

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

MINUTES

December 4, 2014

1:00 – 4:00pm

Legislative Office Building, Room 206-208

Concord, NH 03301

Welcome and Introductions

The meeting was called to order by Commissioner Mary Vallier-Kaplan, Chair, at 1:05pm. Present in addition to Commissioner Vallier-Kaplan were Commissioners Donald Shumway, Nicholas Toumpas, Douglas McNutt, Roberta Berner, Yvonne Goldsberry, Wendy Gladstone, Jo Porter, and Susan Fox. Also in attendance was Kathy Sgambati from the Office of the Governor.

Absent: Commissioners Kenneth Norton, Tom Bunnell, and Gustavo Moral.

Commissioner Vallier-Kaplan welcomed everyone and reinforced the purpose of the Commission as a body appointed by Governor Hassan and is charged with providing feedback to the Governor as the Medicaid Care Management (MCM) program is planned and implemented. As a reminder, the MCM Commission meetings will move to the second Thursday of each month beginning in January 2015. Also, the Commission will submit the set of guiding principles that were approved in November, to the Governor's office for Step 2 MCM planning and implementation. This effort is moving forward to a conversation with the Governor about the principles and their future use.

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

Minutes of the November 6, 2014 Meeting

There is one correction to the minutes of the November 6, 2014 meeting. It will be revised that both Commissioners Porter and Goldsberry attended the meeting virtually. After this revision, upon a motion duly made and seconded, the minutes of the November 6, 2014 meeting of the Commission are approved.

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

DHHS MCM Update

Commissioner Vallier-Kaplan introduced Commissioner Toumpas for an update on MCM implementation. The presentation began with a review of monthly enrollment for the MCM program, both Step 1 and the New Hampshire Health Protection Program (NHHP), a brief review of the December Key Program Indicator (KPI) report, and provided an update on Step 2 MCM planning.

Commissioner Toumpas explained that the MCM program began on December 1, 2013 and has been underway for one year. It has been a year of learning. As a reminder, the principles of the program include whole person management and care coordination, increasing the quality of care, payment reform

opportunities, budget predictability, and purchasing for results and delivery system integration. As of December 1, 2014, 140,225 people were enrolled in the MCM program. The 21,127 includes those in NHHPP and those in MCM who haven't selected a plan. Well Sense Health Plan has 76,135 members, while New Hampshire Healthy Families (NHFF) has 64,090 members. When looking at overall eligibility, majority is low income children and parents.

Commissioner Toumpas described that the NHHPP began in August 2014, which reflects an additional enrollment increase in the program. As of December 3, 2014, 25,468 individuals were enrolled in the NHHPP. Over 11,000 of these clients are new to DHHS and have not had health insurance in the past, while 6,895 are new to the NHHPP but have been clients in the past. When an individual is deemed eligible for the NHHPP, they have 60 days to select a plan. Currently, 10,828 are enrolled in Well Sense Health Plan and 9,552 are enrolled in NHFF. The remaining 4,385 are in Fee for Service as they have not yet enrolled in a plan.

Commissioner Toumpas explained that enrollment in the Health Insurance Premium Payment (HIPP) program as part of the NHHPP is a lengthy process. Currently, 92 individuals are enrolled in the HIPP program with 611 others potentially eligible for HIPP. In general, DHHS projected an increase of 50,000 people in the NHHPP over the course of five years. DHHS has achieved over 25,000 in just five months.

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

Commissioner Shumway recognized how fantastic it is to have over 25,000 individuals enrolled in the NHHPP and congratulated DHHS for its excellent work.

Commissioner Porter mentioned that this is a 3,000 person increase since last month. This is a big number and increase month over month is phenomenal.

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

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

For each major domain, Commissioner Toumpas reviewed the notable results. Member requests for assistance accessing providers have fallen, as members have become familiar with program and services. DHHS is continuing to review these measures also adding additional measures into the program. DHHS continues to monitor the number of emergency department visits. Member calls remain being answered quickly and within MCM contract standards. Also, clean provider claims are being paid within MCM

contract standards for timeliness and pharmacy authorization rate continue to trend upward. In Quarter 2, the health plans received 37,448 requests for non-emergency medical transportation.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the KPI Report and mentioned that DHHS distributes the report to a listserv and the public can request to be added to the list. This is a great tool to monitor specific issues such as therapies, pharmacy, and transportation.

