# Medical Care Advisory Committee (MCAC)

## Monday, January 9, 2023

## MINUTES

**Present:** Holly Stevens, Chair, Lisa Adams, Michael Auerbach, Kathy Bates, Jake Berry, Vanessa Blais, Kelley Capuchino, Lisa DiMartino, Tamme Dustin, Joan Fitzgerald, Ellen Keith, Ellen McCahon, Kara Nickulas, Dawn McKinney, Karen Rosenberg, Rhonda Siegel, Lisabritt Solsky Stevens, Kristine Stoddard, Carolyn Virtue, Brendan Williams, Elinor Wozniakowski
**Alternates:** Brooke Belanger, Deodonne Bhattarai, Amy Girouard, Emily Johnson, Michelle Merritt, Isadora Rodriguez-Legendre, Kristen Schmidt
**DHHS:** Henry Lipman, Alyssa Cohen, Sarah Finne, Rob Berry, Dawn Tierney, Melissa Hardy, Jessica Gorton, Sandy Feroz, Leslie Melby, Krysten Finefrock, Kerri Schroeder, Jessica Gorton, Jordan McCormick, Vernon Clough, Laura Ringelberg, Jody Farwell, Sara Lacharite, Deb Sorli, Catrina Rantala, Carolyn Richards, Peg Clifford, Lise Farrand, Melissa Nemeth
**Guests:** Deb Fournier Susan Paschell, Henry Veilleux, Lara McIntyre, Erica Ross-Skianes, Vicki Jessup, Brooke Holton, Trina Loughery, Mike Miller, Debra Lang, Amy Pidhurney, Rachel Chumbley, Nicole St. Hillaire, Stephanie Myers, Kate Kaplan, Josh Krintzman, Richard Siegal, Nicole Valanzola

**Announcements**
The Chair requested Zoom participants raise their hand to be called on. Members of the public will all have an opportunity to speak.

**Review/Approval: December 12, 2022 Minutes**
Motion to approve.
Joan Fitzgerald proposed the Adult Dental Benefit section be revised to replace "guidelines" with "public policy" to align with NHDHA terms. Alternative wording, "professional guidelines," was adopted because the term, "public policy," implies state laws and regulations.
Karen Rosenberg proposed the He-M 310 section be revised to reflect discussion *during* the meeting, rather than *after* the meeting. Removal of the last sentence, **"**Following the meeting, staff confirmed that He-M 310 was not brought to MCAC for review because it does not contain a Medicaid component. Rather, it addresses the rights of individuals in the DD system. Staff will follow up with Karen Rosenberg," was adopted.
Minutes approve as amended. M/S/A

**Agenda Items – February 13, 2023**
- CMS HCBS Quality Measures

**Medicaid Expansion: Letter of Support**
The Chair asked whether MCAC should write a letter to support legislation to continue Medicaid Expansion. The letter will also request that the Expansion be permanent. Holly Stevens, Lisabritt Solsky, and Carolyn Virtue will draft the letter and send it to MCAC for review and comment.

**Adult Dental Benefit Update**
**Sarah Finne, DMD, Medicaid Dental Director**
State plan and waiver amendments were submitted to CMS in December. DHHS weekly meetings are ongoing with Delta Dental and DentaQuest. Network development is the highest priority.

Revisions to He-W 566 include the addition of the new adult dental benefit, as well as changes to the children's benefit section to reflect ADA changes to orthodontic treatment codes. Treatment services will not change.

**Public Health Emergency: Medicaid Coverage and Continuous Enrollment**
**Alyssa Cohen, Deputy Medicaid Director, Deb Fournier, UNH Health Law & Policy**
The federal Consolidated Appropriations Act of 2023 decoupled the continuous enrollment requirement from the Public Health Emergency. Continuous enrollment will end on March 31, 2023. On April 1, 2023, Medicaid will return to regular eligibility requirements and operations per federal legislation that decoupled eligibility from the PHE. Beneficiaries with continuous coverage must demonstrate eligibility to keep their coverage. They will lose coverage for failure to renew or become ineligible due to a change in circumstance.

To keep Medicaid coverage, it is no longer *optional* to complete redeterminations or respond to DHHS requests for information about eligibility status. DHHS will send yellow renewal notices over the next few months to those who must complete a redetermination or provide information. Stakeholder participation is encouraged.

States cannot initiate renewal for more than 1/9th of the entire caseload per month. States must submit an Eligibility Renewal Distribution Plan to CMS and report monthly on state enrollment/eligibility activities/trends.

The unwind plan will evolve over time. DHHS is working first with those who are most likely to lose eligibility, as well as working on analyses of the population, informing providers, and involving stakeholders to assist beneficiaries.

Timeline to initiate renewals:
February: Yellow notice will be sent regarding the need for renewal or additional information.
March: Beneficiaries must respond to the Feb. request.
April 1: DHHS will close renewals initiated in Feb. if it has not received a renewal application or additional information requested.
December enrollment: 102,482 individuals (41% of 248,454 total enrollment) were in protected status, of which 29,905 pending ineligible.

