Medical Care Advisory Committee (MCAC)

July 17th, 2023

Minutes

Members: Elinor Wozniakowski, Rhonda Siegel, Joan Fitzgerald, Lisa Adams, Carolyn Virtue, Tamme Dustin, Kelley Capuchino, Kara Nickulas, Lisabritt Solsky Stevens, Ellen Keith, Ellen McCahon, Jake Berry, Lisa DiMartino, Paula Minnehan
Alternates: Emily Johnson, Karen Blake, Brooke Belanger, Deodonee Bhattarai, Jim Zibailo
Excused: None
DHHS: Henry Lipman, Reuben Hampton, Laura Ringelberg, Shirley Iacopino, Vernon Clough, Jody Farwell, Sara Lacharite, Margaret Clifford, Lise Farrand, Carolyn Richards, Jordon McCormick, Catrina Rantala, Krysten Finefrock, Sarah Finne, Susan Drown, Wendi Aultman, Katja Fox, Jonathan Ballard, Olivia May, Melissa Nemeth, Jessica Gorton
Guests: Ellen MacNeil, Joey Rolfe, Julie Lovingood, Lorien Wilson, Allison Deptula, Alyson Hughes Christian, Amy Hamberger, Ashley Wall, Bill Keena, Charlene Vickers, Diana Lacey, Dorothy Moller, Eryn Glassey, Garret Zayic, Geoff Keegan, Jesika Pandya, Kurt Strohmeyer, Laura McIntyre, Marcia Bagley, Marissa Berg, Matthew Baker, Natalie Norberg, Nicole Dows, Patrick Quann, Rob Hockmuth, Sarah Doherty, Suzanne Thexton, Tamara Durot, Trina Loughery, Shaun Thomas, Cheryl Frey, Erica Skianes, Brendan Wangler, Krystal Chase, Deborah Fournier, Clyde White, Jamie Burnett, Conor Sairese Laing, Brook Holton, Kathy Bates, Lindsey Magee, Nick Toumpas, Nicole St Hilaire, Richard Sigel, Amy Pidhurney, Josh Krintzman, Heidi Kroll Gallagher, Janan Archibald, K. Jenkins, Mike, Vanessa, Nicole, NH Care Collaborative, The Dupont Group

Announcements
Carolyn Virtue noted that she had asked prior to this meeting whether the MCAC meeting could be recorded. Henry Lipman responded that he was unable to re-engage with the Chief Legal Officer of DHHS in advance of the meeting with the time available. He agreed to follow up. There were no other announcements.

Review/Approval: June 19, 2023
MCAC voted to approve the minutes for June with the correction of two misspelled names. Carolyn Virtue opposed the motion to approve the minutes. Deodenne, the alternate for Disability Rights Center, had a question about minutes from last meeting regarding whether Zolgensma is covered. Henry confirmed Zolgensma is covered.

Agenda Items – August
- There were no requested agenda items.

He-M 504 Provider and Provider Agency Operations Melissa Nemeth, Bureau of Developmental Services

(Brief discussion of related rules 503, 505, 819)

- Previously, the He-M 504 draft proposal was brought to MCAC. On June 28th, an emergency rule was filed. DHHS is now working through the rulemaking process. This is a new rule for providers in the Developmental Disabilities Services system. Previously, all of these providers would be contracted with area agencies but to come into compliance with a corrective action plan there are several new requirements.
    - One new requirement is that providers must be able to directly enroll in Medicaid and bill Medicaid. This was part of the impetus for this rule. The rule lays out the roles and responsibilities for providers and provider agencies. There are distinctions in expectations for agencies and individual providers. These distinctions include what they must do to provide services, complete