Commissioner Goldsberry asked about the percentage of clean claims vs. total numbers of claims. DHHS will take this request back to differentiate between the two.

Commissioner Toumpas asked the Commission and public to review the report and submit comments in terms of phrasing, level of detail, and additional measures to DHHS.

DHHS Step 2 MCM Update

Commissioner Toumpas provided an update on Step 2 MCM planning. As a reminder, as presented at the November meeting, Step 2 MCM originally had three phases: (I) mandatory enrollment, (II) the Choices for Independence (CFI) waiver and nursing facility (NF) services, and (III) the Developmental Disabilities, Acquired Brain Disorders, and In Home Supports waiver services. A key change is that Phase I and II are combined into one phase. Commissioner Toumpas explained that Step 2 MCM will be phased-in with a gradual approach, and that design considerations of managed long term services and supports, including provider contracting and payment, will evolve over time. As it relates to the timeline, on July 1, 2015, DHHS will require all populations to enroll with a health plan for their medical services, CFI waiver services, and NF services. On September 1, 2015, coverage with the health plan begins for each of these services.

The stakeholder input process will continue through December 2014. Initial stakeholder engagement and input was completed in October 2014, with additional forums being held to elicit stakeholder feedback on the Step 2 Design considerations. This feedback will help DHHS develop its final design plan and waiver, in conjunction with the MCM Commission principles submitted to the Governor.

To date, the Department has held two stakeholder sessions in December where it presented further Step 2 design detail for discussion. Three additional sessions are scheduled throughout the rest of December. All stakeholder forums have webex and conference line. The feedback received throughout this period will be used as DHHS continues to develop the design concepts. Another round of public sessions will be scheduled for early 2015. The schedule for the five sessions is as follows:

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

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

Public Comments and Questions on MCM Implementation Update by DHHS

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

Commissioner McNutt attended stakeholder session held on December 1st and explained that it was very well attended and that a lot of comments were made. The forum was largely an opportunity for individuals to raise concerns and more information about Years 2-3 of the program was presented. Nothing that arose was surprising. The issue of transitioning rates from Year 1 to Year 2 came up a lot, and the idea of having this evolve over time was recommended.

Commissioner Vallier-Kaplan recommended for the Commissioners to attend a session if they can.

Public comment – A primary issue raised during the first stakeholder sessions was to maintain the independent case management agencies in place currently for the CFI waiver population. This system is effective and working well, and DHHS should not let the MCOs provide case management because it is not independent or conflict-free.

Public comment – During the first stakeholder session, concern was expressed about Step 2 requiring rate negotiations directly between providers and the MCOs.

DHHS NHHPP Update

Commissioner Toumpas explained that the Premium Assistance Program is the third phase of the NHHPP. This phase will transition the population from managed care coverage to Qualified Health Plans beginning on January 1, 2016 (per SB 413). Public hearings and the comment period for the Premium Assistance 1115 Waiver concluded on October 31, 2014. The final waiver application was submitted to and approved by the Fiscal Committee on Monday, November 10, 2014 and submitted to the Centers for Medicare and Medicaid Services (CMS) on November 20, 2014. This waiver application can be viewed [here](#). The waiver must be approved by CMS by March 31, 2015 for the program to continue.

Unrelated to the Premium Assistance 1115 Waiver, DHHS submitted its Building Capacity for Transformation 1115 Waiver application to CMS at end of May 2014. Since that time, DHHS continues to have discussions with CMS on the transformations and is currently revising the waiver application to demonstrate how delivery and payment systems will change with new Federal funding. The focus of this waiver is around building additional capacity for mental health and substance use disorder services. DHHS is holding a public session regarding this waiver on Friday, December 19th.

Commissioner Shumway asked if there is an opportunity to integrate primary care and behavioral health services within the Building Capacity for Transformation waiver. Commissioner Toumpas reiterated a core principle of MCM is to view the whole person, so this is very much a goal of DHHS, and is a core strategy of DHHS moving forward but requires transitions and culture change. It is a significant challenge but exciting work that the waiver can help support.

