Health and Human Services Oversight Committee
Friday, April 25, 2025 at 1:00 p.m.
Draft Minutes

Present: Reps. Pearson, MacDonald, Woods, Weber, LaMontagne, and Rep. Drye, who will be joining the committee but who has not yet received her official appointment.

A second version of the minutes from March 28, 2025 was handed out to correct printing errors in the initial version. The reprinted minutes were moved, seconded and passed unanimously.

Commissioner's Report: Henry Lipman, DHHS Medicaid Director, gave the Commissioner's Report on the NH Community Re-entry Program Update. A 1115 Waiver has been filed to allow certain services to be covered which would not be allowed under traditional Medicaid. The Community Re-Entry Waiver would be our fourth waiver application, and we are hoping for a waiver for presumptive eligibility for CFI. The Community Re-Entry Waiver is for sentenced adult and youth. Currently there is a prohibition forbidding Medicaid to pay for service provided behind the walls of correctional facilities. The waiver provides some Medicaid benefits behind the walls, saving money for the state and counties. This is a new waiver to help with recidivism for those with substance or mental health issues. The purpose is to connect individuals with substance use disorder or mental health issues for 45 days prior to release with reentry services. A similar provision for youth services was passed by Congress, so youth re-entry services are mandatory. The elements of the program were walked through. Participants receive referrals to mental health and primary care service providers, and they are given a 30 day supply of medication. Blood pressure and medication assisted treatment are monitored. This is a five-year demonstration project, and it must be shown to be cost effective, and therefore budget neutral, to continue. The program will be started in the state facilities first, and then extended to the county jails. The state Department of Corrections has five facilities: the program has been implemented in four of them. Youth who have been tried as adults are eligible for both programs. More intensive case management

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is available to youth until age 21 or up to age 26 if the youth has ever been in the foster care system. Youth may be categorically eligible. The program is looking at early screening diagnosis and assessment. The youth program has a more holistic approach than adult treatment which is more focused on substance abuse and mental health. We need to be prudent managing financial risk until return on investment has been demonstrated. The rollout timeline is this: It started at the beginning of the year for youth. For the first few months they looked at looked at eligibility. April saw the first releases. Currently, 30 people are enrolled; 10 have been released, and 20 are waiting to be released. They are assessing the services--they might be able to use telemedicine, and participants will have insurance cards when leave prison. NH is the second state to stand up the program. They are meeting with counties to assess what they will need. With feedback, they are more confident about higher chances of success. An early win was one participant who got housing and employment because they were already in treatment. This population has been identified as a priority population for care management under Medicaid. Commissioner Hanks was an early thought leader on this project. Everyone is hoping to drive the recidivism rate down.

Rep. Pearson asked about the need for good tracking for the funding. We have to have independent evaluation of the plan for that issue. Rep. Woods asked about next steps. They will extend the program to two or three counties and work out from there. They have a grant request in with the federal government which would allow them to go faster in face of the current hiring freeze. Rep. MacDonald asked if they would start with counties with higher populations? Readiness will be the key; they have not selected the counties yet. Rep. MacDonald noted that NH and California are very different. What led us both to this? Their program is very different. Theirs is more expansive than ours. We and CA have been planning the longest; the rest of New England is working to stand up these programs as well. NH has a motivated Corrections community. Rep. Drye asked them to consider starting with Sullivan County, and Rep. Weber put in a request for Cheshire County. Rep. Woods asked about funding sources. The hope is that funds will be self-generating, as evaluations and

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assessments are lower cost items, and we hope there will be savings on ER visits and re-incarceration. We have already been spending money on reincarceration and support services etc. There is a need for some new money for telemedicine infrastructure support.

DD and ABD Waitlist Quarterly Report: Melissa A. Hardy, Division Director, Division of Long Term Supports and Services (DLTSS), and Jessica D. Gorton, Director, DLTSS-Bureau of Developmental Services, New Hampshire Department of Health and Human Services. We currently fund 100% of requests of all three waivers, Developmental Disability, Acquired Brain Disorders, and In-Home Supports. They have predictions of who will be entering system so they can predict how many people will need to be served in the future. They had 75 DD requests and funded all of them. Those rated A are those exiting school; those rated B are unconnected with a school or are coming in from out of state. 29 withdrew their request for services. Nine were As. Some are staying in school until age 22. Twenty Bs, new to the system, withdrew—either they have another waiver or service, or they might not need services until quarter 3, or they might have medical reasons, for example, hospitalization. Forty-two should start services, but twelve did not. Eight had eligibility issues, and four had family requests not to start services. Sometimes services have not started because of workforce availability. There has been no actual waitlist since 2010. Rep. LaMontagne asked why we don't qualify them early? Those rated qualify medically and are put on the list, but then they must finish filling out the Medicaid paperwork.

