

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

Draft MINUTES

**July 10, 2014
1:00 – 4:00pm
Legislative Office Building, Room 306-308
Concord, NH**

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, Vice Chair, Ken Norton, Roberta Berner, Doug McNutt, Nicholas Toumpas, Tom Bunnell, Gustavo Moral, Yvonne Goldsberry, Jo Porter, Susan Fox, and Wendy Gladstone. Also in attendance were Rep. Harding, Rep. Moffett, and Rep. Waldner.

Absent: None

Commissioner Vallier-Kaplan welcomed everyone and invited the Commissioners and guests to introduce themselves. The public was encouraged to stay for the entire meeting and participate in public comment and question time allotted at the end of the meeting.

Minutes of the June 5, 2014 Meeting

There are corrections to the draft minutes of the June 5, 2014 meeting. Draft minutes will be passed along for corrections and reposted to the Governor's and DHHS's websites. Upon a motion duly made and seconded, it was unanimously voted to correct, repost, and approve the minutes of the June 5, 2014 meeting of the Commission.

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 Update of Implementation of NH Medicaid Care Management

Commissioner Vallier-Kaplan introduced Commissioner Toumpas for an update on Medicaid Care Management (MCM) Implementation. Commissioner Toumpas gave a high-level overview of where DHHS is with respect to several components of the MCM program, and then accepted questions from the Commissioners and the public.

Commissioner Toumpas stated that with the program being in place for 7 months, DHHS has seen overall a significant increase in Medicaid caseloads from January. Caseloads at end of May 2014 were 138,562, which is an increase of 11,500 from the beginning of the calendar year. The main driver of the increase is the change in how eligibility is determined for the Medicaid program using the modified adjusted gross income (MAGI) criteria from the federal government. MAGI was initially put into place when Medicaid expansion was going to be mandatory for states. It aimed to simplify and streamline Medicaid eligibility across all states, and enabled a number of people to become newly eligible. MAGI applies to three areas: children, parents/caregivers of children, and pregnant women. In New Hampshire, 70% are children, 20% are parents/caregivers of children, and the remaining 10% are pregnant women. As a result, this has

increased DHHS' Medicaid caseload. Since the bulk of this increase occurred from January to March 2014, Commissioner Toumpas is confident that the majority of these newly eligible people are enrolled in one of MCM plans. There is always a lag factor for the dashboard report in terms of calculating Medicaid caseloads. As of the end of May 2014, Medicaid caseloads were at 138,762. As of July 1, 2014, the number of people in the MCM program is 120,964, who were either mandated or chose to be in the program. It is up 119,790 from last month. The movement of people is subject to change again, as Meridian Health Plan will be departing the MCM program at end of this month.

Commissioner Toumpas stated DHHS is working with Meridian Health Plan to help them transition recipients to the other two health plans. As of earlier this week, almost 13,000 of roughly 30,000 recipients self-selected a new health plan. Recipients have until today (July 10, 2014) to enroll/self-select into one of other two plans. Beginning July 11, 2014, DHHS will auto-assign the remaining recipients into one of the other two plans. When the program started, for those who were auto-assigned into a health plan, they had 90 days to change for whatever reason. Of the 120,000 approximate members in the MCM program, Well Sense health plan has 45% or 55,161 members, and New Hampshire Healthy Families health plan has 37% or 44,986 members.

Commissioner Toumpas stated G&C recently approved the MCO contract amendment for the two remaining MCOs and refreshed rates beginning September 1, 2014. Changes were roughly 5.7% increase on average in the capitation rates. The major change in contract amendment #4 is the introduction of the phased-in implementation for MCM Step 2, which may be renamed to MLTSS. The Governor released a statement at the beginning this month about the phased-in implementation approach and 120-day period allowing for public comment and forums, that Lorene Reagan and Susan Lombard will review with the Commission today. The formal input process is from mid-July until mid-November. All populations who can now voluntarily opt-out of MCM will be mandated into MCM on January 1, 2015. Those enrolled in the CFI waiver or in Nursing Facilities will be mandated into MCM on April 1, 2015. MCM coverage of the other three waivers (DD, ABD, and I.H.S.) has not yet been decided. After the formal public process, the coverage date will be determined. Other changes in the MCO contract include:

- Removed the 2:1:1 auto-assignment between the three health plans. Those currently enrolled with Meridian Health Plan will be assigned 1:1 between Well Sense and NHHF health plans.
- MCOs will be required to defend their decisions before the DHHS administrative appeals unit.
- Drugs for Hepatitis C were carved out of the contract because of the extraordinary costs. For the time being, these drug costs have been removed and will be passed through from the Department.

Regarding the New Hampshire Health Protection Program (NHHPP), Commissioner Toumpas stated that the NHHPP timeline was announced and beginning last week (July 1, 2014), DHHS began taking applications for eligibility determination. The health insurance premium payment (HIPP) program begins on August 1, 2014 and coverage of services begins on August 15, 2014. To date, 2,102 people are enrolled in the NHHPP. Over 2,500 people have applications processed, so roughly 430 people were not eligible for NHHPP and were referred to the federal marketplace for coverage. Of those, 99 people have employer sponsored insurance and will go to the HIPP program once it is up. At this time, DHHS cannot do a final calculation until HIPP and the necessary systems are in place.

DHHS is still working with the federal government, as specified during the June meeting, about the federal marketplace that opened in October 2013, the number of people applying for coverage, and those not eligible for subsidies. About 38,000 people went through the federal marketplace. DHHS is working with the federal government to get data that will be critical for DHHS to know where these people are and where operationally staff need to process applications once received. DHHS expects to have this data in place shortly.

Also for the NHHPP, Commissioner Toumpas stated that rates are being developed, and DHHS is working with its actuary Milliman and the two MCOs regarding these rates, which CMS has to review and approve before DHHS can move forward with MCO contract amendment #5. Depending on CMS, DHHS plans for this contract to be in place, after approval from next week's G&C meeting (July 16, 2014).

To help providers and to help the MCOs work with them, it is not feasible to reopen negotiations with providers. Therefore, DHHS is specifying in the contract the per member per month (PMPM) rates with MCOs that they will be benchmarked against Medicare. DHHS will define a fee schedule that MCOs will pay to providers and will include a UD modifier on the claim in the fee schedule to mitigate MCO negotiation with providers.

All but one state plan amendment (SPA) have been approved by the federal government. One SPA will be presented to the Fiscal Committee on July 25, 2014 regarding nonpayment for non-emergency use of the Emergency Department.

