

Governor's Commission

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

**MINUTES
March 12, 2015
New Hampshire Hospital Association, Concord, NH**

Welcome and Introduction

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 1:10 pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Nicholas Toumpas, Roberta Berner, Yvonne Goldsberry, Tom Bunnell, Kenneth Norton, Wendy Gladstone, MD and Jo Porter. Commissioner Vallier-Kaplan welcomes everyone and states that there will be no live streaming at this meeting. She thanks the NH Hospital Association for hosting the meeting and invites the Commissioners and the public to introduce themselves.

Commissioner Vallier-Kaplan states that the materials and the minutes from the meeting will be posted on the Governor's website and the DHHS website. She then thanks The Disabilities Rights Center and the Quality Council for presenting at the February meeting.

Commissioner Vallier-Kaplan references minutes from last meeting. A motion is made and seconded and the minutes of the February 12, 2015 meeting of the Commission are approved.

Commissioner Vallier-Kaplan updates the committee and public regarding issues since the last meeting. Wellsense had a meeting with the pediatric providers to discuss the changes in regards to Children's Hospital in Boston. Commissioner Wendy Gladstone went to this meeting. Commissioner Gladstone summarized the highlights of the meeting. She was called by Wellsense to discuss the children in need of specialty care to go to network providers in New Hampshire. Children in need of specialty care may also go to other hospitals in Massachusetts not necessarily Children's Hospital. Karen Jorgenson, Chief Medical Officer identifies fifteen (15) to twenty (20) children that are being transferred to New Hampshire providers. Many of these members are no longer children. There are also children that will finish their treatment at Children's Hospital. Transportation also was discussed. There seems to be some difficulty along the seacoast and up north with access to transportation. Network adequacy is important and the committee will be updated on this. Overall, it was an upbeat meeting.

Commissioner Vallier-Kaplan has two other updates since the last meeting. Lisabritt Solsky is has taken a position with Wellsense as the Executive Director. Congratulations to Lisabritt. And there has been a request by ABLE NH to provide a log of inquired received by the public. Commissioner Shumway and his staff have provided that list to them.

Commissioner Vallier-Kaplan then reviews the agenda for the meeting. There will be an update from Commissioner Toumpas on monthly enrollment and monthly review of key indicators. Commission Tom Brunell with then introduce Jeff Meyers, Director of Intergovernmental Affairs at DHHS and Jennifer Patterson, Life and Health Legal Counsel for New Hampshire Insurance Department to give an update on the CMS approval of the 1115 Premium Assistance Waiver, Commissioner Yvonne Goldsberry will then introduce Laura Davie, UNH Institute on Health Policy and Practice who will give an update on Care Transition. There will then be time for public input in general.

DHHS MCM Update

Commissioner Toumpas states that this presentation is updated and refined each month to provide a standard MCM update. The presentation focuses on enrollment updates, the Key Program Indicator (KPI) report, Step 2 MCM planning and implementation, other updates, and general Q&A from the Commission and the public. The MCM program began on December 1, 2013 and has been underway for 15 months. 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. Commissioner Toumpas states he will go through the monthly enrollment update, NHHPP, Key Indicator Report. He will then open the meeting up for Q&A regarding these numbers.

Monthly Enrollment Update

As of March 1, 2015, there were 152,106 people enrolled in the MCM program. The 21,442 enrolled in Medicaid but not enrolled in MCM consists of several groups: those who are not mandatory and therefore cannot be mandated into the program, those who have opted out of the program, those who have been deemed eligible for the New Hampshire Health Protection Program (NHHPP), and those who have enrolled in the MCM program but have not yet selected a plan and therefore remain in fee-for-service (FFS) until they do so. In terms of MCM program enrollment by plan, Well Sense has 82,247 members enrolled and New Hampshire Healthy Families has 69,859 members enrolled. Low income children ages 0-18 make up the majority of MCM program population, as it does in the Medicaid program itself. Other areas include non-MCM enrollees and NHHPP enrollees who have not yet selected a plan, as well as the others who have not yet opted into program.

NHHPP Update

Commissioner Toumpas states that there are 36,830 recipients enrolled in NHHPP as of March 10, 2015 and 18,342 are new to the Department, while around 9,605 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, 16,374 are enrolled in Well Sense Health Plan and 14,586 are enrolled in NHHF. The remaining 5,336 are in Fee for Service as they have not yet enrolled in a plan.

Commissioner Toumpas explains that the Health Insurance Premium Program (HIPP) as part of the NHHPP has dramatically lower numbers than what was projected. Currently, 176 individuals are enrolled in the HIPP program with 361 others potentially eligible for HIPP.

