NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MEDICAL CARE ADVISORY COMMITTEE TELECONFERENCE MEETING
November 15, 2017
DMA Kirby Building, 1985 Umstead Drive, Conference Room 132, Raleigh, NC
Teleconference No. 919-850-2820

The Medical Care Advisory Committee (MCAC) met via teleconference on Wednesday, November 15, 2017 at 10:30 a.m. – 12:00 noon.

ATTENDEES

MCAC Members in Person: Gary Massey, MCAC Chairman

MCAC Members via Telephone: Kim Schwartz, Samuel Clark, David Tayloe, William Cockerman, Stephen Small, Billy West, Jr., Paula Cox-Fishman
NOTE: Due to technology difficulty with the State's teleconference line, the following MCAC members were unable to participate on the call: Marilyn Pearson and Ted Goins

MCAC Interested Parties: Mary Short, Jenny Hobbs, Jean Andersen

DMA Staff: Sandra Terrell, Jay Ludlam, Mona Moon, Melanie Bush, Debra Farrington, John Stancil, Sarah Pfau, Terry Pennington, Sabrena Lea, Pamela Beatty

CALL TO ORDER

Gary Massey, MCAC Chair

- Gary Massey, MCAC Chair, called the meeting to order at 10:30 a.m. followed by a roll call of the members. Quorum declared. Chairman Massey welcomed and thanked everyone for their participation.

OPENING COMMENTS

Sandra Terrell, Director - Clinical & Operations, DMA

- Sandra Terrell highlighted the topics of discussion for the MCAC meeting. She stated that there are a lot of moving parts and it is very important that the Division hears from the MCAC to help guide us in these next important phases of the Medicaid Transformation. The meeting was then turned over to Jay Ludlam.

MEDICAID TRANSFORMATION UPDATE:

Jay Ludlam, Assistant Secretary, Medicaid Transformation, DHB

- Jay Ludlam noted that NC released two RFIs, one of which contains specific questions or issues, on which the State is looking for feedback. PHPs seeking to respond are asked to submit a non-binding Letter of Intent which indicates to the State they intend to participate in the bidding process long term and have a desire to potentially win as a statewide commercial plan or regional PLE.
- Jay provided a detailed description of the Operational and Actuarial RFIs. The Operational RFI includes topics, i.e. enrollment, credentialing, appeals and grievances, services, and specific questions to be addressed by respondents and identification of best practices the State may not have identified or considered in its research.

- The Actuarial RFI is a detailed technical document which outlines NC's rate setting methodology, assumptions and approaches. In the managed care bidding process, the State will identify actuarially sound rates that it requires MCOs to accept if they bid and ultimately win a slot in the RFP contracting process. This means there is no competitive bidding on rates and the State will establish actuarially sound rates. In the RFI, the State is seeking feedback from MCOs or actuarial organizations. By releasing the RFI the State hopes there is less discussion about how numbers were arrived at and more discussion about the services beneficiaries need and will receive.
- A question was raised if rate setting as described in this context is about what the State will pay PHPs and not based on what PHPs will pay providers.
- Jay responded, that is correct, however there are assumptions built into the rates regarding services for which the PHP would reimburse providers. The rates are also based on current utilization, current beneficiary mix, eligibility categories, and include regional, age, gender and risk adjustments based on beneficiaries' medical conditions. The rate setting methodology also factors in administrative cost the MCO must bear to support or deliver the services. Additionally, CMS Medicaid managed care rules, set standards for Medical Loss Ratios (MLR) which are minimum thresholds established so that MCOs in managed care program must spend at least 85% of each dollar on medical care. State may exceed the MLR but PHPs can't offer rates lower than 85%.
- Another document recently released is the *Behavioral Health/IDD concept paper*, a mini white paper, which outlines the proposed designed for behavioral health/IDD. This is not an RFI and is therefore open to all for feedback.
- Current CMS engagement activities were reviewed by Mr. Ludlam including DHHS' recent communication with CMS regarding the amended waiver application. In 2016, NC submitted a waiver application which CMS had not approve. With the new administration, the NC DHHS Secretary sought to make modifications to the original application in order to align the Department and NC with the new managed care rules and flesh additional programs or services it identifies as necessary for the managed care program to be successful.
- NC has gone through proposed amendments with CMS to identify potential sticking points which NC can address before a formal amendment is submitted and the formal negotiation on state terms and conditions begin. CMS has been very responsive and willing to work with NC to compress the timeline in order for NC to submit the amended application in a couple of weeks.
- Mr. Ludlam reviewed the entire amended 1115 Demonstration Waiver Application noting that NC is seeking approval to waive provisions in the law that governs what Medicaid programs can do. He emphasized two components of the application:
    - NC's seeking of authority to use different financing mechanisms to support the program
    - The need for NC to submit a State Plan Amendment in conjunction with 1115 waiver amendment. Due to federal rules, CMS needs to preapprove the managed care amendment before approving the SPA, which can be approved later. He noted that the 1115 amended waiver by itself is not the full extent of the Medicaid program operation in a managed care environment.
- Mr. Ludlam noted that although the review at this meeting will be detailed, NC plans to publish the amended waiver via the web, notices in newspaper and will make sure MCAC members get an email copy with link.
- He provided a summary of the 1115 waiver from page 1 of the application including NC's goal to improve outcomes by pairing the managed care program with initiatives to support and enhance the capabilities of providers, strengthen access to care and improve health though evidenced based health related interventions spearheaded by public private regional pilot programs. He highlighted the specific initiatives, reviewed the goals of the waiver and defined criteria by which NC would help CMS evaluate whether pilot/waiver is doing things it intended to do. The hypothesis proposed by the state outlined in the comments were in the areas of Measurably Improve Health, Maximize High-Value Care to Ensure the Sustainability of the Program and Increase Access to Care.