Everything is in place regarding the substance use disorder (SUD) benefit. DHHS worked closely with providers on designing the SUD benefit. They are supportive of the service array and phased-in implementation approach. Services will be available either on day 1 of the benefit, 6 months after it begins, 12 months after it begins to allow for provider communications and for DHHS and the MCOs to get provider networks in place capable of delivering these specific services. The MCO contract amendment #5 for the NHHPP will have specific language regarding prior authorization for services and prescription drugs.

Commissioner Toumpas invited the Commissioners to ask questions.

Commissioner Goldsberry asked if rates that are benchmarked to Medicare are only for the NHHPP and not part of the overall Medicaid rate refresh. Commissioner Toumpas clarified that the rates in contract amendment #4 are for existing Medicaid members and are based upon dollars available that are in the budget currently. SB413 mandated that DHHS have enhanced rates close to Medicare. These rates are for the same services; however, the MCOs will only pay providers the enhanced rates for NHHPP members. The contract language makes sure that this is being honored by the MCOs in terms of payments and there is no "cherry-picking" by providers, therefore the enhanced rates will not impact access to services.

Commissioner Tom Bunnell asked about January 1, 2015 and the switch to require enrollment of non-mandatory members in MCM. First, how many people in this category have selected to not be in MCM right now, and secondly, does DHHS need a waiver to mandate MCM enrollment? Commissioner Toumpas clarified that a waiver is needed. As of July 1, 2014, there are 120,946 members in MCM. There are almost 16,000 members not in MCM. This number continues to decline month over month, but roughly 16,000 would be within the mandatory enrollment group.

Commissioner Toumpas also clarified that a Section 1115 "Building Capacity for Transformation" Demonstration Waiver was submitted by DHHS to CMS in May 2014. CMS has approved the waiver application as complete, and posted the documents for a formal public comment period. The federal public comment period ends on August 6, 2014. Afterward, DHHS will negotiate with CMS and see what support CMS will provide. DHHS also is developing a Section 1115 Demonstration Waiver for the premium assistance program within the NHHPP. These are both integral to what we are doing right now. The premium assistance waiver needs to be submitted by December 1, 2014, and DHHS has begun significant work on the next phase of the NHHPP to ensure coverage through the marketplace begins in January 2016.

Commissioner Goldsberry asked about comments received on the contract revision revolving around rates. She specifically asked if recommendations on medical homes, linking payments, and system capacity have happened. Commissioner Toumpas clarified that the contract amendment was divided into two amendments because of urgency and needs. Amendment #4 that G&C recently approved was urgent and needed to set rates effective July 1, 2014. Details on amendment #5 cannot be provided yet as negotiations are still occurring.

Commissioner Vallier-Kaplan asked if the next amendment will be available by the MCM meeting in August 2014. Commissioner Toumpas clarified that the plan is for the amendment to be shared with G&C on July 16, 2014. If it is approved by G&C, it will be a late item for the MCM Commission meeting, but this information will be available online and to providers to show the rates and contract language. If all goes as planned, the MCM Commission will know the results from G&C by the next meeting. Commissioner Vallier-Kaplan reiterates that everyone will be eager to hear about the medical home issue.

Commissioner Porter asked for distinctions between the NHHPP population and the current population covered by Medicaid. Specifically, the Commissioner asked about the SUD benefit being available to the NHHPP population only and the reimbursement rate distinctions between the NHHPP and the other population.

Commissioner Toumpas agreed and further clarified. Due to the Medicaid benefits and the alternative benefit plan (ABP) for the NHHPP, two key differences in the ABP are a chiropractic benefit and SUD array of services. It is DHHS' desire to get approval to cover a SUD benefit for the existing Medicaid population for MCM Step 2, but it is a budget issue. The Department does not currently have authority to do so. The process for developing a budget for July 2015 has already started and will get started in earnest with the Governor's phased-in process. As an example, if Client A enrolled in the NHHPP and Client B enrolled in the existing Medicaid program, Client A and Client B can have the same service from the same provider; however, the provider could be paid different rates. This was required under SB413. From a service standpoint, it is a different population, even though it is the identical service paid at two different rates. Commissioner Toumpas cannot comment on exact differences until the reimbursement rates are approved by CMS. This adds a level of complexity. DHHS worked closely with the MCOs to stand up this program in the timeline warranted, given what was at stake for 50,000 people. We dissected the current fee schedule and it was agreed upon by the MCOs and DHHS. The MCOs will have this obligation to pay; the contract language provides protections to make sure they are paying and there is no favoritism on the provider side.

Commissioner Shumway asked to describe the SUD treatment benefit and what is covered. Commissioner Ken Norton answered by stating it is a robust set of services that will be phased in. The service array goes across all credentials, from peer support services and recovery coaches to Masters Licensed Alcohol and Drug Abuse Counselors (MLADC) and residential treatment. As Commissioner Norton indicated, Commissioner Toumpas agreed it is a robust benefit. Commissioner Toumpas further described that Jeff Meyers, Joe Harding, and Katie Dunn worked closely with SUD providers to define a robust benefit that would be feasible for implementation. A challenge is having a robust provider network available to put a robust SUD benefit in place. There were a number of capabilities that providers did not have yet, which led to a phased-in approach for SUD benefit.

Commissioner Shumway asked if the contract amendment for adjusting MCO rates also includes expansion for behavioral health improvements, according to what we have reviewed before the Community Mental Health Agreement (CMHA), or any specific changes in mental health. Commissioner Toumpas explained that the rates for behavioral health follow the same model and same structure that we use for the existing Medicaid program. For 22 separate rate cells, there is a base PMPM rate and then based upon level of acuity for a mental health diagnosis, there is an add-on rate. Between the Ten Year

Mental Health Plan and CMHA, there are certain components of these dollars oriented toward provision of services. These dollars are reflected in PMPM terms. Other dollars are allocated toward infrastructure and building capacity and community teams and are not reflected in PMPM terms, but are reflected in the CMHC contracts directly.

Commissioner Shumway asked to review the prior authorization language relative to prescriptions. Commissioner Toumpas explained that this language is still a work in progress and therefore cannot comment on it, other than stating it is driving towards a more streamlined process for prior authorization between health plans. DHHS has held a few meetings with the MCOs regarding prior authorization and the Department is looking at a uniform process. It will be complex to be uniform between Fee-For-Service (FFS) and MCM. In October, providers will have to work with five other health plans on the marketplace with their own prior authorization requirements. DHHS will convene additional discussions to move towards streamlining this process, but again there is a need to recognize the complexity. Contract language will reflect DHHS' intention to move forward with this. At the next MCM Commission meeting, DHHS should be able to review this language in more detail.

