

Medical Care Advisory Committee (MCAC)

May 9, 2022
Minutes

Members Lisa Adams, Kathy Bates, Jake Berry, Kelley Capuchino, Lisa DiMartino, Tamme Dustin, Ellen McCahon, Paula Minnehan, Sarah Morrison, Kara Nickulas, Ronnieann Rakoski, Karen Rosenberg, Carolyn Virtue, Brendan Williams, Michelle Winchester

Alternates: Deodonne Bhattarai, Amy Girouard, Dawn McKinney, Kristin Schmidt, Susan Stearns, Nichole Von Dette, Elinor Wozniakowski

DHHS: Henry Lipman, Alyssa Cohen, Brooke Belanger, Rob Berry, Dr. Sarah Finne, Jordan McDonald, Dawn Landry, Janine Corbett, Shirley Iacopino, Laura Ringelberg, Leslie Melby, Melissa Hardy, Katja Fox, Susan Drown, Abby Rogers, Jody Farwell, Joshua Roe, Leslie Bartlett

Guests: Lucy Hodder, Deb Fournier, Lisabritt Solsky Stevens, Susan Paschell, Emily Johnson, Rich Sigel, Kim Mohan, Dr. Robert Hockmuth, Audrey Gerkin, Jesse Fennelly, Heidi Kroll, Krystal Chase, Lisa Pettengill, Vicki Jessup, Bill Keena, Janan Archibald, Trina Loughery, Rachel Chumbley, Sarah Momson

ANNOUNCEMENTS

- Members interested in Chair or Vice Chair positions are asked to contact Henry Lipman, Carolyn Virtue, or Leslie Melby.
- Carolyn Virtue announced the resignation of Michelle Winchester. She stated it's with sincere gratitude to recognize Michelle's work for the MCAC. Michelle resigned in April effective immediately. She will leave a huge hole in the area of policy expertise. She will be missed.

Brooke Belanger announced that as of June 13, 2022, MCAC meetings will be held in a webinar format. This change will ensure transparency with the public and bring a new voting mechanism. Using this format, MCAC members and speakers will be designated as Panelists and thus be seen on screen. Members of the public, designated as Attendees, will not be visible on screen. If they wish to speak, they may raise their hand and be recognized.

MINUTES: APRIL 11, 2022

Motion: Carolyn Virtue moved the minutes be amended to reflect that Heidi Kroll of Gallagher, Callahan & Gartrell inquired about the status of payment allocations to independent case management providers for the remainder of the year. The Department's response is included in the minutes. M/S/A.

Motion: Minutes approved as amended. M/S/A

AGENDA – JUNE 13, 2022

- Legislative Update

MEMBERSHIP SUBCOMMITTEE

Carolyn Virtue, Chair

Motion:

1. Accept the resignations of Leslie Aronson, Nancy Rollins, Michelle Winchester, and Sarah Morrison.
2. Affirm the appointment of Joan Fitzgerald of the NH Dental Hygienists Association as Member.
3. Affirm the appointment of Lisabritt Solsky Stevens of Easter Seals as Member.
4. Affirm the appointment of Dawn McKinney of NH Legal Assistance as Member to replace Michelle Winchester.

Members have 30 days to consider the motion. Vote to take place June 13, 2022.

Motion: The following motion was made April 11, 2022.

With the approval of the Medicaid Director, the Membership Subcommittee recommends reappointment of the following individuals for an additional 3-year term ending June 30, 2025: Lisa Adams, Michael Auerbach, Kathleen Bates, Lisa DiMartino, Tamme Dustin, Ellen Keith, Paula Minnehan, Ronnie Rakoski, Marie-Elizabeth Ramas, Karen Rosenberg. M/S/A

Motion: Appoint the following individuals as Alternates for a vote on June 13:

Emily Johnson of Granite Case Management as Alternate for Carolyn Virtue

Susan Silsby of Easter Seals as Alternate for Lisabritt Solsky Stevens

Cheryl Steinberg of NH Legal Assistance as Alternate for Dawn McKinney

Myra Nikitas of the NH Dental Hygienists Association as Alternate for Joan Fitzgerald.

Debra Cutler of Conifer Health Solutions/Dartmouth-Hitchcock as Alternate for Elinor Wosniakowski

The process to appoint Alternates will be changed upon passage of the MCAC bylaws (emailed May 5, 2022).

MEDICAID TO SCHOOLS (MTS) RULE

Brooke Belanger, Director of Medicaid Enterprise Development

NH Medicaid is seeking feedback on the MTS rule, He-W 589. The John Snow Institute (JSI) is hosting the second of two listening sessions on May 13 in order to obtain feedback from schools and stakeholders on the [Medicaid to Schools Rule \(MTS\)](#). This session is open to all. JSI, funded by the NH Charitable Fund, is the Department's policy resource for technical support to schools.