background check requirements, and there is a section on the process for becoming enrolled as a Medicaid provider. There is also a section on the payment for services, and on pass-through billing that is permissible under Centers for Medicare and Medicaid Services requirements.
    - The rule allows for a contract for only some services—not all services in the Bureau for Developmental Services system would be billable through this organized health care delivery system. There are sections on third party billing and the monitoring and determination of cost-effectiveness which includes cost reporting and other information to be provided.
    - There are sections in this rule addressing utilization review, fraud control and protection, and provider agency staff requirements regarding training and qualifications that must be maintained. There is also a section on how the provider would be able to suspend or revoke enrollment. There is also a section on the discontinuation of services.
- The Department clarified that the regular rulemaking process for He-M 504 will follow the MCAC bylaws, including presentation of the rule and inclusion in a Subcommittee if the MCAC chooses prior to the regular rule submission to the Joint Legislative Committee on Administrative Rules.
- Notwithstanding the emergency rule concerns expressed by several members of the MCAC, the Department clarified the time-sensitivity of ensuring services were not disrupted. The Department further acknowledged that while the need for this rulemaking was known, there was a need for extensive stakeholder engagement processes to arrive at a consensus on approach with directly affected parties.
    - The concerns that were raised included a question from Carolyn Virtue concerning why the rule could not be presented to MCAC in further advance, a question from LisaBritt Solsky on the necessity for emergency rulemaking, and a concern from LisaBritt surrounding the revenue impacts of providers transitioning to a new system.
- Carolyn Virtue raised a concern on whether the Department provided a copy of the rule when it became publicly available. While the Medicaid Director was unaware of communications during the MCAC meeting, following the meeting it was clarified that the emergency rules were posted online on the Office of Legislative Services Administrative Rules website and emailed to a broad distribution consisting of hundreds of recipients including providers and area agencies.
    - The website is available at https://gencourt.state.nh.us/rules/emergency_rules/default.aspx
- Melissa noted that the deadline for written comments will be created when the rule is filed. The attendee representing Life Coping also asked if she is correct that the 504 rule addresses billing but not the conflict-free requirements.
    - Melissa said 504 references the accordance with 503 which is where the conflict-free requirements are located. Melissa noted that the information for being a willing and qualified provider is referenced.
    - LisaBritt asked if 504 references a rule that does not exist.
        - Melissa noted that the current 503 rule includes the words “conflict-free” but is not as robust as the proposed 503 rule. A participant asked about the statutory authority from RSA 171. Melissa noted RSA 171 A-18 includes a reference to the federal statute that the corrective action plan is based on.
- Carolyn noted there is a subcommittee on 505. This subcommittee had a meeting on He-M 505 a few weeks ago. Melissa noted He-M 504 was not referenced in that meeting, but rather He-M 503. There was a question asked about service coordinator definition in He-M 505, Department expressed that He-M 503 is in fact the rule that discusses service coordinator so had offered to add it into 505. There was a question about He-M 503 and whether it should be added to the subcommittee and the Department will do that. The June 15 Subcommittee meeting did not discuss He-M 504. Carolyn followed up with an email to the

Medicaid Director and will send it out to the MCAC. Carolyn made a motion to expand the rule subcommittee to include He-M 504, 503 and 505. Kelley Capuchino will join the subcommittee as well as Marissa Berg.

- Marissa asked if we could get a schedule of upcoming rule changes. Olivia May and Jess Gorton confirmed that is in the works and will be provided. Jess raised that when In Home Supports Waiver meeting was convened, she asked if we could engage family members or recipients in the Subcommittee. Henry asked if the engaged stakeholder group wanted to sit in on the Subcommittee if that would be permissible. Carolyn confirmed.

Medicaid Care Management 3.0 Reprocurement Henry Lipman, Medicaid Director;

Jonathan Ballard, MD, Chief Medical Officer

Henry Lipman and Dr. Ballard presented on Medicaid Care Management (MCM) 3.0.