Commissioner Tom Bunnell asked about the differences between benefits and rates between the current Medicaid population and the NHHPP, and if there is potential opportunity to tweak contract language on the prior authorization process and apply it "across the board" which includes the NHHPP, MCM, and the Medicaid FFS systems. Commissioner Toumpas agrees that this is the intent, but reiterated the complexity of doing so.

Commissioner Vallier-Kaplan raised the point about how the Commission continues to receive letters/presentations around the issue of therapy services. She asked how DHHS' conversations related to therapy services are occurring. Commissioner Toumpas will provide a response after the meeting break so that he may consult with Lorene Reagan and Susan Lombard.

Commissioner Vallier-Kaplan explained that anything presented here today or sent via email, phone, or mail will be put into a list for DHHS to follow up and opened the meeting to the audience for comments and/or questions.

Public Comments and Questions on MCM Implementation Update by HHS

John Poirier, New Hampshire Health Care Association, asked Commissioner Toumpas if by requiring MCOs to come up with a payment that is closer to Medicare than what the current Medicaid rates are, where does that money come from? Commissioner Toumpas stated for the NHHPP, all services are 100% federally funded until December 31, 2016. Starting January 1, 2017, the state begins to incur 2% of whatever the costs of services are. SB413 required that DHHS seek to have the NHHPP rates benchmarked against Medicare, where possible. However, not all services have a Medicare equivalent to benchmark. Nonetheless, all spending for the NHHPP is 100% federal dollars until December 31, 2016.

Chris Dornin, writer for The New Hampshire Challenge, Inc, asked about Meridian Health Plan's transition out of the marketplace. Specifically, he asked if the other two MCOs can drop out at any time, and if so, what the process and penalty is. Simply, Chris asked if DHHS has quality assurances in place. Commissioner Toumpas stated that when DHHS launched the MCM program initially, there were three MCOs. The primary reason was a federal law requiring MCM clients to have a choice. DHHS decided to work with three health plans in case one decided to leave. There is contract language allowing any health plan to leave the MCM program for whatever reason. Meridian's CEO called Commissioner Toumpas directly, and what DHHS publically released is the same thing said privately by Meridian. Meridian Health Plan is located in Detroit and has opportunities in neighboring states. They made a business decision to focus in that region, not in New Hampshire. They went through a formal notification process,

and DHHS is monitoring what is happening. Meridian Health Plan will pay for remaining services in accordance with the contract language. With respect to quality, DHHS is gathering data now, and the primary focus of the MCM program has always been quality of service and outcomes. DHHS presented to the Commission at an earlier meeting in Claremont with Dr. Doris Lotz providing an overview of the Quality Management Program and the external quality review process. This is posted publically on the DHHS website. DHHS continues to monitor MCM and data is just coming in. Commissioner Porter is working with DHHS on this currently. Katie Dunn and Andrew Chalsma will provide this data analysis to Commissioner Porter to give glimpse of quality metrics as well. This is scheduled to be presented at the August Commission meeting.

Rep. Howard Moffett, who represents Loudon and Canterbury, asked if it was an appropriate time to discuss issues with payment under the MCM program. Commissioner Vallier-Kaplan agreed that it was an appropriate time. Rep. Moffett was there to support a constituent named Laura Darling, Owner and Principal of KidsSpeak Therapies LLC, which delivers speech pathology services in Concord. Mrs. Darling runs a small business providing services to children through and under the auspices of Medicaid FFS and MCM. She has had a long history of difficult interactions with a whole tangle of organizations involved in MCM. She will speak to Commission. As a State Representative, Rep. Moffett was very proud to vote for Medicaid expansion. It was the most important vote he made, and he strongly supports the program and understands interest of the State in making sure that the program is managed well and efficiently through the MCO process. Mrs. Darling has had a series of issues trying to get payment for basic services provided to Medicaid beneficiaries before and after MCM over the past 17 months. She is caught between Xerox claims processing, KEPRO who authorizes services, the MCOs, and DoIT that operates the billing processing software. Rep. Moffett and Mrs. Darling have provided two pieces of information to the Chair and Commissioner Toumpas that document some of the frustrating experiences she has had: a two-page letter and her resume. Mrs. Darling is a qualified health care practitioner, and serves on the State of New Hampshire Licensing Board of Speech Pathology per appointment by Governor Lynch and the Executive Council. She also served as President of the New Hampshire Speech-Language Hearing Association, and as Vice President of Governmental Affairs. Rep. Moffett saw Mrs. Darling's letter dated April 1, 2014 and makes it clear that they are not pointing at DHHS. Explains that he believes these are good people who are understaffed, overworked, have a limited budget, and are trying to figure out how to navigate a complex system; They review her letter and ask to use it as a roadmap to crystallize problems. Laura Darling, owner of KidsSpeak in Concord, provides occupational and physical therapy, primarily pediatric speech pathology from birth to young adult. She is a therapist, provider, and biller. She offers small/intimate services for those in the home and community, and offers skilled therapy services to families seeking results. It is an important facet to this community and she has been doing this for several years during the Healthy Kids Silver and Gold program. Since the transition in 2013 to Xerox, it has been a "nightmare" for Mrs. Darling according to her account. Details are in the provided letter. Recently, she hand-delivered claims to Xerox at the Pillsbury Building in Concord, where they were signed as received, and the claims got lost. Mrs. Darling has reviewed the third party liability details provided by the MCOs. She explained that she is unable to be paid because she usually does electronic billing and the MCOs do not allow for crossover claims like commercial payors. She explained how New Hampshire's billing system is different. They do not have same process as national commercial payors. Claims need to be done by hand in order to get them through correctly. Mrs. Darling's claims haven't been paid for a long time. She explained that Meridian was the most professional and polite to work with. Working with Well Sense has been difficult for children to access their benefits and for services to be authorized. For two recent claims, Mrs. Darling asked for an appeal, and during the peer-to-peer discussion they had not even read the report. It is a time constraint – two weeks or more, to ask for appeal and by that time half a month has passed and the child is not progressing and is not able to get services. With Meridian, an appeal could be scheduled right away, which is not the case anymore. As another example, during the transition from Meridian Health Plan to Well Sense, a parent has called Mrs. Darling twice, who spent time contacting the provider. When the parent called again the day of the MCM

Commission meeting, Well Sense told the parent the right documentation was not received. The parent found out that they were going to transition from Meridian as of July 1, 2014 and automatically would receive coverage until September. When the parent requests services, she has to send in additional documentation. It is time consuming and getting prior authorization has caused so many problems that she cannot provide services, and has either stopped them or is giving them for free. Her staff cannot work as such. This is very specialized and highly skilled staff and there are people in need who want this service, and it is a good service. Mrs. Darling thanked the Commission and audience for listening, and opened for questions.

