

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

MINUTES

August 7, 2014

1:00 – 4:00pm

**City of Manchester, Health Department – Room 162-164
1528 Elm Street, Manchester, NH 6246466**

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, and Susan Fox. Also in attendance were Lucy Hodder and Brittany Weaver from the Office of the Governor, Rep. Howard Moffett, Sen. Donna Soucy, Eric Hunter of Well Sense Health Plan, and Stefanie Svoboda of New Hampshire Healthy Families.

Absent: Commissioner Wendy Gladstone

Commissioner Vallier-Kaplan welcomed everyone to the meeting, thanked the City of Manchester Health Department for hosting, and informed the public that the meeting would not be streamed online or via phone.

Commissioner Vallier-Kaplan clarified that the Commission's scope of work includes the New Hampshire Health Protection Program (NHHP) because it is part of the Medicaid Care Management (MCM) program at this time. The Commission receives up-to-date reports on how the implementation is going, and while the Commission has not paid the same level of attention to the NHHP as it has to Step 1 and Step 2, it still remains within its purview. Commissioner Vallier-Kaplan took the opportunity to acknowledge the amazing and significant work that DHHS has done over a short period of time to plan for and implement the NHHP to bring Medicaid services and coverage to a very important population in NH that has not had coverage for a long time. Commissioner Vallier-Kaplan recognized that it is not an easy task and wanted to be sure that the Commission and the public acknowledged the amount of work DHHS has undertaken in addition to everything else it is responsible for every day of every week of every year.

Commissioner Vallier-Kaplan explained that the meeting will begin with a general update from DHHS and then transition into particular topics including transportation services and data reports as the Commission begins to receive meaningful data to reflect upon the impact and performance of MCM to date. There will be dedicated time for Q/A with respect to these particular topics, as well as an open public comment period to ask questions, bring up concerns, and provide compliments at the end.

Commissioner Vallier-Kaplan explained to the public that in order to achieve the best results, individual concerns should first be brought up to the MCOs, then to DHHS, and then to the Commission. If individual concerns are initially brought up to the Commission, they are usually turned over to DHHS and then back to the MCOs. Commissioner Vallier-Kaplan explained that if issues are brought up during the meeting, the Commission would appreciate a written copy so the issue can be shared.

Commissioner Vallier-Kaplan invited the Commissioners and guests 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 July 10, 2014 Meeting

There are no corrections to the minutes of the July 10, 2014 meeting. Upon a motion duly made and seconded, the minutes of the July 10, 2014 meeting of the Commission are approved.

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

DHHS MCM Update

Commissioner Vallier-Kaplan introduced Commissioner Toumpas for an update on MCM implementation. Commissioner Toumpas set the context that DHHS is seven months into the implementation of MCM and that it is one of the most significant and complex public policy initiatives the State has undertaken. The goals of the program from its outset were around quality, better outcomes for those that we serve, and to change the way we pay for and deliver services. DHHS is keenly aware of current challenges at the system level and that these challenges have an impact on individuals. Commissioner Toumpas assures the Commission knows that DHHS hears these issues and is actively working to resolve them so that we can move forward to achieve what we had originally envisioned through this program. As it relates to the key areas of concern raised by the Commission and the public, there is a process for resolving these issues. An individual's first course of action is to go to MCO, and then to DHHS. An issue raised during the last meeting was the provider experience from the exit of Meridian Health Plan and subsequent transition to the other two MCOs. Today's meeting will contain an update on the NHHPP in MCM and will specifically address transportation. For this portion of the meeting, representatives from both Well Sense and New Hampshire Healthy Families (NHHF) will discuss how their specific process for transportation works.

MCM PRINCIPLES: Commissioner Toumpas recited the guiding principles of the MCM program, which are to look at whole person management and achieve this with care coordination. Medicaid is the largest program in all of State government, with a budget of well over \$1B. Many areas of the system work very well, while there are some that need to be better coordinated to increase the quality of care (right care, time, and place) to improve the quality of life and overall health of the population. A significant issue in health care and the long term care (LTC) industry is payment reform, e.g. how we pay for the delivery of services, and being more predictable in an up and down budget climate to build the foundation for transformation within the Medicaid program. This Commission has previously discussed health homes, patient-centered medical homes (PCMHs), and other innovations that support a whole person approach. These innovations are on DHHS' radar screen for the MCM program.

MCM ENROLLMENT REPORT: Commissioner Toumpas provided an update on the monthly and overall enrollment numbers in the Medicaid program. Also, he shared the first publication of a key performance indicators report that will be updated monthly via a dashboard that will be presented to the Commission and posted publically. A chart presented showed the number of people within the MCM program from December 2013. There were 104,284 members in December 2013. This is up to 121,444 as of August 1, 2014. There are 16,000 individuals who are not able to be in the program or have the ability to opt out. The growth in the Medicaid program as of the end of July 2014 was close to 140,000 with roughly 120,000 enrolled in MCM. The difference between those enrolled in Medicaid but not MCM are those can opt out or by statute. There are others who have not made a selection of a health plan; therefore, they do not show up in the MCM numbers. There has been a dramatic increase in Medicaid caseloads

between January 2014 and now. DHHS has seen an increase of 11,000 individuals since January 1, 2014. The majority of these enrollees are children (70%). Parent caregivers and pregnant women are also included within this number. This increase is not from a change in State law, but rather a change in the eligibility calculation for Modified Adjusted Gross Income (MAGI). When Meridian Health Plan announced that they would exit the State, they had 31,000 members. DHHS gave these members until July 10, 2014 to self-select a new MCO, of which 46% did. The balance of members was auto-assigned to one of other two MCOs, Well Sense or NHHF. The 31,000 members are nearly evenly distributed, with a slightly larger portion transitioning to Well Sense.

