Legislative Commission on Primary Care Workforce Issues

December 19, 2019 2:00-4:00pm at the NH Hospital Association –Conference Room 1, 125 Airport Road, Concord

Call in information:

(267) 930-4000

Participant Code: 564-395-475

Agenda

2:00 - 2:10	**Welcome and Introductions**
2:10-3:00	**State and Federal Policy: Impact on Primary Care & Behavioral Health**- Lucy Hodder, Professor of Law, Director of Health Law and Policy, UNH Franklin Pierce School of Law and College of Health and Human Services, Institute for Health Policy and Practice
3:00-3:20	**Update: DHMC Family Medicine Residency** - Cathy Morrow, MD, Chair, Department of Family and Community Medicine, Geisel School of Medicine
3:20-3:55	**2020 NH Legislative Landscape: What's Happening?** • Rep. Polly Campion • Please come prepared to give a quick summary of bills your organization is prioritizing
3:55-4:00	**Happy Holidays** **Adjourn**

Next meeting: Thursday January 23, 2:00-4:00pm

State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: December 19, 2019

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Hospital Association (Rm 1)

Meeting Notes

TO: **Members of the Commission and Guests**

FROM: Danielle Weiss

MEETING DATE: December 19, 2019

Members of the Commission:
Rep. Polly Campion, NH House of Representatives
Laurie Harding – Chair
Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair
Stephanie Pagliuca, Director, Bi-State Primary Care Association
Mary Bidgood-Wilson, APRN, NH Nurse Practitioner Association
Donald Kollisch, MD, Dartmouth-Hitchcock Medical Center
Mike Ferrara, Dean, UNH College of Health and Human Services
Trinidad Tellez, MD, Office of Health Equity
Bill Gunn, NH Mental Health Coalition
Tyler Brannen, Dept. of Insurance
Pamela Dinapoli, NH Nurses Association
Dianne Castrucci, NH Alcohol and Drug Abuse Counselors Association
Guests:
Danielle Weiss, Health Professions Data Center Manager, Rural Health and Primary Care
Leslie Melby, NH Medicaid
Anne Marie Mercuri, QI Nurse – Maternal and Child Health Section, DPHS
Barbara Mahar, New London Hospital
Cathleen Morrow, MD, Geisel Medical School

Meeting Discussion:

2:00 - 2:10 **Welcome and Introductions** – Laurie Harding – Chair, NH Commission on Primary Care Workforce Issues

2:10-3:00 **State and Federal Policy: Impact on Primary Care & Behavioral Health-** Lucy Hodder, Professor of Law, Director of Health Law and Policy, UNH Franklin Pierce School of Law and College of Health and Human Services, Institute for Health Policy and Practice

Refer to presentation "The Changing Healthcare Landscape."

Note: Lucy presented with these slides in October; she returned this month to continue the conversation.

3:00-3:20 **Update: DHMC Family Medicine Residency** - Cathy Morrow, MD, Chair, Department of Family and Community Medicine, Geisel School of Medicine

- Started process of establishing a residency at Cheshire in Keene
  - 6-6-6 model

- GMEC (Graduate Medical Education Committee) must exist to be a teaching hospital
    - Must have community person involved
- This is Cheshire's residency – not DHMC's
    - Motivated by complexity of trying to recruit and retain primary care physicians
        - Facing same demographic trends including an aging workforce
- Have financial commitment from 3 entities
    - DHMC
    - Cathy's department – Family and Community Medicine
    - Cheshire Medical Center
- Have timeline
    - Anticipate the first residents to walk through the door in July 2022
- Biggest obstacle
    - GME funding
        - Arcane rules
    - Unsure of what federal funding is going to be
    - Obstetrics; but Cheshire is unique – CNMs do all the OB work and they'll be training physicians
- Federal level – more grant opportunities for pipeline investments
    - Primary care and rural-focused training money coming out
- No name yet
- Once established, NH will have 3 residencies

3:20-3:55 **2020 NH Legislative Landscape: What's Happening?**

- Rep Polly Campion – 1078 bills, many retained in committee from last year that have been reworked
    - Most important to us is the Commission reauthorization bill
        - Extended life of Commission for next 4 years to 2024
        - Changed name to Commission on Interdisciplinary Primary Care Workforce
        - Modified duties
        - Bi-partisan
            - Hennessy is prime sponsor
        - Waiting for 1st hearing date
    - Telehealth bills
        - Introduced last year to expand services and create payment parity between remote and face-to-face services
            - Uphill battle from payers
        - Co-sponsoring – for SUD, specifically for MAT
            - Controversial
        - Clarifies prescribing certain drugs via telemedicine, different from MAT
    - Required coverage by providers
        - Medicaid to block grant funding – Marsh's bill
    - HB 233 – Changes to the ACA requires insurers to provide essential services
    - HB 166 – Committee to study obtaining insurance for those who are uninsured
    - SB 293 – Covering for Medicaid recipients who lost benefits reimbursing FQHCs
    - HB 739 - Parity and spenddown requirements for mental health services
- Commission on Commissions hearing – Alisa Druzba, DPHS
    - Biggest issue is how we're different from other commissions and taskforces that exist; justify our existence
        - Commission on Mental Health Workforce Development and how it differs
            - This commission covers the entire primary care workforce and quality
- Leslie Melby, NH Medicaid – refer to handout "Current Workforce Legislation."

3:55-4:00 **Happy Holidays**
Adjourn

Next meeting: Thursday January 23, 2:00-4:00pm

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The Changing Healthcare Landscape

Primary Care Workforce Commission
September 26, 2019
cont. December 19, 2019

By Lucy C. Hodder

Lucy.hodder@unh.edu

Professor of Law, UNH School of Law

Institute for Health Policy and Practice

A VISION FOR PATIENT-CENTERED PRIMARY CARE:

Taken From: Policies to Transform Primary Care: The Gateway to Better Health and Health Care; Center for Consumer Engagement in Health Innovation; Garrett, Hwang, Miller, Howitt, and Maass; December 2018

"A transformed health system that meets the health needs of all people must start with a re-envisioning of how we deliver and pay for primary care in the United States. Primary care serves as the gateway to the health system for many people and their source of consistent health system contact. If we can utilize primary care to catch chronic health issues or social needs early and address those needs in a coordinated and comprehensive way, it is possible to lower health care costs, improve health outcomes and patient satisfaction, and begin to tackle health disparities.

Patient Centered Primary Care Collaborative Recommendations

In August 2018, the Patient Centered Primary Care Collaborative (PCPCC) published its “Consensus Recommendations on Increasing Primary Care Investments”. One of the recommendations was that “primary care investment should be tracked and reported through a standardized measure.” They noted that “long-term, systemic change demands a system that ensures a standardized measurement at the health plan level across all payers to track and publicly report primary care investment. This data is essential to demonstrate that increases in investment lead to improved quality.”

What are the Sustainability Goals of the US Centers for Medicare and Medicaid? *Value and transparency*

- "Americans enjoy the benefits of the best healthcare providers and innovators in the world. Yet while the volume of care consumed by American patients has not increased dramatically compared to similar economies, the cost of care in the United States has accelerated at an alarming pace."
- "Healthcare costs are growing faster than the U.S. GDP, making it more difficult with each passing year for CMS to ensure healthcare for generations to come. The status quo is simply unsustainable."
- "The 15 percent of beneficiaries with 6 or more chronic conditions accounted for 51 percent of spending in 2015".
- "CMS's Central mission is to transform the health care delivery system to one that moves away from delivering volume of services to one that delivers value for patients – **one that provides high quality accessible care, at the lowest cost."**

Relative Value?

- PCPs salary increases (3.4%) v. SPS salary increases (4.4%) in 2017-2018 (Medscape)
- Biggest increases were in ER, cardiology and urology
- Top paid:
  - Orthopedics
  - Plastic surgery
  - Otolaryngology
  - Cardiology
  - Dermatology
- Primary care physicians generate almost as much revenue for hospital systems as specialists

"ER visits and hospital admissions should be considered failures of the healthcare system until proven otherwise."

