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

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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 Ain’t 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.

“…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.”

MAP OF PENDING AND COMPLETED HOSPITAL MERGERS AND AFFILIATIONS

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

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

Prospective Payment Systems Hospitals
3 Concord Hospital
8 LRGHealthcare, Lakes Region General Hospital

Critical Access Hospitals
16 Cottage Hospital
19 Franklin Regional Hospital, LRGH Healthcare
23 Speare Memorial Hospital
25 Valley Regional Healthcare
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.

Determinants of Health

- Environment 19%
  - Smoking
  - Obesity
  - Stress
  - Nutrition
  - Blood pressure
  - Alcohol
  - Drug use
- Human Biology 20%
- Lifestyle 51%
- Health Care 10%

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/
Advanced Payment Models

- Fee for service
- Pay for reporting
- Pay for performance
- Shared savings
- Shared savings and risk
- Population based payment - capitation
- Population based payments (global budgets)
- Integrated finance and delivery system

Shared savings/risk and connection to appropriate care

- Bundled Payments
- Commercial and state Quality Payment Programs
- ACOs
- PCMH/Medical Home

Source: HCPLAN APM Framework

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

# Current NH Commercial Carrier Efforts

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Efforts</th>
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<tbody>
<tr>
<td><strong>Anthem</strong></td>
<td>- Enhanced Personal Health Care (EPHC) program</td>
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<tr>
<td><strong>Cigna</strong></td>
<td>- Cigna Collaborative Care</td>
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<td></td>
<td>- Cigna Accountable Care (CAC)</td>
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<tr>
<td><strong>Harvard</strong></td>
<td>- Provider partnerships</td>
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<td>- Elevate Health tiered network products</td>
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<td>- Benevera Health population health products</td>
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<tr>
<td><strong>Tufts</strong></td>
<td>- Provider partnerships</td>
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<tr>
<td></td>
<td>- Freedom Plan tiered network products</td>
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</table>
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
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
Changes For Medicaid Expansion

- **Aug. 2014**: Medicaid Expansion Bridge Program
- **1 Jan. 2016**: New Hampshire Health Protection Premium Assistance Program begins
- **1 Mar. 2019**: Work and Community Engagement Requirement (WACER) in effect
- **1 Sep. 2019**: New MCO contract in effect with Wellsense, Centene and AmeriHealth
- **1 Jan. 2019**: NHHPP terminates and Granite Advantage Program begins:
  - Med Ex Adults transitioned from Qualified Health Plans to Managed Care Plans
  - No retroactive coverage
  - Copays equivalent to traditional Medicaid
- **1 June 2019**: Work or community engagement must begin (suspended effective July 29)
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
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
Fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs.

HCP-LAN APM framework Category 2C and above.

Health outcomes consistent with state priorities.

Community mental health, FQHCS, large and small providers.

All payer alignment.

Transparency.

Provider engagement.

Quality measures must accompany cost targets.
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
Plans of (Safe) Supportive care NH
State and Federal CAPTA/CARA Requirements

- Notification of Birth
- Federal Data Reporting
- POSC Development
- Monitoring Referrals and Service Delivery
- Child Abuse and/or Neglect Reporting Process
### NH’s Plan of Safe Care Process

*SB 549: RSA 132:10-e and f*

<table>
<thead>
<tr>
<th>Infant Born…</th>
<th>Health Provider Shall..</th>
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<tbody>
<tr>
<td>“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…”</td>
<td>“… 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.”</td>
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</table>
How is NH determining its POSC process?

Baby Born
It is best practice to begin developing a POSC prenatally.

Is the infant affected by prenatal drug and/or alcohol exposure?
- Yes
  - No POSC is required by law
- No
  - Notification of Birth* & POSC Developed

Notification of Birth* & POSC Developed

Is a mandatory report made?
- Yes
  - POSC is sent to DCYF and sent home with mother upon discharge
- No
  - POSC is sent home with mother upon discharge.

*Notification is captured through two situational surveillance questions on the birth certificate.
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?
What is NH’s Plan of Safe Care?

<table>
<thead>
<tr>
<th>Supported Care for Methadone and Infants</th>
<th>Individual's Plan of Safe Care</th>
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**Description:** This Plan of Safe Care, developed collaboratively with the mother, coordinates existing supports and referrals to new services to help safeguard and stabilize the infant while in the hospital. The Plan of Safe Care is to be shared with the mother’s and infant’s generalist and supports.

1. **DEMOGRAPHIC INFORMATION**
   - Name of Mother
   - Name of Father
   - Name of Infant
   - Mother’s DOB
   - Father’s DOB
   - Infant’s DOB
   - Mother’s Address
   - Father’s Address
   - Infant’s Address

2. **CURRICULAR IMPACTS** (e.g., parent support, family/parent classes, employment, education, recovery counseling, etc.)
   - Parenting support
   - Employment assistance
   - Education assistance
   - Substance use counseling
   - Recovery counseling

3. **STRENGTHS AND GENETICS**
   - Family history
   - Medical history
   - Substance use history

4. **HISTORICAL HISTORY**
   - Maternal medical history
   - Infant’s medical history
   - Family medical history
   - Other medical issues

5. **EMERGENCY CARE AND CONTACTS**
   - Mother’s phone number
   - Father’s phone number
   - Infant’s phone number

6. **POSTDISCHARGE PLANS**
   - Follow-up appointments
   - Referrals to community resources

**If any changes to this Plan of Safe Care are made, notify the health care provider immediately.**

**Confidentiality:**
- The information contained in this Plan of Safe Care is confidential and is intended only for the use of the mother and the infant’s health care providers. No one other than the mother, the infant, and the health care providers may access this information without the mother’s permission.

**Legal Requirements:**
- This Plan of Safe Care is a legal document and is subject to the Family Violence Prevention and Services Act (FVPSA).

**Mandatory Reporting:**
- If the mother is a domestic violence victim, this Plan of Safe Care is subject to mandatory reporting requirements.

**Discharge Planning:**
- The discharge planning process is coordinated with the mother and the infant’s primary care provider. The discharge plan shall include follow-up appointments, referrals to community resources, and any other necessary steps to ensure the safety and well-being of the mother and the infant.

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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
Patient Flow

211

Doorway

- Referrals to Hub
- Information and referrals to other agencies, if applicable
- Direct Client transfers to Hubs
- Staffing / reporting

- Screening and Assessment
  - Crisis intervention
  - Clinical Evaluations and Plan Development
  - Continuous Recovery Monitoring
  - Facilitated referrals to SUD, Health, Social supports
  - GCPRA Interviews

Spoke / Referral Partner

- Direct Supports
- Clinical Services
- Case Management
- In / Outpatient Treatment
- Monitoring / Service Coordination
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.
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.