised.

AUGUST 1, 2013

DHHS Medicaid Overview

Commissioner Toumpas reported that the Department is currently focused on the care management program leading up to "Go Live" which depends on Significant Network Adequacy development. They are confident that the three MCO's will have enough provider agreements in place or promised to move forward with the target date of December 1, 2013. After the briefing on Monday August 5, they will make a formal statement.

The Medicaid Expansion Commission is meeting weekly and has held four meetings to date.

These meetings included a presentation of "Medicaid 101" by the department, a report on the Lewin analysis, and an overview by the NH Insurance Dept. of the implications of Medicaid expansion. Upcoming meetings will include speakers from the National Governors Association, and The National Council of State Legislators; a panel of NH experts from NH Fiscal Policy Institute and the NH Center for Public Policy; and a structured session for public comment. The Commission report is due on October 15, 2013.

The State Innovation Model (SIM) is a grant that NH received to develop a design for payment and delivery reform in long term supports and services across the life span. We have applied for an extension to the deadline which if approved, will move the deadline to the end of the year. The focus of the SIM work is on all payers; Medicaid, Medicare, private insurance and the Veterans Administration. There will be additional forums for stakeholder input on the design. The Department expects to apply aspects of these designs to Step 2 of MCM.

The 1115 Waiver team is working with CMS, SIM, and national and regional Medicaid groups to build the authority that is needed for care management. In the month of August the high level concept will be completed and reviewed with CMS and then a wider group of stakeholders. The grant process dictates a scripted approach for stakeholder engagement.

Commissioner Vallier-Kaplan invited the Commissioners to ask questions.

Commissioner McDowell asked for clarification on the intersection of the 1115 Waiver and Medicaid Care Management. Commissioner Toumpas replied that, setting SIM aside, the Waiver is needed to mandate specific populations into MCM. This will help provide services earlier and bring better outcomes and lower cost. But the Waiver is a dynamic model and we're working to see what other items tie into 1115 by consulting with CMS.

Commissioner Goldsberry asked if the 1115 Waiver design would be complete this August.

Commissioner Toumpas said yes. There are sessions scheduled in August that address the intersection of SIM, Step 2, and Hospitals. CMS has requested a high level design to direct a meaningful discussion on our specific issues and problems. They will then assist us in framing the authority we need to accomplish our goals.

In response to questions from non-commission members, Commissioner Toumpas reported that Jeff Meyers, Director Intergovernmental Affairs, DHHS is leading the 1115 Waiver team. The Waiver is focused on the existing Medicaid population. In the application preparation the Department is striving for high quality analysis, budget neutrality over 5 years and consultations with CMS along the way. This preparation will help in the approval process but we don't know how long that will take once the application is filed. Our target date for additional federal funds is November, 2014. CMS is expecting us to leverage the Waiver for Medicaid

Implementation of the Affordable Care Act

Commissioner Vallier-Kaplan shared a video by the Kaiser Family Foundation that gave an overview of ACA. Go to, <http://kff.org/health-reform/video/youtoons-obamacare-video/> to see the video, "The YouToons Get Ready fo Obamacare: Health Insurance Changes Coming Your Way Under the Affordable Care Act". Topics reviewed in the video were, who will be covered, the different kinds of coverage available, changes to expect, Medicaid expansion, options for low income people, the enrollment period and incentives.

Community and Provider Training to Support Client Enrollment

Commissioner Vallier-Kaplan introduced Christine Shannon, Bureau Chief, Planning and Research, OMBP and Maya Glover, Senior Management Analyst, OMBP for a report on Community and Provider Training to Support Client Enrollment. Their presentation included, Strategy Development, Communication Plan and Resource Development and Events.

In summary, they are striving to deliver a balance of information and guidance that is timely, accurate and is sufficiently detailed but not a burden to providers. The instructions and trainings aim to be inclusive and responsive toward assisting clients and managing business processes. They will offer community-based public forums and have a standing request for feedback and suggestions (see Power Point presentation).

