

Governor's Commission

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

**MINUTES
September 10, 2015
Legislative Office Building
Concord, NH**

Welcome and Introduction

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 1:07 pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Nicholas Toumpas, Roberta Berner, Thomas Bunnell, Gus Moral, Jo Porter, Yvonne Goldsberry, Susan Fox and Ken Norton. Commissioner Doug McNutt and Commissioner Wendy Gladstone were unable to attend. Commissioner Vallier-Kaplan states that the purpose of the meeting is to engage in conversation around implementation of Care Management and that right now they are at a critical point between Step 1 and Step 2. She states that Commissioner Toumpas will update the Commission and the public on Step 2 later on the agenda. Commissioner Vallier Kaplan states that next month the meeting will be held outside of Concord. She then welcomes all and asks the Commissioners and the public to introduce themselves.

Commissioner Vallier-Kaplan states that the materials and the minutes from the meeting will be posted on the Governor's website and the Department's website.

Commissioner Vallier-Kaplan references the minutes from the August 13, 2015 meeting. A motion is made to approve the minutes and seconded. The minutes of the August 13, 2015 meeting of the Commission are approved.

Commissioner Vallier-Kaplan states that there are no new correspondences since the last meeting. Commissioner Shumway states that he received an email from NH Physical Therapy Association with a request for a data set for access to care for individuals that are receiving various physical therapy services. Commissioner Shumway wants the receipt of this email to be reflected in the minutes. Commissioner Vallier-Kaplan comments that one thing you will notice is that if there are any significant follow-up issues from the last meeting, Commissioner Toumpas will address these first. Commissioner Vallier-Kaplan introduces Commissioner Toumpas.

DHHS MCM Update

Commissioner Toumpas opens by reviewing the agenda and states that he will follow up on open items from the last meeting. He explains he will review the monthly enrollment numbers, give an update on the behavioral health network, and give a personnel update, a Step 2 update, and a waiver update. The first item is the follow-up regarding the question: Is consumer directed care part of the 10 essential benefits? Commissioner Toumpas states that the short answer to this question is "no". If someone is in the Health Protection Program they can apply and declare themselves Medically Frail and then they can get the full range of Medicaid Long Term Care Services and with that would come the consumer directed option. If they are in the regular Health Protection Program then no, it is only for the Medically Frail that has this option. Commissioner Toumpas opens the meeting up for questions. There are no questions.

Monthly Enrollment Update

Commissioner Toumpas states that the Care Management program has been in place for 22 months. As of September 1, 2015, there were 162,654 individuals enrolled in the MCM program. This is the traditional Medicaid population along with the NH Health Protection Program population. We continue to grow but the line is flattening out and the growth in the Health Protection Program is slowing down. There are 17,098 enrolled in Medicaid but not enrolled in MCM which consists of several groups: those who are not mandatory and therefore cannot be mandated into the program, those who have opted out of the program, those who have been deemed eligible for the New Hampshire Health Protection Program (NHHPP), and those who have enrolled in the MCM program but have not yet selected a plan and therefore remain in fee-for-service (FFS) until they do so. There are about 2,800 individuals in this category. Looking at the mandatory enrollment slide, the majority of Foster Care population has already opted into MCM. Moving along the graph a significant number of SSI have also opted in. A significant number of HC-SCD (Katie Beckett) populations are still out along with the Medicare Dual eligible. The next slide looks at those that are in the waiver programs. You can see the numbers and breakdown of those that have opted out versus those that have opted in. These include the ABD,CFI, DD,IHS waivers and Nursing Homes. These are the populations that we are focusing on for Step 2 phase 1. In terms of MCM program enrollment by plan, Well Sense has 88,383 members enrolled and New Hampshire Healthy Families has 74,271 members enrolled. Low income pregnant women and children make up the majority of MCM program population, as it does in the Medicaid program itself. Other areas include non-MCM enrollees and NHHPP enrollees who have not yet selected a plan, as well as the others who have not yet opted into the program.

Commissioner Toumpas opens the meeting up for questions from the Commission. There are no questions.

NHHPP Update

Commissioner Toumpas states that there are 42,707 recipients enrolled in NHHPP as of September 4, 2015, and 21,169 are new to the Department. These are individuals that were uninsured and now they are enrolled into the program. There are 10,644 new to the NHHPP but have been clients in the past. In the Medically Frail category there are 2,314 in the ABP and 422 of Medically Frail in standard Medicaid. There are 282 enrolled in the HIPP program, which is the program for those that have access to employer insurance and it is deemed cost effective for them to be in the program, remains relatively small. The HIPP program has been discontinued due to actions from the legislator and the budget. There are 21,018 enrolled in WellSense Health Plan and 18,284 are enrolled in NHHF. There are 2,744 are in Fee for Service/not yet enrolled in a plan.

Commissioner Toumpas asks the Commission if there are any questions. There are no questions.