Commissioner Vallier-Kaplan thanked Commissioner Toumpas for this update and asked if the changes in the waiver relate to Commissioner Shumway's question. Commissioner Toumpas agreed and explained that changes are being made to have a unified concept and are targeted in this area to provide opportunities for people to conduct demonstrations.

Commissioner Vallier-Kaplan announced a meeting break until 2:15pm.

Urban Institute Evaluation of Step 2 Update (Presentation Slides available on the DHHS MCM Website)

Commissioner Vallier-Kaplan introduced Commissioner Porter to introduce the next part of the meeting. This part contained two different presentations from two different organizations to discuss findings from the review of the first year of MCM. The Urban Institute (UI) is an independent evaluator supported by the Endowment for Health. The UI will present qualitative findings, and quantitative will come later in the plan.

Ashley Palmer from the UI thanked the Commission for inviting her to present the report's findings, and thanked the Endowment for Health for supporting the work and convening providers and advocates who provided input on the methods and were key informants. The presentation included highlights from a report that will be released the week of January 29, 2015, following incorporation of stakeholder input, titled Risk-based Managed Care in NH's Medicaid Program: A Qualitative Assessment of Implementation and Patient Experiences in Year 1. This report will be posted both on the Governor's and DHHS's website when available.

This evaluation was designed to assess Step 1 of the transition to MCM, which are state plan amendment services for most beneficiaries. The report also incorporated stakeholder feedback on Step 2 of the transition and that Step 2 can use lessons learned. Step 3, the NHHPP, was not part of the evaluation as it was implemented too late to be included. This will be a three year evaluation that started in January 2014, using a mixed methods evaluation that uses qualitative and quantitative data. Qualitative data is to understand and document the implementation process for MCM and to identify transition experiences in terms of health care continuity, quality, and utilization. The quantitative component will then assess impacts of access service use, quality, and cost. So far, the Urban Institute conducted 23 key informant interviews in the Manchester/Concord area and the North Country. They are also reviewing documents such as the MCO contract, Medicaid Quality Strategy, KPI Report, and MCM Commission materials. Interview topics included State oversight, plan selection, credentialing, contracting, prior authorization, coding and billing, denials and appeals, education and enrollment, provider networks, continuity of care, quality and access, and case management. The UI is also conducting focus groups. Focus groups included parents of healthy children, those using the mental health system, and those receiving LTSS.

The UI uses standardized qualitative techniques to analyze data, transcribe, code, and look at themes from all interviews, as information comes from multiple informants. A summary of findings from Year 1 includes:

- Initial implementation of managed care in NH's MCM program went relatively smoothly along several dimensions:
 - Providers and patients had ample education about the transition
 - State took on a strong oversight role
 - Major stakeholders were in constant communication
 - Access to providers appears not to have been hindered to this point
- But there is potential for improvement in some key areas as MCM evolves:
 - Providers and patients reported significant problems related to the prior authorization processes, particularly with regard to pharmacy services
 - Case management programs are still developing
 - A great deal of uncertainty exists with respect to the implementation of Step 2

Commissioner Fox asked for clarification as to what case management programs are still developing. Ashley Palmer explained that this relates to the health plans case management programs, specifically.

In terms of education and enrollment, the process of educating patients about the transition to risk-based managed care was seemingly successful. As compared to other states, NH seems to have had a high number of beneficiaries self-selecting their plans. Selection criteria included provider networks and "extras" offered by plans. Those who didn't self-select were auto-assigned according to an algorithm.

In terms of State oversight, NH conducted extensive outreach with providers and enrollees and sees this transition as an opportunity for a new level of oversight. Also evident through an extensive quality strategy, there is strong State oversight of health plan quality. In terms of provider experience, few issues were reported related to contracting or credentialing with plans. Providers did not express a lot of concern related to claims submission and payment. A few payment issues did surface, such as information gaps, unique billing and coding arrangements, and denials. Provider representatives at the health plans were reportedly not particularly helpful, specifically relating to turnover of health plan reps; higher level staff most helpful.

