Medical Care Advisory Committee (MCAC)
December 13, 2021
Minutes

Members: Lisa Adams, Gina Balkus, Kathy Bates, Jake Berry, Krystal Chase, Sai Cherala, Lisa DiMartino, Tamme Dustin, Paula Minnehan, Sarah Morrison, MacKenzie Nicholson, Kara Nickulas, Ronnieann Rakoski, Bill Rider, Karen Rosenberg, Jonathan Routhier, Kristine Stoddard, Carolyn Virtue, Michelle Winchester
Excused: Ellen Keith
Alternates: Dawn McKinney, Holly Stevens, Nichole VonDette, Elinor Wozniakowski
DHHS: Henry Lipman, Alyssa Cohen, Brooke Belanger, John Williams, Rob Berry, Dr. Sarah Finne, Dawn Landry, Leslie Melby, Deb Sorli, Janine Corbett, Leslie Bartlett, Jody Farwell, Joshua Roe, Jordan McCormick, Allyson Zinno, Lise Ferrand, Shirley Iacopino, Laura Ringelberg
Guests: Lucy Hodder, Deb Fournier, Nick Toumpas, Susan Paschell, Rich Sigel, Deb Ritcey, Bill Keena, Rachel Chumbley, Lisa Adams, Sarah Aiken Koutroubas, Janan Archibald, Karen Blake, Kelley Capuchino, Jasmine Harris, Jesse Fennelly, Nicole St. Hillaire, Tammy Whalen, Nicole Burke

Announcements
Carolyn Virtue read the following into the record:

> Last evening I received a call from Veronica, an 80-year old woman who had received a letter from DHHS stating she would be losing all services effective February 2022. This was terrorizing to her because she has lost every person close to her and she is literally all alone in this world. She believed what the letter said, no food, no medical care, etc. I surmise this is a financial issue. At present CFI Case Managers do not have an ability to exchange information with the department to resolve concerns such as this. To be clear, the Case Manager cannot call to find out what documentation is needed to resolve this situation. No demand was made in the letter as she read it to me last evening. There is no clear path for the Case Manager to contact the department, the case manager paid by department to advocate on her behalf. Although I have the privilege to one off this to the Medicaid Director for resolution, I remain concerned for similarly impacted individuals without that option.
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> Last week, through Executive Order, a plan was developed to clear hospital beds by discharge to nursing homes and residential care. I have no objection to the steps taken to fortify the institutional arm of long term care. I am very concerned that community based care options were not similarly fortified, thereby creating preference to institutional care while putting community based care out of reach to those needing care. If not addressed forthwith, this action has the potential to undermine years of effort and resources the department committed to rebalancing the Long Term Services and Supports system. The data is there to support the fact, transfer to home from the acute and subacute settings makes is far more likely the individual will return home successfully at all. These actions of the executive order do not temporarily upset the balance of the continuum of care, the damage is permanent in many cases. Our citizens have a statutory right to explore a community based care alternative to nursing home care and we need to start taking actions to ensure the choice is there.

Carolyn Virtue asked that action be taken to ensure access to community based care. Paula Minnehan responded that hospital social workers work extremely hard to ensure patients' discharge to the appropriate setting, whether it be to a nursing facility or home and community based care. Hospital patients deemed appropriate for HCBS are not discharged to nursing facilities. The executive order does not alter this, that

patients be placed at a higher level of care than they need. Rather, the purpose of the executive order is to relieve the pressure for hospital beds due to the COVID surge.

Carolyn Virtue recognized the work of hospital social workers, and noted she wants to make sure that future efforts focus on ensuring that community based care options are meaningfully offered and preserved and that patients are made aware of the choices available to them. If the institutional option is guaranteed to be reimbursed, and the community alternative is not, there is no real choice for the hospital social worker to offer.

Dawn McKinney asked if the Department had data about patients transferred to nursing homes following the Governor's executive order. While acknowledging the heroic work at hospitals, she questioned whether there is any role for home and community based care services to play in dealing with the COVID surge. She suggested that with presumptive eligibility, HCBS providers could also support patients.

Review/Approval: Nov 8, 2021 Minutes
M/S/A

Agenda Items for January 10, 2022

- Medicaid patients hospitalized with COVID – numbers
- COVID legislation update
- Communication from MCOs to members re: COVID vaccines and booster
- Presumptive eligibility history

Send additional agenda items to Carolyn Virtue, Henry Lipman and Leslie Melby.