Commissioner Toumpas remarks that he reviews these numbers each month at the Commission meeting and they are stable. He then asks the Commission if a report with the numbers should be generated each month and shared. There are other reports that break down population by eligibility categories that have a significant bearing as we move forward into SFY 16 that may be more beneficial to the Commission. Commissioner Shumway states that the presence of this information shows the tremendous success of the NH Health Protection Program.

Commissioner Toumpas responds that there is one significant component to this success which is answering the question “so what”. There are 42,000 people that now have health insurance coverage and what does this translate to when we talk about stability of providers, about uncompensated care and the Medicaid enhancement tax and what does it look like in the area of reduction of the uninsured in either a

Community Health Center or the Community Mental Health Center. This is what is important when we get into the discussion of the NH Health Protection Program and the expansion and the reauthorization. It is important for people to hear what the stories are beyond the numbers to show what this really means to the individual and the family.

Commissioner Toumpas asks if there are any questions or comments for the Commission or public. There are no comments or questions.

Commissioner Toumpas then updates the Commission on the Behavioral Health Network. The department is meeting with a delegation from the mental health centers and will be working with them on a weekly basis between now and the target date to get an arrangement in place to get behavioral health services back into the managed care and capitated model by November 1st. This will then allow the Department to work on the contracts and get them in place by the first of the calendar year.

We have drafted a MOU between the Department,, the CMHCs and the Association that represents them so that it commits all parties to a course of action to try and get something done. The date driven approach that we want to take to the discussion begins today. This is a short term solution because there was no agreement and the program would have become unraveled.

Comment from Commissioner Ken Norton: November 1st sounds good.

Commissioner Shumway asks if Commissioner Toumpas can explain the managed care fee for service program. Commissioner Toumpas explains that in the traditional program the Department would pay the MCOs a per member per month (pmpm). This would include care coordination and care management activities for the population that it may serve, the administrative overhead to process claims and run an operation and the dollars to pay the claims for the recipients. Under this managed care FFS model, the Department would continue to work with the MCOs and provide them with a pmpm for the care management coordination and the administrative overhead to process the claims. This way all the bills come through the MCOs for services that are being provided. This will allow for the continuation of the whole person view in real time. Under this arrangement the CMHCs would continue to bill the MCOs but the Department would reimburse the claims through the MCOs and back to the centers on a Fee for Service (FFS) basis. It is not a sustainable long term model and the Department and the CMHC's understand that. We have developed an MOU to commit all parties to sit down and go through the numbers to come up with something and have an aggressive timeline.

Commissioner Shumway asks Commissioner Toumpas if he will keep the Commission updated on the results of the negotiation and how the resources deployment will impact services.

Commissioner Toumpas states that the goal is to eliminate managed care FFS and move the CMHCs back into managed care. The Department is not a party to the negotiations between the MCOs and the Centers. We need to make sure that they are all looking at the same data but ultimately it is between the MCOs and the Community Mental Health Centers.

Question from the Public: The State is not in a contract with the providers but is the direction to move to capitation?

Commissioner Toumpas responds that there were a couple of things that the Department wanted to emphasis moving to Care Management. One was quality and the reports until now were mostly process. Now we are focusing on outcome. The second part of it has to do with payment reform to break away from the FFS model. The Department has contracts with the MCOs and pays them a certain amount each month depending on the eligibility category. It is then up to the MCO to work with the provider and

provider group to determine the fee. When we move into CFI the Department will set the rate for the first year. When we get into the Nursing Facility it is our intent to also set the rates for the first year.

Personnel Update

Commissioner Toumpas reports that he has a couple of personnel updates that he wants to share with the Commission. The Department is going through a redesign and he will give an update at a future commission meeting. Commissioner Toumpas states that he has appointed Ms. Michelle Harland as the Director of Bureau of Behavioral Health. The Department has created a position for Ms. Katja Fox who is a healthcare policy analyst for a strategic immigration between substance abuse and mental health services. She will be working between these areas and tie in primary care.

Andrew Chalsma now becomes the Director of Data Analytics and Dr. Doris Lotz will become the Chief Medical Officer to assure that there is coordination between all the clinical areas of the Department. There is a matrix reporting structure so these areas do not report to her directly.

Step 2 Update

Commissioner Toumpas states that the Department has received approval from CMS for the 1915 (b) waiver which allows the Department to mandate enrollment of most populations into the Care Management program for medical care. It is not the waivers services, only medical. The Department has submitted the MCO contract and rates to CMS for approval and is moving forward with the necessary revision to the He-W 506 MCM Administrative Rule. The Commissioner then describes the four (4) phases of Step 2 and the timeline. He explains that we need to be mindful of all of the overlapping initiatives such as coordinating mandatory enrollment, annual MCM open enrollment, and the transition of NHHPP Bridge enrollees to Premium Assistance program enrollment activities. This must be managed through communication to providers and advocates working with clients and providers. The Department is also finalizing high touch readiness activities to support individuals, families, case managers and provider agencies with the mandatory enrollment process. We are completing the MCO Readiness Review for managing complex members. The Department is finalizing processes to ensure guardianship and authorized representative information sharing with MCOs. The results of all of this work will allow the Department to finalize the date for opening the 60 day Mandatory Enrollment period.