NH MCM Quality PERFORMANCE REPORT: Commissioner Toumpas explained how the performance indicator report is represented in a dashboard in order to track and improve outcomes. DHHS put together this report on quality, since quality was the clearest priority in moving into the MCM program. Each MCO reports over 400 pieces of information to DHHS regularly to assess the overall results of the program. DHHS is enhancing its data analytics capability to establish baseline data and look at trends. Key indicators are a tool for monitoring the performance of the program within various domains. The report is organized by these domains and forms the foundation for future reporting. The Commission previously discussed DHHS developing a report card to compare the two MCOs. Commissioner Toumpas explained that this is something DHHS is looking into developing, and is currently mocking this up to provide this type of report moving forward. Some indicators have prescribed benchmarks that are either industry standards or stipulated in the contract. A number of indicators show a trend to be able to show performance, underscoring that quality and outcomes is a key driver of the MCM program. Measures will be provided to an independent external quality review organization (EQRO). It is a Federal requirement that the data DHHS has regarding program performance is reviewed externally.

Commissioner Toumpas turned the meeting over to Commissioner Porter to present the set of key indicators with examples. The report provided contains the following key indicators, listed below with examples of measures provided for each:

1. Access & Use of Care
 - a. Member to provider ratio
 - b. Request for accessing providers
 - c. Transportation, ambulatory, inpatient, and pharmacy categories
2. Customer Experience of Care
 - a. Welcome calls
 - b. Time answered
 - c. Hold times
 - d. Multiple measures out of CAHPS survey to be completed in Winter 2014
3. Provider Service Experience
 - a. Claims processing
 - b. Provider call center activity
 - c. Provider satisfaction survey
4. Utilization Management
 - a. Authorization determinations
5. Grievance & Appeals
 - a. Tracking number of both
 - b. Disposition of both
6. Preventative Care
 - a. Health risk assessment completion
 - b. HEDIS measures
7. Chronic Medical Care
 - a. Pharmacy dimension
 - b. Additional HEDIS measures

8. Behavioral Health Care
 - a. Follow-up appointments after hospital discharge
 - b. Behavioral health survey
9. Substance Use Disorder Care
 - a. Service category
10. General
 - a. EQRO

Commissioner Porter explained that it is important for the Commission to consider that there were three domains specifically called out to the Governor as areas to watch: enrollment status, member satisfaction, and provider issues and concerns. As we look at the above list, it is important to recognize that all have been addressed. Recommendations for individual measures to look at were also provided. From a quick view, it seems that most if not all are addressed. The Commission will take this list of indicators and cross-walk them to what was initially recommended to determine if all recommendations were addressed precisely.

Commissioner Toumpas explained that this is a report and a dashboard that DHHS believes is vital to managing the program. DHHS provided this data because it is necessary to monitor performance of program. There are a number of indicators (about 470 measures) in Exhibit O of the MCO contract in which data is reported. DHHS is employing a system to capture this data and to do surveillance, which will be a key management tool for the program. In addition to the indicator guide, a user guide will be provided to compliment this in which each measure and domain will be described in detail.

HORN RESEARCH REPORT Commissioner Toumpas reiterated that an independent EQRO is required of all Medicaid programs via 42 CFR 438.301. DHHS engaged Horn Research to conduct focus groups in May 2014 to capture member feedback on their experience with the MCM program to date. The report from this effort is posted on both the DHHS and MCM Commission websites. A key high-level finding is that participants indicated they had received adequate notice about the change to MCM. Most said they selected a plan based upon their PCP participation. However many said they didn't understand the MCO, the benefits, or the coverage detail. Some expressed confusion between the roles of the MCO and DHHS. It was good to have these focus groups to get a baseline and to inform Step 2 planning. Overall, the participants reported that access to primary care had stayed the same but that they experienced difficulty with access to specialty and pharmacy care. They did not correlate the quality of care to the MCOs but rather to the provider. Most felt that their care was well coordinated and they had an active role in the process. Participants suggested certain improvements, including adding adult dental care and easier access to pharmacy. Some also suggested that Medicaid expand to include adults and provide clearer rules for eligibility, which DHHS believes the NHHPP and MAGI address.

IDENTIFIED MCM AREAS OF INTEREST and DHHS RESPONSE: Commissioner Toumpas explained how DHHS is focusing on key issues and that certain focus areas being addressed include service authorization for therapies (PT, ST, and OT), authorization for medications, authorization for non-emergent medical transportation, and administrative burdens. DHHS is planning to do outreach to a number of different provider organizations specializing in these areas. For therapies, emails and letters have been sent directly to DHHS, to the Commission, and even to the Governor's office. Commissioner Toumpas reiterated that this needs to be raised directly to MCOs first. If the issue is not resolved in a timely manner, an individual can escalate it to DHHS. DHHS is requiring existing data and requested ad hoc reports from the MCOs to determine the scope of this therapy authorization problem to develop a solution. DHHS recognizes the need for a common interpretation of the EPSDT standard and is sitting down with the MCOs twice a week to work on these issues. Data and oversight confirm there are issues with therapies, therefore DHHS is reviewing policies to make sure they are clear and applied by each MCO to be consistent. RSA-171-A is a significant piece of legislation/law that has been reviewed. DHHS

believes it is compliant, but given the number of issues that have been raised, DHHS has asked for a review by the NH Attorney General to ensure interpretation is consistent with intent. For pharmacy prior authorizations, DHHS has looked at a number of denials to collect data and is making sure that drug formulary and stipulations are being formally followed. DHHS will provide information to providers and to the Commission once it is available.