- There is an aim not just within Medicaid but across DHHS to promote optimal health and access. Having a more meaningful and holistic role for providers is a key goal.
- As an aside, this slide deck will be made available to attendees after the meeting.
- Dr. Ballard noted that this is the first time we are seeking public feedback, bringing to MCAC first. A central component is centering the relationship with the patient and their providers. This is a new component to the program.
    - Key Objectives
        - Focusing Managed Care Organization-delivered care management on a more targeted subset of the population.
        - Using medications is another focus and New Hampshire will continue to ensure access to new therapies. We will improve management of more routine medications while bringing the breakthroughs to access.
        - Community Mental Health Center (CMHC): there are aspects of the current capitation arrangement that can be built upon which we will detail later in the presentation.
        - A primary complaint in the program is the reliability, access, safety and quality of non-emergency medical transportation (NEMT).
        - We seek to capture the full potential of program integrity functions.
- Key Model Changes
    - Focusing on preventive services and ensuring the care coordination and care management components are brought to the closest level to care delivery. We made that attempt in the current procurement through local care management and did not get as far as was hoped. This will include introducing payment for certain services at a primary care level.
    - Pharmacy: high cost pharmacy risk pool to manage high cost therapies. If you consider the pipeline of new therapies, a carve-out may not be sustainable. There will need to be new utilization criteria developed. Thirdly, some states are experimenting with a single pharmacy benefits manager (PBM) for the managed care program. We are not proposing to do that from the outset of the program, we want to understand other state experiences, but potentially multiple years in.
    - Care management will target four populations representing less than 3% of total beneficiaries.
    - CMHC: there is a lot of complexity in the current model. We are looking to move into a single contractual structure that will be on the platform of a per member per month payment under a directed payment with incentive payments on top of that, designed to provide an integration of services beyond what they are today. This will engage more alignment with the objectives to reduce ED boarding.

- NEMT is problem prone throughout the country and we seek a better level of performance.
- Program integrity objectives are to strengthen accomplishments particularly around third party liability and coordination of benefits, evaluation of claims patents that are inappropriate.

- Primary Care and Preventive Services Model
  - There will be additional covered service codes around preventive care due to the recently passed budget. The model begins with the primary care provider (PCP) and member engagement in the middle. Wellness visits are a key tool. This reflects the goals of integrated whole person care. The Health Risk Assessment (HRA) is a standardized form for all MCOs and we intend to engage the public in improving that document. The HRA can identify medical issues as well as health related social needs. We want to ensure providers can participate more in this. The current procurement made some progress on HRA usage but to enhance it we feel we must bring it closest to patient contact.
  - We also seek to engage primary care in the comprehensive medication reviews and medication therapy management. Preventive screenings also encompass the service component—coordination and follow through. Closed Loop Referral is also related to this. Medicare has also recently announced a model—selecting states that have large populations with disjointed care in the Making Care Primary model.
  - Pharmacy Model
    - Encourage more provider level review, more activities will need to be reimbursable.
    - We also extend pharmacy efficiency analyses—currently included in every amendment, this is an exercise with the actuary to examine pharmacy prescribing practices and opportunities to improve the efficiency. This may include alignment with the diagnosis, amount dispensed. This is not usually a very large opportunity, but it is important to stay on top of it.
    - Seek to engage patients more through member incentives to participate in medication reviews.
    - The new high-cost pharmacy risk pool presents a new strategy to manage a growing cost within the program and share risk with the MCOs.
    - There is an option for a single PBM model—this decision will rely on emerging experience in other states with this recent model. This builds on the intents of the uniform PDL.
  - Care Management
    - Episodic care management will continue and we will more closely target priority populations with the MCO care management approach.
  - Dr. Ballard reviewed the care management services grids outlining the MCO and PCP responsibilities.
    - Stakeholders are engaged on primary care provider willingness and capacity
    - Emphasized role of the MCO on supporting financing and analytics to enable this.
  - CMHC – maintains much of current system
    - Eliminate MOE provisions
    - Eliminate individual negotiations on PMPM funding
    - Address abrasions in current system
    - Supporting CMHC staffing
    - Simplify administrative work
  - Non-Emergency Medical Transportation
    - Increase oversight of transportation brokers and subcontractors.
    - Repeated issues in reliability, quality issues, safety issues, and access issues.
    - We will continue to use a broker model.
  - Several new program integrity initiatives serve to improve oversight.