Also for mandatory enrollment we have been active in doing informational meetings for clients and providers. We will also continue planning for the integration of the CFI Waiver services into the MCM program. The key to the CFI waiver is that it is not the decision of the Department because it requires a 1915 (c) waiver which is more extensive than the 1915 (b) waiver. Commissioner Fox sent out material about contract issues. Commissioner Toumpas recommends that the Commission review this information and look at the waiver language which dictates much of the contractual terms and conditions. There will be public hearings and we will finalize (and post for public input) the 1915 (c) Waiver amendment and continue training and education. The Department continues efforts to support the CFI Case Management and Provider Agency enrollment with MCOs. The Department hosted a “Meet and Greet” session with the MCOs and CFI providers in August and the MCOs have also shared information with the providers. Commissioner Roberta Berner asks if the nursing facilities workgroup that has been met could share the types of concerns that were discussed. Mr. John Porier, Executive Director of HealthCare Association responds that some of the concerns are with the transportation broker and some of the companies they are using. When transportation first went through the MCOs they were sending inappropriate vehicles (such as taxis for more acute residents). We are working to make sure the appropriate vehicle’s show up so that the appointment is not missed. These are basis issues.

Commissioner Toumpas then asks the MCO representatives in the audience if they have anything to add.

Ms. Lisabritt Solsky responds that WellSense recognizes that the needs of nursing facilities are a little different and bringing together the Department, the MCOs and the transportation company will help to come up with solutions.

Commissioner Toumpas states that there is a need for a dialogue and when that happens it is important that people understand the issues and the needs of the individuals.

Commissioner Mary Vallier-Kaplan states that it would be great to hear the outcome of this meeting as it succeeds as will set a precedent to figure out how to do this as there will be new issues.

Commissioner Toumpas explains that in his time at the Department it is clear that transportation is the life blood of what we do. We have a challenging transportation system in New Hampshire. There have been efforts to get coordination. We had a system that worked in some areas and other areas it didn't. With new players it brings to light the issues.

Question from the public: Is it possible to share a date for the 1915 (c) Waiver?

Commissioner Toumpas states that the department is aggressively moving forward with the 1915 (c) Waiver but that he does not want to attach a date to it yet.

Follow-up question from the public: Will there be a similar process for the 1915 (c) Waiver as it was for the other waivers?

Commissioner Toumpas states that it will be more like the 1115 waiver. We will have public forums and input sessions. We want to engage people given the significance of what we are doing.

Commissioner Mary Vallier-Kaplan adds that when this happens there will be conversation and exploration at the Commission level.

Waiver Update

Commissioner Toumpas gives an update to the Commission on the waivers. The 1915 (b) Waiver has been approved. The Choices for Independence 1915 (c) waiver is what the Department is working on now. The other two waivers are the 1115 Premium Assistance Program Demonstration Waiver which has been approved and a team is now working on this program. This requires individuals eligible for and /or enrolled in the Health Protection Program to enroll in a commercial health plan, called a Qualified Health Plan (QHP). Enrollment in the QHP will begin in November 2015 and coverage begins January 2016. The other waiver is the 1115 Transformation waiver which remains with CMS. There continues to be discussions with CMS but this type of waiver is at the discretion of the Secretary of Health and Human Services because it a demonstration waiver. This waiver focuses on mental health, substance abuse and primary care.

Commissioner Mary Vallier-Kaplan has a request that if the Department has anything compiled as to what we have learned from the information sessions, case management sessions and forums that could be shared with the Commission that would be helpful to give us the feedback that the Department is hearing.

Commissioner Toumpas states that there are teams set up to work with CFI providers mapping out processes. We have assigned someone from our Information Division who is proficient with the lean process and is working with CFI providers to standardize language and get everyone on the same page. For example various terms are being used such as case management and care coordination

interchangeably. In some cases they mean the same thing but at other times they mean something different. The Department is also doing this with Nursing Facilities. We are working with the county nursing homes but will also start working with private nursing homes. So we are looking at what is working now and what is not working.

Commissioner Vallier-Kaplan comments that the Commission has subgroups working on consumer protection and network adequacy. The Department has assigned Ms. Deborah Scheetz as the liaison to work with the Commission and the subgroups on these priorities. Perhaps the best way to handle things move forward is for Ms. Scheetz to communicate back to the Department what has been done at the workgroup and share with the Commission what is being done at the Department.

Question from Ms. Kathleen Sgambati: Does the 1115 Transformation Waiver have anything to do with SIM?

Commissioner Toumpas responds “no”.

