Minutes

Behavioral Health and Addiction Services Advisory Committee

September 20, 2016

Board Members Present: Robert Feder, Paul Frehner, Christopher Kozak, Janine Corbett sitting in for Kenneth Norton, Amelie Gooding, Courtney Gray, Michele Merritt, Stephanie Savard, William Brewster, Stephen Kozak, Richard Lafleur, Andrea Rancatore, NH Senator Dan Feltes, NH Representative Ed Butler, NH Representative John Hunt, Lucy Hodder, Peter Mason, Joseph Plaia, and Abby Shockley.

Board Members Unable to Attend: NH Senator Jeb Bradley

New Hampshire Department Representative: Jennifer Patterson, Health Policy Legal Counsel

Insurance Commissioner Roger Sevigny welcomed everyone and started the meeting at 1:30 p.m. Commissioner Sevigny reminded everyone of the purpose and mission of the group, as well as the two hour time frame for the meeting and that public comment will be heard at the end of each meeting. He asked that anyone from the public who would like to comment to sign in on the sign-up sheet near the entrance of the meeting room.

Commissioner Sevigny recognized Janine Corbett who was sitting in for Ken Norton. He then introduced two members who could not attend the meeting last week and asked them to give the Board a little background information of who they are and what they do.

Dr. Robert Feder: is a psychiatrist with a private practice in Manchester, NH. He is the legislative liaison for the NH Psychiatric Society and an active member of the APA (American Psychiatric Association). Has practiced in a variety of settings and has treated mental health and substance abuse conditions in adults and adolescents. For the past several years he has been specializing in treating Opioid Use Disorder in adults. Has dealt with the health insurance industry on a daily basis and is familiar with how the system works and has always been concerned with improving it.

Amelie Gooding: is the program director at the Phoenix House in Keene, NH which provides substance abuse, mental health, and/or support services. It is an in-network provider for most major insurance carriers, managed care programs, and Medicaid. Amelie has been working for over 10 years with public and private insurance companies. She served on the Governor's commission for two terms as a public member representing treatment and is now part of the Treatment Task force.

Continuing with his opening comments, Commissioner Sevigny briefly spoke about the market conduct examination that the NHID is conducting and that NHID staff is looking into it very deeply and that Tyler Brannen will be getting data for the analysis.

Jenny Patterson asked for comments about the minutes for the August 30th meeting—Senator Dan Feltes gave a little background information on SB 502, provider parity and the startup of the Stakeholder working group that springboarded into this broader group. There were no other comments. Jenny Patterson then passed out the NHID staff list which was requested by the Board at the last meeting. We then continued on with the agenda for the today's meeting.

Tyler Brannen, Health Policy Analyst at the New Hampshire Insurance Department gave an update to the group about NHID Network Adequacy requirements. He discussed the Network Adequacy statute which has existed for about 20 years and that the current rule which have been around for 10 years and exist to ensure reasonable access for consumers. He said that the legislature knew that a lot of people didn't know much about the health insurance they buy, so the legislature imposed the network adequacy requirement. The NHID has been holding public workgroup sessions to revise the existing rules in order to make improvements. In 2014, when the ACA launched, we had what is termed a 'narrow network' with Anthem's product on the exchange. While the narrow network provides the opportunity for cost effective networks, there was increased scrutiny of the existing regulatory requirements. The NHID efforts are a response to the ways health care delivery has changed, including how patients can receive care from multiple provider types for services historically only provided in a hospital setting. The revised rule will impact the 2018 products. The NAIC also recently adopted a Model Law for network adequacy. NH is ahead of the game, but our model is in line with the NAIC's. NHID rulemaking will begin in the next couple of weeks, and we have been working with carriers to run the GeoAccess software and make adjustments to the draft rules. Designating behavioral health services as a core service, to which access must be provided within the community, is one of the biggest changes in the department's new network adequacy model. At this point, Tyler asked for questions.