Commissioner comments and/or questions regarding the DHHS Update:

Commissioner Shumway asked if DHHS is expecting a formal response from the Attorney General's office on RSA-171-A. Commissioner Toumpas confirmed yes.

Commissioner Goldsberry asked if there will be a review of professional literature with respect to the pharmacy prior authorization issue, to anticipate an ongoing structure for review of best practices, to see where this is working for an isolated set of cases, and to determine what occurs when new medications arise. Commissioner Toumpas explained something realized as they have transitioned into MCM. There are a number of things traditionally done by DHHS that will be transitioned to the MCOs moving forward. The principle for this process will be to trust but verify. DHHS needs to ensure it maintains oversight of the functions that the MCOs are performing on its behalf. There are certain areas within DHHS, this example of research regarding changes in pharmaceutical best practices being one, that they have been strong at, but then there are other areas to strengthen such as data analytics to build this capacity in the Department.

Commissioner Goldsberry explained how this will be the same for all aspects of MCM and DHHS should proactively to look at best practice protocols. Commissioner Toumpas agreed and explained that one of the examples that have come up is Hepatitis C drugs. These drugs are incredibly expensive and combined with the aging population, this is an area that the MCOs raised and best practices that DHHS has looked at.

Commissioner Norton asked about the specific aspect of RSA-171-A that is being reviewed, as it is very broad. Commissioner Toumpas agreed that it is very broad but did not identify the specific area that is being reviewed with the Department of Justice, but the review will be comprehensive.

Public Comments and Questions on MCM Implementation Update by DHHS

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

Lynn Aboujaoude, Community Crossroads, asked a question regarding quality data from the MCOs. What part of data collection is specific to those with disabilities? Will there be data for this?

Commissioner Toumpas explained that DHHS will speak to this in more detail during the LTSS portion of the meeting. One of the things that DHHS needs to do is to find appropriate quality measures, as specific services for those enrolled in waiver services are not within the scope of the MCO contract at this point.

Public comment not identified; Community Crossroads – First, we are unclear about Children's Hospital Boston and Tufts having a contract with Well Sense or NHHF. Second, in terms of the people who have opted out of MCM, we have heard that those who did so cannot be forced to participate in Medicare Care Management until a waiver is written to request CMS approval as part of the Step 2 process. Is there a timeframe for those who opted will be transitioned into Medicaid Care Management? For this second part, if someone is able to opt out voluntarily, can they opt in or out at any time? Commissioner Toumpas explained that the first phase of MLTSS is mandating participation in MCM for populations that can currently opt out. Yes, DHHS cannot do that without a waiver from the Federal government. Lorene Reagan from DHHS will speak to this in more detail today and will speak about the stakeholder forums

recently started. For those who did not understand the process and timeline of waiver to implementation, DHHS cannot mandate this population in without approval from the Federal government and will not do so without a robust and inclusive stakeholder process, to include parents.

Public comment not identified; Community Crossroads – Can you explain the date already in place for mandatory enrollment? The current target date for mandatory participation is January 1, 2015. Commissioner Toumpas stated that like anything else in policy, you must set a target date, and adjust accordingly based on progress toward goal. The initial target date to launch Step 1 MCM was July 1, 2013, but the program officially launched on December 1, 2013. Commissioner Toumpas repeated what Governor Hassan has explained multiple times: we will go live when we are ready to go live. Another example is the NHHPP target launch date of July 1, 2014. The program will officially launch on August 15, 2014. Public commenter notes that the January 1, 2015 date for mandatory enrollment seems aggressive. Commissioner Toumpas explained that DHHS considered many factors including the time required for all entities to become ready. The key point is that someone who has voluntarily opted out cannot be mandated into the MCM program without authority.

Commissioner Vallier-Kaplan asked the public to focus questions on the MCM troubleshooting topics previously described, e.g. therapies and pharmacy prior authorizations and to defer other questions to the Public Comments section of the meeting.

Rebecca Whitley, Disability Rights Center, referenced Commissioner Toumpas' previous comments about the MCOs mandating coverage for children under EPSDT. Is this process taking into account the new guidance from CMS on services for children with autism? Commissioner Toumpas confirms yes, this guidance is being taken into account by the MCOs. Can you clarify the short term corrective action strategies taken to address prior authorization issues? Commissioner Toumpas stated that DHHS needs to ensure that as it works with the MCOs there is a common understanding of the prior authorization policy and will communicate any changes in practice.

Commissioner Vallier-Kaplan asked for update on the Meridian Health Plan transition. Commissioner Toumpas explained that as the numbers presented earlier indicate, it was a roughly 50/50 split into Well Sense and NHHF, and that this process went remarkably smooth for both MCOs. We had the full cooperation of not only Meridian but the other two MCOs present at the meeting as well. This was not something we expected to happen, but the architecture of the program indicated that this could happen and we managed it successfully. Also, Commissioner Toumpas clarified that there is no barrier for a child getting services from Children's Hospital Boston. Marilee Nihan, Deputy Commissioner of DHHS, and the MCOs will address this later in the meeting. We understand the public comment that the providers serving individuals do not know that there is no barrier, so we will add this update to subsequent forums.