Atul Gawande, Hotspotters, 2011

merger/affiliation activity

New Hampshire Hospitals

A View from the Economists:

- Overall prices are 12 percent higher for monopoly hospitals than for hospitals with four or more competitors. *The Price Aint Right? Hospital Prices and Health Spending on the Privately Insured., NBER, May 2018.* *https://www.nber.org/papers/w21815*
- When hospitals and health systems merge they often cite lower costs and operational efficiencies as the main reasons, and a report this year from the National Bureau of Economic Research indicates that only very modest savings take place. https://www.healthcarefinancenews.com/news/hospital-merger-and-acquisition-activity-slows-down-third-quarter-large-scale-transactions

"…**what we do know is that after a merger, even if there are cost advantages, those most certainly do not translate into lower prices**. For instance, one study found that, when hospitals in the same market merge, prices tend to increase by 7% to 10%. Another estimated that the average price of a hospital stay in the markets with the highest rates of consolidation increased by 11% to 54% in the years following M&A**. I am aware of no study that suggests that M&A leads to lower prices for consumers."**

1/9/19 David Willis, Advisory Board;https://www.advisory.com/research/health-care-advisory-board/blogs/at-the-helm/2019/01/hype-mergers;

https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html

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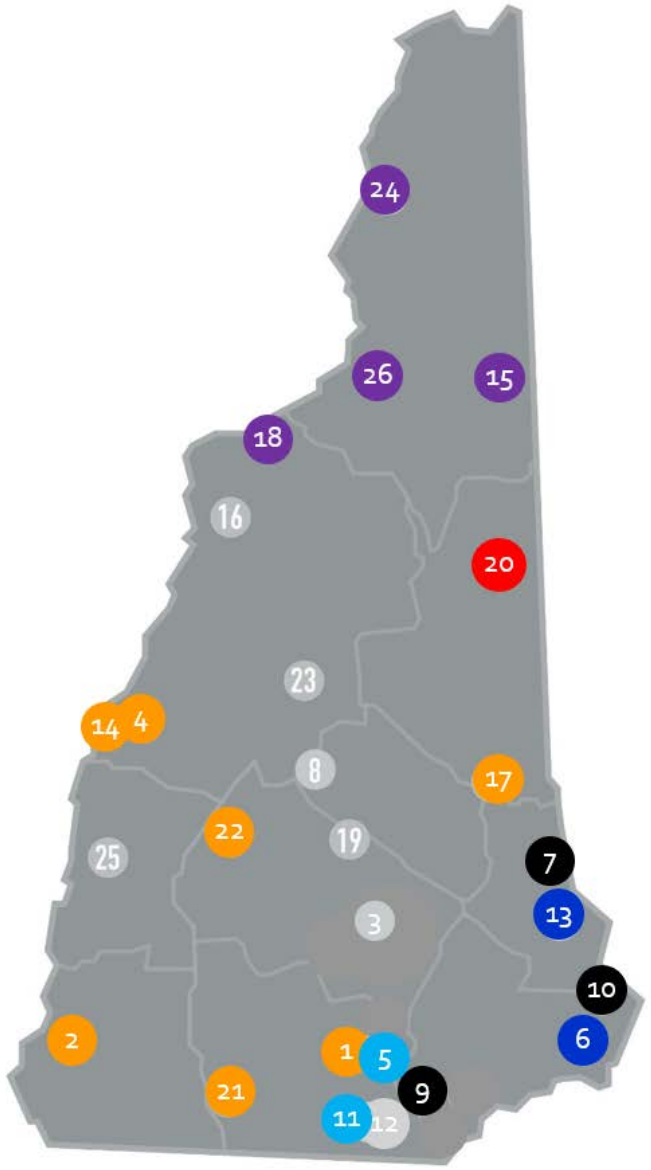
MAP OF PENDING AND COMPLETED HOSPITAL MERGERS AND AFFILIATIONS



Prospective Payment Systems Hospitals

3 Concord Hospital
8 LRGHealthcare, Lakes Region General Hospital
12 St. Joseph Hospital, *a member of Covenant Health*

Critical Access Hospitals

16 Cottage Hospital
19 Franklin Regional Hospital, LRGH Healthcare
23 Speare Memorial Hospital
25 Valley Regional Healthcare

North Country Healthcare: 2016

15 Androscoggin Valley Hospital
18 Littleton Regional Healthcare (pending withdrawal)
24 Upper Connecticut Valley Hospital
26 Weeks Medical Center

MaineHealth, ME

20 Memorial Hospital

HCA Healthcare, Inc, TN

7 Frisbie Memorial (**pending**)
9 Parkland Medical Center
10 Portsmouth Regional Hospital

Mass General Hospital (Partners), MA: 2016

13 Wentworth Douglass Hospital
6 Exeter Hospital (**pending**)

Clinical Affiliations with MGH

1 Catholic Medical Center
11 Southern NH Medical Center

SOLUTIONHEALTH: 2017

5 Elliot Hospital
11 Southern NH Medical Center

GraniteOne Health

1 Catholic Medical Ctr.
17 Huggins Hospital
21 Monadnock Comm Hosp. 2016

pending

Dartmouth Hitchcock

2 Cheshire Medical Ctr.
4 Dartmouth Hitchcock Medical Center
14 Alice Peck Day
22 New London Hosp.
Mt. Ascutney Hosp. (VT)

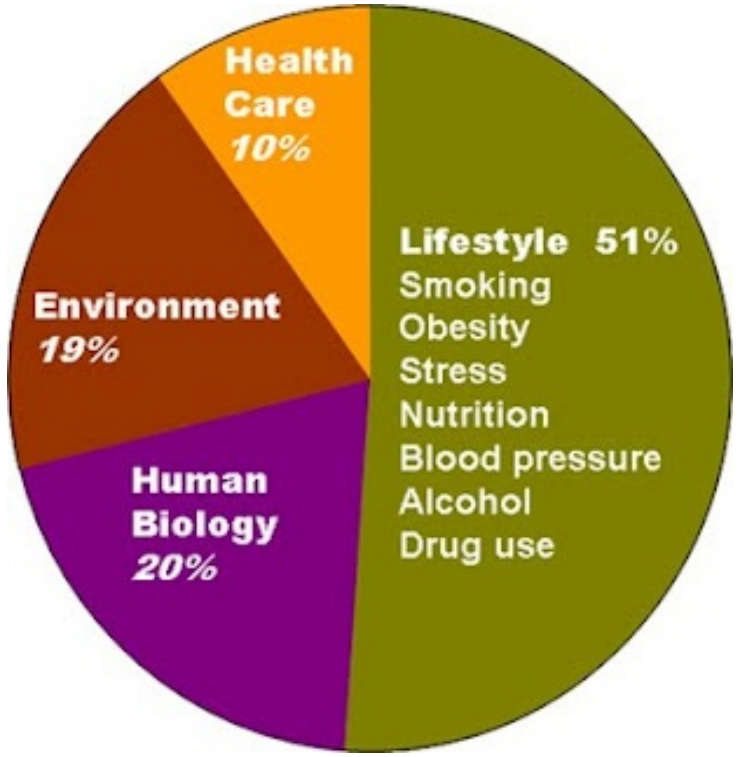
What Makes Mergers Work?

Deloitte surveyed hospital executives to identify integration practices that were more often associated with successful mergers and acquisitions. Specifically, they found that a merger was more likely to be viewed as successful when leaders:

- Developed a strong strategic vision for pursuing the transaction;
- Had explicit financial and non-financial goals;
- Held leadership accountable, often at the vice-president level, for integration efforts;
- Identified cultural differences between the organizations;
- Made clear and upfront decisions on executive and mid-management leadership;
- Aligned clinical and functional leadership early in the process;
- Followed best practices for integrating the acquired or merged organization into the parent organization; and
- Implemented project management best practices, with tracked targets and milestones, from day one of transaction close until two years after.