Ms. Sgambati asks Commissioner Toumpas to describe a little about the changes in Step 2 in relation to SIM?

Commissioner Toumpas explains that SIM 2 is broader than Medicaid. It is a planning grant that is not executing of anything. The Department has a contract that was approved by Governor and Executive Council from an organization out in Oregon that will facilitate the process. It is designed to step back and take a look at the structure of our health delivery system. Not just Medicaid. The 1115 waiver is focused on Medicaid but on areas of behavioral health, substance use disorder, and integration of primary care. The reason this waiver is at the sole discretion of the Secretary is because it is a demonstration. You can think of this as the Federal government going into venture capitalism. We are coming up with a set of dollars that the State spends in general funds for health related services but that are not being matched by Federal dollars. We have identified this pool of dollars that we want to get a Federal match on over a five (5) year period and we will do a transformation on these areas of behavioral health and substance abuse. This is exciting but right now the focus is on selling the concept to the Federal government. Once we get the approval it then becomes how we do that. This is funding pilots to transform how we deliver those types of services.

Ms. Kathleen Sgambati wants to understand the transformation of the system through the 1115 Transformation Waiver compared to what is already being done with Step 2 and how SIM plays into the changes that have been made over the two years.

Commissioner Toumpas explains that part of this is that taking advantage of an opportunity when it comes along. There are changes to the healthcare delivery system that SIM will impact. The 1115 Transformation Waiver came about as a result of something entirely different. What we did was that we steered it to the issues that are important right now. The management team is looking at what is different and what is overlapping. In the future instead of doing waiver updates we will be doing implementation updates.

Commissioner Ken Norton responds that maybe we can reframe the question: If and when the waiver is approved, how will that impact both SIM, and the States implantation of Step 2 and the planning for that?

Commissioner Toumpas responds that there would be discussions about this. SIM is much broader than just behavioral health, substance about and primary care so it might be helpful to put together a diagram so you see the intersect because a lot of this is going to depend on the timing of these grants and overlapping with each other. Even with SIM the Federal Government announced that they would not do

the implementation. So we put together a blue print to bridge together and convene a number of stakeholders. It is something that is sponsored by the Governor and is identifying stakeholder that will be part of that planning effort.

Commissioner Susan Fox asks if the 1115 Waiver would be combined with Managed Care.

Commissioner Toumpas: No, these are not services. The 1115 is not supplanting what is in the general funds. What we are saying is that we are going to come up with a number of innovations at a high level. If the Federal government comes in and gives us X amount of dollars over a five year (5) period, they will want to look at the types of innovations and once we get the go ahead we will have to translate this to tangible projects, RFPs and other things that will be operations.

Commissioner Tom Bunnell asks if the 1115 transformation waiver is approved will there be a process setup up for select groups of providers that may come together that are designed in such a way that resources are coming together where there is money flowing between the Department and those providers that won't be through the MCOs and that won't be through managed care? This will be its own demonstration project.

Commissioner Toumpas responds that we are talking about integration. Right now we have people coming in one door for mental health services, another door for substance use disorder services, another door for primary care services and another door for human services such as housing, nutrition and other services. How do we bring that together at a community level to demonstrate in a pilot that type of integration? It is one thing to say four agencies in one particular area will work together but they may not have the skillset and investment dollars to do that. This is where this would come into play. While they are running their day to day operations, the demonstration waiver would help so that we may get success on this and how we would leverage this either in managed care or the subsequent budget with the legislature. Once we actually get the go ahead we will assemble a team and put our RFP or RFA's to make this happen.

Commissioner Ken Norton responds: Based on conversations with CMS and based on the 1115 transformation waiver, do you know where we are with this?

Commissioner Toumpas states that he cannot give details of this but discussions are happening at the highest level. We want to move this forward because there will likely be changes in the Administration at the Federal level. This is not an insignificant amount of money and the Federal government is not required to do this. It depends on whether we made a compelling case and now it is a matter of having them follow through on it.

Commissioner Norton asks if the existence of the mental health agreement impacts the 1115 waiver.

Commissioner Toumpas states that we are treading on thin ground because on one hand the Federal government told us to comply with the mental health agreement and then on the other hand we are asking them for funds.

Commissioner Mary Vallier-Kaplan states that this has been a useful conversation and calls at break until 2:30.

Discussion of Quality Outcome Indicator Report

Commissioner Jo Porter opens after the break and states that the discussion on quality will be cut back by 30 minutes. Commissioner Jo Porter gives an update that prior to this meeting there was a meeting this morning at NAMI. We had a two hour session focused on data reporting. At the last few meetings of the Commission we have held off on the key indicator report which is a report update that the Commission

has been updated on for the past eight months. The Department has been putting a lot of resources into the Medicaid Quality Information System (MQIS) that has all of the indicators that we are looking at and many others. This morning there was a dedicated session about that system and some of the quality outcomes that have been displayed on that system. The website is now live and anyone is interested in looking at that system can go to medicaidquality.nh.gov. There are hundreds of measures organized by topic. Mr. Andrew Chalsma described that there are several needs to manage and analyze hundreds of measures on quality and performance to support the Departments commitment to transparency. Dr. Doris Lotz had 118 slides that are on the webpage. On the front page there is an icon that will get you to the slide deck. It provides indicator by indicator on selective topics and shows where there are areas for improvement and where things are going fine. As a Commission as folks are using it and have questions, there are web and email addresses on the website for help.