The third phase of NHHPP is the Premium Assistance Program (PAP) which will take effect on January 1, 2016. Commissioner Toumpas states that Jeff Meyers will give a detailed update later in the meeting.

Commissioner Toumpas opens the meeting to the Commissioners and public for comments and/or questions on MCM enrollment numbers.

Question: In regards to HIPP, are you seeing that other states are also in the same situation where there are few people enrolled?

Answer: HIPP is mandatory. There are fewer people that have access to employer health insurance than we originally thought. Not all states have this mandatory requirement.

Question from Commissioner Tom Bunnell: It may be helpful to know how many of those that do have employer insurance were eligible for HIPP with the cost effectiveness formula.

Answer from Commissioner Toumpas: As we move for reauthorization of this program we will be drilling down more into those numbers. According to a paper put out by the New Hampshire Hospital Association, there has been an 18% decrease in emergency room visits since this program was implemented. During the Finance Committee public forums there was testimony of how this program has positively impacted families. We can't just look at cost but must also look at the impact to communities.

Commissioner Toumpas reviews 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:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

For each major domain, Commissioner Toumpas reviews the notable results. He discusses what it means when there is a variance in what is expected with the data and the ability to drill down to see what is going on.

In December nearly 100% of requests for transportation rides were approved. The majority of approved and scheduled transportation rides are delivered. He stated that he has asked the MCOs for additional data for those rides not delivered. The largest proportion of approved and scheduled trips was not delivered as a result of members cancelling or rescheduling the trip. He also states that DHHS compared utilization for the last three months before the implementation of Care Management and the same three months the following year. The comparison saw a 44% increase in one-way rides per 1,000 member months, after the implementation of Care Management.

Emergency department visits, are lower in the MCM program than either NH Medicaid pre-MCM or New England and national Medicaid Managed Care rates. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid members is slightly higher than the NH Medicaid pre-MCM rate. The Department is continuing to follow this trend.

Commissioner Toumpas states that next month Dr. Doris Lotz and Commissioner Jo Porter will review the Key Indicators Report in more detail as well as the Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report. He states that most of the measures in the report are color coded so it is easy to compare New Hampshire against the other rates.

Provider clean claims are begin processed with in the MCM contract standards for timeliness and provider calls are being handled quickly. Commissioner Toumpas reviews the Service Authorization Summary focusing on pharmacy. He states that last month the denial rates were high so the Department had the MCOs do a deeper dive. There was a data error with one of the MCOs which has since been corrected. The pharmacy data has been removed from the table on the next slide and is currently being validated. The next report will show what the real numbers are.

Commissioner Toumpas opens the meeting to Commissioners and the public for questions.

Question from Commissioner Jo Porter: Figure 8.2 from the Key Indicators Report specifically excludes NHHPP. Does that mean that other figures included NHHPP? Commissioner Toumpas stated that he would check into this.

Question from Commissioner Ken Norton: Can you address the pharmacy formulary and mental health specifically and the fact that someone has to fail one medication in order to receive the one they want? Are there any standard formularies by MCOs?

Answer from Commissioner Toumpas: We are exploring allowing the MCOs to use their own formularies. There are a number of things we are looking at in regards to the contract and the pharmacy utilization.

Commissioner Vallier-Kaplan thanked DHHS and the MCOs for providing more information regarding the transportation issue.

CMS Approval of the 1115 Premium Assistance Waiver

Commissioner Tom Bunnell introduced Jeff Meyers, Director, Intergovernmental Affairs and Jennifer Paterson, Life and Health Legal Counsel, NHIDs.

Mr. Meyers gives an overview of the pending waiver applications before reviewing Special Terms and Conditions of the New Hampshire Health Protection Program Premium Assistance 1115 Medicaid demonstration waiver that was approved by Centers for Medicare and Medicaid Services (CMS).

He reviews the Building Capacity for Transformation, Section 1115 Demonstration Waiver which was included as a paragraph in SB 413. The legislation included a paragraph describing a Medicaid waiver to transform Medicaid services in New Hampshire. This waiver application was originally submitted to CMS at the end of May 2014. CMS provided feedback and urged New Hampshire to amend the application to focus on Behavioral Health. There was a Public Session was on Friday, December 19 2014 and DHHS briefed both the House and Senate. The amendment was resubmitted to CMS on February 22, 2015.

In New Hampshire, the demand for mental health and substance abuse services is increasing; provider capacity is already strained and the system capacity that exists is not well positioned to deliver the comprehensive and integrated care that can most effectively address the needs of patients with severe behavioral to deliver the comprehensive and integrated care that can most effectively address the needs of patients with severe behavioral health problems or comorbid physical and behavioral health problems. This demonstration responds to this pressing need and proposed to transform the delivery system for some of the most medically complex and costly Medicaid beneficiaries.