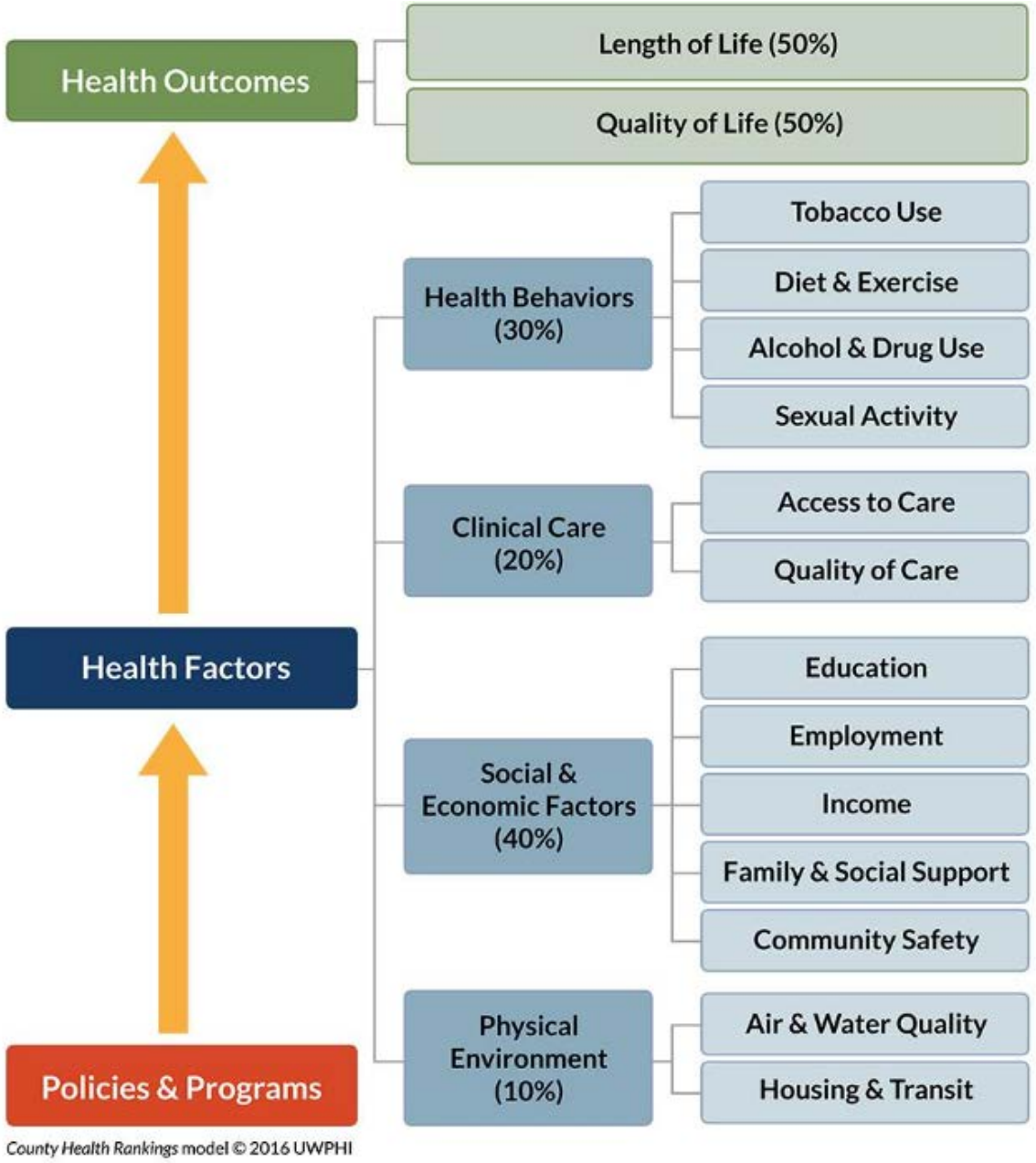
https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/hospital-mergers-and-acquisitions.html

Determinants of Health



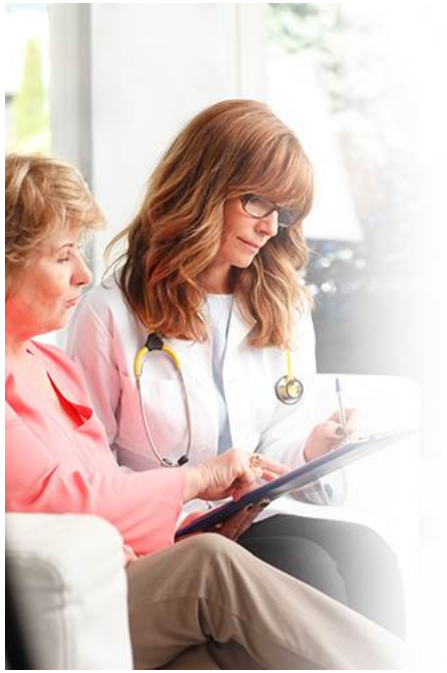
Adverse Childhood Experiences have a tremendous impact on future violence victimization and perpetration and lifelong health and opportunity.

Public Health: The Other 80%



What is Population Health? What Does it Have to Do with Payment?

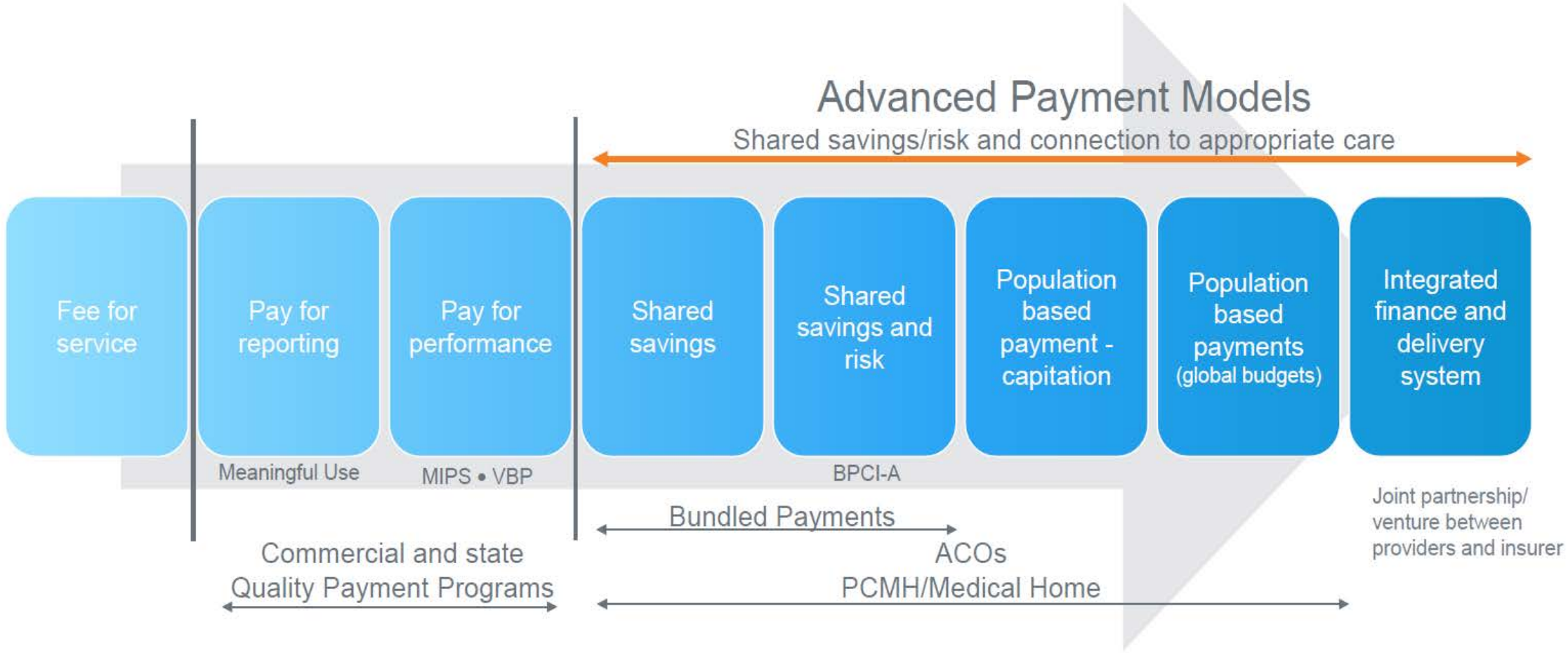
- Health care professionals partner with populations to improve the health of populations by promoting health, preventing disease, and addressing health inequities. Outcomes include:



- Advocacy to decrease health disparities
- Policy making to address health disparities
- Improving health outcomes of populations in need
- Implementing cost effective strategies to address health disparities
- Leadership strategies to impact safety, cost, and clinical outcomes
- Executing educational approaches to improve clinical decision making and evidence-based practice
- Developing practice guidelines

Alternative or Value Based Payment: Process by which the payments for services to address health needs are made in exchange for valuable care measured by the best achievable quality of the outcome and the patient experience for the price offered.

https://nhhealthcost.nh.gov/



Source: HCPLAN APM Framework

https://cernercorporation.gcs-web.com/static-files/4578dfdd-df4b-48b9-b97e-130cfc39ff62

Changes and Trends in APM Framework

Care management support strategies

Engagement with clinical and administrative providers

Using social workers and multidisciplinary teams to address SDOH and link community providers

Integrate benefit design guiding patients to lower cost higher quality providers

Tailoring analytic support to provider capabilities

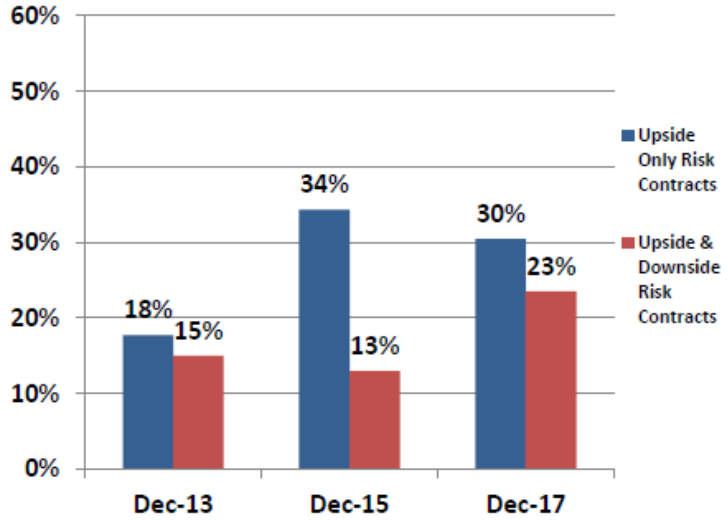
What's a Good Alternative Payment Model?

1. Does the APM pay for the high-value services needed to improve patient care?
2. Does the APM align the payment amount with the cost of delivering high-quality care?
3. Does the APM assure each patient they will receive appropriate, high-quality care?
4. Does the APM make the cost of diagnosing or treating a health condition more predictable and comparable?
5. Will a provider only be paid under the APM if a patient receives services?
6. Are payments under the APM higher for patients who need more services?
7. Is a provider's payment under the APM based on things the provider can control?
8. Will a provider know how much they will be paid under the APM before delivering services?

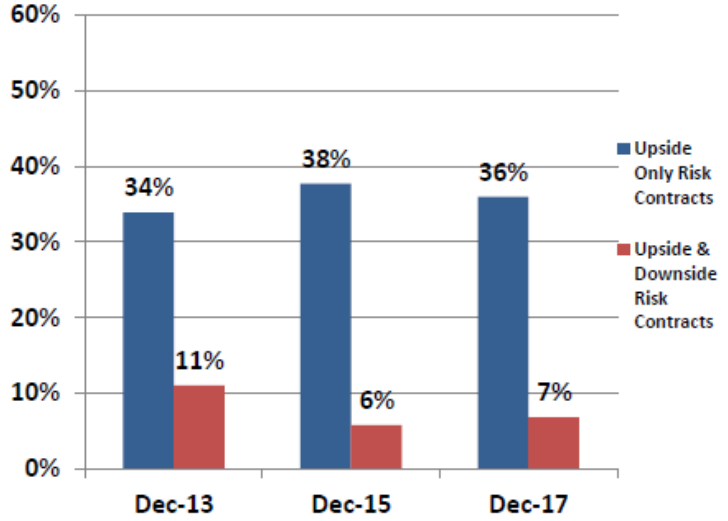
APPENDIX

Percentage of Fully-Insured and Self-Insured Members in Risk Contracts

Percentage of Fully-Insured Members in Risk Contracts



Percentage of Self-Insured Members in Risk Contracts



Source: NHID Annual Hearing data 2014-2018. Includes all markets.

Current NH Commercial Carrier Efforts

Anthem	Cigna	Harvard	Tufts
• Enhanced Personal Health Care (EPHC) program	• Cigna Collaborative Care • Cigna Accountable Care (CAC)	• Provider partnerships • Elevate Health tiered network products • Benevera Health population health products	• Provider partnerships • Freedom Plan tiered network products

CMS- Medicare and Innovation

What's New from CMS

- CMS Primary Care Initiative:
  - Direct Contracting Path
  - Primary Care First Path
- Changes to Bundled Payments
- Adjustments to ACO/MSSP: Pathways to Success
- Meaningful Measures Initiative
- Medicare Advantage changes

What's Happening in NH

- FQHC Advanced Primary Care Practice Transformation Model (medical home)
- BPCI Advanced in cardio and ortho (physicians and systems)
- Million Hearts
- Health Care Innovation Awards
- NNE Practice Transformation
- New reformed ACOs

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MACRA, MIPS Transition

MACRA engenders widespread payment reform for physicians, regardless of their specialty

MACRA basics impacting Medicare beneficiaries

- Replaces the Sustainable Growth Rate (SGR)
- Extends the Children's Health Insurance Program (CHIP)
- Transitions from fee-for-service to pay-for-value

Physicians **must** choose one of two paths:

1 Advanced Alternative Payment Models (APMs)

5% Lump Sum Payment

- Comprehensive End-Stage Renal Disease Care Model
- Large Dialysis Organization (LDO) arrangement
- Non-LDO two-sided risk arrangement
- Comprehensive Primary Care (CPC+) Model
- Medicare Shared Savings Program (MSSP) Track 2
- Medicare Shared Savings Program (MSSP) Track 3
- Next Generation Accountable Care Organization Model
- Oncology Care Model, two-sided risk arrangement only

2 Merit-based Incentive Payment System (MIPS)

Performance-based payment adjustment

Clinicians are evaluated based on their Composite Performance Score (CPS)