Commissioner Moral opened the time for questions from the Commissioners.

Commissioner Goldsberry asked for information on the coordination across areas of communication and how providers will know if they should call the Department or the MCO with their questions. Ms. Shannon replied that the Call Center operators will be trained in what to ask so they can help them and will be able to look up the client status (mandated, enrolled, fee for service).

Commissioner Porter asked if there is a sense of the overlay between the Department communications and the MCO communications. Ms. Shannon replied that there is an account manager from each of the MCO's working with the Department and all materials from both will be shared.

Commissioner Shumway asked how the Department intends to broaden connection to providers. Ms. Glover replied that they plan to make contact with additional providers through various associations and by working with divisions within the Department that have direct contact with providers. They also recommend to all that the best way to stay informed is by regularly checking the Department website and to share broadly.

Commissioner McDowell asked if the training sessions would be targeted to specific groups. Ms. Glover replied by saying yes, but anyone can attend the trainings and they will be available electronically. Commissioner McDowell advised that peer support groups are a very valuable way to share information.

Commissioner Moral asked if the Department is comfortable with the funds allocated for the roll out and training. Commissioner Toumpas replied that the focus now is on what needs to be done and that the dollars cannot be a barrier to progress. The strategy is to leverage existing infrastructure to accomplish the roll out and to listen to feedback and make adjustments.

Commissioner Bunnell asked if the fee for service will continue for a certain subset of people.

Commissioner Toumpas said yes, fee for service will continue for those who are exempt, people who opt out or those waiting for the 1st of the following month when their enrollment plan will begin. Commissioner Shumway asked for a comparison of the number of people who might be in fee for service and the number in MCM. Commissioner Toumpas replied that he would look into that information and get back to the Commission.

Commissioner Shumway asked if the Department will be tracking the numbers of providers who enroll, what plan they enroll with and who opts out. Commissioner Toumpas said yes they can track this.

Commissioner Porter asked for a discussion on the roll of the clients and providers in the decision of choosing a plan. Commissioner Toumpas replied that the providers roll is to advise and interpret for the client. Commissioner Goldsberry asked if there are protections and/or a grievance process for providers. Ms. Glover replied that in the training for providers they will learn how to guide and not direct the clients.

In response to questions from non-commission members, Ms Shannon stated that the Department has contracted with Maximus to assist in taking the volume of enrollment calls expected. They will also track lost calls and time waiting. Commissioner Toumpas remarked that assuring adequate provider networks is what the MCO's are working on now and that those networks should provide the continuum of care needed. Once someone is deemed in Medicaid, they can apply to the MCO for enrollment. The department will consider establishing an "issues" list on the website where providers can go to see the issues that are being addressed.

Workplan for Upcoming Reviews and Recommendations

Commissioner Shumway reviewed the Commission's working goals to: build stakeholder knowledge and readiness, critically review the implementation plan detail and bring forward recommendations (see Power Point presentation). The Commission must also make sure that there are no critical points where a smooth transition is not possible, especially for vulnerable individuals.

Hearing as we did at the beginning of the meeting, the descriptions of all the different projects underway, we see major changes in this state and nationally. Provider readiness requires a sense of that whole. During the meetings, the Commissioners and the non-commission members have made comments and asked questions and the Department has addressed those issues. In the best situation, this process would eliminate the need for a recommendation to the Governor.

Commissioner Shumway summarized the first recommendation to the Governor made in May in which the commission recommended the Governor support the implementation of Medicaid Expansion in New Hampshire.

The second recommendation under consideration at this time is for the Governor to acknowledge the intense efforts of department staff. This could include a report on the active process of the department to identify and address priority areas of concern and a partnership with EFH/Urban Institute for an independent evaluation.

Upcoming meetings will include issues related to: behavior health, medical homes, grievance and rights protection, presentations from the MCO's and Step 2 considerations. We welcome suggestions on locations for upcoming meetings.

Commissioner Vallier-Kaplan invited any final questions.

In response to questions from non-commission members, Commissioner Toumpas stated that Step 2 is focused on services to the Long Term Care populations and includes those with developmental disabilities and community based care.