The questions and answers from the session were captured this morning and will be available.

Commissioner Mary Vallier- Kaplan asked the Commission if there was anything they wanted to put on the record regarding this morning's session.

Commissioner Yvonne Goldsberry stated that she asked a question at the earlier session regarding comparison of data sets for Long Term Supports and Services and what comparators might be used. The response was that there may not be a LTSS data set out there to use but they would use whatever was available.

Commissioner Don Shumway stated that this was an extraordinary accomplishment. Any individual can look into any measure and customize it for their own use. This is one of the most important works of the Department. Commissioner Bunnell thanks Commissioner Toumpas and Commissioner Porter for developing this tool. It is shockingly modern and very user friendly. If there are ever Federal funds available to update the DHHS website they should be pursued.

Commissioner Toumpas comments that when that Dr. Lotz presented the measures in Newport years ago, one of the comments made was what are you going to do with all of this data you are collecting and will you have anybody that will be able to look at it. This is the result. Our commitment was to collect the data. We are benchmarking against New England, National and what we had pre managed care. This underscores the commitment we had and the team did a fabulous job working with Commissioner Porter and others in and outside of the Department.

Another point on the redesign of the organization is that we have elevated quality to the top of the chart instead of embedding it in other areas of the Department. Now we can focus on the whole individual.

Commissioner Porter states that people on her team did amazing work on this and she wishes she could take credit but she cannot.

Ms. Kathleen Sgambati remarks that on behalf of the Commission and the MCAC she would like to thank Dr. Lotz and Mr. Andrew Chalsma for the presentation this morning. The ability to generate your own reports is remarkable. When looking at this and comparing where we are at this time with Step 2 we were considered average. This is less than stellar when describing the results. This is comparing to the New England average which is significantly higher than the national average. So that by most accounts the results is pretty impressive for the first days of managed care. The Governor spoke with some of the Commission members this morning and stated that Step 2 must be just as solid. The other thing that it gives us is very specific areas to work on. It will give us the ability to redirect efforts As the medical

community begins to set standard it will give us benchmarks that not everyone else's average but what the goals may be for each medical interaction. Ms. Sgambati passes on her congratulations and asks to pass on out thanks.

Commissioner Porter makes one more comment that there was a question at the morning session about the assumption of the accuracy of the MCO data. The response is that the data is validated internally for some measures, the external quality review organization audits on more complex measures, national measure are audited and surveys are required to use approved vendors. Another question was asked about the New Hampshire Health Protection Program and why it is excluded. The response was that the data is being collected and analyzed but the Department does not want this data to throw off the other data. This population is separated.

Commissioner Mary Vallier-Kaplan now turns the meeting over to Commissioner Susan Fox.

Commissioner Fox begins by stating that over the past few months the Commission has been looking at the Long Term Services and Supports as we move into Step 2. For several months the nursing homes and county presented on that side of LTSS and now we are beginning to explore the community based LTSS and how this is structured and funded. As a commission we laid out our principles and we are concerned about network adequacy and participant protections. There are three presenters today to discuss this topic to include Ms. Gina Balkus representing the NH Home Care Association, Ms. Paula Faist from Adult Day Association, and Mr. Joel Green the director of the Merrimack County ServiceLink Resource Center to talk broadly about community services.

Ms. Gina Balkus thanks the Commission for having them today. She begins by describing the Granite State Home Health Association. Granite State is a nonprofit agency that represents 39 home care agencies licensed in NH. Most members are Medicare certified agencies that provide a full range of skilled nursing and therapy services. There are 30 member agencies that provide services to Medicaid beneficiaries enrolled in the Choices for Independence (CFI) waiver program. These agencies range from non-profit community agencies such as Visiting Nurse Agencies (VNA), statewide agencies such as Ascentria, and small agencies such as AV Home Care in Berlin. She also explains that they have locally-owned private businesses such as Interim Healthcare which is statewide, Silver Touch in Merrimack, and Lakes Region Care and Comfort in Laconia. Ms. Balkus then explains what CFI is. It is a Medicaid waiver program for elderly and adult citizens in need of long term care services. There are two areas of eligibility. Financial eligibility is determined by DHHS and clinical eligibility is determined by a clinical assessment conducted by DHHS contracted RNs. The results of the medical assessment are shared with DHHS and a determination is made by BEAS staff. A client is deemed to be eligible for nursing home care but can choose to receive services in home and community-based settings. There are several types of settings which include mid-level care, home support services such as adult day programs, home health care services such as RN visits, home health aide visits and homemaker services. The Department gets the assessment and then authorized the services that the client will receive. They then hand it over to a case manager who will organize that array of services. They reach out to providers in the community to deliver the services. Providers are reimbursed only for authorized types and units of services. By Statute people on CFI must spend less than in a nursing home. NH RSA 151 E: 11 (II) states that the average annual aggregate cost of mid-level care cannot exceed 60% of nursing home costs. Average annual aggregate cost of home services cannot exceed 50% of nursing home costs and no person whose costs will exceed 80% of nursing home costs shall be eligible for mid-level or home services (unless waived by the Commissioner). Ms. Balkus then explains the services provided by home care services which include skilled nursing visits, home health aide/LNA visits, personal care, and homemaker services.