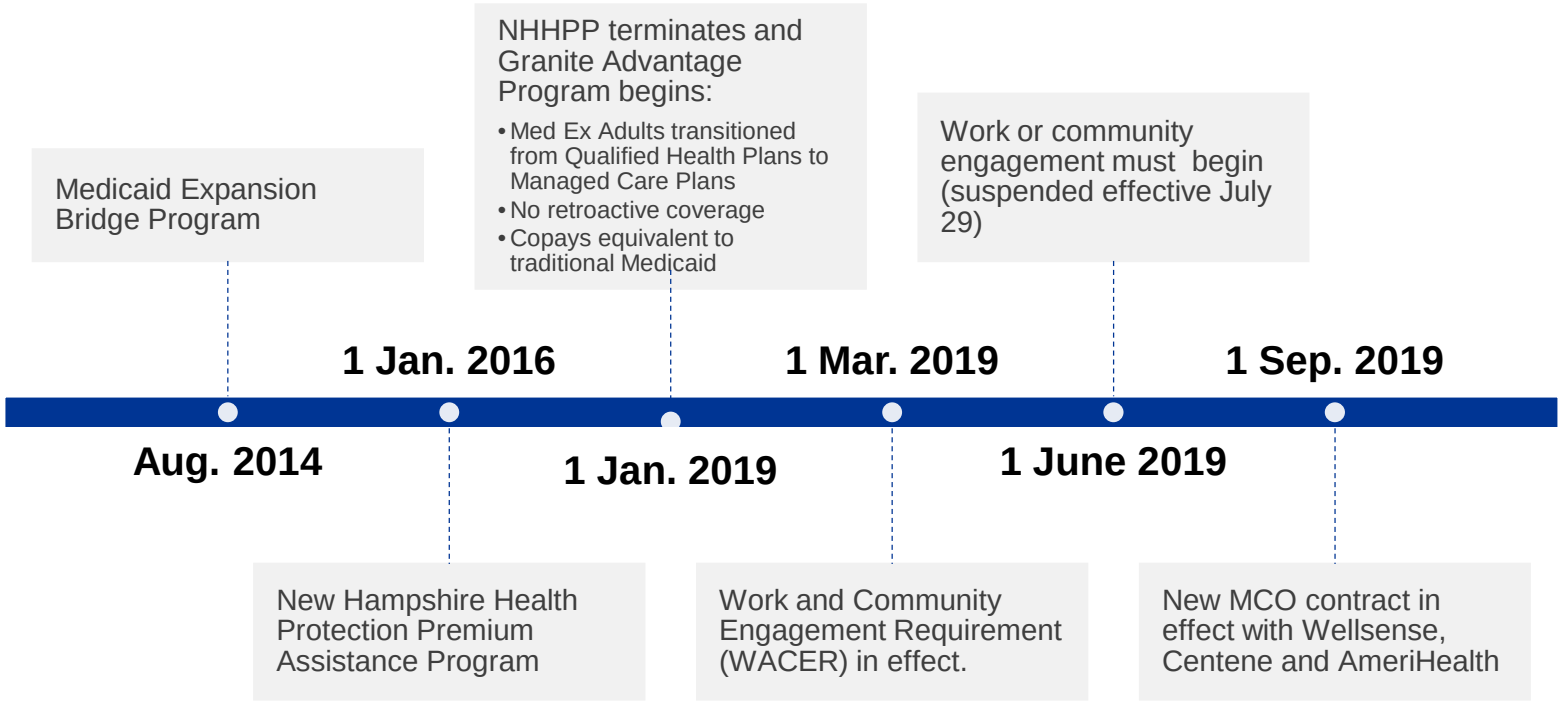
Quality	60%
Resource Use	0%
Advancing Care Information	15%
Clinical Practice Improvement Activities	25%

*CPS domain weights (%) are for the 2017 performance year

New Hampshire Medicaid expansion

Recent Developments

Changes For Medicaid Expansion



Changes to the Current Medicaid Care Management Program

Key Areas

- Care Coordination and Care Management
- Behavioral Health (Mental Health and Substance Use Disorder)
- Emergency Room Waiting Measures
- Support the Community Mental Health Centers and Substance Use Disorder Providers
- Pharmacy Counselling and Management
- Beneficiary Choice and Competition
- Withhold and Incentive Program and Sanctions
- Alternative Payment Models
- Cost Transparency
- Accountability for Results
- Public Reporting
- New Provider Supports
- Quality Management and Access
- Children with Special Health Care Needs
- Community Engagement -- Granite Advantage Members
- Heighten Program Compliance and Integrity Provisions
- Medical Loss Ratio

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Work and Community Engagement Requirement

- Federal judge found NH's WACER and elimination of retroactive coverage illegal.
- CMS did not have authority to grant NH's 1115 waiver
- Case is on appeal

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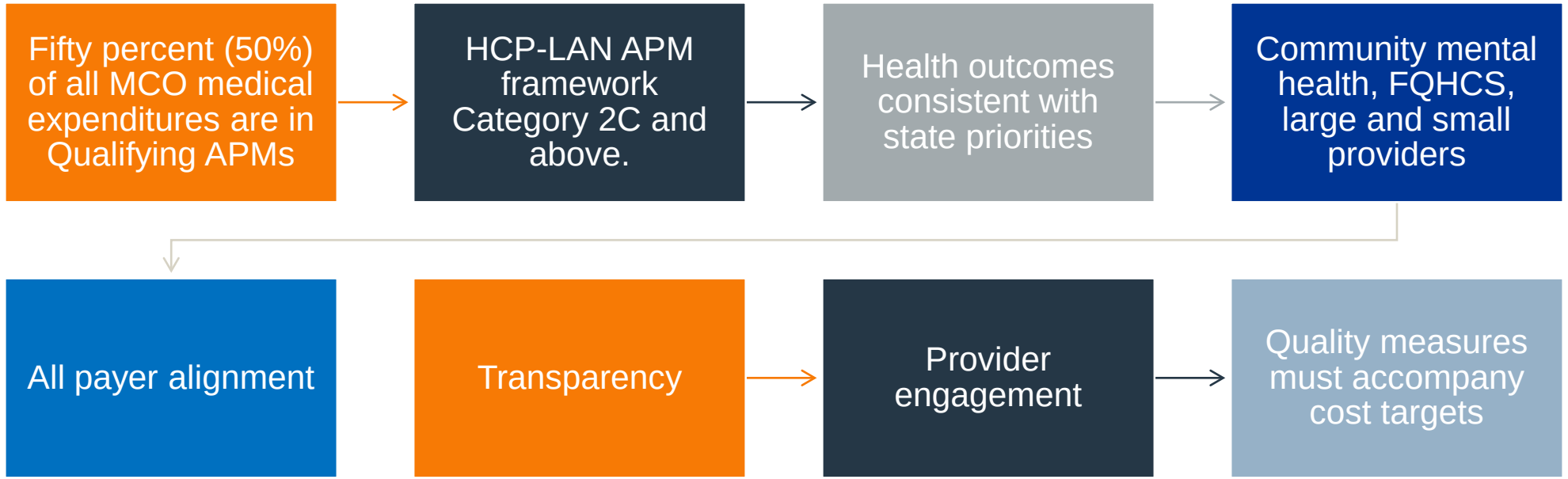
Medicaid APM Strategy: Managed Care Contracts – Sept. 2019



State Health Priorities

- 10 Year Mental Health Plan:
  - Recommendations for SFY20 & SFY21
    - Medicaid Rates for Mental Health Services
    - Action Steps to Address Emergency Department Waits
    - Renewed and Intensified Efforts to Address Suicide Prevention
    - Enhanced Regional Delivery of Mental Health Services
    - Community Services and Housing Supports
    - Step-up/Step-down Options
    - Integration of Peers and Natural Supports

DSRIP Transformation Waiver

- Integrated behavioral health
- Shared care plans
- Health risk assessments and care management