Update on MCM Transportation Services

Commissioner Toumpas transitioned the meeting and introduced Commissioner Moral to discuss troubleshooting transportation services. Commissioner Moral explained how TransportNH previously sent a letter and that letter is the catalyst for this conversation. While the data evaluation may remain unanswered, this is focused on MCM. Access is important in terms of going to a place that may have the best care in world, but if you cannot get there it is tough. The populations impacted the most are those with disabilities, and it is important that those populations be kept in mind. The Horn Research results also referenced transportation issues but interestingly did not provide a recommendation regarding transportation in its conclusions. Issues that have come up to date range from some individuals that agree that everything is fine, while some do not have access to needed oxygen during transportation, which is very concerning. Another issue is the length of approval time, which often does not meet the timely needs of families and providers.

Commissioner Toumpas explained how DHHS anticipated issues regarding transportation services prior to the transition over to MCM. DHHS is working with the MCOs, and they are both present at the meeting to speak to this issue. DHHS has not seen much in the way of issues raised directly to the Department. However Commissioner Moral has forwarded recently many issues from specific providers, which were then forwarded on to whichever MCO was involved. Commissioner Toumpas emphasized that when an issue is presented to DHHS, it may be systemic and therefore not something that can be addressed individually. For transportation, requirements were built that weren't prescriptive. The MCO model focuses on safety, quality, consistency in inspection standards, background checks for all drivers, and safety protocols for unaccompanied minors receiving non-emergent medical transportation (NEMT) services. Transportation providers are regarded for timeliness and courtesy of service based upon client feedback.

Commissioner Toumpas asked a representative from both Well Sense and NHHF to speak.

Eric Hunter, Chief Operating Officer for Well Sense, explained how transportation has been a key point of contention since the very first readiness review before Step 1. Well Sense has subcontracted with Coordinated Transport Services (CTS) since the beginning of the program. CTS participates in readiness reviews and reporting to DHHS. Well Sense is watching them carefully through a defined vendor management process and oversight committee. Their process is that when someone needs transportation, Well Sense will contact CTS and will identify the particular service they need and the needs that they have. They take all this into account before accessing the system that then matches up the closest provider that meets these criteria. If a consumer has a preferred provider, they can certainly select them. Each day, those providers go into a portal to see which rides have been assigned to them and they accept or decline. If they decline, CTS will find another provider. Nobody sits out in limbo. The provider will provide care and then go back into the system to affirmatively show they provide the service. Patterns of use have been different than Well Sense's expectations of about 50% having family/friends providing rides. This is closer to 65%, so the volume not as high as expected. Providers are expecting to serve Meridian members moving forward as well. Well Sense has had some issues, including one case that has gone to fair hearings, however of about 13,000 rides per month, there have only been 7 official grievances on this number. Well Sense will hold CTS accountable just as DHHS is holding Well Sense accountable as well.

Stefanie Svoboda from New Hampshire Healthy Families discussed their transportation approach. NHHF takes transportation very seriously and understands the geographies in the State to make sure transportation opportunities are afforded in whatever capacity possible. NHHF uses a vendor named Access to Care, which is a non-emergent vendor throughout the State that credentials and contracts with providers. The NHHF process is similar to Well Sense. Members, providers, or family members reach out to Access to Care or are routed through NHHF. In terms of timelines, NHHF generally requires a 3-day advanced notice, which is important to ensure correct provider and timing is giving to member interest. This process allows for certain timelines, e.g. hospital discharges, where 3 hours is needed after, and is the same with urgent trips to be handled in a timely manner. Transportation is assigned to a provider using 3 steps: defining (1) the needs of the member, e.g. wheelchair, (2) the member's region, and (3) the best available provider based upon satisfaction and timeliness reports. The current understanding is that timeliness for payment is running about 2 weeks dependent on timely entry of time from provider drop off to pick up and the submission of claims. All claims are facilitated through a portal.

Comments and Questions on MCM Update on Transportation Services

Commissioner Moral asked for the names and contact information for the respective transportation points of contact from each MCO. The public expressed concern about who to contact at each MCO to get

through to discuss transportation. Well Sense and NHHF agreed to provide contact information in a timely manner after meeting.

Commissioner Moral asked for each MCO's approach toward using local transportation in rural areas. NHHF maintains a network of providers within Access to Care to cover these areas. Stefanie Svoboda clarified if Commissioner Moral referred to public transportation or to a vendor that is local to the community? Commissioner Moral confirmed the intent to discuss vendors local to the community. Therefore, Stephanie explained how NHHF's model is intended to use resource within a specific region or proximity. Eric Hunter, Well Sense, explained how the CTS system is designed to look for the closest transportation provider, which would include local providers if applicable.

Commissioner Goldsberry followed up and explained how local transportation providers are finding it difficult to become certified providers. They are not qualifying or are missing contact information for vendors. How would a local provider get a contract? Eric Hunter explained how CTS does this contracting process for Well Sense, but if a provider has a specific issue, they can contact the Well Sense office directly. There are specific requirements to look for in terms of safety and background information, and the MCOs need to ensure this first and foremost. Commissioner Goldsberry explained how some of these providers may have previously been certified as a provider under Medicaid. Eric noted that there are times when the MCOs have greater, more stringent standards that are beyond existing Medicaid standards which is not only relevant to transportation but to other services as well. Stefanie Svoboda, NHHF, agreed and explained a similar process for NHHF. Access to Care does the contracting and credentialing components within the program, and certain necessary standards are key components to participation. The standards are contained in the meeting presentation shared by Commissioner Toumpas.