Discussion and questions ensued. Senator Feltes asked how the department is integrating the Federal Parity requirements in developing the NH network adequacy model. Tyler explained that the network adequacy rules are a result of the state network adequacy statute, but additional parity requirements may also be enforced. Representative Butler asked if the rules include access requirements for substance use treatment, and Tyler explained that they do. People should be able to access primary care and other core service providers closest to home; should be on par what others access in their own communities. Accessing services close to home is a step toward parity. Dr. Feder interjected that there is concern in the psychiatric community that there is a woefully inadequate representation of psychiatrists in the carrier networks. The issue of adequacy in general is tied to the low rates of reimbursement. The majority of patients with private insurance are seeing nurse practitioners rather than psychiatrists. This is a national problem. Tyler agreed that there are larger problems with the supply of providers in the system, and those problems may be related to payment levels. Jenny Patterson commented that the legal requirements with respect to what services must be covered, including EHBs and parity, are separate from network adequacy requirements, which look at access to providers who offer those services. Changes in network adequacy requirements don't change the scope of behavioral health services that are covered under the benefit design.

Dr. Paul Frehner asked if there is still an opportunity for the group to give input on network adequacy. Jenny Patterson replied that our working group is wrapping up, but there is opportunity for public comment during the formal rulemaking process, and we will also take what we hear today into consideration. Commissioner Sevigny mentioned that on the national level, there has been extensive discussion on network adequacy including CMS efforts to move this function from the state to the federal level.

Commissioner Sevigny invited anyone who would like to attend the NHID annual public hearing on health costs - November 4 at the UNH Law Center from 9:30 to 11:30 am.

At this point the presentations from the four carriers were heard.

Anthem—Dr. Richard Lafleur began his presentation talking about adequacy, access and how Anthem took a three year look-back and is evaluating behavioral health access to services, and now focusing on behavioral health and primary care integration at the insurance plan level— Anthem is looking at whole spectrum. Anthem anticipates the providers will improve integration of BH (behavioral health) and PCPs (primary care providers), and Anthem has created a very integrated forward looking health plan looking at BH integration with medical care. Also looking at 3 critical components- 1. Identification 2. long-term treatment, and 3. recovery. Anthem is not playing one inning on BH and SUD, but are playing whole game. Some of the things they are doing to address the 3 components: PCPs are identifying members at risk based on the services they seek, and encouraging use of SBIRT (Screening Brief Intervention and Referral to Treatment), sending us feedback, started this over a year ago. Individuals don't want to be labeled, practitioners know this, and we are providing additional resources like home visits to assist PCPs. Anthem wants them to screen and use additional information, sometimes its pharmacy information for early identification. Under the Medical Home program (EPHC) PCPs can look at claims when they come in to help identify patients early. Also Anthem is assisting in designing treatment sites and support, working with Medical Society, hospitals and the NH Foundation of Healthy Communities to create more MAT locations and availability. From the feedback received from physicians, they need assistance for Behavioral Health support. Anthem went out and initiated recovery awareness to enhance the continuum of care. A pilot program was started in Connecticut- AWARE. Anthem has contracted also with Hope for Recovery. Anthem has also supported BH home visits. Anthem is looking for more providers and physicians to be contracted for home visits. , Anthem is also building on pharmacy programs, that align with the processes of providers in managing controlled substances and designate pharmacies as many providers also do -pharmacy home. Additional activities include extensive medical feedback to pcps, implementing tele-medicine for both medical and BH. Also Anthem is expanding BH, Anthem added seven IOPS, and are working with PCPs build medical neighborhoods.

Jenny Patterson asked Dr. Lafleur about the timing of expanding the pilot program in Connecticut and Dr. Lafleur replied that it is alive and growing and New Hampshire's will be implemented in NH next month. Michele Merritt from New Futures asked if Anthem could look more broadly and engage more providers, and also train medical providers to use CPT code to provide Ambulatory Detox. Anthem will now support reimbursement for medical providers and be brought up to the same level as psychiatrist performing ambulatory detox with suboxone. Anthem is working on that, and working on screenings, referrals to BH clinicians, expanding network, and enhancing awareness that local community providers are available. Lucy Hodder asked how BH care and treatment is brought into the process. Under the EPHC program Anthem pays a pmpm (per member per month) and dollar amounts are based on risk. Between 87%-95% of Anthem's contracted PCPs are in the EPHC Program which encourages enhanced personal healthcare and identifies patients with risk and gaps in care which includes identification of BH issues and supports this process with reimbursement for care coordination. Stephanie Savard from Families in Transition asked if they looked at cost reimbursement for in-house and spreading treatment because peer recovery support is just as valuable. Dr. Mason asked how they are getting this information out to the providers with Dr. Lafleur replying that they use an email list- eblast topics, care coordinators, working with PCP's bringing information to them directly and building a collaborative network among PCPs for best practice sharing , which is ongoing. Discussion continued on this subject. And Dr. Mason interjected that they need a better strategy, mailing literature doesn't necessarily work all the time, as providers may not read it. Also wanted to know how they are vetting people, credentialing, wrong people in network can be

dangerous. Anthem looks across the board, receives information from patients, from providers, constantly looking at information and it cannot be hearsay information, but does investigate complaints.