Doorways

- 2-1-1
- Access to evaluation and referral to treatment

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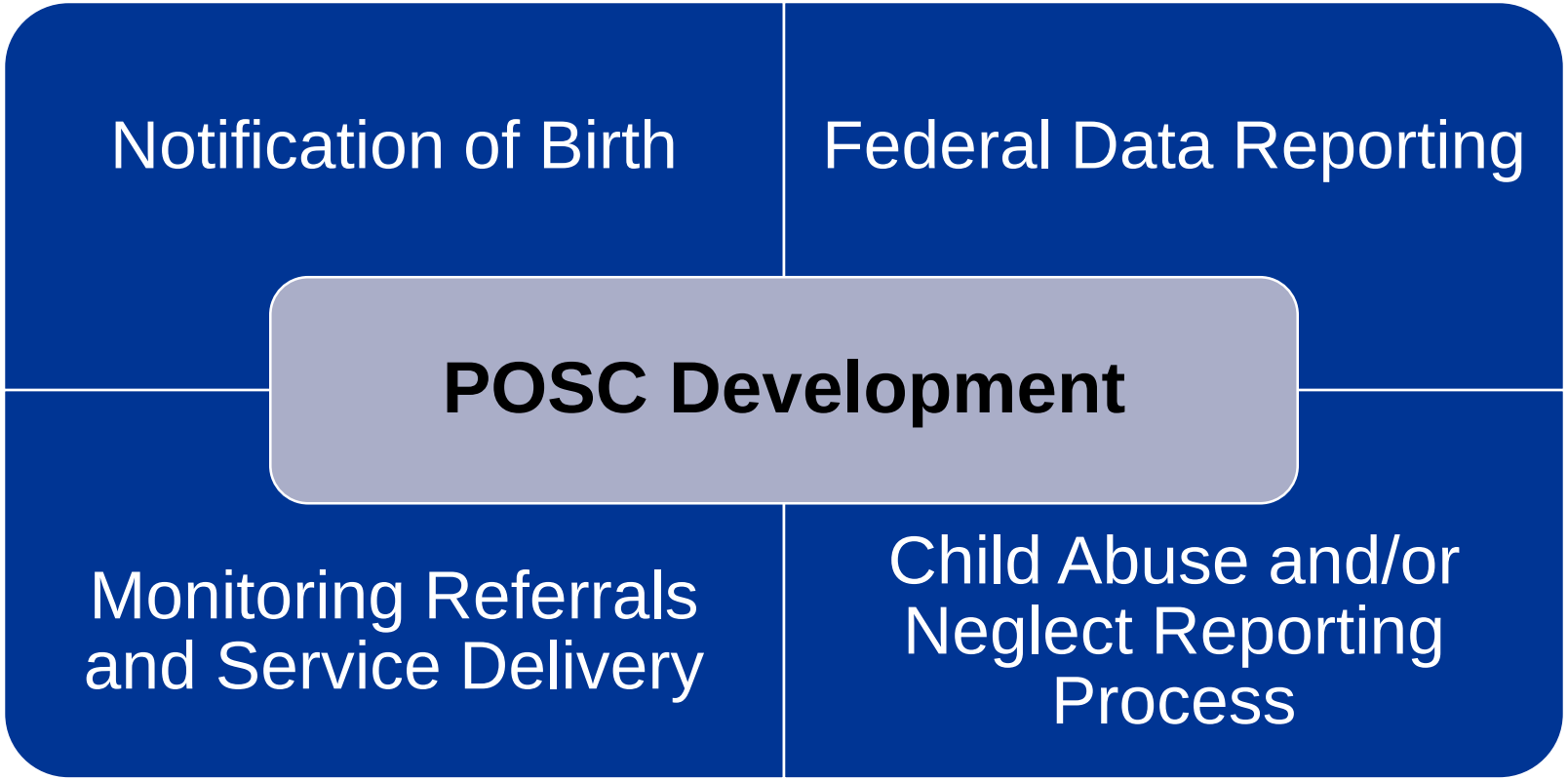
Plans of (Safe) Supportive care NH
State and Federal CAPTA/CARA Requirements



NH's Plan of Safe Care Process

SB 549: RSA 132:10-e and f

Infant Born…	Health Provider Shall..
"When an infant is born identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder…"	"… the health provider shall develop a Plan of Safe Care in cooperation with the infant's parents or guardians and NH DHHS, Division of Public Health Services, as appropriate."

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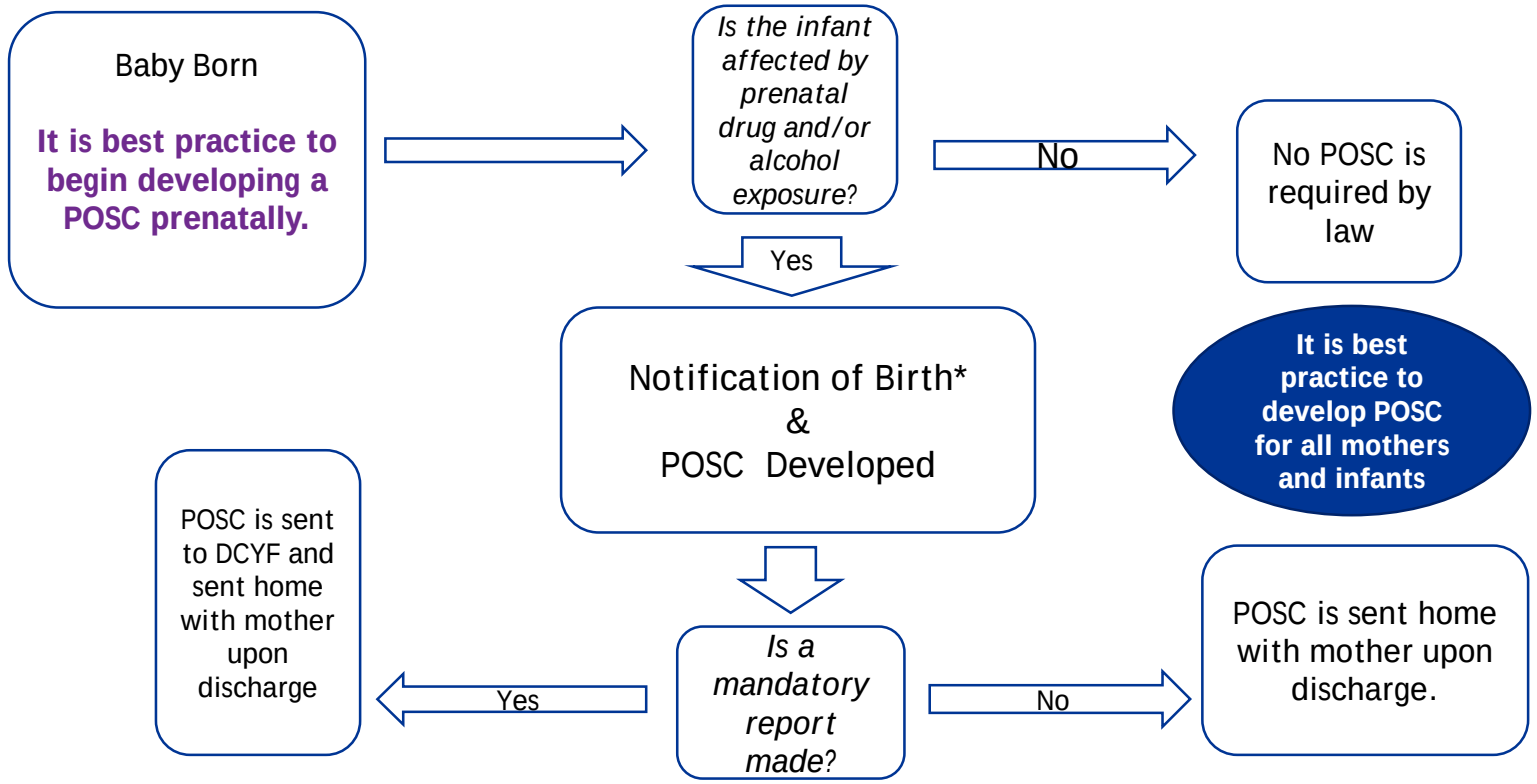
How is NH determining its POSC process?



*Notification is captured through two situational surveillance questions on the birth certificate.

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Guidance Q&As

- What is a Plan of Safe Care? What is its purpose?
- Who needs a POSC?
- Who develops the POSC? When is it developed?
- What is “Notification”? How is it different than a mandatory report?
- Are hospitals required to make a mandatory report for all infants exposed prenatally to drugs and/or alcohol?
- What happens to the POSC when a report of child abuse and/or neglect is made?
- What types of information about infants exposed prenatally to drugs and/or alcohol is shared and with whom?
- POSC-Where does it go?
- Does the POSC contain information protected by 42 CFR Part 2 (Part 2)?
- What types of services are included in the POSC?
- What if a mother declines to participate in developing a POSC?