Providers noted that the single biggest issue they faced with regard to MCM was prior authorization. Patients also reported experiencing similar problems that resulted in delay of care and burdensome processes. The State is aware of provider issues and has expressed a desire to ease administrative burdens. In Step 1, case management programs were developed by both health plans but they were small and seemingly not fully developed. These may not be fully developed because of a lack of resources but also the lack of historical data on individuals, which the State has indicated will be provided.

Focus group findings included information on the ability to obtain appointments, transportation, and translation. Patients noted few problems accessing primary, specialty, and emergency department care when they needed it, and provider networks did not seem to suffer. Transportation came up in each focus group and there was concern about accessing this service. Also, two focus group participants noted that translation is a problem for the Nepalese community in long term care system, and phone lines posed a problem.

As it relates to implications for Step 2 of MCM, providers reported concerns about the prior authorization requirements as they pertain to long-term services and supports, and some were concerned that disabled populations will not have the information that they need to make an informed health plan choice. Another concern heard was it would be difficult for patients to decipher which providers are with which plans. Having strong provider directories is a good step in the right direction, but still includes a population that needs assistance to make these decisions. Easier to access and understand information would be beneficial.

Looking ahead, the UI will monitor prior authorization and case management, as well as consistency of pre- and post-managed care data and cost savings. Questions can be submitted to APalmer@urban.org.

Public Comments and Questions on Urban Institute Evaluation of Step 2

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

Commissioner Gladstone mentioned that as a physician, she is hearing that colleagues are unhappy, but did not get this flavor from the report. How can we listen to these concerns if they are not being reported? Providers see the reason for MCM being to control cost. If this is a principle goal, then care management is an important piece and it is hard to hear that it is a small piece. The MCOs will have access to better data to enhance case management, and IU will look at this in year 2 of evaluation. IU did not want to minimize provider experience.

Commissioner Goldsberry commented that the State should continue looking at the provider contracting and credentialing process for Step 2 even though it was not identified as a problem in Step 1 by the UI evaluation. Step 2 providers are not at the same place as Step 1 providers. DHHS needs to provide more information to this group of providers. This is a positive aspect in Step 1, but cannot lose sight of this as an issue to watch in implementing Step 2.

Commissioner Shumway asked about the UI's methodological progression. Looking at areas to monitor moving forward, will there be a quantitative assessment that is not available today? The UI will use a mixed method in future years and while quantitative assessments will be added, qualitative methods will still be used in year 2-3 of the evaluation.

Commissioner Porter mentioned that the primary work was done in July. We now have the KPI Report and systematic tracking comes after qualitative reporting, so it will be more of a systematic approach moving forward.

Commissioner Berner asked if the UI has done this in other states. They have previously, but not currently. Comparative information in terms of past UI reports is available online.

Commissioner Fox commented that moving forward, the hope is to conceptualize care management in Step 2. We will see a lot more overlap of case management that already exists in long-term care system. The issue with prior authorization needs to be improved for long term services and supports.

Scott Westover of New Hampshire Healthy Families thanked the UI for presenting and speaking with the health plans as part of process. One comment is that we need to be careful when the report is released as it is a moment in time and not a contemporary view. The rate of change and improvement needs to be considered. This report shouldn't be used as a proxy for success in Step 2. We cannot have a Step 2 conversation in a Step 1 medical world. Step 2 is not a medical model; it is a whole person model that is orienting an entirely different infrastructure. 100% of Step 2 membership will be enrolled in care management far beyond a medical model. We need to allow the MCOs to bring this insight to the process. The number of accommodations that MCOs are making to meet the needs of providers should be referenced. For example, NHHF made an initial authorization timeline of 30 days for personal care attendants. After learning more about what these organizations do, the authorization timeline is now one year. NHHF is working with home care agencies to understand their level of services so it can change the authorization process, which is something that should be captured in a quantitative way.

Eric Hunter of Well Sense Health Plan explained that measuring in July only reflects Step 1, and Step 2 wasn't planned to start yet. The infrastructure of Step 2 was not being built when this review occurred. We can use the Step 1 experience to identify where business needs to change for Step 2. It is about habilitative care; it is important to keep in mind that the focus was different.