Harvard Pilgrim (HP) – Dr. William Brewster started with some background information on how Harvard has partnered with Optum/United Behavioral Health, and is set up to transfer referrals to providers. They have weekly meetings with care management; discuss chronic disorders to connect with BH. Meeting with directors every month to look at trends. If providers are frustrated with Optum they can come in and talk with HP. Michele Merritt commented about billing/coding issues for screening services (SBIRT) if the test comes back positive, with Abby Shockley concurring. Michele asked for a telephone number to call. Dr. Brewster gave her one. Continuing, he said that HP is working on developing a relationship with HOPE for Recovery, and they are also looking at surrounding areas for best practices. He explained that each part of the state has different needs and infrastructure that they respect and want to be flexible to fit. HPHC is working on PCP-BH integration, have a couple of grants to support this effort. One is a two-year grant at DH (Dartmouth Hitchcock) to identify issues with frequent use of ERs (Emergency Rooms) by some patients often with BH overlay. The second is a grant with Foundation Medical Partners in Nashua to support hiring and embedding psychiatric ARNP's in the PCP practices. Working on what fits in each county, each provider group. He emphasized that with HP there is no "wrong door" to getting someone the help they need.

Tufts Health Freedom Plan - Steve Kozak explained that Tufts Health Freedom Plan (THFP) is new to the NH community. He is the Director of Behavioral Health and is also a behavioral health clinician. He explained that all carriers are deeply committed to the behavioral health of their members. He noted that THFP takes any willing provider into its network in order to maximize access to care. They want to have a state-wide network of local community-based practitioners so that PCPs can refer to and work with the practitioners they know, from their own community with Behavioral Health as part of the same eco-system. He talked about utilization management; THFP does not require prior authorization, we don't want to slow down the treatment process or impede access to services, first get treatment plan, get the ball rolling. In order to balance this with the mandate we've been given to make the most of the money that employers are willing to spend on health care, once someone has started a course of treatment we will monitor and manage it in order to avoid unnecessary or ineffective services.

Dr. Paul Frehner interjected that in his area Tufts reduced the rate paid for telemedicine services by 20% compared to the rate for the same service provided in the office. Steve responded that telemedicine is a new benefit for THFP, had to start somewhere and they took the CMS process for setting telemedicine rates. Had to start somewhere, over time they will revisit approach but this was a national model. Michele Merritt asked about the demand for services like peer recovery coaching. Steve replied that historically services like this were not covered by commercial benefits, but that as evidence emerges that they are an important component of recovery they are examining whether and how to add these services to commercial plans. Many traditional substance use disorder services were not health care services provided by licensed health practitioners and so were not viewed as covered by insurance. Janine Corbett from NAMI added that not everything that is good for patients is covered. Steve continued that when we hear that we look into it and do the best we can with information given. Dr. Lafleur and Dr. Brewster adding that it varies from day to day.

NH Healthy Families (HF) - Andrea Rancatore explained that HF is in the Marketplace and Medicaid. They recognize peer recovery support services. The clinical and networking departments work hand in hand to see how to improve the network and expand with providers who go above and beyond. They are aligning benefits with providers, focusing on improving care management, and helping providers meet all needs. They have a SUD (substance use disorder) resource line you can call in 766-769-3735. They have daily contact with ER's to check on a whether any members have been admitted, which has proven to be effective. Their prior authorization requirement triggers care management. Jenny Patterson asked if Andrea could talk about the difference in Medicaid managed care (MCO) coverage, versus the Premium Assistance Program which uses private coverage.

That was the end of the carrier presentations.