- Mr. Ludlam reviewed the proposed July 2019 timeline and provided a detailed description of key features of the proposed public-private pilots. Eligibility groups were identified; but, because of the length these were not read word for word. Instead, Mr. Ludlam encouraged people to review this section of the waiver at their convenience. He described the methodology to determine eligibility and noted of the 2 million people estimated to eligible, approximately 1.5 million will be enrolled in managed care with an additional 400,000 people being covered if Carolina Cares is passed by the General Assembly.
- Mr. Ludlam covered the details of and differences with standard and tailored plan and the specialized PHP for children in foster care, children in adoptive placements and former foster youth who aged out of care up to age 26.
- Additional details were provided on the waiver including:
    - Overview of BH/IDD Tailored Plans including populations, care management responsibilities, etc.
    - Public-Private Regional Partnership Pilots
    - Excluded and exempt populations including the option for members of EBCI to choose to participate in managed care or remain outside of managed care.
    - State wideness for managed care
    - Access to care and network adequacy standards
    - PHP rate setting and cost settlement for essential and safety net providers
    - Establishing a Tribal Uncompensated Care Pool
    - Innovation Workforce Fund
    - Telemedicine Alliance and Innovation Fund
    - Section 5 included the Implementation Schedule which was reviewed yesterday with G.A. and includes a request for rapid approval by CMS of IMD provisions for SUD, readiness reviews and launch of standard and tailored plans.
- The financing section was not reviewed in detail. But Mr. Ludlam noted that the state will negotiate with CMS to demonstrate that waiver is budget neutral. Proposed waivers and expenditure authorities were referenced. He noted that the waiver contains extensive detail about the State's effort to keep the public informed. Because the original waiver NC had extensive notice requirements that apply to this amendment, the State is considered to have met the requirement. However, NC intends to continue to engage with stakeholders in the interest of transparency and having a well-informed approach. The request was made that the MCAC committee members be prepared to offer comments on the waiver at the Dec. 8th meeting, contact Mr. Ludlam or submit formal comments as outlined in the waiver.
- Mr. Massey inquired about the various pilot projects and whether they will be administered by DHB. Mr. Ludlam noted that these pilots represent a public private partnership that PHPs, DHB and others will work on together. Mr. Massey inquired if the committee could be informed about similar pilots that have been used in other states. Mr. Ludlam agreed that this information could be provided.
- Mr. Massey opened the floor for questions from committee members as outlined below:
    - **Question:** When will the updated waiver come out?
    - **Answer:** Within the next couple of weeks
    - Mr. Tayloe commented and requested that committee members receive the documents as early as possible to have adequate time to review the waiver and prepare before the next meeting. Mr. Ludlam agreed that if the document was not available with sufficient time for the committee to review, we will have an additional call; however, that being said he anticipated that the document would be released in sufficient time.
    - **Question:** What will telemedicine innovations looks like and what is the State seeking to do given the many innovations that CMS has been involved in?

