

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MEDICAL CARE ADVISORY COMMITTEE MEETING
June 23, 2017
McKimmon Center, 1101 Gorman Street, Raleigh, NC 27606
Teleconference No. 919-715-0769

The Medical Care Advisory Committee (MCAC) met on Friday, June 23, 2017 at 9:00 am; McKimmon Center, Raleigh, NC.

ATTENDEES

Members in Person: Gary Massey, MCAC Chairman, Kim Schwartz, Marilyn Pearson, Billy West, Jr., Ted Goins, Paula Cox Fishman

Members via Telephone: William T. Cockerman, Derek Pantiel, Linda Burhans, C. Thomas Johnson, Stephen Small

Medicaid Staff: Dave Richard, Sandra Terrell, Roger Barnes, Patrick Doyle, Debra Farrington, Julia Lerche, Janice Norris, Nancy Henley, Tabitha Bryant, John Thompson, Sarah Pfau, Jon Yochum, Michael Eliahu, Teresa Smith, Kimberly Shore-Price, Terri Pennington, Pamela Beatty

MCAC Interested Parties: Mary Short, Nichole Mitchell, Leslie Wolcott, Grace McCall, Beverly Hamilton

CALL TO ORDER

Gary Massey, MCAC Chair

- Gary Massey called the meeting to order at 9:00 am followed by a roll call of the members. A Committee Quorum was declared. Chairman Massey welcomed and thanked everyone for their participation. The Committee approved the May 25th meeting minutes. Gary noted that the minutes for the March 24, 2017 meeting were in progress and would be approved at the next meeting on September 22, 2017.

OPENING COMMENTS

Dave Richard, Deputy Secretary, DMA

- Dave presented a broad perspective on the DHHS segment of the NC State Government Budget:
 - The General Assembly provided the Medicaid rebase requested by the Division.
 - The budget allows \$15million to reinstate the Graduate Medical Education (GME) program which has been in a flux for the past several years.
 - We are doing a better job in our budget forecasting. The Division was most aggressive in our rebase and forecast for this year than in the past 4 years. There is a risk reserve in the budget this year. Overall, the General Assembly did well by us this year. There are provisions that we were not thrilled about. Some providers were upset about our provider prepayment claims provision, but the provision is designed to help us manage the repayment process, reduce fraud, and identify providers who are not supposed to be in Medicaid. We promised to work with the providers to ensure that they understand what we are doing and how we will manage it.
 - The biggest provision relates to improving Medicaid eligibility determinations, accuracy and timeliness reporting. We are committed to partnering with the counties to correct this.
 - Regarding Medicaid Reform, there are a lot of things up for grabs in the General Assembly. We support the requirements pertaining to LME/MCOs in House Bill 403. We take the audit report seriously, and are doing our own fraud investigation of how Cardinal spent money.
 - **Question:** Kim Schwartz asked whether there will be resources for an expansion of rural health residency in the \$15million allocated for the GME program?

- **Answer:** Dave replied that the General Assembly established a joint legislative oversight committee which will include both DHHS and Education Committee members to review the GME program with us about how best to manage the GME program going forward which includes the issues pertaining to rural health.
- **Question:** Paul Cox-Fishman: As the Division moves forward with the investigations of the Cardinal bonuses, is there going to be a monitoring of staff receiving bonuses concurrently with clients on the waitlist for services and those experiencing cuts in services for both Medicaid and state planned services to ensure that this does not happen again?
- **Answer:** Yes, there will be monitoring. The auditor's report raised a serious question about executive salaries inside of publicly managed care organizations. We must think about the skillset needed and recruit the type of talent needed to do managed care. The salary plan that we have is nowhere close to what Cardinal CEO received. Senate Bill 403 has the state doing a study that includes DHHS, State Personnel and other. House bill restricts the salaries to a different level. We are paying attention of what others are doing. As well as Cardinal. Lot of things are complicated about this beyond the egregious things that are clear. We are all on the same page that this should have never happened.
- **Comment:** Chairman Massey applauded the State's effort and commented that it is going to be a growing issue as we bring private sector organizations into Medicaid that are not under the same guidelines as our Medicaid providers. Also, commented on Paula's concern pertaining to the Waiver list. Clearly it should take priority over how we get people covered and not take them off the program.
- **Comment:** Billy West stated that this is not a new problem; just a new problem with our public MCOs. Provided the following suggestions for thought as the investigation takes place. Billy encouraged the State to (1) chat with some of the provider networks; however, you see fit, (2) look at different books of business, and (3) obtain public education by going to some of the community meetings.
- **Comment:** Marilyn Pearson added that in public health, we get different streams of money and they make it clear what you can do with that money. That is a big part of it that people do not understand. I am involved in both the behavioral and public health. I know what I can do in regards to public health; with behavioral health, there are still some issues.
- **Comment:** Paula Cox-Fishman: Whatever this system turns out to be it is only going to be as good as the contract that is written. Suggest letting attorneys outside of the company look at it to "Oh No" moments.
- **Comment:** Billy West agreed that compensation needs to be looked at. The market forces are going to drive the way we have traditionally looked at things in the public sector. That must change and it is a slippery slope.