The Consolidated Appropriations Act, 2023 (CAA): (1) ends the continuous enrollment requirement by March 31, 2023; (2) phases out enhanced FMAP Apr 1, 2023 - Dec 31, 2023; (3) creates unwind reporting requirements; (4) creates additional verification steps for disenrollment due to lost contact; (5) mandatory 12-month continuous coverage of children 18 and under as of Jan 1, 2024; (6) permanent state option for 12-month continuous coverage of postpartum women (NH not yet elected); (7) removal of the limitation on FFP for eligible juvenile inmates pending disposition of charges as of Jan 2, 2025; and (8) screenings and targeted case management for certain juvenile inmates.

If those in the protected category don't respond to DHHS notices, a 10-day notification will be sent to them. If no response, they'll be notified of termination to include information re: reapplying and the right to a hearing.

Henry Lipman announced that Alyssa Cohen will be leaving the Department Feb 2nd. Members thanked Alyssa for all her work on Medicaid. He noted that staff will be assigned to continue the work of managing the PHE unwind.

**Department Updates**
**Disability Determinations**
**Kerri Schroeder, Bureau of Family Assistance**
As of Dec 16, 2022: 16 children were pending of which 5 had Medicaid; 218 adults pending of which 167 had Medicaid, 69 at 90+ days, 39 awaiting nurse write-up or final sign-off, 9 pending medical records, 21 consultative exams scheduled, 0 HC-CSD case over 90 days.

**MCO Contract**
**Henry Lipman, Medicaid Director**
G&C approved Amendment 9 which incorporates legislative rate increases, includes transportation for family and friends for consistency among MCOs and vendors, adjusts rates by 1.5% to reflect a lower risk than rates set in July, and a rate increase to SUD residential treatment code H0010 to reflect 3.7 ASAM level of services. The Department is working on Amendment 10 and reprocurement. The current contract ends August 2024. Public comment will be requested.

**HCBS Spending Plan**
**Henry Lipman, Medicaid Director**
DHHS has submitted items for the third phase and is awaiting CMS feedback. A total of $100 million will have been expended.

**Waivers**
- SUD-SMI 1115 Demonstration
  An amendment adds the dental benefit. State and federal comment periods are complete
- 1915(j) Personal Care State Plan Amendment
  The Department is currently working with CMS.
- 1915(i) Supportive Housing State Plan Amendment
  DHHS will meet with other states to gain insights on how they implemented their waivers.

**He-M 503, Eligibility and the Process of Providing Services**
**Jessica Gorton, Bureau of Developmental Services**
BDS is under a corrective action plan with CMS and is amending He-M 503 to comply with the plan and to make changes to reflect ongoing initiatives. Many changes are based on stakeholder feedback (provider agencies, area agencies, families). The rules promote individual choice, clarity in procedures, streamlined intake and eligibility requirements, and compliance with federal requirements.

Proposed changes include:
- Updates to timelines for intake and eligibility decisions and development of service agreements.
- Updates to overarching system expectations around service coordination such as who can and cannot be a service coordinator and addition of language to ensure an individual has meaningful choice and freedom from conflict of interest.
- Individual service agreement requirements, the personal profile section, and assessments information necessary for individuals receiving waiver services.
- Requirements of an area agency to contract with a provider are removed.
- Requirements for documentation of information for the allocation of funds.

MCAC Comments: Carolyn Virtue submitted the following statement to include in the minutes to reflect her comments made during the meeting on the Service Coordination sections of this rule:

> CMS has made clear regardless of what the service is called, if billed under case management codes, the regulations governing case management must be followed. This work has been going on for seven years. The language in this rule does little or nothing to provide a framework for ensuring case management is delivered as required by CMS. CMS directed NH to address current violations of the federal conflict of interest (COI) rules, which requires the State to separate service plan development/case management providers from direct service providers."
>
> This rule develops a new system whereby "individuals" (poorly defined in the rule) without any qualifications identified, deliver the case management service outside of the system NH recognizes to

enroll providers of case management, including licensure. NH has required case management licensure for almost 30 years and the statute (NH RSA 151:2-b) in regard to the same was enhanced effective August of 2022.

The language included in this rule does nothing to bring service coordination (case management) into compliance with federal regulations, it creates loopholes to avoid compliance. I strongly urge the department to bring this service into compliance with the conflict of interest and provider qualification standards outlined by CMS and NH Statute.
There was discussion about whether or not to form an MCAC subcommittee in regard to this rule between Holly Stevens, Karen Rosenberg and Carolyn Virtue, it was decided to take that discussion off-line.

BDS clarified that provider qualifications are listed in a different section of the rules. Waiver services are not state plan services.

**MCAC Medicaid Rules Review Process**
**Rob Berry**
With regard to He-M 310, MCAC should have the opportunity to provide input on rules as specified in the *Medicaid Rules Review Process.* The document identifies He-W 500, He-W 800, certain He-C, He-E, and He-M rules with Medicaid service, waiver, eligibility, or rate setting components, and any other rule located in another chapter that has a Medicaid component. Due to some ambiguity, the Department will err on the side of providing information to the MCAC to ensure transparency. The Department is in the process of developing a more efficient way to evaluate which rules are subject to presentation to MCAC and is open to discussion of any rule MCAC wants to review.

Adjourn. M/S/A