In response to other questions from the public, Commissioner Toumpas stated that the department's broad language access will continue and the MCO's have a multi-cultural component.

SEPTEMBER 5, 2013

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 Vallier-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.

OCTOBER 3, 2013

Commission Review and Discussion of DHHS Quality Plan

Commissioner Kaplan introduced the DHHS Quality Plan discussion. The plan was distributed in September. The Commissioners have had time to review and are invited to ask questions.

In response to a question from Commissioner Moral regarding reference to disabilities, it was stated that this is structured later in the document.

In response to a question from Commissioner Goldsberry about criteria for consistency in MCO goals, practice guidelines and review, Ms. Katie Dunn, Associate Commissioner and Medicaid Director, DHHS, stated that behavior health will be identified separately now and items for developmental disabilities will be added at a later date. This quality strategy focuses on Step 1 and lays the foundation for Step 2 and Step 3.

Commissioner Shumway stated that from this document (the Quality Plan) the department will be producing a dashboard, monitoring access to care, creating the NH Medicaid Annual Report and providing these analytic documents to the public. The External Quality Review (EQR) organization, Health Services Advisory Group will; receive data, evaluate, calculate measures, report and provide training for DHHS and external stake holders. The EQR trainings for DHHS staff begin on October 18, 2013. Ms. Dunn added that the Quality Strategy is an over arching

strategy, not limited to MCM, and that the Department is working with the Urban Institute to identify key areas of concern.

In response to a question from Commissioner Goldsberry regarding closing the loop between the results of implementation data and the quality improvement measures, Ms. Dunn stated that the department is using CMS grant funding to build staffing resources and infrastructure to accomplish the analysis. They are building an IT system with methods to catch problems sooner and are developing an advisory group to work with the EQRO contract.

In response to a question by Commissioner Moral regarding performance improvement projects, Ms. Dunn stated that each MCO develops separate performance improvement projects based on the members they have.

MCM Implementation Update

Commissioner Toumpas introduced Mary Ann Cooney, Associate Commissioner, DHHS and Carol Sideris, Client Services Director, DHHS, for an update on MCM implementation (see slides).

Ms. Sideras reported that enrollment has gone well to date and is increasing steadily. People can enroll through the Call Center, on line through NHEasy or with a paper form. The gaps in the number of calls received and the number of people enrolled are generally due to the fact that they want to talk to their provider first or they need to find a provider. The client experience is surveyed and DHHS staff participate in a daily debriefing with the Call Center to address any issues immediately.

Ms. Cooney reported on Client Communication initiatives including; enrollment packets mailed, client web-site, enrollment reminders on call waiting messages, posters, community events and enrollment supports with established community networks. The department relies on community partners for direct communication with clients who have communication challenges.

The focus is to help people have the provider that they want. The department is working with the MCO's to continually update the provider directory as they include additional providers.

In response to a question from Commissioner McNutt, Ms. Cooney replied that the Service Link Providers are working with their own clients and are included in the enrollment totals.

In response to a question from Commissioner Goldsberry, Ms. Sideris stated that the department does not provide the MCO's with any names until they are enrolled. The clients should not receive any direct communication from the MCO's until they've chosen their plan and are enrolled.

Ms. Sideris replied to a question from Commissioner Porter stating that the department is closely connected with each MCO and each MCO knows exactly what communications are going out from the department to the public. The MCO's are conducting information sessions for the public.

In response to other questions Ms. Sideris stated that the deadline for self selections rolls over 4 days in late November. November 27 is the last date to make any changes for December 1. Some people have the option to opt out at this time if they: are dual eligible; are a nursing home resident; a child; want to wait to see if their provider will be included; want to wait for a more complete understanding of how it works. Anyone who opts out now can opt in at a later date.

In response to questions from the audience, Ms. Sideris replied that providers will be able to see the plan that a client is enrolled in through the Eligibility Management System. The MCO's will continue to recruit providers and the provider list will be continually updated.