Legislative Preview – 2022, John Williams, Esq, Director of Legislative Affairs
Legislative highlights presented:
LSR 22-2271*, relative to including certain children and pregnant people in Medicaid and the children's health insurance program*. Bill not yet published
HB 1536 ***relative to expanding Medicaid to include certain postpartum health care services.*** Increases Medicaid postpartum coverage from 60 days to 12 months. DHHS to consult with CMS re: FMAP availability.
LSR 22-3089, ***relative to expanding Medicaid to include certain postpartum health care services and making an appropriation therefor****.* Companion to HB 1536.
LSR 22-2857, ***establishing an adult dental benefit under the state Medicaid program*****.** Amendment to HB 103 (below) proposed.
HB 103 ***establishing a dental benefit under the state Medicaid program.*** House retained.
HB 1405 ***allowing out-of-state mental health care providers to provide telehealth treatment during a public health emergency.*** Amends licensing statutes.
LSR 22-2934, ***relative to Medicaid reimbursement rates for hospital birthing services****.* Bi-partisan support.
HB1526 ***relative to income eligibility for in and out medical assistance.*** To help people who must spend down income to regain eligibility. 2020 legislation raised the income limit, but suspended funding in FY 21/22 budget. HB 1526 removes suspension of $5.37 million.
HB 602 ***relative to reimbursements for telemedicine.*** House retained 2021. Recommended for interim study.
HB 503 ***codifying the council on housing stability and relative to telehealth and medically assisted treatment for substance use disorder*****.** Adds a provision for MAT for SUD.

The Healthy603Coalition is tracking over 30 COVID bills, some of which are problematic. MCAC will be updated monthly on these bills.

Public Health Emergency Unwind Metrics, Lucy Hodder, Deb Fournier, UNH Health Law & Policy
83,941 beneficiaries are in protected status as of Nov 30, of which:
- 28,615 are pending ineligible. But for PHE, they would have been ineligible.
- 55,326 overdue redeterminations (not started or not complete).

***Pink letter Campaign**:* prepares for the end of PHE:
21,049 pink letters issued. 3,322 beneficiaries (15.8%) have completed redeterminations. Redeterminations are increasing since the pink letter campaign began.

***DHHS Call Campaign*:** DHHS is using data analytics to increase outreach to high health care utilizers. Staff are calling vulnerable individuals to remind them about their redeterminations and assist them in real time on the phone. The first targeted populations being called are long term care, elderly, and disabled. Of 1,400 individuals called within a two-day period, 1,283 people were reached. The next group to be called are children (parents or guardians).

Update Your Address Campaign: Launched by text, e-mail and social media on Nov 23 to encourage updates of addresses.

Other Unwind Outreach Strategies include stakeholder meetings and beneficiary lists for providers. Providers may contact Alyssa Cohen to obtain a list. DHHS will meet with a large stakeholder group late Jan/early Feb followed by stakeholder meetings with various organizations, and meetings with Navigators.

Public Forum: 1915(b) Waiver Renewal, Mandatory Enrollment in Medicaid Care Management, Dawn Landry, Medicaid Policy Administrator
The current 1915(b) waiver will expire March 31, 2021. With this third waiver renewal, DHHS seeks to continue its authority to mandate enrollment for two years and align monitoring activities. The waiver renewal application will be submitted to CMS by December 31, 2021 and posted on the Department's website. Public comments can be submitted to: 1915bwaiver@dhhs.nh.gov.

Governor's Executive Order (EO) on Surge: Hospital Discharges to Long Term Care Facilities, Henry Lipman, Medicaid Director
To deal with the COVID surge, Fiscal and G&C approved funding outlined in a recent EO with the goal of freeing up acute care hospital beds. The state is working to accelerate the discharge of individuals who meet the criteria for nursing facility and not CFI, whose financial determination for Medicaid is in process. The EO does not forego the choice for CFI; people have the option as well to CFI. The 1135 waiver will be used to allow hospitals to use alternative spaces for inpatient care.

Concern was expressed that individuals in hospitals are not offered the choice for home placement, and that the EO assures facility payments, but can the same assurance be made for HCBS options? Henry stated that while not all individuals can be supported in the community and therefore require nursing facility level of care, this concern will be shared with DHHS senior management for what could be made available in the CFI realm similarly. Regarding payment, the EO ensures payment is covered for alternate beds as a temporary fix. A presumptive eligibility pilot was proposed in the HCBS spending plan; CMS suggested during technical assistance that an "emergency plan for community based services" to prevent institutionalization might be a better and faster approach to pilot.

According to Paula Minnehan, hospital case managers' job is to work with patients and their families to identify the setting the patient wishes to discharge to and the supports needed to support that. If

appropriate for HCBS, individuals will be discharged to the community. Hospitals have been working for months to address discharge issues with the focus on the right care at the right place.

MCAC Subcommittee He-E 801 Rule, Michelle Winchester

A list of issues on the final He-E 801 rule was sent to MCAC members, Henry Lipman, Wendi Aultman to inform them of the subcommittee's work. Issues of concern that still remain in the final proposal:

1. There remains a lack of service coverage standards. Case managers assess, draft a care plan, and submit to DHHS for authorization. DHHS requires that the plan meets the needs of the individual. This standard is much too broad. The subcommittee recommends individual coverage standards.
2. CFI waiver cannot cover State Plan services. DHHS has not described the distinction between waiver and state plan services. Need to describe distinctions.
3. He-E 801.10(b) provides a formula for a "cost of care" contribution for residential care participants, which, in practice, is actually used instead as a calculation for a "room and board" contribution. This is problematic in two ways. One, federal law requires the calculation of a "cost of care" contribution. Two, Medicaid may not pay for room and board costs in residential care facilities.
   The actual process and the correct characterization of the "room and board" calculation should be included in this rule, as should the actual formula for calculating the participant's funds that are available for the federally required "cost of care" contribution.