Next was the discussion of member issues. Jenny handed out the summary of issues that members had raised, both at the last meeting and also in subsequent communications. The purpose was to see what areas were of greatest interest to the group going forward. She noted that many of the issues had already been touched on during the Q&A following the carrier presentations.

Discussion ensued from various board members on the forms and paperwork required for prior authorization and how it takes so much time, it is hard to navigate. Different companies have different forms. Steve Kozak explained that they want to make sure they know what they are authorizing, because there can be misuse by the patient, sometimes by the pharmacy, which drives up costs.

Chris Kozak from Community Partners/Service Link reminded everyone to look at the insurance side and that people are changing from one plan to another, some change plans every 90 days. If prior authorization didn't save money they would stop doing it. If there is a 100% approval for the providers at the table then that's marvelous, but it's not 100% for everyone. It would be irresponsible as plans to stop, because diversion is a very real problem with suboxone and narcotics with misuse by patients and using multiple providers. Commissioner Sevigny added that this topic needs a deeper dive.

Jenny Patterson referred back to the survey that was sent out for topics to be discussed, which were: network adequacy, prior approval, utilization review, so many different processes. Jenny asked what the committee wanted to focus on at the next meeting. Abby Shockley, Substance Use Services at DHHS added that there should be consistency in the messages that carriers are providing. Previously, DHHS had heard there is no prior authorization for suboxone. There is some basic system stuff that is different depending on who you ask. There have also been issues with the prescription company auto-generating denials for suboxone, which was just a computer issue.

For future conversations: prior authorization was at the top of the list, inviting pharmacists and PBMs. Medicaid managed care. Legislation passed last year for a standardized form for Rx prior authorization; the NHID is working on rulemaking under this law and could talk further about it (there is a stakeholder group).

A public member in the audience, Pam O'Sullivan, commented that Massachusetts removed prior authorization for 3 FDA approved medical assisted treatment drugs.

Dr Feder would like to see a conversation on coverage for smoking cessation.

Michele Merritt would like NHID to review legislation that will impact 2017 plans.

Lucy Hodder said that if prior authorization is a good management tool, what should we see in the BH field that impacts questions on parity.

Discussion continued between the members and some members of the public about variation in clinical practices, the utility of prior authorization, scope and nature of clinical practice, what does evidence /research show as a best practice? Jenny Patterson asked if providers can bring to this to the table. Matt Veno from HP commented that there is a sharp difference of opinion on the variation of clinical practice, and the usefulness of utilization management. It may be beyond the scope of this group, as the managed care statue has existed for 20 years and those issues may not be solved here. We need to have a better understanding as a group of the scope and variation of practice for behavioral health as a group. What does the research say? It would be helpful to have independent research presented on the value of managed care that is not from either the provider or the carrier side. Dr. Brewster responded that this is the "holy grail" and that the research is emerging, but we are not there yet.

Rep. John Hunt interjected that if each insurance company has a different process, we need to get closer to a solution. He asked if carriers are sending out information to providers that they are not reading due to time restrictions and if it includes information on how to not have prior authorizations denied. Jenny Patterson referred to the passage of SB532 which requires carriers to use ASAM (American Society of Addiction Medicine) criteria in determining medical necessity for SUD treatment services, making it more likely that insurers will speak the same language as providers. Also, how no prior authorization is required for the first two routine outpatient visits of an episode of care.

Janine Corbett emphasized the issue of network adequacy as a key topic of conversation for the committee. There are capacity issues, work force development, and credentialing issues that would be good to focus on.

Michele Merritt asked about using the all payer claims database (APCD) as a resource to look at which providers have carved out behavioral health services from their specialty and the services they can provide.

Jenny Patterson added that the provider directory requirements from the NAIC model are being incorporated into the NHID's network adequacy rule. Tyler added that the network adequacy regulation is not going to replace what carriers need to do in contracting with providers. The focus will be on what services the provider actually provides. Having the specialty itself is not enough. They will look at the provider's history and if they have carved out those services they won't be included, or considered in determining whether the carrier meets network adequacy standards.

Wrapping up the meeting Jenny Patterson said that it sounds like the group wanted to talk about prior authorization and credentialing issues. Dr. Paul Frehner commented that there was a deficit in reimbursement rates for children and families; family therapy lower reimbursement rate.

Meeting ended at 4:45, next meeting is November 2 in same room 100 from 9:30 – 11:30 am.