- **Answer:** In the amended waiver, there are 2 components for telemedicine innovations including a Telemedicine Alliance and Telemedicine Innovation funds. The Alliance is designed to increase provider awareness and education through establishing an independent statewide telemedicine alliance with the responsibilities as outlined in the waiver. Mr. Ludlam reviewed the funds and how funds would be awarded.
- **Question:** With the RFI and requirement for non-binding letter of intent, to be one of final MCOs/PLEs, do you need to respond to RFI?
- **Answer:** No, it would be helpful for the State to know how many potential PLEs/MCOs would bid and if there is any interest in participation but it is not required.

MCAC SUBCOMMITTEES UPDATE:
Gary Massey, MCAC Chair

- Mr. Massey noted that at previous meetings, the committee discussed the establishment of subcommittees which would allow members and others to do a deeper dive in very specific areas. The initial thoughts which will be confirmed at the December meeting is that MCAC members would act as chairs of the subcommittees and the MCAC would seek out other folks who have interest to be part as well. He cautioned that this would be a fast track of activities after the first of the year with MCAC's effort to help the Department work through the design and implementation of managed care. He further noted that this will require some time commitment from members.
- Debra Farrington reviewed the PowerPoint with the MCAC which included details on how the MCAC might establish subcommittees to have detailed conversations on various subjects. The committee received numerous comments from interested parties seeking to be involved and their inclusion in subcommittees would be a way to engage a broader group of individuals. Ms. Farrington further reviewed the structure, committee names, charter, role of members, logistics for implementation of subcommittees and a brief list of individuals who have initially expressed interest in participating.
- Ms. Farrington agreed that at the December meeting the committee will be able to see a draft of bylaw revisions and for each of the subcommittees a more detailed charter, timelines for committees to start and end and identify which MCAC members are interested in joining select subcommittees.
- Ms. Terrell noted that the existing bylaws permit the MCAC to stand up subcommittees without modifications.
- Mr. Massey requested that each member look at the list of committees and be prepared in December to identify in which subcommittee they want to participate.
- Mr. Tayloe asked about the process by which people who are not a part of MCAC can express interest or become involved.
- Ms. Farrington responded that a solicitation will be developed, an announcement sent out with detailed information and MCAC will appoint subcommittee members.
- Ms. Paula Cox Fishman noted that she can see where substance use disorders would fit with Behavioral Health; but, suggested that a different committee be considered for set up for people with I/DD.
- Ms. Farrington inquired whether if in this instance, certain smaller subtopics could fall under the broad area. For instance, for Behavioral Health, there could be focused discussions on I/DD, Mental Health and SUD. Ms. Fishman commented that this could work. She noted that attention however needs to be paid to silos and also consideration given to the needs of individuals with I/DD as many of their needs are long term in nature. She emphasized the need to have different representation for each group.

PUBLIC COMMENTS

- Mr. Massey opened the meeting for public comments.
- Mary Short raised a question about Managed Care Program Actuarial RFI and whether it accounts for Tailored plans? She raised concerns now, if it does, so that when that RFI is posted, hopefully it will address her concerns. The question relates to the use of "utilization" in setting capitation. Services are authorized as medically necessary and yet are never utilized because there is no workforce/staff/provider agency. Reviewing utilization does not capture that issue. She emphasized the need for the capitation to reflect the authorization of medically necessary services rather than the utilization.
- Mr. Ludlam responded that given the technical nature of the question he was not able to provide a response but requested that Ms. Short ask the question through the RFI public comment process.
- Jenny Hobbs noted that she attempted to call into the conference call for 25 minutes and was unable to get connected as there were no available lines. Mr. Massey thanked her for the observation and noted that we would follow up to identify and correct the problem.

CLOSING REMARKS

- Mr. Massey reported that the committee has vacancies on the MCAC for Districts 9 and 10. Requested that members assist with identifying potential members. He noted that solicitation for committee membership would be sent to various associations.
- Jean Andersen asked whether there is an application process available on the website.
- Pam Beatty indicated that there is not; but, she would make the application available to Ms. Andersen. Ms. Andersen was encouraged to initiate email communication with Ms. Beatty.

MEETING ADJOURNED