- Other changes
    - Standardize alternative payment model requirements.
    - In-Lieu-of-Services for Health Related Social Needs—there are opportunities for the program to further participate in that space.
    - There are 46 states that have Dual Special Needs Plans, or D-SNPs.
        - Part of why NH does not have them is a function of the current arrangement of county funding for long terms services and supports and while that law is not likely to change, a recent federal report suggests states may one day be required to have these. There is a benefit to having these plans—such as more options for beneficiaries.
    - Performance based auto-assignment will continue to be leveraged for connecting members to high performing MCOs.
    - House Bill 2 provisions—postpartum coverage, doulas, and lactation support and donor breast milk.
- Next steps: A draft RFP and model contract will be put out to public. This slide deck is an overview of what is contained.
- Ellen Keith thanked presenters for attention on oversight of transportation vendors. If there is a study committee, bringing in the owners of some of these companies for the process would be beneficial.
- Kelley Capuchino thanked Dr. Ballard and Henry. She noted annual CPT updates cause a barrier for coordination and integration reimbursement issues.

End of Continuous Coverage – Henry Lipman, Medicaid Director

The protected population was almost 104,000 at the end of continuous coverage. Thus far, we've been working through the monthly unwind. About 28,000 more of the protected group remain to be redetermined. Our strategy is to focus on those who are more likely to close first and coming up in Aug/Sep are the biggest groups of long term care recipients, children and home and community based services recipients. Something we have learned is that the process can be more challenging for beneficiaries when their redetermination involves asset verifications. We are spreading the distribution of redeterminations for these populations. Redeterminations for children will be extended to the end of December and long-term services and supports recipients until end of February. This will allow eligibility workers and stakeholders supporting beneficiaries to help avoid becoming overextended with assistance. The last thing the Department wants is someone eligible to close particularly if they are home and community-based services recipients because this could lead to them being institutionalized.

- Kelley Capuchino noted it would be a large benefit for persistent and severe mental illness.
- We currently have a 90 day reconsideration period. We will be extending that to 120, so adding another 30 days for individuals to potentially respond.
- Will also be adding flexibilities for missing verifications and extending 30 days.
- These changes will all come into play in August.

Questions about home and community based services populations prompted sharing of slide 13 which demonstrates that only 7 individuals of these cohorts terminated due to a failure to redetermine.

Deb Fournier touched on focused stakeholder work underway. In the end of July we will begin stakeholder groups. We are also working with education partners to ensure back to school efforts include renewal reminders.

June had fewer renewals due and the composition was different. 70.8% of non-protected retained coverage which is better than our historic trends. In the protected group, numbers went down this month but 68.2% of non-protected have retained coverage, 19.3% of protected have retained coverage. We expected that the protected would have lower numbers.

- In terms of referrals to the Marketplace, we are up to 16,912 referrals that have occurred for renewals in March-Jun, which does include the previous 8,000 pending ineligibles that were referred. We had a meeting with the Center for Consumer Information and Insurance Oversight last week and that will enable more referrals to navigators.
- As an extra add-on since end of May, we did additional outreach to regular users of health care services. The larger population represents many more with no utilization. When we contact high utilizers, they are largely aware of the need to redetermine.
- Henry reviewed targeted outreach efforts outlined on slide 14.
- Joan Fitzgerald asked Deb Fournier to share the current stakeholder groups. Joan suggested school based hygienists being included.

Department Updates

- Time allowed for an update on dental from Dr. Sarah Finne.
    - The Department will continue to work with the dental vendors. Network continues to grow slowly but surely. Claims review shows a slow but steady increase in claims but we believe 6-9 months experience will be a better picture of utilization.
    - Focusing on areas of the state most in need of mobile support for service access. Soon we will release more information on mobile van locations.

Adjourn. M/S/A