There are two other waivers currently in the works. The 1915 (b) waiver will authorize the requirement of Medicaid recipients who were considered voluntary in the Care Management Program [including those who opted out] to be enrolled into Managed Care Organization [MCO] for their medical care. The 1915(c) waiver must be amended to comply with new federal regulations. To comply, the state must submit a transition plan on how we will come into compliance with these new regulations. All these waivers that are pending will need to be touched within the next couple of months.

New Hampshire Health Protection Program Premium Assistance (PAP) Waiver

The PAP waiver is a one year demonstration waiver to use funds to purchase certified policies offered in the marketplace. This program will be implemented on January 1, 2016. There are about 38,000 in the voluntary Bridge to marketplace program. This waiver enables the state to move the NHHPP individuals to choose on the marketplace. The medically frail will not go on the exchange. American Indian/Alaska Native individuals will be excluded from the demonstration. Those enrolled in employer sponsored insurance will also be excluded. This program is called the Health Insurance Premium Payment (HIPP) program. The bulk of the new adults age 19-64 will be those who have incomes at or below 133% FPL. The estimate for the number of individuals in this group that will move into marketplace is about 50,000. About 5-10% will self-identify as medically frail. The Alternative Benefit Plan (ABA) includes the ten (10) essential benefits. CMS requires New Hampshire to provide certain services that are not included in the ABA. These are called wrap around benefits. The state will provide these through its fee-for service Medicaid program wrap-around benefits that are included in the ABP but not covered by the qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, family planning services and supplies, and certain limited adult dental and adult vision services. There will be cost sharing. All cost sharing must comply with federal Medicaid laws and regulations. Premium Assistance enrollees with income under 100 percent of FPL and American Indians/Alaska natives will have no cost sharing. Premium Assistance enrollees with income at or above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements and must include an aggregate cap of no more than 5 percent of annual income that is determined on a quarterly basis. The purchase of QHPs on the marketplace will be paid for with 100 percent federal funds through December 31, 2016. There will be co-payments for some services NHHPP new adults with incomes <100 percent FPL will not be subject to co-payments for any service. Those new adults with incomes 100-133 percent FPL will be subject to co-payments for certain services including inpatient advance radiology, generic and brand name drugs and visits to a specialist. Enrollment begins on November 1, 2015. If the MCO has a health plan on the Exchange, members will be auto enrolled into that plan. There will also be an internal and external review of appeals. CMS has approved the waiver and if authorized after 2016 we have an additional two years.

Mr. Meyers then introduces Jennifer Patterson from the NH Insurance Department to discuss at a high level what a QHP is. Other questions that she will answer include: What is the Insurance Department's role? How do we help consumers? And what are the consumer protections available to this new population? Ms. Patterson states that carriers design plans to meet the standards of the Insurance Department and submit them for review and certification. To be certified as QHPs on the Marketplace, issuers and their health plans must meet all applicable federal and state statutory requirements and standards. The New Hampshire Insurance Department (NHID) will review and recommend certification of QHPs to the HHS Center for Consumer Information and Insurance Oversight (CCIIO), which will have the opportunity to ratify the certification recommendations. Because of the Affordable Care Act (ACA) this process has an aggressive

timeline. There is a limited open enrollment period. The Insurance Department makes the first round of reviews and CMS has the final approval. The timeline for health plans to submit their plan design to join the NH Health Insurance Marketplace is April 1, 2015. When the plans are submitted, the Insurance Department reviews the forms, rates and requirements that carriers must comply with. This includes carriers posting and updating provider directories, format must be easily understandable, and the network must be adequate. The Insurance Department must make this information available in June. Once a consumer has enrolled in a plan then the consumer is protected. NH insurance law requires an internal appeal process and an external review process. There is an external process for medical necessity. These are requirements under the ACA. Ms. Patterson states that in many respects the QHP review process will be the same as last year. The one difference is that every carrier offering a QHP must be willing to except NHHPP enrollees. One of the plans must also meet the 94 percent actuarial value plan.

The meeting opens for questions from the Commissioners and the public.

Question from Commissioner Bunnell: Is there an expected public announcement whether the MCOs will qualify on the market?

Answer from Ms. Patterson: The Insurance Department does not release information on proposed intentions. The carriers themselves may make an announcement if they choose to.

Question from Commissioner Yvonne Goldsberry: If the MCOs do not come forward with a plan on the marketplace, what happens to the NHHPP members?

Answer: There will be an open enrollment and the members in the MCOs will get a notice to pick a plan. They will be able to log into NH Easy or call the Medicaid Service Center. If they do not pick a plan they will be auto assigned and have a time period to switch plans.