Commissioner Fox commented that it would be fascinating to do a qualitative study about process shifts in the MCOs from an acute system to long-term care system.

Public comment – Page 11 of the report explains that information provided was adequate to make a decision about MCM. Personal experience was that information given to the consumer about choosing an MCO was not adequate. I need much more information, as long-term care services are important to me. I chose a health plan based upon providers, but when I chose the health plan, I had to go to different providers. For Step 2, this information needs to improve. This is consistent with what was heard during the focus group for those receiving long-term services and supports who were enrolled in Step 1.

Health Services Advisory Group (HSAG) External Quality Review (Presentation Slides available on the DHHS MCM Website)

Commissioner Porter introduced Debra L. Chotkevys to discuss the External Quality Review Organization (EQRO) effort within MCM. Any state that has MCM must have an EQRO to evaluate the care. HSAG is charged with evaluating quality, timeliness, and access to care. The Centers for Medicare

& Medicaid Services (CMS) provides protocols that EQROs must follow. HSAQ is the EQRO for 17 different states. Activities completed in the first year were MCO contract compliance review, focus groups, CMS adult core set measures, and Consumer Assessment of Healthcare Providers surveys. The review looks back one year, so HSAG looked at the FFS population. The EQRO technical report must contain certain sections, overview, methodology and findings, and opportunities for improvement and recommendations. HSAG found that at the time, the three MCOs scored high during contractual compliance onsite reviews, especially in areas such as wellness and prevention, cultural considerations, and quality management. If they did not score high, the MCOs were required to revise plan documents and retrain staff to ensure compliance with the NH requirements. Once the visits were complete, HSAG supplied the MCOs with reports and the MCOs then began working on corrective action plans (CAPs). HSAG will reevaluate these CAPs this spring and ensure that they were implemented.

In addition, focus groups were held in May 2014 in Laconia and Manchester with 18 members. HSAG also conducted individual phone interviews with 18 members. Findings relate to overall experience with MCM, access to care, quality of care and care management, information needs, improvements to MCO and Medicaid. Recommendations from this group include improving benefit and coverage information, improving prescription preauthorization processes, expansion of health benefits, e.g. dental services, expanding physician information, and tailoring health education materials to the member. HSAG shared these findings with DHHS, which were then shared with the MCOs. These recommendations will assist DHHS and the MCOs as they transition the Step 2 population into managed care.

The CMS adult core set measures focus on pre-natal care and postpartum care. Rates were generated for the two measures using the National Committee for Quality Assurance (NCQA) and Health Effectiveness Data and Information Sets (HEDIS) specifications. 53.04% of women received timely prenatal care, and 63.55% received postpartum care. This is the very first HEDIS study done in NH. HEDIS has very explicit requirements of codes that can be counted. HEDIS requires provider education, and this is a baseline study. CAHPS survey responses showed that people are engaged in their care with a 34.6% of FFS population response. NH was above the 2013 NCQA child Medicaid national averages.

Other activities underway are performance improvement projects (PIPs), validation of MCO performance measures, and access reporting. The steps for a PIP are defined in the protocols. Well Sense and NHHF have developed four PIPs and the life cycle spans multiple years. The State has also defined four PIPs based upon HEDIS and CAHPS measures. This data is collected over one calendar year, and the MCO-defined PIPs will occur in January 2015.

In terms of performance measure validation, the State defined 34 performance measures that HSAG looked at with respect to how the MCOs coded their system to report accurately. HSAG conducted onsite reviews of the information systems at the two MCOs in September 2014, and a final report is to be published on December 5, 2014.

Activities designed that are not yet able to start focus on having encounter data, which HSAG has not yet received, but test files are just starting to post. HSAG will validate the encounter data once available. HSAG will also report performance measures once encounter data is available. The MCOs have many performance indicators that they are required to give to the State, which will then be passed to HSAG for reporting to show a comparison across the plans.