For In-Home Supports, eleven childrens' waivers were requested, and all were funded. Two withdrew, all nine others are receiving all or partial services. Rep Drye asked are there more services if there are fewer recipients? No, any extra is held in reserve. The quantity of services needed is generally already known in advance.

For Acquired Brain Disorder, four requested services, but three withdrew, Medicaid is not yet set up for those recipients. Some of these crossed over to the Choices for Independence waiver instead. One applicant was funded but did not start services because their Medicaid application was not completed. ABD consists of anoxic brain injury, physical injury, or

stroke. Rep. Pearson noted he had heard good feedback. The community is saying that services have improved and people feel more listened to.

Medicaid Quality Strategy and Priority Areas of the MCM 3.0 Contracts – Henry D. Lipman, FACHE, Medicaid Director, Division of Medicaid Services, and Meredith J. Telus, Director, Division of Program Quality and Integrity, New Hampshire Department of Health and Human Services. Medicaid Care Management 3.0: Henry Lipman gave an introduction to the quality system. With the reauthorization of Medicaid Advantage, there were issues of procurement, and the end result is this Procurement 3.0, starting Sept. 1st. The procurement process takes almost 9 months. Dr. Ballard worked on this. They moved more dollars into the provider community to pay for services for primary care. We want a real patient/provider connection for preventive care, care coordination, and medication. 30% of cost is medication. They have a program to ensure that there are not too many medications all working at cross purposes. We need records of all medications for insurance, so if they go over a certain number, a comprehensive review is conducted to ensure there are no contra productive interactions. Some people are on up to 30 different medications. Another issue is gene therapy, which is very expensive. New medications are out, but one costs $2.4 million per child. SB 119, which allows brand substitution is helpful, for lower cost purchases. For Certified Community Mental Health Centers, there will be a standard contract for direct pay of a specific amount direct to critical care providers starting September 1. Sometimes there is an enhanced federal match for a more comprehensive array of services. They are bringing on Centers one by one, and strengthening the quality program. We need better oversight of non-emergency medical transportation. A model of prevention for improved health is being worked on. They are working on integrated pharmacy management and payment to managers for pharmacy review, in addition to the polypharmacy reviews, along with continuous review of prescribing practices. There is a shared risk pool with MCOs to make sure expensive therapies are used effectively. 66 current items cost over $100,000, and there will be an explosion in these therapies. The new CMHC funding model slide was walked through.

Rep. Pearson asked about the repercussions for practices. They may be quite substantial for some practices, they are trying to get that worked out. Rep. Woods asked about technical treatments coming down road. They

have a consulting service and advisory group to advise the Department, which could give a presentation.

Susan Drown, Erin Metcalf, and Meredith Telus presented on Medicaid Care Management Priority Areas and Quality Levers: This is a quality strategy required for the managed care programs. Access, timeliness, and quality of care are assessed. There is a quality focus on critical areas—see slide 3. Six criteria listed in the report were reviewed. Slide 4 has both provider levers and managed care levers. Rep. Weber asked for clarification as to the nature of the levers. Levers are activities and programs--see item four on slide five. They are financial in nature and can be used as incentives to providers or to MCOs. You can measure quality, as, for example, how soon are pregnant people getting care—in their 1st, 2nd or 3rd trimester. Rep. Lamontagne asked if the providers were fee for service? All are under managed care agreements with managed care organizations. Slide 6: MCOs are required to participate in a withhold and incentive program. Two percent of the capitation per month is held back; MCOs earn this money of they meet their targets. Unearned money goes into an incentive pool based on exceptional performance. Incentive payments can be used for high dollar improvements. They are based on annual performance in one calendar year, and paid in the next calendar year. There are currently nine measures, of which seven are the nationally standardized ones. Slide 7 reflects performance-based auto-assignment. This is not mandatory, but MCOs can earn new members into their plans. The Department has monthly measures and they can have more flexibility. Liquidated damages are mandatory based on severity of violations. Issues could be timely and accurate submission of data, and lack of meeting performance standards. Penalties escalate with repeated violations. Slide 9 reflects that MCOs must complete four improvement projects—three clinical and one non-clinical. In 18 months, if they don't meet their goals, they are subject to liquidated damages, but if they if improve they may earn incentives. Rep. Drye asked what happens if the incentive pool is empty. That has not happened to date. Rep Lamontagne asked what happens when the member does not choose an MCO. Many do not choose an MCO, so the Department auto-assigns them--about 1000 per month. MCOs