Commissioner Moral asked about access to transportation services during holidays and weekends. Eric Hunter, Well Sense, explained that on days in which the State is open, providers are accessing and open as well. This is the same with discharges on urgent off days. While the full suite of CTS services may not be offered 24/7, CTS will address relevant needs for covered services when they occur on off days. Stephanie Svoboda agrees that if there is an appointment, there is interest in getting the member to the appointment in a timely fashion. Holiday and weekend services are dependent on the situation and are coordinated on a case-by-case basis.

Public comment; not identified – I understand that when providers submit information for credentialing, there are specific services for which providers cover. Is this how this works? Stefanie Svoboda, NHHF, confirms that this is referring to designating a region that they serve. This provider, in particular, serves many towns, but was told that MCOs look at this regionally as they assign trips. Dispatchers do not seem to understand areas that they serve. Another question is around an instance where a driver from this service took information from the portal and went to a client's home, and when they arrived, there was another driver in a private vehicle or taxi there. This is a big loss for the provider as some drivers come from 200 miles away to provide a 10 minute trip. Clients call directly and say that this is happening. If a client says that they wish to request a certain provider, they will receive it. There are very few providers in this provider's service area, so they do not want other providers to come in and take rides from them, and do not want to be forced to close their service down. Stefanie Svoboda explained how it all depends on availability and it can be for a variety of factors that providers are driving far distances for trips. This can also relate to how clients are ranking providers in this region, e.g. how performance is evaluated. NHHF makes all of this information transparent and encouraged the provider to contact them directly for specific concerns.

Barbara Salvatore, EngAGING NH, asked for the MCOs to address the issue of transportation service providers not assisting clients from their doorway into the vehicle and then from vehicle to the providers office. Eric Hunter, Well Sense, explained how this occurs in almost every instance, however if

there were instances where this did not occur, it was because the transportation service provider did not ask enough questions to know this level of need. This is an issue that Well Sense is aware of and is addressing to make improvements in accurately assessing level of need.

Rebecca Harris, Transport New Hampshire, asked if the MCOs could tell her how many transportation provider companies and drivers in total each MCO has in their network. NHHF did not have the exact number on hand, but will send to DHHS via email for distribution publically. Well Sense has 792 drivers through 51 companies within its network, which does not include friends and family members. This information will also be distributed by DHHS.

DHHS NHHPP Implementation Update

Commissioner Toumpas introduced NH DHHS Deputy Commissioner, Marilee Nihan, to provide an update on the implementation of the New Hampshire Health Protection Program (NHHPP). The State is implementing Medicaid Expansion in the State via this program, which is a statewide effort that took several state agencies and the Governor's Office to help get legislation passed, and is on the verge of launching this month. DHHS contracted with the two MCOs, Well Sense and NHHF, in July to provide services to the NHHPP population. All three organizations have been meeting on a weekly basis since the middle of April to prepare for the service of this new population. As of late, all three organizations have been meeting twice a week to troubleshoot and ensure everything is running smoothly. DHHS has been providing provider forums around State, including the North Country. For providers of this population, the legislation called for enhanced rates. DHHS worked diligently with CMS to get the best possible rate structure available, and the MCOs are now contracting with these providers. Approximately 8,800 individuals have reached out directly to DHHS, and DHHS also has the names of about 40,000 individuals who previously applied via the Federal marketplace.

To review key dates, DHHS began enrolling NHHPP members on July 1, 2014. On August 1, 2014, the mandatory health insurance premium payment program (HIPP) cost effectiveness testing began. So far, DHHS has transferred about 300 referrals over to its HIPP vendor. Next Friday, August 15, 2014, coverage will begin for these individuals under the fee-for-service (FFS) environment until September 1, 2014 when MCM coverage will begin (or the beginning of month after they select a plan). DHHS is enrolling 250-300 individuals every single day. Of the 8,800, most all of them have selected the alternative benefit plan (ABP), which is the minimum requirement of the 10 essential health benefits that federal regulations require be offered to new enrollees. Another 69 individuals have attested to standard Medicaid as they have been designated as medically frail, and therefore able to opt out of the ABP package.

Commissioner Vallier-Kaplan again congratulated DHHS on the work done so far to bring this service to the State and opened the meeting to public comments or questions.

Commissioner Goldsberry congratulated DHHS on its ability to get the cost effectiveness process to work. During a previous meeting, the Commission discussed how technically difficult this is. Commission Toumpas explained how the Department is just getting to the starting line of the program and how it has been an incredible team effort across DHHS with internal and external support to bring health coverage to approximately 50,000 individuals in the Granite State.

Commissioner Vallier-Kaplan announced a meeting break until 3:15pm.

MCM Data Reports

Commissioner Vallier-Kaplan introduced Commissioner Porter to further discuss the MCM data reports and then opened the meeting for comments and questions from the Commissioners and the public. Commissioner Porter explained how the data components included in the enrollment reports indicate where people are, e.g. which plans, and their movement. This information, the indicators reviewed previously, and the results from the focus groups that are part of the Horn Research report will be part of a future performance management tool Commissioner Toumpas referenced earlier.

Commissioner Shumway congratulated DHHS on the volume of data emerging, its analytic quality, and the transparency of the information. When you look at the combination of reports received today, it is a very open examination of the implementation and its transitional process. You live in a world of a microscope, so bringing this volume of high quality information out is extraordinary. It indicates challenging areas, e.g. pharmacy, and corroborated therapy areas, but is also an extraordinary document that shows the very high volume of success that underlies this. It will be important for the Commission to collect this information and digest it, so preparing this for a thoughtful workgroup session could be useful and valuable as discussed by the Commission at its July meeting.