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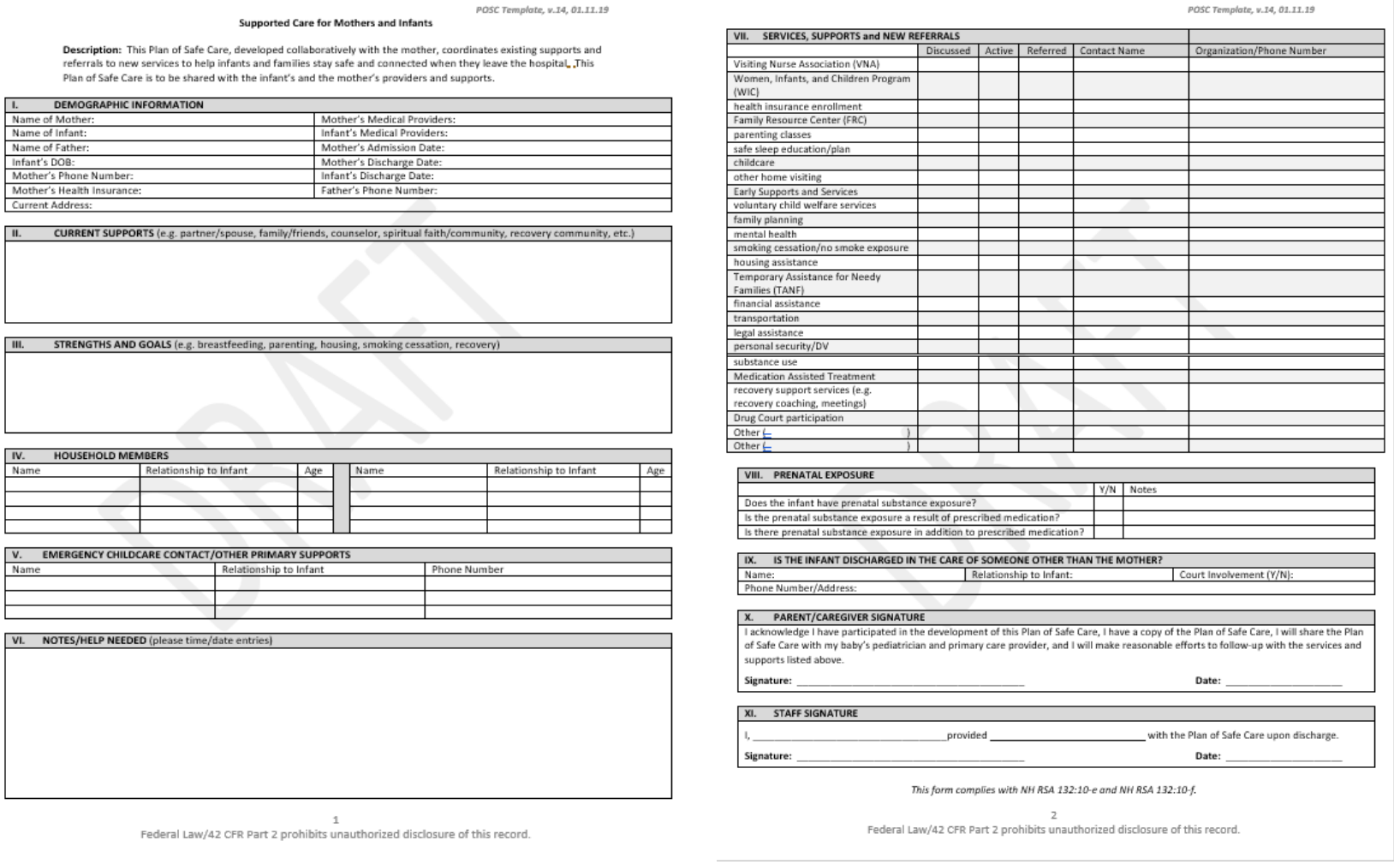
What is NH's Plan of Safe Care?



POSC Template, v.14, 01.11.19

Supported Care for Mothers and Infants

Description: This Plan of Safe Care, developed collaboratively with the mother, coordinates existing supports and referrals to new services to help infants and families stay safe and connected when they leave the hospital. This Plan of Safe Care is to be shared with the infant's and the mother's providers and supports.

I. DEMOGRAPHIC INFORMATION	
Name of Mother:	Mother's Medical Providers:
Name of Infant:	Infant's Medical Providers:
Name of Father:	Mother's Admission Date:
Infant's DOB:	Mother's Discharge Date:
Mother's Phone Number:	Infant's Discharge Date:
Mother's Health Insurance:	Father's Phone Number:
Current Address:	

II. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

III. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, recovery)

IV. HOUSEHOLD MEMBERS

Name	Relationship to Infant	Age		Name	Relationship to Infant	Age

V. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS

Name	Relationship to Infant	Phone Number

VI. NOTES/HELP NEEDED (please time/date entries)

1
Federal Law/42 CFR Part 2 prohibits unauthorized disclosure of this record.

POSC Template, v.14, 01.11.19

VII. SERVICES, SUPPORTS and NEW REFERRALS

	Discussed	Active	Referred	Contact Name	Organization/Phone Number
Visiting Nurse Association (VNA)					
Women, Infants, and Children Program (WIC)					
health insurance enrollment					
Family Resource Center (FRC)					
parenting classes					
safe sleep education/plan					
childcare					
other home visiting					
Early Supports and Services					
voluntary child welfare services					
family planning					
mental health					
smoking cessation/no smoke exposure					
housing assistance					
Temporary Assistance for Needy Families (TANF)					
financial assistance					
transportation					
legal assistance					
personal security/DV					
substance use					
Medication Assisted Treatment					
recovery support services (e.g. recovery coaching, meetings)					
Drug Court participation					
Other (_)					
Other (_)					

VIII. PRENATAL EXPOSURE

	Y/N	Notes
Does the infant have prenatal substance exposure?		
Is the prenatal substance exposure a result of prescribed medication?		
Is there prenatal substance exposure in addition to prescribed medication?		

IX. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE MOTHER?

Name:	Relationship to Infant:	Court Involvement (Y/N):
Phone Number/Address:		

X. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share the Plan of Safe Care with my baby's pediatrician and primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Signature: _____ **Date:** _____

XI. STAFF SIGNATURE

I, _____ provided _____ with the Plan of Safe Care upon discharge.

Signature: _____ **Date:** _____

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

2
Federal Law/42 CFR Part 2 prohibits unauthorized disclosure of this record.

NH Doorways

- 9 Doorways
  - AVH
  - Littleton Hospital
  - LRGH
  - Wentworth Douglass
  - Concord/Riverbend
  - Cheshire Medical Center
  - DHMC, Lebanon
  - Granite Pathways, Manchester
  - Granite Pathways, Nashua
- Soft opening on January 1
- Funded by SORS grant – OUD patients