All three MCO's cover all Medicaid Services. There is a side-by-side comparison that show's additional services unique to each plan. The enrollment packet mailing included a comprehensive letter, side-by-side comparison of the plans, NH Easy Pin number, paper application and phone numbers for questions. Ms. Sideris reported that there have been technical problems with the Call Center server but a mitigation plan is in place.

Behavioral Health Quality Indicators and Integration with Primary Care PCMH

Commissioner Norton introduced Eric Riera, Administrator, Bureau of Behavioral Health and thanked him for the many innovations he brought to the state including Housing First and Project Red and the partnership with UNH to develop and track outcome measures with more transparent reporting to the public.

Commissioner Norton asked Mr. Riera a series of questions related to quality indicators for behavioral health in the DHHS Quality Plan.

While some Mental Health services are provided to acute clients, most Medicaid dollars go to people with long term needs. How will MCO's acknowledge this? For instance will they provide longer term treatment authorizations etc.

Each MCO has a different approach to managing authorization for services.

Both the MCO's and CMHC's have indicated a desire to meet together to identify and develop efficiencies. One example would be efficiencies in congruent billing processes. Will DHHS be arranging this type of meeting as we approach a Go-Live date? *The department is encouraging standardization but at this time, the MCO's are coming at it from three different perspectives. We will look at Kansas as an example and plan to work on this later this fall.*

How will MCO'S promote consumer directed care - particularly for behavioral health? What is the role of peer and family supports and how will they be promoted by the MCO's?

We encourage the MCO's to leverage the rich resources in peer and family support services. There are variations in how each MCO embraces resources.

Contracts call for MCO's to be responsible for operating within the Americans with Disabilities Act/Olmstead guidelines. Contracts also call for moving the ten year plan forward. How will that occur? What KPI's and/or accountability measures will be included?

The MCO contracts mandate the use of the CANS and MANSA assessment tools. These tools measure progress and can also be used as community and collaboration tools to help identify programs with high success rates. We are centered around the Person Centered Plan approach and aim to identify and discuss the needs of each individual. The state is taking the lead on building the infrastructure on ADA. We will continue to support and reimburse the services we have now through funds incorporated into the MCO contracts.

The 10 year plan is relatively silent about children's behavioral health. Are there specific quality indicators that have been developed for this area?

The 10 year plan excludes children's behavioral health. As we gain experience, and the children's plan gains momentum, priorities will be set and included in the MCO process.

Contracts call for one of the key performance indicators to be reducing usage of NH Hospitals. How will this be measured? Likewise, how will the current situation with people being boarded in Emergency Departments be addressed and what performance indicators will be used to measure progress?

Contracts call for the development of a number written proposal (within 6mos.) for review and approval by DHHS regarding new, innovative and cost effective models of providing emergency services, reducing admissions and increasing community tenure, the development of policies relative to coordination of care/primary providers, establishment of a collaborative agreement with NHH re; seamless discharge plans and plans for reducing admissions to NH Hospitals. What is the status of these proposals/reports – have they been submitted and have any been approved and can we get copies?

This has been developed and copies can be made available to this Commission. The hospitals have an interest and discussions are occurring in redeveloping capacity. We are hoping the MCO's recognize the importance of local capacity. There are a number of key initiatives in process for reducing the need for hospitalization and developing primary care and community services.

As you are leaving your position, are there any specific recommendations you have for the MCM Commission regarding areas of focus?

The project with UNH is critical to bringing the information to the public so they are able to gauge how the system is doing, to celebrate success and focus on critical areas that need more attention. The information needs to be available, accurate, timely and able to inform decisions.

In response to a question by Commissioner Shumway, Mr. Reira stated that DHHS has given the MCO's flexibility to create the model for payment methodology with the community mental health center providers.

A Community Health Center and Community Mental Health Center Perspective of Integrated Care

Commissioner Norton introduced Bill Gunn, Capital Region Health Center and Steve Arneault, Center for Life Management to discuss MCM and the integration of the medical home.