Commissioner Goldsberry commented that as Commissioners, as they begin to have this data, they will need to move out of implementation mode and into maintenance, and will want to connect quality improvement efforts to this data in the future.

Commissioner Norton stated asked if some of the different indicators that talk about numbers of paid/denied or approved/disapproved claims will be broken out. Commissioner Toumpas explained that to the extent that this data is there and this is possible, it will be broken out.

Commissioner Toumpas thanked the Commissioners for their comments and reiterated that the focus of the key indicators is around supporting the overall goals they want to achieve from the MCM program. DHHS knows that it needs to drill down into this particular data and determine where things are not consistent or where the misunderstandings of what requirements and polices are. This is a continuous improvement process with a clear focus, and is a significant effort that involves thousands in the State. We knew when the program began that there would be issues to deal with and we would need to do so in a responsible way. We are doing it as best and responsible as we can, and doing so in a way that moves the program and its goals forward.

Commissioner Porter highlighted a couple of places in the Horn Research focus group report where folks felt they were aware of this change, but that there were limits in the information that they had to make choices between the MCOs, e.g. report cards. Commissioner Porter asked if there are plans to develop this type of resource for consumers. Commissioner Toumpas explained how when DHHS was putting together communications to do outreach prior to the focus groups, they found that consumers think very differently. Some respond more to facts, while some more to high level information. Part of the challenge is to understand the demographics and how to best reach them because we have not fundamentally done so in the past. DHHS is developing multiple outreach strategies that need to be implemented to get these folks into the door and into an MCO that are really focused around the door and the overall opportunity the MCM program presents.

No comments or questions from the public. Commissioner Vallier-Kaplan stated that the Commission will strive to have things posted before the meetings, if available, so that the public can look at the data and ask questions on what they see. The Horn Research report is on website currently and the key indicators report will be posted. We will continue this discussion at the September Commission meeting.

DHHS MCM Step 2 Update

Commissioner Vallier-Kaplan introduced Lorene Reagan and Susan Lombard, DHHS, to provide an update on the ongoing Step 2 stakeholder forums. The 120-day stakeholder input period is underway and DHHS is seeking feedback during this process to determine how to best move forward with the timeline for Step 2 implementation. DHHS began this 120-day process in mid-July. The public is encouraged to visit the DHHS website, click on the MCM logo, and select Step 2 for a listing of over 20 forums scheduled between July and the end of September that they can join. The public should understand that the first part of the 120 days is to solicit input. DHHS heard clearly from stakeholders that they do not want a plan for review, but rather they want to help inform the plan. DHHS respects and appreciates that feedback, and has structured this first part to hear from stakeholders in three key areas:

- What to retain from the current system
- What are lessons learned from Step 1
- What quality measures are needed to understand that MCM is working

Lorene Reagan explained how this part of the stakeholder process will focus on these three questions. The second part of the process will be to incorporate information from the DHHS State Innovation Model (SIM) Model Design and relevant state research, and bring this information back to stakeholders as high level Step 2 design concepts. The public has also asked about a plan being ready to submit to the Federal government. Lorene Reagan explained that as DHHS solicits input, it will simultaneously be developing plan on parallel track. DHHS will use the entire 120-day period for stakeholder input, plan development, and input back to DHHS. In addition to this 120-day period, there will be formal hearings held as part of any application made to CMS. Overall, there will be many opportunities between now and November 15, 2014 to provide input.

Susan Lombard discussed what has been heard in the Bureau of Elderly and Adult Services (BEAS) stakeholder forums to date. BEAS and the Bureau of Developmental Services (BDS) have been working very closely together on these forums and value the public's feedback and their time taken to attend. BEAS has had 7 input sessions so far. These were held primarily with providers and stakeholder groups with whom DHHS has an ongoing relationship and see regularly. They have been tagged onto meetings as already scheduled and have added a few more to reach out to as many stakeholders as possible. Over 200 people have attended between the 7 sessions, and DHHS has started to plan out the next level of sessions. Once these future sessions are scheduled, they will be posted online. Public comments have started to be submitted through new email addresses that DHHS created for Step 2 as well.

Susan Lombard reviewed the common themes that surfaced over the 7 sessions held so far:

- Questions about what rates being paid by MCOs to providers will look like
- Provider contracting and network adequacy requirements
- Prior authorization process being timely and responsive to consumer needs
- MCOs being adequately prepared and comfortable in the LTC arena
- Adequacy of services
- Request for training and education to small providers entering into the MCO environment
- Training and education to the MCOs on the nuances of LTC

Lorene Reagan explained that the first Bureau of Developmental Services stakeholder forum was held on Monday, August 4, 2014. Over 70 participants attended either in person or via the webcast. The following things were heard during this forum:

- If members will continue to receive services through an Area Agency
- Concern about therapy services
- Concern about pharmacy authorization
- The need to ensure full and complete MCO understanding of individuals with complex medical and/or LTSS needs

- The need for an adequate provider network for medical services and LTSS
- Concern about mandatory enrollment for both children and adults

Lorene Reagan explained that DHHS hears and understands these concerns, and that the Department is committed to developing a plan for implementing Step 2 that will address each of them.

Commissioner Vallier-Kaplan noted that almost all of the Commissioners have been to a forum and therefore asked them for any questions or input they have on the presentations to date.