A motion was made to support the work of the He-E 801 Subcommittee and support and formalize MCAC objections in a letter to JLCAR for Thursday's meeting. M/S/A

Department Updates

New Medicaid Staff: Dawn Landry introduced new members of the Medicaid of the Policy Unit.
Janine Corbett, Medicaid State Plan Administrator is responsible for service and reimbursement rules.
Jody Farwell, Administrator, Eligibility & Enrollment, is responsible for Medicaid eligibility rules.
Josh Roe, Program Specialist, is responsible for updating rules.
Brooke Belanger introduced Jordan McCormack, Provider Relations Manager. Jordan manages the Medicaid Provider Relations Unit.

Medicaid Enrollment Update, Alyssa Cohen, Deputy Medicaid Director

As of December 6, 2021 – 232,995 individuals were on Medicaid (+31.3% over pre-pandemic figures), of which,

- 83,739 on Granite Advantage (+62%)
- 149,256 on Standard Medicaid (+18%)

MCO Contract Amendment #7, Henry Lipman, Medicaid Director

Governor & Council approved Amendment #7 authorizing amendments to contracts with AmeriHealth Caritas NH, Boston Medical Center Health Plan, and Granite State Health to provide health care services to Medicaid enrollees through the Medicaid managed care program.
Highlights include:

- HCBS spending plan which includes a new directed payment initiative estimated at $28 million of potential enhanced federal funding for specified home and community based services. Requires Fiscal Committee, G&C, and CMS approval of the methodology.
- Genetic testing reimbursement for hospitals in accordance with HB 600.
- Funding for the removal of certain limits on the home visiting benefit for pregnant women and infants ages 0-1.
- Rate correction for neuro-psychiatric testing
- New durable medical equipment (DME) and supplies (breast milk storage bags, peristeen pumps)

- Behavioral health crisis treatment program services transferring to the State's redesigned Mobile Crisis Response Program and moved from the Managed Care Contract on an interim basis until utilization is better known.
- Preferred drug list (PDL) updates to include different formulations of drugs already included on the PDL.
- Funding for an additional 6 beds for Community residential services.

HCBS Spending Plan Update, Henry Lipman, Medicaid Director
The Directed Payment for the HCBS spending plan within managed care authority has been developed, and DHHS responses to questions on the Appendix K authority were submitted to CMS Friday. The FMAP associated with the Plan will go to Fiscal Committee and G&C for approval to accept and expend; the proposal is for enhanced FMAP of $73 million. Years 2 and 3 may qualify for another $23 million each year. Focus in the first round is direct care workforce. This item will be a standing agenda item.

Waivers Update, Alyssa Cohen, Deputy Medicaid Director
- Supportive Housing 1915(i): DHHS submitted responses to the CMS Request for Additional Information (RAI). CMS has 90 days to respond.
- SMI amendment: The Department is working on responses to CMS questions about our SMI amendment to the SUD waiver.
- 1915(j) waiver for personal care: Under the current 1135 disaster waiver, family members are currently allowed to be paid for the personal care they provide their loved ones. DHHS would like to extend this flexibility after the PHE.

Disability Determinations
As of Nov 26:
- 252 adults (187 with Medicaid coverage); 32 adults >90 days (24 with Medicaid)
- 27 children (11 with Medicaid coverage); 2 children >90 days (2 with Medicaid)

Question to take back: Are there written materials provided to people who withdraw their APTD applications?

Dental Benefit update, Sarah Finne, DDS, Medicaid Dental Director
The Legislature will vote on HB 103 in January. Final amendment will include a removable denture benefit for disabled adults and adults residing in nursing homes.

Rule: He-M 524, In-Home Supports, Melissa Nemeth and Sandy Hunt, Bureau of Developmental Services
- The rule has been restructured. Details were added, and a separate section for each service category offered through the in-home support waiver was added. The rule includes definitions and requirements for coverage for services.
- Some services can be provided remotely and in acute hospital settings.
- Eligibility and waiver requirements are now in one place.
- Clarified that if individual is in a foster care setting, in-home supports can be provided as long it doesn't duplicate other services.
- Based on a recent change in the law, providers may check the DCYF registry to determine if a potential provider is on the registry for founded abuse or neglect.

The Participant Directed and Managed Services (PDMS) Subcommittee is working on a manual for participant directed and managed services. The goal is to develop a standardized manual for families and agencies to ensure a consistent approach statewide.

The rule filing was expedited to prevent expiration, thus providing additional time to work on the rule. Comments are due Jan 12, 2022. There is a six-month deadline to complete. Amy Girouard will chair the He-M 524 Subcommittee. Members who wish to participate should contact Amy.

Rules
The following rules are on consent:
He-W 841.03 MEAD; He-W 856.04 Personal Property Resources; He-W 830.01 Living w Specified Relative; He-W 806.55 Deemed Income

Motion to adjourn. M/S/A