Commissioner Jo Porter asks about the process by which the utilization of services takes place. Is there a group of services that are authorized under case plans or is it done on an individual basis?

Ms. Balkus responds that there is a medical assessment done and the client is determined eligible. Once that is done the determination lasts a year. The nurses go every 60 days to reassess. There is a back and forth flow between the nurses in the field and the case managers who are coordinating the services and DHHS who are authorizing the services. Sometimes there is confusion as to who decides what.

Commissioner Susan Fox states that if people are working with an individual they can request more services from DHHS if things change.

Commissioner Mary Vallier-Kaplan asks if this is a NH coordinated service or do most states have a version of this?

Ms. Balkus responds that she believes that all states have some version of this. They may run it differently and call it something different.

Ms. Balkus continues reviewing the CFI statistics. There are approximately 2,425 home care clients as of SFY 15 with an average annual cost per case of \$ 18,360 (SFY14). This has been comparable over the past three years. This is for all CFI services. Ms. Balkus reviews the reimbursement structure for RNs(\$90.16/visit), HHAs(\$29.60/visit less than 2 hours), HHAs (\$5.74/15 min unit), PCSPs (\$4.38/15 minute unit), Homemakers (\$4.56/15 min). The estimated annual costs for SFY 15 for RNs, HHAs and homemakers are \$8.3 million. PCSPS is \$24.5 million.

Ms. Kathleen Sgambati asks Ms. Balkus if under homemaker and personal care there are comparisons to actual costs?

Ms. Balkus states that she does not have comparisons because she can only compare to Medicare Cost reports and Medicare does not have homemaker and personal care services. They only do home health aides and nurses. It would be challenging to collect this data.

Commissioner Tom Bunnell asks about the budget that was vetoed by the Governor and if the numbers are better with the new budget?

Ms. Balkus does not want to talk about the budget at this meeting but agreed to discuss this with Commissioner Bunnell after the meeting.

A question from the public asks if the SFY 15 estimated annual cost for RNs, HHA and homemakers of \$8.3 million is down?

Ms. Balkus responds that the number of services authorized by the Department has decreased. What has changed in the medical condition of CFI recipients to create this decrease or is it a function of trying to use more cost effective ways to handle this population. The challenge is how to make these decisions and how to manage this.

Ms. Balkus continues with the challenges and opportunities facing the CFI providers and to how to assure that the appropriate service array is being provided to the client. There is currently a population shift, a back and forth of the relationship between the department that authorizes the services, the case managers that arrange the services and the providers that provide the services. It is important for a dialogue to take place. If there is a nurse in the home and the client takes a turn for the worst we need a mechanism for the MCOs to get involved. What are the clinical criteria used to make these changes and how do you assess the quality of care that is provided to determine this. Another thing that the MCOs must think about particularly for the dual eligible population who are over 65, Medicare has strict criteria for when someone is eligible. Will the MCOs be overseeing this? This gets complicated. The agencies are

sometimes in the best situation to deal with this. Another challenge is the 20 year history of inadequate reimbursement. Ms. Balkus reviews the history of inadequate reimbursement for home care services. (See slide deck entitled Home Care Presentation to Governor's Commission on MCM pages 7-9).

Ms. Kathleen Sgambati remarks that when you look at the Departments history of rates isn't it true that part of the reasons that things have gotten worse is because of changes in the Medicare rates?