Commissioner Vallier-Kaplan appreciated Mrs. Darling taking the time to document this issue and to come to the Commission meeting. Commissioner Vallier-Kaplan requested Mrs. Darling to send an electronic copy of her letter so it can be shared more easily. Commissioner Vallier-Kaplan will pass this concern to DHHS who will provide attention to it.

Commissioner Donald Shumway said he received four other emails or letters since the last Commission meeting that describe similar concerns around the State. The concerns often describe policy problems such as when a person with an extended condition or developmental disability (DD) is not accepted as medically necessary for ongoing services unless gains are being shown immediately. Letters received described significant percent of revenue being impacted. Commissioner Shumway asked Mrs. Darling to comment, to which she responded they are denying services as not medically necessary. Some parents are not allowed to consider therapy services because they were told to go through school-based services and get an IEP. Quite a few service requests were denied. After which, Mrs. Darling asked for peer-to-peer reviews twice. With Well Sense, it is difficult. It will affect revenue, but more importantly, it will affect the families and children.

Commissioner Donald Shumway had an opportunity to speak to representatives from DHHS and they are generally aware of this issue. DHHS would like the opportunity to discuss during the break and can address this after the break.

Commissioner Ken Norton thanked Mrs. Darling for the details provided. Initially regarding #8 in her letter, she asked for a formal problem solving process. Commissioner Norton asked if these have gone through the 1-800 number at the Department and its Ombudsman. Commissioner Ken Norton clarified that these services are run through DHHS, which coordinates this function. Mrs. Darling confirmed and stated that she is always on phone. She has called the 1-800 number for the MCOs, has contacted people directly, and even contacted Commissioner Toumpas. Denials are not allowing services. The State of New Hampshire has a mandate for early intervention services, and the Governor sponsored this bill. Regardless, Well Sense is denying these services.

Rep. Moffett added that he is not a health care specialist, but it does seem to him after spending several hours with Mrs. Darling, the problems she has described seem systemic and likely are being experienced by others. Regarding #8 in her provided letter, this request seeks to establish a process for accountability with timetables and goals so this won't happen to others. This is important to her to have a formal process that works through these problems systemically. Some could be things Mrs. Darling should have done herself. If so, she will take responsibility.

Commissioner Goldsberry stated that there is a distinction between post-acute care therapies and those that are longer term. This shows that these distinctions need to be made during Step 2 of MCM to be clearer about the prior authorization process for these services during Step 2. Furthermore, Commissioner Goldsberry stated if the State is experiencing these situations now, they will occur in Step 2.

Commissioner Fox referred to CMS guidance that EPSDT requires therapies and services, especially with the many children who have autism. She wondered how this new guidance plays into the question and if this helps resolve the situation. Lorene Reagan responded to clarify that an advisory guidance was issued yesterday; therefore it was not planned as a discussion topic for today's meeting. This guidance requires further DHHS internal review and analysis. DHHS put copies of the guidance at each of the Commissioners' seats and provided extra handouts for the public in attendance. It is a bulletin from CMS that updates their policies, which are supportive of the necessity of these long term therapeutic supports for people with autism spectrum disorders.

Commissioner Vallier-Kaplan closed on this topic and confirmed that DHHS representatives will discuss this during the break to provide further information after the Commission reconvenes.

Update on MCM Six Month Report on Quality

Commissioner Vallier-Kaplan turned to Commissioner Porter to provide an update on the upcoming August presentation six month quality review data reporting. According to Commissioner Porter, MCM has made three recommendations to the Governor to date. A key recommendation was regarding public reporting. Looking at the first six months of data with analytics is the first step in implementing the recommendation post monthly enrollment reports.

Commissioner Porter stated that it is a six-month review and the data sets are under review at DHHS. Katie Dunn and colleagues are reviewing the reports, which will be shared with Commissioner Porter and Dr. Lotz on key findings before the next MCM Commission meeting. Reports will be distributed to the MCM Commission before the next meeting. It also is important to note that the MCM Commission has talked about the Endowment for Health who contracted with the Urban Institute to do a third party review. The third party review is scheduled for next week and members from the MCM Commission are helping with gathering feedback on the first few months of program. They will be going across the State next week, specifically in Littleton, Portsmouth, Manchester, and Concord.

Commissioner Vallier-Kaplan said there is also a CMS-required external evaluator, and asked if the information will be integrated with this. Commissioner Toumpas confirmed and responded that it is part of this process that Commissioner Porter spoke to. It will be data plus interpretation of data. Commissioner Vallier-Kaplan reiterates that if people are interested, this will be presented at the next meeting on August 7, 2014 which is intended to be in Manchester.

Commissioner Norton asked if any metrics include complaints filed, types, and resolutions. Commissioner Porter responded that she has not seen reports yet. Early information said the focus of initial reporting was on member communications, claims, grievances and appeals, pharmacologic management, and utilization management. Commissioner Porter confirmed that this will be a part of the initial six-month review.

Commissioner Vallier-Kaplan opened the meeting for public comments and questions on MCM quality review.

Public Comments and Questions on MCM Quality Review

Karen Blake, parent of a child, asked if there will be feedback in Littleton and if it will be public. Commissioner Porter responded that there is a focus group scheduled, but does not have the exact information on hand. The Urban Institute contacted service agencies in that area to connect the evaluator with members covered by MCM. Most focus group work will also cover a set of providers. At the time, Commissioner Porter did not have further details to share.

Commissioner Norton mentioned that there is a focus group are specifically looking for people receiving behavioral health services at NAMI next Tuesday and that he could provide contact sheets if anyone wants to be involved. They are limited to people receiving behavioral health services from an MCO. The payment for attending is a \$50 gift card to Wal-Mart.