Commissioner Goldsberry asked about how the Balancing Incentive Program's (BIP) current implementation will mesh when Step 2 is implemented. Lorene Reagan noted this as something that DHHS has been keeping key leaders connected with. Specifically, a leadership group meets every Friday morning to make sure the Department is thinking about how to align initiatives like BIP, and others.

Commissioner Berner asked about obtaining input from the Counties. Susan Lombard explained how DHHS has reached out to County representatives and had a meeting scheduled, however there was a last minute cancellation. This is still very much a consideration and a group in which DHHS plans to engage.

Commissioner McNutt attended two forums and said there was good attendance at the last one. The summary that DHHS provided was accurate, but he added that he took away the need for provider education in a big way. The Commission should not overstate this, but it is extremely important as these providers are not typical medical providers today.

Commissioner Porter explained how in earlier Commission meetings, the group talked about parameters for network adequacy as defined by legislation. Are there definitions that are being looked at on the LTSS side? Susan Lombard explained how DHHS has not yet selected a definition for what this will look like. Commissioner McNutt adds that there are states that have rules on network adequacy for LTSS to reference, and DHHS plans to do so.

Commissioner Vallier-Kaplan commented on her observation of the process at the forum she attended. The strategy is appropriate to ask stakeholders what they are thinking before the Department does the work, but it appeared that it was also very difficult for people to generate this information spontaneously during the forums. They are used to responding to work that already has been done rather than influence the creation of the work. Would it be helpful if questions could be posted in advance of the forum? Susan Lombard took this feedback as particularly helpful as DHHS schedules its next tier of forums. Lorene Reagan added that this same suggestion was made by stakeholders at the first BDS session and that DHHS has decided to change this approach for future forums, but also plans to bring to future forums the input received to date. These trends and themes should be seen as starting points, and examples that DHHS consider to be important current quality measures.

Public Listening Session and Next Steps

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

Sarah Aiken, Director of Public Policy and Community Outreach, Community Support Network, Inc – While the Commissioners should know that there is a lot of overlap between the BEAS and BDS stakeholder forums for Step 2; they are encouraged to attend both. Sarah Aiken read a written letter distributed to the Commission relative to DHHS's current approach to Step 2. Because CSNI is a formal association of the ten area agencies in New Hampshire and there is a defined process to release letters, the letter was only sent the morning of the meeting. CSNI did not anticipate a response from the Commission during the meeting and provided the letter in hard copy. In the letter, CSNI applauds DHHS for delaying

Step 2 from its original start date of December 1, 2014. CSNI is disappointed that DHHS negotiated a new phase of start dates with the MCOs without consulting the Commission. CSNI is concerned that DHHS has selected an arbitrary date for Phase 1 of Step 2 without explaining what the public process will be to achieve federal regulatory approval and what projections will be in place to ensure an effective transition for this vulnerable and complex population.

CSNI expressed these concerns based upon the way that Step 1 unfolded on December 1, 2013. MCOs have failed to meet their contractual obligations around honoring prior authorization of services and medications for the first 60 or 90 days of the program. CSNI believes more prescriptive protection prior authorization processes must be in place prior to implementing Phase 1 of Step 2. DHHS needs a plan to correct prior authorization issues immediately. CSNI also recommends that DHHS go back to the “prescribe prevails” approach that has been utilized in the past under the fee-for-service program, specifically for all drug classes so that all patients will have equal access to medicines that they need and their doctor prescribes. Finally, CSNI is concerned that the MCOs demonstrate a fundamental lack of understanding of long-term care. CSNI believes that DHHS should only move forward with any phase of Step 2 when the MCOs demonstrate a stronger understanding of developmental services and LTC. CSNI also asks that DHHS apply a similar “provider prevails” approach to OT, PT, and SLP services for the LTC population. CSNI does not understand why there appears to be a rapid push to add new people to Step 1 when there continues to be significant issues that have not been resolved with these medical services. CSNI asks the Commission to take a more active role in providing recommendations to the Governor around the current challenges with Step 1 services and recommend that Phase 1 Step 2 should not be implemented until these issues are addressed.

Commissioner Vallier-Kaplan thanked CSNI for submitting the letter and thanked Sarah Aiken for reading. While it was difficult to respond during the meeting, the Commission assured that it will work with DHHS to provide a response. This was an opportunity to review with the public that when the Commission receives letters like this or outstanding issues are identified, they are documented, distributed, and monitored. The Commission plans to separate out issues that are more individually focused from those that are more systemic in nature.

Commissioner Bunnell restated the need for a waiver to be pursued for the opt out population to come into managed care and asked if this waiver will be a Section 1115 Demonstration waiver. Commissioner Toumpas agrees that an 1115 waiver is an option, but that DHHS is still exploring this process and its options. Commissioner Bunnell added that if it is this type of waiver, there will need to be a robust public process to do so, e.g. a draft is required to be publicized and posted online for written public comments at the State and Federal levels.

Public comment; not identified – There seemed to be a conflict between Lorene Reagan and Commissioner Toumpas in terms of their view on starting Step 2. Commissioner Toumpas disagreed with this statement and explained how DHHS has set a target date and a plan that it needs to move forward with. DHHS must set a target date in order to do this, and it continues to work towards it and identify the issues throughout the process. Commissioner Toumpas also recognized the need for full support from the Governor. DHHS is trying to be transparent and put as much information as possible out publically. Like anything else that DHHS needs to do, it needed to set a target to work towards in order to move forward with the NHHPP and the MCO contract.