Ms. Balkus responds that we have had these inadequate rates all along. We have managed to cover those rates because agencies had a pretty healthy Medicare population so we were able to cost share. Two things have happened in the past couple of years that are impacting the cost share. The first is that under the Affordable Care Act (ACA), Medicare home health rates have been cut 14%. This is being phased in at three and one half (3 ½) % a year starting in 2014 to 2017. In January we will be in year three (3) of a four (4) year rate cut. This has really diminished Medicare margins. The second thing also related to the ACA is that the requirement for a face to face visit and this must be documented. The regulations that CMS have enacted related to what constitutes sufficient documentation by the physician is really cumbersome. Because of this a lot of the physician documentation does not pass. When the documentation does not pass the home health agency does not get paid for the services they have already delivered and the claim gets denied. The Medicare contractor for New England was extremely aggressive when reviewing face to face documentation. New Hampshire has \$2 Million dollars in denied claims. This does not come out of the physician's pockets but from the home health agencies pockets. Once again this has impacted cash flows and margins for home health agencies. So there have been changes at the Medicare level but the real problem is inadequate Medicaid rate. There are more and more home care agencies are stating that they cannot do CFI anymore. In the past month a large agency in Keene has announced it would no longer serve CFI clients. Case managers are scrambling to get coverage. One of the challenges is there are not a lot of agencies that will step into this market and there is also a workforce shortage because of the inadequate rates. So you have workforce shortages and the inability of home care agencies to cover the losses and now there is a situation of network inadequacy. So the MCOs need to understand that even if the Department sets the rates for the first year, come the second year when the MCOs are to contract with CFI providers there may be no CFI providers that are willing to contract with the MCOs to provide the services. These are the challenges but there is an incredible opportunity here. There is nobody else in the home dealing with these frail elders and adults besides the home care agencies to see what is going on with the clients and what their needs are. There is an opportunity for preventive care to keep these individuals out of nursing homes and hospitals if it is done right. It all depends on the approach and on how careful you structure the waiver and the contract. How can we be sure that these clients that are poor and medically frail get the services so we can keep them in their home and save the State money?

Commissioner Susan Fox then introduces Ms. Paula Faist, from the NH Adult Day Association. Ms. Faist begins by placing the audience in the Adult Day Center at 3:28 PM. At this moment there are people that they are toileting, people that are being feed, medication, singing, physical movement and many other things happening. We do it all but in the adult day environment. Adult Day has struggled for many years and there are the same issues that Ms. Balkus stated earlier. This is a safe setting. They do everything that home care does except in an adult day care setting. Adult Day and home care should go hand in hand. The benefits of attending an adult day center are numerous. Adult Medical Day Centers can help individuals remain in their own homes. Person centered activities can help prevent or delay costly long-term care alternatives, such as nursing home care. Attending an adult medical day can also reduce unnecessary hospitalization due to ongoing health monitoring. Partaking in an adult medical day can help keep loneliness and depression at bay. Day centers also help families maintain employment thereby paying taxes and putting money back into the economy. Adult Day Care Centers have contracts with Medicaid and the VA. Long Term Care Insurance will pay for adult day. The cost per person per day is about \$75 .

The Medicaid rate is \$49.24 per day. Transportation is a big issue for the Adult Day Centers. Care plans are important and the MCOs want these plans before we even get the client.

Ms. Faist ends her presentation and thanks the Commission for inviting her.

Commissioner Susan Fox then introduces Mr. Joel Green who is from the ServiceLink Resource Center Network. Mr. Green gives a brief overview of the ServiceLink network. This is a statewide network located in all the counties in the state. One of the strengths of ServiceLink is that it is local. We know the people in our communities so that we can help people in our community. Mr. Green states that he will review the types of services they provide, who calls them, who goes into their offices and what the role of ServiceLink is. There are a number of services they cover. Their backbone is referrals. They get a significant number of calls. Locally in Merrimack County they have gotten around 10,000 calls a year on average for the last 4 to 5 years. Over the past year there have been 83,000 calls. This is to request information to connect people to services. ServiceLink has a database they share with all locations. In this data base there are thousands of services. When they search the database they can find services within 25 miles or less from where the person lives. That is why it is important to know their address. Options counseling is also a priority. Every office has Options councilors. This is where ServieLink connects to CFI as a port of entry for a lot of folks. The information is offered in three different ways, by phone, in person in the office or in their home. They will then do an assessment to determine options for that individual. In addition to that ServiceLink provides Medicare counseling and is involved with the State Health Insurance Program (SHIP). October 15th will start open enrollment until December 7th. Last year in Merrimack County they sent out 850 cards and as of this morning there are already 1000 cards to be sent out. Another program the ServieLink has is the Senior Medicare Patrol which helps people recognize where fraud may be happening. ServiceLink also has caregiving coordination. ServiceLink contracts with the State and they get federal money to provide small grants to families to help with respite and home care needs and medical equipment. ServiceLink also has a support group for care givers. There will be an article in the Concord Monitor this week regarding this program. They also provide veteran's services (VIPP) which is a program designed to help veterans stay in their homes. In addition ServiceLink has contracted with the State through EasterSeals. This is "Ask the Question Program". Providers ask the question, "have you served in the military" to everyone who comes in the door. ServiceLink is also involved with the No Wrong Door project now known as NH CarePath. The phone number on the webpage for NH CarePath is the ServiceLink number. Locally they work with area agencies, health centers and district offices as the foundation for this. Mr. Green then explains the types of people that come to their offices. They are all ages. There is a rise in need of care giver support for grandparents who have children that are addicted and are taking care of their grandchildren. All ServiceLinks have fiscal agents and in Merrimack County it is Community Action Program.