MEDICAID BUDGET UPDATE

Roger Barnes, Interim Chief Financial Officer, DMA

- We are continuing to grow in enrollment with increases in the AFDC under 21. Seeing a shift in the MIC. That category remains the same in the forecast; but, decreasing in growth because some of the kids are aging out and moving into other programs. On target with our forecast to date.
- Year to date as of April 2017, we are slightly above our expenditures in comparison to the prior year 2016. Hospital expenditures, skilled nursing and physician expenditures are our drivers.
- Total summary through the end of the year indicates that we are going to be about 3.9% favorable to the authorized budget.
- Total Medicaid expenditures were \$567.7M or 5.1% favorable to the authorized budget.
- **Question:** Kim Schwartz asked if the inpatient services included in the hospital expenditures category relate to hospital billing or is that all ambulatory care?
- **Answer:** Roger responded; you are right under hospital expenditures, it is an accumulation of inpatient, outpatient and ER that includes all outpatient services performed in hospitals. It would not include ambulatory care. ER and outpatient services are down.

- **Question:** Billy West asked what do you contribute the ER decreases to?
- **Answer:** Roger's thoughts were that patients are going into the physicians' offices and that FQHCs are expanding in those areas. Also, we are seeing a higher acuity in the hospitals which are driving that expenditure up.
- **Question:** Chairman Massey asked if the free standing ambulatory care in other costs?
- **Answer:** Roger responded yes.
- **Comment:** Roger acknowledged the Fiscal Planning & Analysis staff, Michael Eliahu and his excellent teammates for their expertise making it better for us to zero in better on our rebase and forecasting. It is a constant. In addition to looking at what we are spending, we also look at policies being developed and fiscal impacts, and providers as well. I appreciate them.
- **Comment:** Dave Richard extended kudos to Roger for the incredible job in his role as CFO and the entire Finance team as well as to all the folks that do the work in Medicaid. Getting the forecast correct is one of the most important things. Also, give credit to the General Assembly and the Office of Budget Management. We all came to a number that we believe is correct. If we keep finishing where we are not asking the General Assembly for more money, then they will trust us.

MEDICAID TRANSFORMATION UPDATE

Dave Richard, Deputy Secretary, DMA

- Our transformation effort has been going on for a while. The rubber is hitting the road in terms of our next step is with CMS and operationalizing. We do not have an approved waiver from CMS. As an agency, we are working towards July 1, 2019 as our deadline for planning purposes to go live. We believe our engagement with CMS will begin the end of July or early August 2017. There are a lot of operational things that need to take place; not to mention the actual negotiations with CMS. Every assumption that we are making is based on Medicaid as it exists today.
- There was an outpour of comments from our listening sessions from people across the State. You guys gave us great comments. We came away with valuable efforts; details include items such as:
 - Increase coverage for more people in North Carolina
 - Physical and Behavioral Health Integration (IDD, Substance Abuse and Behavioral Health). No one disagreed with this one.
 - Social determinants of health
 - Care management and population health
 - Improving the quality of care
 - Paying for value
 - Hospital Supplemental Payments
- We are working very hard to develop a concept white paper that will have details of what we plan to submit to CMS. The concept paper will include lots of specifics pertaining to what the system should look like as we make this transformation that were not in the high-level 1115 Waiver that we proposed to you. As soon as that paper is ready to go public, we will solicit your feedback. The formal kickoff of our engagement with CMS will begin late July to early August. Dave shared a draft copy of the concept paper pertaining to the Behavioral Health and IDD Integration with Physical Health in our specialty plan. Stated that this is very important to the Agency.
- Comments from Committee members (Chairman Massey, Kim Schwartz, Paula Cox-Fishman, and Billy West) led to a lengthy conversation about regional specialty plans and a fully integrated plan of primary and mental health care to treat the whole person; which are very important components to the Secretary and the Division. This is a conversation that will not go away as there is a lot of work to be done around the integration of physical and behavioral health, said Dave. Discussion also included the lack of ambulatory care serving Medicaid populations especially in rural areas and the State not offering alternatives, Telemedicine be a study and not an action. Dave commented that the Division is in robust conversations with the Secretary about telehealth and tele medicine and how we adjust those policies.