Commissioner Don Shumway thanked Mr. Meyers for the overview of all the waiver programs. Commissioner Shumway then asked if there is information on the medical loss ratio from the NH Insurance Department.

Answer: The statutory standard for MLR is 80%.

Question from Commissioner Ken Norton to Ms. Patterson: Does the Insurance Department have a mechanism to identify if plans meet parity? Up to 25 percent of the plans are not meeting parity.

Answer: QHPs are subject to meeting parity. The Insurance Department will review this, as well as other components. There will be a market conduct review if standards are not being met. There is also a Memorandum of Understanding (MOU) that requires the plans to comply with parity.

Question from Commissioner Porter: November 1, 2015 is open enrollment. From April to November carriers will be contracting with providers and building their networks. Experience with enrollment in Step 1 found it difficult to choose a plan while the provider networks were still being developed. How solid are the provider networks?

Answer: If a provider does not have an adequate network they cannot sell in that county. The network adequacy review in New Hampshire will be conducted in New Hampshire. It is fairly unlikely to be the same situation as with Step 1.

Question from Nancy Rollins: Do the ins and outs (spend downs) populations get addressed in the waiver?

Answer: Mr. Meyers states that he will bring the answer to this question back to the committee at the next meeting.

Question from unidentified party: The transition plan for the final Home Care rule is being submitted soon. Can this happen at the same time as the 1915 (c) waiver? Does this waiver include the CFI population?

Answer: Yes

Care Transition

Commissioner Yvonne Goldsberry introduces Laura Davie, UNH Institute on Health Policy and Practice. Center on Ageing and Community Living is collaboration between UNH Institute on Disability and the Institute for Health Policy and Practice. Ms. Davie states that all New Hampshire residents have access to person-centered options which allow them to live and age in the communities of their choice. She presents her slide deck “Center on Aging and Community Living” which was handed out to the Commissioners. She highlights the following:

- Provider is a term that is used both in the medical model and community/social services model.
- The term “community-based organization”- it is broader than organizations typically included under the medical model. It includes social service based organizations- slide 6).
- Care transitions are one aspect of care coordination.
- There are many job titles, both in the medical model and in the community care model, that provide aspects of care transitions/coordination. We need to better identify those titles and their functions. Leverage what exists, fill in the gaps as needed.
- Payment models need to include community based (social service) providers to improve health outcomes.

Ms. Davies then discusses the outcomes of the Person Centered Hospital Care Transition pilot. Outcomes include:

- Outcome 1: Reduce hospital readmission rates for target population
- Outcome 2: 80% of participants report feeling prepared for discharge
- Outcome 3: 50% of medical and social providers report good communication of medical and social services
- Outcome 4: The referral process to link patients to community resources is improved
- Outcome 5: 80% of participants report confident in their ability to navigate the medical and social systems.

Ms. Davies also reviews the nursing facility transition as follows:

- INTERACT (Interventions to Reduce Acute Care Transfers)
- Cultural Change Coalition
- Community Passport model
- Granite State Independent Living- Nursing Facility Transition Services

Take Aways

- Integrating/aligning community (social service system) care system with medical model is a comprehensive and integrated approach
- Community based organizations make a difference in health outcomes

- Do not build a program or define payment models in silo-community-based organizations exist and have expertise.

Comment: A representative from the New Hampshire Hospital Foundation states they are very focused on reducing readmissions. Part of the Affordable Care Act is to reduce harm from hospital acquired conditions. The goal is to reduce readmissions by 20 percent. They worked with twenty-four (24) acute care hospitals and had three (3) state workshops. There were approximately 100-150 people at each session. They brought in the subject matter experts at the local level. They had exposure to national meetings and webinars. They focused on pulling from all expertise and worked with communities.

Question from Commissioner Gladstone: Who is paying for this? How are the various community services coordinated?

Answer: The hospitals are funding the effort to reduce readmissions. ? There is a penalty if they have too many readmissions.

Question from Ms. Gail Brown for Mr. Meyers: I am thrilled about the transformation waiver but is the potential still there to build in the original adult dental benefit into the plan? She states that she is wondering why it was taken out to begin with. Commissioner Toumpas states that we had to negotiate with CMS and we will continue to push for as much as we can get. Nothing is out but there is still work to be done.

Commissioner Vallier-Kaplan thanked the commissioners and the public for attending the meeting. She states that the next meeting is April 9, 2015 at New Hampshire Hospital. We are hoping that Robin Preston from CMS will still be able to attend.

Follow-Up Items

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

- DHHS will continue to report on the high pharmacy denial rates
- Commissioner Toumpas will report at the next meeting on additional data he has requested from the MCOs on rides not delivered to clients that requested transportation
- Commissioner Toumpas will find out if the Key Indicators Report specifically excludes NHHPP.