Commissioner Susan Fox thanks all of the speakers and opens the meeting up for questions from the Commission and the public. She states that part of the message is that the CFI waiver services include a wide array of community services that have to come together to help this population stay at home. The CFI waiver is not a 24 hour support it is more of an augment to the 24 hour support.

Comment from Commissioner Gus Moral: This really gives a good picture of what it is to service a person that receives LTSS. This was a very good picture of the challenges and opportunities facing these providers.

Commissioner Yvonne Goldsberry explains that in the operations workgroup one of the issues that came up was the need to be aware of the different life cycles of services within CFI. Right now the quality data is focused on managing acute care. How will the MCOs be sensitive to a completely different care management and be able to manage this different population?

Ms. Gina Balkus responds that at the home care level they have already had to deal with this. The MCOs tell the provider to submit the claim to Medicare and get a denial only then will they cover it. But for home care agencies the criteria for admitting somebody to a Medicare episode of care versus a Medicaid episode of care are different. Medicare is more stringent. So if a VNA knows that a client will not meet the Medicare criteria they cannot submit a claim to Medicare because that is fraud. So we have had to work with the MCOs to help them better understand what qualifies for Medicare. They know this client and they are not homebound but they need homecare but they can still get up and leave without assistance therefore Medicare will not cover it. But Medicaid criteria does not include being homebound so they do qualify. These are the issues we need to work through with the MCOs. Homecare on the State Plan side is acute but it is over a period of multiple visits. Initially we would have to get a prior authorization so they have worked it out with the MCOs to approve care plans for the first 5 visits without a prior authorization. This is an operational issue and an administrative issue because of the burden on staff for the level of documentation. This could be a problem for CFI providers.

Comment from Paula Faist comments that Medicare does not consider Adult Care as a reimbursable service. The MCOs have asked the Adult Day Care providers to bill Medicare first but they can't do that.

Commissioner Jo Porter comments that her group will have many questions on network adequacy and there is a lot of inference of network inadequacy. She continues that their work as a committee is to identify how big the gap is. She is curious on quantifying the network inadequacy.

Commissioner Susan Fox states that the other issue about network adequacy is that as we go forward the population is growing older with the baby boomers and there is going to be a greater need for services. The opportunity here is that home care is less expensive and it is important to keep people in their homes.

Ms. Gina Balkus states that there are two levels of network adequacy. One is having enough agencies and the other is their ability to take on clients which changes sometimes on a daily basis based on their workforce. Network adequacy will fluctuate and this will be more challenging to get a handle on.

Ms. Kathleen Sgambati adds that it will be really helpful to see what has happened to the provider community over the past several years in different service cohorts and if there actually has been a decrease in the number of homecare agencies. It will also be interesting to see how many people are being accepted into the program now versus several years ago. She states that she has gotten letters from providers that say they cannot do it anymore. She does not know what that looks like cumulatively but it needs to be compared to the trajectory to the growth that is being mentioned. There is a need for that data.

Commissioner Mary Vallier-Kaplan thanks everyone for presenting and to those that attended the meeting.

Commissioner Toumpas makes a comment that we are an aging population and an aging workforce. The number of state employees that can retire in the next couple of years is staggering. This has an impact on operations and not just in the Department but across the board and what we are seeing is that every network, the DD network, home care for the elderly, hospitals, Community Health Centers has this common theme. He states that he would frame it not from the standpoint of the agencies, what is needed is some systemic way to deal with this workforce issue. The Department met with all the CMHC directors and their board chairs. What is happening is that someone will develop a program to give workforce incentive to develop people only to have that person hired by another network. If we only look at it from a CFI, DD, nursing homes, mental health, we are missing it because someone will develop something only to have it taken by someone else. So the Department has an initiative we are kicking off to designate someone in the Department to focus on workforce. Not only in the Department, but across the board. The first step is to do an inventory. There are a number of things going on now but they are not

coordinated. Public Health has a state loan repayment program to get people in medically underserved areas of the state. You bring someone on board and reimburse the tuition so they can pay back their loans. Can we take something like this and mock it up to develop additional capabilities. We raised this at the MCAC meeting last month. This idea was floated by them and we got very positive feedback. We cannot hire psychiatrists at NHH and CMHC. There are no people to do the services. We are looking at this in a more fundamental way. We need to be proactive. We will kick this off and come back here to share

Commissioner Mary Vallier-Kaplan thanks the Commissioners and the public adjourns the meeting at 4PM.

Follow-Up Items

The following items were noted during the September MCM Commission Meeting:

1. Commissioner Mary Vallier-Kaplan has a request that if the Department has anything compiled as to what we have learned from the information sessions, case management sessions and forums that could be shared with the Commission, that would be helpful
2. Commission requested a timeline and update on Waiver Services