In Spring 2015, HSAG will conduct two more focus groups and hold an annual meeting with the MCOs. HSAG will also validate the eight PIPs, performance measure calculations, a provider survey, and a focus study of the MCOs prior authorization process and do comparisons also against Medicaid fee for service program, another CAHPS survey, and 8 adult core set measures. Technical assistance will be provided as requested.

Public Comments and Questions on HSAG (Health Services Advisory Group) External Quality Review

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions, and added that it is encouraging to see how standardization in certain processes is being incorporated.

Commissioner Shumway asked how encounter data is being evaluated. HSAG works with DHHS to identify the indicators to be used once data is received. An indicator such as how long it takes to rectify claims is an example, but this can be customized. This can bolster the KPI Report as well.

Commissioner Goldsberry explained that it seems the process improvement studies could be a good format to use in Step 2, as some of the things measuring could array nicely into Step 2.

Commissioner Vallier-Kaplan asked HSAG if there are things missing that could be added to the MCM Commission work. This is a program that will mature. HSAG has made recommendations to DHHS for the future and Step 2 population. Both plans are starting to prepare for this as well.

Public comment – What information can you share for measures/standards that relate to LTC? HSAG has not got there yet because these services need to be in the program for a year before it can be evaluated. HSAG has not yet looked at what to add, but will invest time in this. Most HEDIS indicators were written for acute care, so modifications will need to be made.

Commissioner Porter added that there was value in the focus group report, and most of the report was reiterated in technical report. Are there incremental steps that can be reported out on before this next report in next December? HSAG explained that as each task is completed there is a deliverable to DHHS that can be shared at DHHS' discretion.

Commissioner McNutt asked about measures being used in Tennessee that relate to LTC. HSAG can look into these measures in conjunction with the DHHS Quality staff.

Public Listening Session and Next Steps

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

Public comment – Of the 7 states that have moved forward with MLTSS, are they capitated HMO models or a mixture? In Tennessee, all the MCOs are for-profit capitated models. Also, for benchmarking, the idea that this Commission could bring benchmarking would be instrumental as CMS literature is delayed. Should we really combine the silo of acute care with long-term care? Listening to the Governor, we are doing this to save money and provide better quality and integration. As it relates to integrating, do acute care and long-term care belong in same silo? Or can we look at long-term services and supports and get them into one separate silo to have integration of a different kind of service that is provided separate from acute medical care. Last comment is to look at the September benchmark report. NH is running a \$25-\$50 Million budget shortfall. It seems like this is too much; therefore, should the original mission be modified? We are in a difficult situation from a State budget point of view. DHHS should look at changing the strategy based upon this environment.

Commissioner Shumway congratulated Commissioner Toumpas on one year of success. He also expressed respect for the Well Sense Health Plan effort in improving the behavioral health system and work with the community mental health centers (CMHCs). Given the anxieties with Step 2, we can still see the opportunities provided within the MCM program.

Commissioner Toumpas commented that he hopes that everyone sees, based upon emphasis by the EQRO and Urban Institute report, these issues have been identified and DHHS is working through them and adding data into the process that can be evaluated. This data will continue to be reported on a regular basis so that DHHS can act upon things in a real-time manner. Also, we need to look at the whole person instead of silos, and all of these services can come together in an integrated way. If we do this and do it well, we will save money to use on an aging population, a more complex population, and a growing population, and focus on sustainability. DHHS is monitoring what is happening in other states and learning from it. We were successful with Step 1 as we are one of the last states to transition to MCM. For Step 2, there is also the opportunity to learn from the states doing things that will transfer to NH. It is a process that we need to go through, but the question is, how can we afford not to do this? It will be a massive change, but we do not have a choice but to do it.

Commissioner Vallier-Kaplan adjourned the meeting at 4:10pm. The next meeting will be held at the Memorial Union Building at University of New Hampshire on January 8, 2015.

Follow-Up Items

The following items were noted as follow-up items during the December MCM Commission meeting:

- DHHS to send final crosswalk of Step 2 Design Plan to MCM Commission principles to Commissioners.
- DHHS to differentiate percentage of clean claims vs. total numbers of claims in KPI report.
- HSAG conducted onsite reviews of the information systems at the two MCOs in September 2014, and a final report is to be published on December 5, 2014.