LEGISLATIVE UPDATE

Sarah Pfau, Associate Director, Policy & Regulatory Affairs, DMA

- Sarah reviewed highlights of the 2017 Budget. In addition to the budget bill, there will be a technical corrections bill. Will follow up once the technical bill has been ratified and enacted. A matrix list summarizing the budget bill provisions has been completed. It will be shared once we have a Session Law number and technical bill with last minute changes.
- Sarah expounded on some of the programmatic highlights and other things in the Budget bill. We have the continuation of our annual Medicaid Annual Report which we resumed in 2015. The General Assembly asked us to continue with that. The 2015 and 2016 Medicaid annual reports are currently posted on our webpage.
- Federal regulations require us to re-credential our Medicaid providers at least every five years. This year that provision was repealed for the biennium, and it will be codified and added to our General Statutes.
- There are numerous provisions in this budget bill pertaining to Medicaid eligibility accuracy and timeliness. The Department will have additional oversight and monitoring responsibilities in addition to the ability to impose sanctions, including temporarily taking away the local DSS administrative oversight of eligibility determination functions upon failure to comply corrective action plans. The accuracy and timeliness statutes will apply to the Eastern Band of Cherokee Indians project that will be implemented this year.
- Provisions were also added for the creation of 400 additional slots in the Innovations Waiver program.
- There are two provisions relevant to PCS; one extends the retroactive period for prior approvals from 10 days to 30 days; the other increases the reimbursement rate to \$3.90 per unit.
- New provisions also include the implementation of Medicaid coverage for home visits to pregnant women and families with young children through a pilot program. There is also a provision for ED diversion for ambulance services for individuals with mental health crises. These two provisions will require a legislative report in November 2017.

Question: Marilyn Pearson asked whether the ED diversion program is an expansion of the pilot Community Paramedics program?

Answer: Sarah replied that there was a pilot community based program several years ago. At this point, it is just the development of a plan.

MEDICAID ACCESS MONITORING

Jeff Horton, Utilization Committee Chair, DMA

- The federal government put the Medicaid access monitoring plan into place in January 2016. We submitted the original plan to CMS on September 30, 2016. We looked at utilization which decreased from 2014 to 2015. Those services included primary care and home health services with no increase in ER.
- The access monitoring plan must be updated each year by July. We are currently finishing that.
- We deviated from last year's plan by analyzing beneficiaries' data by age groups 0-20 years and 21 years onward and separately for rural and urban areas. We extracted the dual eligibles.
- We submitted our hemophilia AMRP factors with a state plan amendment (SPA) to reduce reimbursement of hemophilia drugs which automatically triggers an access monitoring review plan. We submitted the plan; received feedback and adjusted it. We looked at some of the same type of parameters as previously submitted access plan which included monitoring provider trends, prescriptions monitoring providers/locations and beneficiaries. Mobile dental care
- Presented a highlight of utilization of primary care services for physicians, nurse practitioners, physician assistants, pre/post-natal services and dental services/rates.

- **Comments:** Roger Barnes added that Dr. Mark Casey is facilitating talks with adult and pediatric dentists to adjust rates for a resolution to operate within our resources and keep dentists from existing the Medicaid program. Further stated that DMA currently cost settles with UNC dental schools and has a dental school state plan amendment (SPA) with CMS off the clock. Once approved, we can assist the ECU with their dental school which is in a more rural area.
- **Comments** from MCAC members (Paula Cox-Fishman, Kim Schwartz, and Marilyn Pearson) led to a lengthy discussion regarding dental care services, support and expansion of the ECU Dental Service Learning Center project, and obtaining mobile public health hygienic dental units; connecting them to the local health departments.

CLOSING REMARKS

Gary Massey, MCAC Chair

- **Kim Schwartz** led a brief discussion on the Opioids crisis. Dave announced that an NC Opioids Crisis Summit is being held in August 2017. More conversation will take place in the future after the Summit.
- **Chairman Massey** discussed the IRS intervention around classification and compensation for Committee members. Members have a choice of waiving the stipend or receiving it and a State Employee W-2 form. Previously received stipends will need to be refunded to the State. However, compensation for mileage and other expenses will continue. Ellen Pittman elaborated further and extended an invitation to the members present to see her for the amount they are expected to refund the State. Members on the phone were asked to reach out to Pamela Beatty.
- **Derrick Pantiel** commented to Dave Richard that everything coming down the pipeline sounds very interesting and commended him for his patience with the progress. Acknowledged that it is not an easy process and that DMA staff are working very hard to provide NC citizens with the support that they need.
- **Chairman Massey** wished Derrick Pantiel success on his relocation and opportunity. Asked him not to go too far and said that they may have something else for him on the Committee.

PUBLIC COMMENTS

Mary Short: asked whether the specialty needs plans mentioned earlier will require Medicaid beneficiaries to be assigned to those plans, or whether beneficiaries will they have a choice not to use those plans.

Dave Richard responded that nothing has been finalized or is in statute at present. He noted that there are a group of folks that will be assigned to those plans, but that individuals can always opt out of the plan.

MEETING ADJOURNED