MEDICAID QUALITY PROGRAM – PART 2, ACCESS TO CARE

Patrick McGowan, Administrator, Medicaid Quality Program

The MCM quality strategy is being presented to the MCAC in three portions: quality levers (4/11/22), access to care (5/9/22), and quality of care (6/13/22). A request for comments on NH's quality strategy was sent to MCAC on May 2nd. Monitoring access to care is comprised of grievances and appeals, service utilization, network adequacy, call center provider requests, member experience survey, and provider phone surveys. NH Medicaid's Quality Strategy is due to CMS June 30, 2022.

Grievances and appeals are monitored as to the number and trend of activities and how quickly the MCOs process those activities. When the number exceeds the normal range, an investigation is undertaken. Grievances and appeals are fairly low.

Service utilization changes may indicate a MCO policy change or that a provider is no longer accepting patients. Control limits provide a consistent indication of a potential access problem. A decrease in visits/1000 members can show items outside the norm. One member from the audience asked if it would be more appropriate to use control limits that were two standard deviations instead of 3. Patrick will follow-up with this question in the final quality strategy.

Network adequacy time and distance standards are analyzed at the county level for each provider type. For example, how many members have 2 primary care providers within 40 minutes or 15 miles. For provider types that don't meet these standards, the MCO must request an exception to time and distance.

When an MCO meets network adequacy standards, the provider access phone surveys (formerly Secret Shopper) will demonstrate whether a provider is not accepting new patients. Phone surveys will also compare New Hampshire Medicaid rates with New Hampshire commercial rates of accepting new patients.

DHHS monitors the trends of MCO call centers receiving requests for providers. Changes in the frequency of requests can indicate a potential barrier to members accessing care. Control limits provide an indication of a potential access problem. If numbers spike, there may be a problem with the network. Note: Member requests for specialist care are expected to run higher than primary care providers.

Consumer Assessment of Health Care, Providers, and Systems (CAHPS) survey questions include members' experience with MCO and providers. There are separate surveys for adults and children, the results of which are audited. Each MCO is required to receive 300 completed questionnaires per survey. If access to care results are below the national 50th percentile of Medicaid MCOs, they are highlighted in the strategy to increase over the next 3 years.

Provider access phone surveys are conducted by the External Quality Review Organization for selected provider types. NH providers are contacted to determine that they're accepting Medicaid; accepting Medicaid and accepting new patients; and projected wait times for new appointments. Information is used to identify salient issues relevant to the population, and provide contextual information for the larger assessment process. Patterns are not statistically representative of the whole population. Asked if it's possible to determine when adult specialist providers deny care to complex care patients transitioning from pediatric specialists, Patrick noted there is no national standard definition of pediatric specialist which makes this type of analysis challenging.

MEDICAID CONTINUOUS ENROLLMENT:

Lucy Hodder and Deb Fournier, UNH Health Law & Policy; Alyssa Cohen, Deputy Medicaid Director

Due to the continuous enrollment requirement during the PHE, enrollment has increased as follows since 2019: Standard Medicaid increased by 17%; Granite Advantage - 69%; Total Medicaid - 32% increase to nearly 239,000. Of the 87,801 in protected status, 60,221 have overdue determinations. 27,580 are pending ineligible with no other category to move them into. The majority in protected status are in Granite Advantage; followed by Medicaid and CHIP children; low income parents and pregnant women; elderly/disabled*; MSP; and long term care (LTC)*.

*Those categorized as LTC are in a facility or a waiver; elderly/disabled are duals, or age 64+/no longer in Granite Advantage.

Medicaid coverage campaign: DHHS has sent 60,711 pink letters to remind beneficiaries to complete administrative actions. The phone campaign is in its second phase contacting those called previously and indicated they would complete their paperwork, but still have not completed their rede. BFA staff are reaching out to this population to try to help the individuals in real time with their redeterminations. 10,800 cases have been contacted through the update address campaign. 38% of elderly, disabled, and LTC clients contacted by phone have secured benefits for another 12 months. Nearly 50% of 9,000 households with children at risk have been contacted.

Well Sense Health Plan and the NH Food Bank will host a redetermination event on May 18th at Broken Ground Elementary School. Other strategies to increase rede rates include ongoing stakeholder involvement; and alignment of the Supplemental Nutritional Assistance Program (SNAP) and Medicaid renewals. In addition, DHHS Customer Service call wait times have been reduced. A report to CMS on the unwind plan is due 45 days prior to the end of the PHE.

All are encouraged to contact DHHS staff with questions or if dealing with a complex case. Questioned about backlogs, the Department explained there is no backlog for new and renewal applications and that time required to process applications does not constitute a backlog.

For individuals age 65+ who remained on Medicaid due to PHE, CMS is proposing a special enrollment period beginning January 1, 2023 for those who should have applied and did not due to the PHE. (Outside of the PHE,

individuals who do not enroll in Medicare within a certain time frame are penalized and charged a premium for each month they did not enroll). However, depending on when the PHE ends, individuals may still have to pay the premiums for a few months before they can enroll in Medicare in January 2023. Henry Lipman met with Senator Hassan's staff to underscore the difficulty some beneficiaries will have to pay premiums.