Deb Scheetz, from Gateways Community Services, explains there is an incredible amount of data being looked at. Dr. Doris Lotz has been examining a lot. Something that has come up repeatedly from Gateways' clients is that Medicaid recipients are looking for a simple report card that would look at complaints, denials, out-of-office approvals, and lengths of times on prior authorizations. People are interested and want to make informed decision on behalf of their children. Gateways had many calls asking for this kind of information as people switched to Well Sense and NHHF. The requested information would be of value to a consumer who is making an informed decision on what plan to choose.

Rep. Lori Harding from Lebanon, Chair of the Primary Care Workforce Commission, was very interested to know metrics collected around access to primary care and wait times for getting an appointment. The available information does not have a good look at this statewide.

Commissioner Shumway stated that if people are interested, there are three upcoming provider trainings hosted by DHHS. The notice was sent out recently by Katie Dunn. The first training focuses on providers helping clients enroll in the NHHPP. The second training focuses on managing business practices for managers and administrative staff. The final training focuses on chiropractic and SUD benefits for those providers. Commissioner Donald Shumway provided the dates.

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

MCM Step 2 Stakeholder Process

Commissioner Vallier-Kaplan introduced Commissioner Fox and Commissioner McNutt. Commissioner Fox said that because DHHS has announced MCM Step 2, the Commission has been focusing on the implementation of this phase of the MCM program. The Commission is particularly focused on the public input process for stakeholder input ensuring wide and adequate participation in this process for both providers and consumers. Commissioner Fox explained that Lorene Reagan and Susan Lombard will discuss this stakeholder engagement process and the schedule of events coming up to ensure wide representation.

Commissioner Vallier-Kaplan turned the meeting over to Lorene Reagan and Susan Lombard from DHHS.

Mrs. Reagan first responded to questions raised by Rep. Moffett and Mrs. Laura Darling prior to the meeting break. Mrs. Reagan explained that DHHS is aware of these concerns and the functional challenges around therapies. DHHS has looked into it and identified providers where it is a challenge. DHHS continues to evaluate and work with the MCOs on the issue of prior authorization of therapy services. Mrs. Reagan acknowledged that Mrs. Darling was looking for information as to whether this is systemic problem or a few providers, and explained that DHHS does not believe it is a systemic problem, but acknowledges its seriousness.

Mrs. Reagan also addressed the CMS guidance released on autism. In terms of functional therapy challenges, DHHS has identified issues that are not just specific to speech physical and occupational. DHHS is finding differences in adjustments between FFS and MCO Medicaid operations. Many

differences are based upon the principles of the MCM program that are different from FFS. In terms of looking at medical necessity, DHHS will continue to work to help providers understand how to describe medical necessity so that MCOs can better understand it. Mrs. Reagan addresses Mrs. Darling's earlier point; with children with challenges related to DD or sensory challenges that are different from acute medical needs, providers need to know how to describe them. DHHS will continue to work with providers on how to do so correctly. For FFS, DHHS had ways of working with providers to retroactively pay for services not previously prior authorized. This is not part of the MCM approach. Mrs. Reagan emphasizes that the expectation is that they will be authorized before they are provided and that DHHS needs to look at these timeframes through appeals. The need to submit more detailed clinical information is different between MCM and FFS programs. DHHS did not have the capacity to request this information in every case, however does recognize the need to better educate providers to align these processes and enable them to provide the level of detail required.

Mrs. Reagan explained that early intervention services from birth to three years of age are not Step 1 MCM services, but rather they are Step 2 MCM services. Any issues or challenges with these services would not relate to the MCOs, they would relate to FFS and therefore DHHS. DHHS is working with the MCOs and understand there have been requests for IEPs for speech therapy services. Mrs. Reagan explained that SB 414 has specific language on this issue and that families are not required to provide this to an MCO when looking for services under the Medicaid to Schools program. Last, DHHS acknowledges and appreciates Commissioner Goldsberry's prior statement about the need to understand the needs to people with long term care (LTC) needs. Mrs. Reagan explained how the lessons learned in Step 1 MCM will certainly be communicated in Step 2 MCM to ensure a different understanding of clinical, medical, and LTC necessity, which is different from those services being provided for currently.

Commissioner Vallier-Kaplan thanked Lorene Reagan and Susan Lombard for providing the meeting presentation in advance and turned the meeting over to Mrs. Lombard.

Mrs. Lombard began with a refresh of the ongoing goals of the MCM Program and of the overall health care reform effort in the State moving forward. Mrs. Lombard explains that as we all talk about Step 2 MCM, we need to be grounded on the goals that got us this far in the process. Step 1 MCM began 7 months ago, and DHHS is currently looking at phased approach for Step 2 MCM, beginning with mandatory enrollment. Those with the option to opt out of MCM last December will receive all services through the MCOs beginning in January 2015. The second phase of Step 2 will begin in April 2015 and will provide services to the Choices for Independence (CFI) waiver and Nursing Facility services. These services will be managed by MCOs. The third phase of Step 2 will provide MCO-managed services to members of the Developmental Disability (DD) waiver, the Acquired Brain Disorder (ABD) waiver, and In-Home Supports (HIS) waiver. The coverage date for the third phase of Step 2 is to be determined.

Mrs. Lombard continued with a discussion of the outreach process. She explained that DHHS is planning a robust stakeholder outreach process for all of the different program areas. DHHS is planning a parallel outreach processes to ensure plenty of input from all populations. Some stakeholder sessions are targeted for people receiving services or for providers providing services through certain waiver programs. There will also be sessions for providers and/or consumers of CFI services for seniors and adults with physical disabilities and nursing facilities. Mrs. Lombard provided the schedule for CFI and nursing facility service-related input. Mrs. Lombard provided a correction to the slide. The State Committee on Aging scheduled for Monday, July 14, 2014 will be pushed to a date to be determined in August. Mrs. Lombard reviews each of the groups, as listed in the slides, with whom DHHS will meet. There are three sessions scheduled to occur in the DHHS Brown Building Auditorium and for those meetings there will be dial-in and webinar capabilities.

Mrs. Lombard reviewed a set of resources that DHHS has made available on the DHHS website regarding managed long term services and supports (MLTSS) via AARP and other organizations. DHHS has established an email address specific for Step 2 MCM comments and questions as it relates to the CFI waiver and nursing home facility services.