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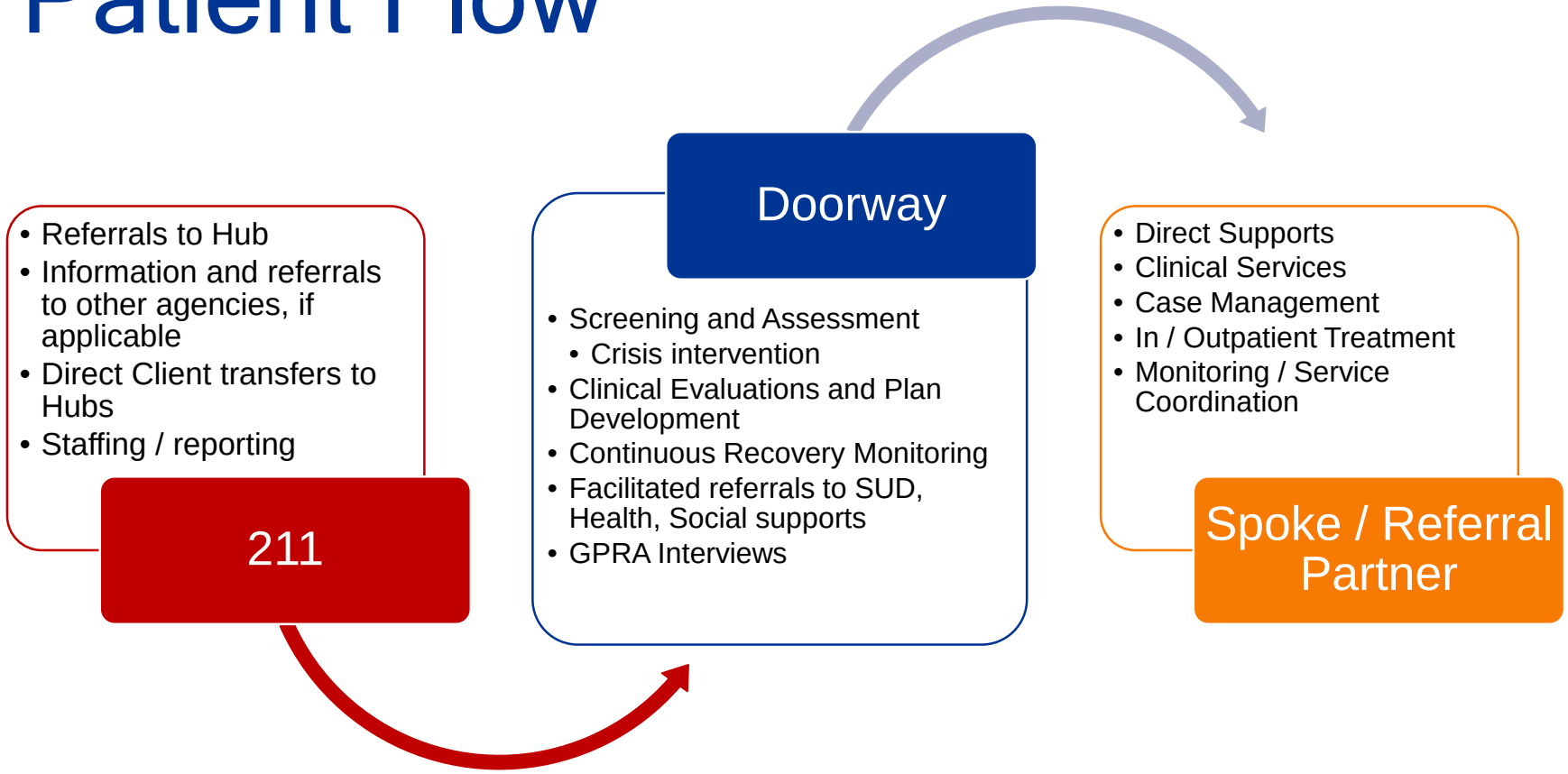
Patient Flow



Massachusetts Legislation

- In Massachusetts, Governor Charlie Baker put forward an emergency bill, **An Act to Improve Health Care by Investing in VALUE** (House No. 4134), to improve the delivery of health care and reduce costs. In his bill, one of the key issues addressed is Massachusetts primary care shortage.
- Governor Baker targeted the primary care challenge by requiring providers and insurers **increase their spending on behavioral health and primary care by 30 percent by 2023** while staying within the state's health care cost growth benchmark .

Massachusetts Legislation cont.

- The Massachusetts Health Policy Commission will monitor health care entities to ensure that they increase their primary care spending. If any health care entity fails to meet the benchmark, the entity will have to file a **performance improvement plan** with the commission.
- The performance improvement plan shall identify the causes of the entity's spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to improve spending performance.
- **BUT WAIT, there's more!** The commission can levy a civil penalty on a health care entity that fails to implement or file an improvement plan with the commission.

NHID Annual Report on 2018 Costs

- On December 17, 2019, the New Hampshire Insurance Department released the final version of its annual report on health insurance and cost drivers. The report looks at 2018 data from insurance companies operating in the state.
- The full report is available on the Insurance Department's website, along with an abbreviated fact sheet for quick reference.

NHID Annual Report on 2018 Costs Key Takeaways

- Some key findings
  - The number of employer-sponsored insurance plans increased in New Hampshire and growth was most notable in the self-insured market
  - Average individual market premiums in New Hampshire matched the national average; both had large increases in 2018
  - Similar to 2017, the New Hampshire small group market premiums in 2018 were close to the average across the United States with only modest increases.
  - The New Hampshire large group market had higher average premiums than the New England and national average.
  - The average deductible increased in all segments from 2017 to 2018
  - The 2018 claim trends were higher than 2017 trends, primarily driven by the shift to higher cost specialty drugs and high-tech radiology and surgery.

Texas v. US

- What happens next?

December 19, 2019

FROM: DSRIP Workforce Taskforce Policy Subcommittee
TO: Legislative Commission on Primary Care Workforce Issues

Current Legislation Relative to Workforce and Integrated Care

HB 739, Requiring parity in the spend-down requirement for mental health and medical expenses
Important to fiscal stability of systems of care, which would potentially support better wages, etc. 2019 legislation

HB 1106, Relative to non-compete agreements for certain mental health professionals
Essentially noting non-compete clauses are not enforceable – although this has been the subject of numerous recent court cases, it is worth watching as we lose public sector healthcare workforce professionals to more lucrative private practices.

***HB 1440, Relative to membership on the board of psychologists and the board of licensing for drug and alcohol and other drug use professionals, and relative to insurance credentialing of out-of-state applicants for licensure as alcohol and drug counselors**
This bill adds 2 members to the board of psychologists and the board of licensing for alcohol and other drug use professionals. There is more language to the bill and worth monitoring as we understand the importance of boards and application processes to our workforce.

HB 1520, Establishing the NH Health Policy Commission
This bill establishes a NH Health Policy Commission to monitor health care delivery and spending.

HB 1521, Adding a peer support specialist to the board of mental health practice
Peer support is an important part of the workforce and plays a key role in bridging the gaps with vacancy rates as high as they currently are in the system.

HB 1576, Establishing a targeted workforce development program
This bill establishes the targeted workforce development program and workforce development fund to provide student debt relief to individuals employed by certain industries in the State. The program and the fund will be administered by the Business Finance Authority (BFA).
The bill changes the purpose of the NH Excellence in Higher Education Endowment Trust Fund from providing scholarships to students, to supporting the targeted workforce development program and workforce development fund.
Question: is health care sector included?

***HB 1623, Relative to telemedicine and substance use disorder**
Clarifies prescribing opioid drugs via telemedicine. Amends Medicaid coverage of telehealth coverage by removing the prerequisite to establish care via face-to-face contact, provided the health provider holds a special registration pursuant to 21 USC section 8.31(h), or is exempt from such registration.

HB 1639, Relative to "In and Out Medical Assistance"

Requires DHHS to amend the income standards used for eligibility for the Medicaid in and out policy. Medicaid has not adjusted the income in nearly a decade, and numerous recipients are forced to have deductibles they cannot afford to pay when accessing services .

LSR 2827, Relative to establishing a Peer Support Program in DHHS

LSR 2958, Relative to the Commission on Interdisciplinary Primary Care Workforce

LSR 2975, Establishing an oversight committee on the office of professional licensure and certification

LSR 3043, Relative to Telemedicine Coverage and Reimbursement

We are also monitoring some legislation that passed last session as it relates to integrated care and workforce, such as SB 86 that looks to integrate and improve mental health and developmental service integration for dually diagnosed patients.