COVID-19 LEGISLATION

Paula Minnehan, Sr. VP, Gov't Relations, NHHA; Abby Rogers, Legislative Liaison, Division of Public Health

HB 1606, relative to administration of the state immunization registry: changes NH's vaccine registry from opt-out to opt-in by providing the opportunity to opt-in/opt-out of the registry for each vaccination. Passed Senate. Awaiting action by the House to concur/non-concur. The bill is problematic for Public Health to operationalize.

HB 1604, including state medical facilities in the statute providing medical freedom in immunizations: requires state hospitals and medical facilities to grant religious and medical exemptions from vaccination requirements, provided that any request for a medical and religious exemptions includes the supporting documentation required by federal regulation.

HB 1022, permitting pharmacists to dispense the drug Ivermectin by means of a standing order and establishing a commission to study the use of Ivermectin to treat Covid-19.: establishes a standing order for Ivermectin and creates a study commission. Efforts are underway to encourage the governor to veto the bill.

HB 1210, relative to exemptions from vaccine mandates: requires employers and postsecondary schools that receive public funds and mandate a vaccination to accept requests for exemption. Will likely go to interim study.

HB 1379, relative to the department of health and human services' rulemaking authority regarding immunization requirements. Removes the HHS Commissioner's authority to add vaccination requirements for school and childcare entry. The bill went to interim study.

LEGISLATIVE UPDATE

Rob Berry, Esq, Medicaid Counsel

SB 408, directing DHHS to make adjustments to the facility fee reimbursement schedule for freestanding birthing centers: adjusts rates paid to freestanding birthing centers to ensure the rate is comparable to that for hospitals. It passed the House and Senate and on its way to the Governor to sign.

SB 422/HB 103, establishing an adult dental benefit under the state Medicaid program: one of the two bills will go to the governor to sign.

SB 407, expanding Medicaid to include certain postpartum health care services and making an appropriation therefor: The House amended SB 407 and sent it back to the Senate.

HB 1526, relative to income eligibility for in and out medical assistance. The bill implements the revised income eligibility standard.

SB 333: relative to licensure of case management services providers: defines and regulates case management services providers.

SB 430, relative to health and human services: includes exemption for members only hospitals; hospitals that take direct pay only being exempt

Further updates on legislation will be provided in June and July.

IHS RULE:

JLCAR had a preliminary objection to the IHS rule. DHHS has until the end of May to respond to comments/testimony.

RULES: CONSENT

He-W 882.01, Termination of Medical Assistance
No discussion.

DEPARTMENT UPDATES:**DISABILITY DETERMINATIONS**

The DDU report will be emailed following today's meeting.

MCO CONTRACT**Henry Lipman, Medicaid Director**

The MCO contract amendment #8 is being worked on for Governor & Council to approve in June. The Department is working with CMS for technical assistance to work out the complexities as to how rates are affected by the end of PHE or an extension of PHE. There are no major contractual changes except for the risk profile. Current negotiations limit what can be shared at this time.

HCBS SPENDING PLAN**Brooke Belanger, Director of Medicaid Enterprise Development**

DHHS received final approval on the directed payment methodology for providers to bill for the workforce reinvestment payment, including career laddering, stipends, and education payments. Emails and letters have been sent to eligible providers informing them to submit a spending plan and an attestation that 80% of payments will go toward workforce. Members are asked to encourage providers who haven't responded to reach out to the Department. There is a dedicated email address for this purpose. Outreach will continue to providers not claiming funds. If not claimed, funds will return to the pool and subsequently paid out.

The final stage of technical assistance with CMS on the disaster state plan amendment (SPA) is under way. Payments for case management will be made at the same time as Appendix K payments. There was a question as to why HCBS case management was moved to the disaster SPA when it had been included in the HCBS spending plan submitted to CMS last July. DHHS responded that this was discussed at the Fiscal Committee and included in quarterly updates to CMS, noting that funds must be distributed in accordance with CMS requirements and approvals.

SUBSTANCE USE DISORDER/SERIOUS MENTAL ILLNESS (SUD/SMI) AND SUPPORTIVE HOUSING WAIVERS**Alyssa Cohen, Deputy Medicaid Director**

- SUD/SMI: CMS sent draft Standard Terms, and Conditions (STCs). STCs are issued to approve and monitor the waiver. CMS final approval is expected end of May. DHHS is gearing up to submit a renewal request of the full SUD waiver which will expire in June 2023 if not renewed.
- 1915(j): Updated documentation will be submitted.
- 1915(i) Supportive Housing: resubmitted to CMS on April 20th which starts the next 90-day review period.
- 1915(b) State plan managed care amendment: to be submitted next week.
- CMS provided technical assistance last week on the 1915(j) Self-Directed Personal Assistant Services waiver.

DENTAL BENEFIT LEGISLATION**Sarah Finne, DMD, Medicaid Dental Director**

Two identical dental bills, SB 422 and HB 103, have passed, one of which will go to the Governor for signature. The adult dental benefit will begin 4/1/23.

BYLAWS SUBCOMMITTEE**Carolyn Virtue, Chair**

Henry Lipman, Carolyn Virtue, Paula Minnehan and Leslie Melby worked on the bylaws and provided 30 days for members to review and comment. A vote on the proposed bylaws is scheduled for the June 13 meeting.

Meeting adjourned.