Mr. Gunn and Mr. Arneault presented a review of Behavioral Health Integration in Medical/Health Homes (see slides). The presentation included the definition of Integrated Care, Primary Care as the "de-facto" mental health system, prevalence of behavioral health problems in primary care, problems in the current system, benefits of integrated care, link between physical and mental health, the impact on cost, opportunities and barriers.

Questions from the Commissioners

In response to a question from Commissioner Moral regarding people with dual diagnosis or developmental disabilities, Mr. Gunn replied that the most efficient and effective method will be the development of creative joint treatment plans by a team of care givers. Primary Care is trying to embrace the Medical Home model toward this end.

Commissioner Goldsberry stated that today, we're hearing the goals of a system redesign and prior to this we heard that the MCO's will promote and support the Medical Home model. Is the onus for system planning with the MCO's? And how will that come together with plans within the department? Commissioner Norton referred this question to the department. Ms Dunn replied that the contract between the department and the MCO's is a tool that brings the experts to the table. Policy makers decide on the appropriation of funds to make changes.

In response to questions from Commissioner Porter, Commissioner Vallier-Kaplan stated that after the Commission has heard about best practices for Medical Homes, we will have the MCO's inform us of their plans. Commissioner Porter continued by stating that we would need to hear from all three MCO's with a side-by-side systems comparison.

In response to a question from Commissioner Norton on the best model from the patient perspective, Mr. Arnault replied that from the patient survey data, we see that people like having access to all their services under one roof and that three times more people will go back to their PCP for their mental health needs because there's less stigma attached to a visit to their PCP.

In response to questions about variability between the MCO's, Ms. Dunn concluded by saying that the department encourages innovation and payment reform from each MCO with the goal of improved outcomes for individuals. Variability is a benefit for the enrollees.

Recommendation #2

Commissioner Shumway introduced the discussion on the second recommendation to the Governor. He thanked Commissioner Toumpas and the department for their valuable contributions. The recommendation is an open agenda, allowing the Commission to carry out the Executive Order 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";

Commissioner Shumway replied to a question by Commissioner Porter, stating that this is a temporary reporting process using elements that are already in place, and will most likely be presented to the Commission in a written report.

Ms. Dunn stated that the NH Medicaid Quality web site is the public reporting vehicle. They will line up the metrics to make decisions on how to frame the next budget session. Commissioner Shumway stated that today's presentation from the department on the enrollment process to date, was very valuable. Commissioner Bunnell thanked the department for the enrollee satisfaction measures. These are significant and important.

The following revisions to recommendation #2 will be considered: change 2nd paragraph to add, "and other reporting requirements" and in the last paragraph, change, NH Legislators to HHS joint committee. Commissioner Porter will write a paragraph defining the level of specificity and/or open-endedness.

Commissioner McNutt suggested that revisions to the recommendation be made and shared electronically before the November meeting.

Six Month MCM Commission Summary

Commissioner Shumway introduced the Draft Summary Report to the Governor and suggested that a vote on the summary occur at the November 7 meeting.

The summary is structured to provide both the historical perspective and future plans of the work of the Commission. It includes the Executive Summary and extractions from the minutes. He invited the Commissioners to review this summary with consideration to the tone of the report, the structure and the reflection of the work. Commissioner Vallier-Kaplan asked the Commissioners to provide additional “ongoing issues” that can be added to that section of the report. Commissioner Porter suggested two sections; one for things we track but are not necessarily critical issues and one for essential points of consideration that need more time. Commissioner Mc Nutt will write a paragraph on the Commission involvement with Step 2 after December 1. Commissioner Shumway asked all to send their responses to him within one week.

Commissioner Vallier-Kaplan invited final comments from the audience.

Ms.Cathy Spinney brought forward a number of questions (see attached) regarding the importance of maintaining established relationships between people with disabilities and their team of providers.

Commissioner Shumway stated that this is a Step 2 issue and that the Commission can incorporate these questions into future agendas as part of the Step 2 discussion, after Step 1Go-Live on December 1.