Mrs. Reagan walked through the stakeholder process plan which has been structured into three tiers. The stakeholder input process will occur over 120 days. One thing heard from stakeholders clearly was the need for members of the elderly and physically disabled communities to have their own forums so voices would be heard. This need prompted DHHS to develop a tiered approach. Mrs. Reagan explained how targeted stakeholder meetings will be used as an opportunity to solicit input on Step 2 priorities. In tier 1, DHHS will have a formal schedule firmly scheduled from August to September. The Quality Council will partner and host a meeting in August, as will the Family Support Council, People First, and the NH Brain Injury Association. This formal schedule will be posted on the DHHS website and the Public Information Office (PIO) is currently working to distribute this information. This information will also be available through the Endowment for Health. For larger meetings, DHHS will request an RSVP to ensure appropriate accommodations. Mrs. Reagan explained that on the DD side, three targeted stakeholder meetings will be held in Concord to discuss thoughts and concerns around including the DD waiver enrollees in Step 2. A similar approach will be taken towards the ABD and IHS waiver enrollees as well. Mrs. Reagan explains how this approach is intentional to allow for these groups' voices to be heard individually as well as collectively. Tier 2 will likely happen in early August and September. Ten Area Agencies have agreed to host forums in the North, South, East, and West portions of the State. Specifically, the North Country will include Conway, Gorham, and Whitefield.

Commissioner Vallier-Kaplan opened the meeting for public comments and questions on the MCM Step 2 stakeholder process.

Comments and Questions on MCM Step 2 Stakeholder Process

Commissioner McNutt remains concerned that the consumer piece of the process relative to elders needs strengthening and recommended that DHHS reach out to ServiceLink to get input from caregivers and consumers in local areas.

Commissioner Fox expressed concern about the lack of representation for people with physical disabilities and explained that the Statewide Independent Living Council is different than Granite State Independent Living. She expressed the need for DHHS to clearly distinguish between adults with physical disabilities and the elderly in its communications.

Barbara Salvatore of EngAGING NH said that there is a missing element of advocacy organizations ranging from the Elder Rights Coalition to the AARP. She emphasized the need to have a wider representation of some of these advocacy organization and those organizations that assist the elderly population with problems, such as the Disability Rights Center.

Susan Lombard explained that DHHS recently spoke with New Hampshire Legal Assistance and this group will be added.

Commissioner Porter explained that stakeholder meetings are open to the public, and asked if it is the hope that the folks in this room as well as a wide audience will connect whomever they think should attend to come? Lorene Reagan agreed with this statement and encouraged RSVPs to make sure they have space. In general, DHHS agreed with this point that the word should continue to be spread, and that most but not all meetings will have a component of either WebEx or dial-in information.

Chris Dornin, writer for The New Hampshire Challenge, Inc, explained that normally public hearings are on a budget or a building bond and the public can weigh in, similar to legislation. He asked if these are public hearings as there is not something concrete to respond to.

To clarify, Lorene Reagan explained and these are not public hearings, but that they are public forums and therefore opportunities for people to come together. Mrs. Reagan explained that these forums will be structured in a way that touches on the areas that are important to people for LTSS, as DHHS heard through the CMS State Innovation Model (SIM) Model Design process, and things that stakeholders feel are important to include in Step 2. Examples of these areas include contracts, quality strategy, and how payments will be made. Mrs. Reagan explained that this structure is intentional and intends to draw feedback in specific areas where DHHS has been told that stakeholders would like to guide the process in. It should be clear that DHHS is not bringing a specific plan to comment on it, as stakeholders do not wish to have a plan to comment on, but instead to comment on the development of a plan.

Commissioner McNutt mentioned that it would be helpful to have education on what stakeholders should comment on, as the Commission has learned from Step 1 that not everyone is informed on these issues.

Commissioner Toumpas explained this is part of the process and DHHS deliberately did not put together a concept because this needs to be developed by stakeholder input. He agreed with Commissioner McNutt's recommendation to provide principles and education information on MLTSS in advance to stimulate discussion. Commissioner Toumpas reiterated that these stakeholders will not be uninformed in terms of this issue, as they live it and are well aware of the things that need to be changed and also need to be preserved.

John Richards asked about the DHHS MCM website and if the meeting presentation and stakeholder forum schedule presented today will be posted there, which is same website as Step 1. Lorene Reagan confirmed that the materials will be posted on both the DHHS MCM website and the Governor's website for the MCM Commission.

Lorene Reagan explained that in the MCO contract there is language that states "Implementation of Step 2 for all populations will be undertaken in accordance with a Program Plan that is prepared after the conclusion of the stakeholder process and after public notice, comment and hearing on the Program Plan." This language is consistent with DHHS messaging to date.

Mrs. Reagan explained that Step 2 will be built on a whole person approach and will build on strengths currently in LTSS system. The program will be value-based and provide a continuum of services and supports to improve quality and manage costs. DHHS will develop quality measures for Step 2 based upon recommendations from stakeholders about what is most important. Mrs. Reagan reviewed the Step 2 MCM implementation roadmap and its components/steps with the Commission. She reviewed the timeline for launch dates for each waiver again, and mentioned that DHHS is looking at and understanding that in January 2015, it will be bringing in the dual eligible population and another group of children previously not required, referred to as Katie Beckett Medicaid enrollees.

Commissioner Berner stated that it looks like the MCOs already have an implementation plan developed in the contract, but DHHS does not have its own plan in place. She asked about the timing for DHHS to develop its implementation plan. Commissioner Toumpas corrected this statement and explained that the MCOs do not have an implementation plan developed, and that the only things in the contract are the dates. He explained that further details for Step 2 will require further contract modifications once the concept is developed and detailed. All that has been currently provided to the MCOs is same as what has been provided to the public, which are the dates for implementation as opposed to an implementation plan.

Commissioner Shumway clarified between the 120 day period that is beginning now for stakeholder engagement, and the 120 days prior to April 1, 2015 when the MCOs will come in with implementation plan for Step 2, Phase 2, which dates back to December 2014. He explained that these time periods will be close, but not overlapping. Commissioner Shumway also explained that there will be a lot of waiver amendments and contracting occurring during that time. He appreciated this timeline, but expressed concern about completing provider contracting by April 1st. There will be a number of providers under BEAS, about 200 CFI providers, and 800 nursing facilities (NFs), and all of them will have to negotiate two contracts with each MCO and do so based upon an emerging set of concepts coming out of the first 120 days and subsequent implementation plans. Commissioner Shumway explained that this window is tight, that contract negotiations can take a long time, and therefore reiterated concern around this aspect on behalf of providers going through this transition, and asked DHHS to consider this point.