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can earn those members. Earned auto assignments reward short-term improvements. The measures are on a system wide level. Rep. Woods commented that he wanted to compliment them on the ways to improve practice, but looking at it from a physician's point of view, physicians are just spending more time seeing a computer, and less time looking at patient. It is de-humanization, and the dehumanization of medicine. How do we re-humanize the practice of medicine? Answer: They appreciate the comment, and this is why they are prioritizing patient/provider relationships. Much of the data gathered is automated from bills etc. Rep. Woods said currently, 78% of physician practices are owned by corporations, and they participate in corporatization of medicine. Please think of ways to make practice more human, like having a human being answer the phone. Rep. Pearson said that is why some people quit, so number of Primary Care Providers is going down—this won't work if no doctors are willing to go into primary care. Please work on this, as currently 20% of all doctors are contemplating leaving practice within five years.

State Office of Rural Health (SORH) Annual Report: Danielle H. Hernandez, Administrator, Division of Public Health Services, New Hampshire Department of Health and Human Services. The State Office of Rural Health must assess the current and anticipated primary health care work force. The Annual Report was presented on the NH Health Care Workforce and Data Collection. Data collection is necessary for accurate supply-demand workforce numbers, and allows for liaison with higher education and professional organizations and agencies for planning purposes. License renewals, practice capacity, geographic distribution, and age are studied to determine anticipated workforce needs for the next five years. The data is organized by public health regions, not counties. The key findings of the report were walked through. It is exciting to go from individual provider reports to a single integrated dashboard with real-time analysis, which will be complete in in FY 2026.

With respect to the workforce supply chain, all professions are going up except for dentists. Advanced practice RN have increased by 42% in one year. Rep. Pearson asked where they where are from. The increases started in 2019, with the emergency orders, when barriers to licensure were lowered, and we have seen good improvement since. APRNs may practice

independently, so there is a lot going into these pipelines. The educational pipeline is more accessible and affordable for an APRN than the physician pipeline. Rep. Pearson asked about training programs. The estimate was that there are seven or eight training programs in-state. Rep. Woods asked about the full-time/per diem mix. This data is collected with the license renewal form. Around 80% of the licensees are fulltime or part time in NH. The decline is for dentists -8%.

An analysis of primary care providers shows we can anticipate a decline in physician providers. Many are nearing retirement age. Physicians have weaker ties to the state than APRNs. Rep. Pearson asked about the family practice residency programs. These are in Coos, Portsmouth, and Cheshire in Keene. The most concerning statistic is that 15% anticipate having no clinical practice in NH 5 years from now. Wait times are getting longer for rural physicians. The distribution is uneven across the different regions. The (unserved?) rate per 100,000 population is now 20%. APRNs have more favorable supply indicators. Rep. Drye asked about Sullivan County. The data is by public health regions, not counties—what can we do for the southern half of Sullivan County?

As a wrap-up, they will come back with behavioral and oral health pieces. The Executive Summary is shown in the blue box on page 6. The focus areas: How do we tackle problem off not enough practitioners? The answer is that we need in-state exposure to in-state training in all areas, especially in the rural areas. There are family practice residencies, and a rural track for Harvard Dental, but there are only 3 individuals in that program. There are other stronger practice programs for APRNs and others. Recruitment Central targets rural areas and the loan repayment helps. These pipelines are limited in funding, and there is a need to invest in these evidence-based programs.

A testimonial was given with respect to the loan repayment program from an individual who had $32 0,000 dental school loans. Please continue to reinvest in dental care. SLURP program is great for those who want to work in public health. All other options outside public health are higher-paying.

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The May meeting will be held on May 16th because of the Memorial Day holiday weekend. Meeting adjourned at 3:08 pm.

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