Cathy Spinney, Chair of the NH DD/ABD Quality Council – Commissioner Norton previously discussed RSA-171-A and asked for the specific area being reviewed by the DOJ. This area should be the service guarantees language used in the law. Among the list of things guaranteed are treatments and medical services. What is guaranteed is not just rehabilitative services, but also treatments that will habilitate them and make them between able to live in the community, maintain, and to make tolerable. These guaranteed

services treatments include medical services and education of a broad array to make their life experience more tolerable. This population is different than us because they need these services for their entire life. They are not healed and/or fixed.

Rep. Howard Moffett, who represents Loudon and Canterbury, attended the meeting alongside Laura Darling, Owner and Principal of KidsSpeak Therapies LLC. Rep Moffett acknowledged that DHHS has reached out to Laura Darling and has made significant efforts to address her concerns. A series of backlogged claims since January 2013 have been paid. They spent 1.5 hours with Commissioner Toumpas, his senior staff, and representatives from Xerox and KEPRO to discuss her other concerns. Although all issues are not yet resolved, it is important to acknowledge the significant efforts made by DHHS on the record.

Laura Darling reiterated her appreciation and mentioned a couple more concerns to share. Mrs. Darling has reached out to the appropriate people already and is waiting for responses on these issues, but was enlightened to learn that early intervention services are not required to be covered by MCOs. She had not realized until recently that these services are part of a waiver program. This is a population that she serves often, so if Medicaid is only limited to certain waiver programs, this limits services. The prior authorization for habilitative services and working on pediatric therapy is important. As Mrs. Darling transitions clients from Meridian to Well Sense and NHHF, she is running into this prior authorization situation and confusion around habilitative and medically necessity. Mrs. Darling does not expect everyone to get authorized, and she is cautious as the process has not been smooth. For third party liability, the State has been wonderful in working with her and Xerox. She uses updated software for secondary electronic billing and is in the process of finding a smooth way for secondary electronic billing to occur for Katie Beckett Medicaid enrollees. She is currently deciding if this process is too much trouble for her, but faxing forms in takes a lot of time to find out that they will not be serviced also. These questions and concerns have been submitted to DHHS in writing as well.

Commissioner Vallier-Kaplan thanked Rep. Moffett and Laura Darling for submitting their comments.

Bruce Moorehead, Nursing Home Administrator, Hillsborough County Nursing Home – Earlier, education was talked about for providers. Providers have a lot of concern around implementing MCM. Questions came up today about pharmacy denials. Does this have anything to do with the drug formularies of the MCOs? Do we know how therapy will operate? When I read a draft contract with the MCOs, the contract read that MCOs would provide therapy. This is a concern because nursing home therapy departments know patients that they treat in house. This will be a problem with continuity and not knowing these residents. We do not know how rates will be developed and by who, and using what basis. Nursing facility budgets are based upon what Medicaid rates are. We heard that the implementation date for Phase 2 will be April 1, 2015, but when will full implementation of Step 2 happen? Finally, a main concern is what will happen with MQIP bed tax and County nursing home matching program from the Federal government.

Susan Lombard explained how these same issues came up at a BEAS stakeholder forum with nursing facilities. These are topics to bring back for people to comment on as they go forward. Different states have handled rate setting in different ways, therefore DHHS is reviewing what the options are. Commissioner Toumpas explained that each of these questions will be taken back by DHHS to provide a response.

Deb Scheetz, from Gateways Community Services, shared things working so far in MCM. In Nashua, it has made a positive impact, specifically as it relates to individuals enrolled in the CareConnect Health Home. One individual had GI issues and was behind in preventative care, so the provider scheduled a colonoscopy. He has a developmental disability, purposeful aggression, so to prepare for this procedure

was going to be difficult. The Health Home got a team together to go through troubleshooting for this. The biggest issue is getting him into the hospital in advance of the procedure to make him comfortable. The health plan expedited this process for him. He is in Health Home because he has two typical chronic disabilities and medical needs. A second instance is of a young girl in the Partners in Health program with cystic fibrosis. Her grandmother does not drive, so they worked with the health plan for transportation to appointments. The systems of support at the health plans do chronic disease management very well. Gateways programs show how families have built a system of support. Gateways is working with both MCOs to do out of network authorizations post-Meridian transition, and both have stepped up. However, there are many steps involved for Beth Israel, Dana Farber, Boston Children's, etc. to get these services authorized. These are additional work elements for area agency staff to support trying to coordinate this care. They will continue to support clients to get the best care possible and best outcomes, but they are also seeing a trend for out of network authorization for specialists in Boston. People feel empowered when they can get their loved one a good outcome, but when they are cut off from services they feel disempowered by the MCM system.

NEXT STEPS:

Commissioner Vallier-Kaplan explained how the work of the Commission also is in transition as the work moves toward Step 2 implementation. She will meet with Commissioner Toumpas and the Governor's Office to discuss roles and responsibilities and what has been working well. The Commission will propose having a work session with the public present in September on the Quality Performance Report if the data is ready. The Commission is also planning on creating the next report this fall to the Governor summarizing the work that has been done to date on Step 1 and NHHPP and describe the role of the Commission in the next phase focusing on Step 2. We anticipate public discussion about this report at October and November Commission meetings.

The next meeting of the Medicaid Care Management Commission will be held at Granite State Independent Living in Concord, NH on September 4, 2014 at 1 p.m.

Commissioner Vallier-Kaplan adjourned the meeting at 4:15pm.