Lorene Reagan explained that the CFI waiver and NF population were identified for an earlier start date because many of these providers already hold contracts with the MCOs via Step 1 MCM. While there is still reason for concern, DHHS hoped the strength of this Step 1 experience would help to ease some of these concerns. Susan Lombard added that DHHS has learned from other states implementing MLTSS that working with providers is crucial and therefore DHHS will continue to do so.

Commissioner Moral noted for DHHS to consider the legal aspect of provider negotiations that will need to be placed into MCO contracts.

Commissioner Fox requested a more detailed timeline as to when amendments, waivers, etc. need to be developed to meet an April 1, 2014 start date. She expressed confusion in terms of how these distinct steps lay out. She also referenced some of the earlier reading that the Commission received for MLTSS which discussed how difficult this process is for small providers, and emphasized that what the Commission has been hearing during Step 1 in terms of provider difficulty will only be more of an issue in Step 2.

Commissioner Porter explained that there are interesting steps in the upfront part of the roadmap for context setting, but early phases of work e.g. comparative analysis, legislative status, and administrative rules may be helpful for the Commission to understand. There are components of legislation for what is feasible and possible in MCO arrangements. As the Commission hears stakeholder input, the caps on what is possible may not be dictated on what DHHS can do, but on what can legislatively/legally occur. Therefore, Commissioner Porter requested that some of the initial pieces that DHHS used to build its roadmap and do competitive analysis before the stakeholder process be shared with the Commission.

Commissioner McNutt is in agreement and commented on the timetable. Specifically, the role of the Commission is to make recommendations and these recommendations need to be made soon as we review the timetable. He asked if DHHS can address the sort of oversight capacity that the State itself needs to have in this process.

Commissioner Goldsberry asked how the information generated during the SIM Model Design process conducted last year by DHHS will flow into this design of Step 2 MCM. Commissioner Toumpas said that this will be part of the context of the stakeholder forums. A lot of the values, principles, and goals for Step 2 were developed during SIM. SIM had a broad representation of stakeholders and developed concepts that can be reacted to for Step 2 regarding payment and delivery reform to get to a whole person approach to service delivery. DHHS can borrow a number of things from this process, therefore Commissioner Toumpas reiterates the need to review the SIM Model Design and strike a middle ground between its content and Step 2 MCM design.

Commissioner Vallier-Kaplan clarified that some things proposed during the SIM Model Design process could be used during these stakeholder conversations to see if the concepts are still relevant, if there are new ideas, etc. She also encouraged that Step 1 lessons learned be used, and asked how formal the process has been to document these lessons and to apply them to Step 2. For example, we learned that small providers are more challenged than large providers, but we do not know how these lessons will be applied.

Susan Lombard added that it is important to recognize that there are a lot of services in Step 1 that are LTC, e.g. mental health services to longer term populations, therapies for children with chronic LTC needs, personal care services as part of the State Plan, etc. Looking at those services and the glitches in getting those services authorized in terms of different approval requirements for non-acute services is an important lesson learned in Step 1 that can benefit Step 2.

Commissioner Bunnell voiced concern about the timeline. It is clear that there is great good faith to ensure that this new piece of MCM and the subsequent transition really works. However, April 1, 2015 is not that far away. Between stakeholder inputs, the creation of implementation plans, payment rates for MCOs that need to be approved by CMS, G&C approvals, and provider contracting, this is a lot that has to happen. Commissioner Bunnell offers the Commission's support to assist with this process.

Commissioner Toumpas stated that inherently, we all need to understand that we are signing up for a massive amount of change, and to look at what DHHS is doing right now. We are seven months into a massive change to the State's Medicaid program. There are clearly bumps in the road to doing this. As we look at the landscape that is changing, there is a massive amount of change that we have already signed up for. On top of this foundation, we are adding 50,000 adults into the Medicaid program via the NHHPP, which will get changed dramatically again in January 2016.

Commissioner Toumpas further emphasized that DHHS understands all of these factors and recognizes that it is a lot of change. He challenged the Commission to say that the status quo will get us to higher quality, better outcomes, and lower cost. DHHS recognizes the risk, but is working to strike a balance. Commissioner Toumpas explained that it is helpful for the Commission to raise these issues; however, every issue is something that DHHS has considered. We have to move forward amidst the uncertainty to set the pace for changes we need to make, away from the status quo that will not serve us well. These are timeframes and guidelines in terms of what we need to do. We were a year late in standing up the MCM Program because we wanted to do it right. Commissioner Toumpas again explained that it is helpful for the Commission to raise these issues, but would like to see concerns highlighted and then mitigations proposed in order to have a constructive conversation. Overall, it would be helpful to hear collectively from the Commission what recommendations it has for DHHS.

Kathy Sgambati from the Office of the Governor reiterated Governor Hassan's message that this program will go forward when it is ready. A lot of work has been put into the stakeholder process and every one of these steps will have a ton of work behind it. Mrs. Sgambati explained to the Governor's Commission that it would be helpful that if there are specific concerns they would like to see addressed, e.g. lessons from Step 1 regarding small providers, to document these issues so that DHHS can begin to specifically address them. As a Commission, if we could identify these things systematically, we would have issues that could be dealt with during the stakeholder forums, but also via a series of recommendations that we could provide to DHHS with dates, times and resources. Mrs. Sgambati encouraged the Commissioners to use their diversity of skills and talents to help shape this program, and noted that going month-to-month to pose these concerns to DHHS is not realistic within the Department's timeline.

Commissioner Porter asked that as the stakeholder forums are completed, if there is an intention of developing a bulleted list of major things heard. Between now and the next MCM Commission there are

at least 7 stakeholder forums, therefore we may miss the opportunity to consider the things that come out of these sessions. Therefore, Commissioner Porter requested that the things that are brought up during the sessions, e.g. the top key issues, be circulated as they are occurring to stay engaged between now and the next MCM Commission meeting.

Commissioner Vallier-Kaplan explained that it is not realistic for MCM Commission members to attend every stakeholder forum; however, encourages members to attend if possible.

Commissioner Norton thanked DHHS for the presentation and stated that it is hard to wrap his head around all of the moving parts, and that it is to the Department's credit to keep everything going. He also stated that it would be helpful to have a work session about these issues that would come in between scheduled meetings.

Commissioner McNutt agreed with Commission Norton and reiterated that it is too much information, given the timeframe that we are dealing with, to occur during monthly meetings. The Commission has a responsibility that is clearly to digest this work as it becomes available.

Commissioner Moral confirmed that the Commission will schedule a public work session that the public can come to but perhaps not participate in as in-depth as the formal MCM Commission meetings.

Commissioner Fox clarified an earlier point regarding Step 2 MCM and the status quo. For herself, Step 2 is the most important thing that will happen in this broader process of MCM and ensuring that LTC is delivered in the best way possible. The concerns expressed today are focused on ensuring that this implementation is being done right. Commissioner Fox reiterated the timeline backing up from April 1, 2015 to show all the steps will be helpful and reiterated the point that her concerns are not around that Step 2 should not happen, but that it should be done right.

Commissioner Toumpas clarified an earlier point in saying that DHHS is in agreement that this should happen right and is aware of the concerns. He explained the hope to receive tangible suggestions from the Commission about what DHHS needs to do to mitigate these concerns, given the parameters that these are contractual, legal, and legislative obligations. Commissioner Toumpas emphasized that this is about the people. At the end of this process are a lot of people whose lives are dependent on what we are doing and we want to do it right, and the status quo and exiting system is simply not going to get us there.

Commissioner Goldsberry reiterated Commissioner Fox's point regarding the timeline and that for Step 1 the Commission had a much more detailed timeline of the process. That was helpful in order to be thoughtful of where we are in the process and provide recommendations. Commissioner Goldsberry requested this detailed timeline for Step 2.

Commissioner Toumpas stated that for the purpose of standing up the NHHPP, DHHS knew it needed to go to all the proper committees and had this all documented in a roadmap. While some of this information is internal to DHHS, some of it can be provided quarterly, e.g. as it relates to G&C, Fiscal Committee, and JLCAR, for example. To lay this timeline out more will help DHHS in terms of managing the work, but it can also be transparent to the Commission.

Commissioner Porter understood that DHHS might not know this level of detail yet, but emphasized that it should know where in process provider contracts fall, for example. She also stated that this timeline should be developed with the Commission instead of just presented to it.

Commissioner Vallier-Kaplan stated that there was a much broader body of knowledge and experience from other states during Step 1 than there is in Step 2, as it relates to MLTSS.

Commissioner McNutt stated that since a contract has not been drafted at this point, this process is different than Step 1. While there is not a contract, there are some overarching issues to begin discussing now. For example, we can discuss how to help the Department help small providers through their own capacity. If we are really talking about a HCBS system, we need to think about those impacts.

Commissioner Shumway stated that the primary function of the Commission is to review and recommend. We have had a process where members bring forward general concepts to be thought of during time between meetings. Therefore, he proposed that the Commission consider a recommendation that DHHS establish a formal problem solving process between Xerox and providers to resolve policy issues for therapeutic services to children.

Commissioner Vallier-Kaplan asked for any objections to pursue this as a potential formal recommendation to the Governor. No objections recorded.

Karen Blake, parent of a child, explained that her child will enroll into the MCM program during phase 1 of Step 2. She asked about the process for that, if there is a stakeholder process for those coming on in phase 1 via mandatory enrollment, and what the steps and deadlines for mandatory enrollment will be. She further explained that the information sessions seem to only address the waiver programs and not the Katie Beckett Medicaid population. Commissioner Toumpas explained that a waiver will be developed for Step 2 that requires a public comment period, so this is a factor in the process.

Public comment; not identified – It is an observation that the Commission members should be congratulated today for speaking from their hearts and being engaged. This is an extraordinary effort to go through. With regard to the DHHS Step 2 presentation by Lorene Reagan and Susan Lombard, MCOs are managing health care across the country, but rarely are they HMOs. We have selected an HMO system to run their MCOs. Today, insurance companies, health homes, etc. are all acting as MCOs. To reiterate an earlier comment, these two HMOs do not have experience with this (MLTSS). How will you integrate the two when you do not even know how HMOs will deliver these services? How do you lower costs while keeping quality to provide a whole person approach? The suggestion is that being ready is obvious, but we are “aiming and shooting”. We need to take the time. The Governor should acknowledge now that this time has come. We need to connect the legislature who provides the money to the academic experts to develop this program. It is not understood how DHHS will have these forums when it does not know how it will provide services. It is a strong encouragement to the Commissioners to tell the Governor that you need more time. A ready-shoot-aim approach should not happen. A ready-aim-shoot approach should. If 1 out of 62 kids have autism and you want to add a SUD benefit too, how will you do this? We need to connect the legislature to what you are thinking. It is a forum, so you should know what the facts are and understand the capabilities of an HMO. Truth and transparency is what we need in government today. We need to then figure out the best possible solutions that the legislature who provides the money agrees with. Step 2 is not the same learning curve. The time has come to deliver a message to the Governor that we are moving too fast and will make a mistake.

Chris Dornin, writer for The New Hampshire Challenge, Inc, asked what has happened in both Kansas and Tennessee.

Commissioner Vallier-Kaplan explained that DHHS is interfacing a lot with Kansas. Susan Lombard added that both Kansas and Tennessee were at a recent roundtable with AARP. She cannot provide a full summary, however explained Kansas’ message regarding spending time preparing providers so they are ready going forward.

Commissioner Vallier-Kaplan asked about reference materials. Commissioner McNutt stated that there are AARP briefs done about the experiences of other states as they have moved to MLTSS, and that these states themselves have websites that are helpful as well.

Public comment; not identified – It is known that the only state with commercial payors involved in MLTSS is Kansas. For 6-7 months, the contract with the Kansas provider base was staying the same. They still did FFS contracts and did not make major systemic payment reform changes until they were into process. This reinforces the concern that we are partnering with commercial payors and we are not sure of their experience.

Commissioner Vallier-Kaplan explained that the other undiscussed agenda item focused on transportation and health will be moved to the next MCM Commission meeting in August.

Commissioner Norton provided a brief update on behavioral health. He stated that the Commission discussed a lot in terms of the SUD benefit and explained how DHHS has done a tremendous job in designing this benefit. However, the Commission did not discuss the community mental health centers (CMHCs). Commissioner Norton described how the CMHCs continue to operate under letters of agreement through the end of July. One CMHC had signed with a MCO and the other nine have not. This is the current status, and it is unclear if it will occur through end of July. Finance continues to be a concern at the CMHCs. The SUD benefit has an interim rule going to the Joint Legislative Committee and will go through the full rule process, but the draft making can be removed. We have accomplished a tremendous amount in a fairly brief timeframe and this provides confidence as we move forward with the enormity of the task at hand. Commissioner Norton concluded that this ability to work with providers and advocates to get a benefit like this in place cannot be understated.

Commissioner Vallier-Kaplan adjourned the meeting at 4:30pm.