

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
MEDICAL CARE ADVISORY COMMITTEE MEETING
August 31, 2017
1985 Umstead Drive (DMA Kirby Building) Raleigh, NC 27606
Teleconference No. 919-662-4658

The Medical Care Advisory Committee (MCAC) met via teleconference on Thursday, August 31, 2017 at 1:00 p.m. - 2:30 p.m.

ATTENDEES

Members in Person: Gary Massey, MCAC Chairman

Members via Telephone: Kim Schwartz, Samuel Clark, William Cockerman, Linda Burhans, Ted Goins, Paula Cox-Fishman, Billy R. West, Jr., Polly-Gean Cox, David T. Tayloe, III, Marilyn Pearson, C. Thompson Johnson, III, David Sumpter

DHHS (DMA and DHB) Staff: Dave Richard, Virginia Niehaus, Patrick Doyle, Roger Barnes, Christal Hilton, Beth Daniel, John Stancil, Pamela Beatty, Debra Farrington, Sharlene Mallette, Jean Holliday, Melanie Bush, Teresa Smith, Kimberly Price-Shore, Julia Lerche, Mona Moon

DHH Staff via phone: Angela Diaz, Sarah Pfau, Terri Pennington

MCAC Interested Parties: Mary Shorts

CALL TO ORDER

Gary Massey, MCAC Chair

Gary Massey, MCAC Chair, called the meeting to order at 1:00 p.m., followed by a roll call of the MCAC members. Pamela Beatty declared a quorum present. Chairman Massey thanked everyone for joining the meeting and introduced representatives attending in person. The meeting was turned over to Dave Richard.

OPENING COMMENTS

Dave Richard, Deputy Secretary, DMA

- Dave expressed the Department's interest in receiving feedback, public comments from stakeholders and the Advisory Committee regarding progress and decisions being made for Medicaid Transformation. He requested that MCAC have monthly teleconferences that are publicized widely for interested parties where updates can be provided on transformation.
- Dave discussed the Proposed Program Design for Medicaid Managed Care that was distributed in August and the importance of feedback for implementation of managed care.
 - Based on the 1115 Waiver the goal is to put the best possible managed care system in place. Some recommendations still need legislative and CMS approval.
 - Additional input is requested from provider organizations, MCAC Committee members, health plans, beneficiaries and community based organizations.
 - Dave went over the PP presentation and advised that members could ask specific questions regarding the PP throughout but requested that they hold questions that are broader in nature until the end.
 - Dave stated the Department considered all the stakeholders' input received thus far while, still looking to get more feedback by 09/08/2017. Additional stakeholder involvement will continue throughout the entire process.
 - Visions and Goals
 - DHHS' vision is to maintain the same care high quality care that we have in North Carolina. The vision focuses on high quality care, population health improvements,

provider involvement and support and to have a sustainable program with predictable cost.

- The broad aspects of the transformation process are to
 - stay focused on the integration of the services for primary care, behavioral health, mental health and substance abuse and address social determinates of health such as housing, food and employment
 - support beneficiaries and providers throughout the transformation process
 - promote quality and value
 - set up relations for success.

- He reviewed managed care that already exists in N.C. and what it will be once the transition is complete. Background- Session Laws 2015-245 and 2016-121 was reviewed including:
 - Exclusion Requirements
 - Dual eligible individuals (Medicare/ Medicaid)
 - Populations that are only eligible for a short period
 - Enrollees that qualify for retroactive coverage
 - PACE
 - *Family planning (required additional statutory changes)
 - *Prison inmates (required additional statutory changes)
 - Dental
 - Services provided by Local Education Agencies
 - Services provided by Child Development Service Agencies
 - Eyeglasses and *provider visual aid dispensing fee (required additional statutory changes)
 - Timeline for Managed Care Go Live
 - Prepaid health plans requirements
 - Proposal for extension of eligibility for parents of children placed in foster care system
 - Provision that PHPs must include all willing providers in their networks.
 - One member expressed concerned about the ability of PHPs to not contract with a provider when the provider does not accept the network payment rates. Expressed a desire for DHHS to establish a strong system to check to be sure that PHPs are not engaging in a race to the bottom in terms of payment.
 - Dave responded that there are rate floors established by the authorizing legislation for providers. Additionally, DHHS' overall goal is that no current Medicaid provider will fail to continue to participate and do so with the plan(s) of their choice. We would see the above "race to the bottom" practice as a failure and something that would be intolerable.

QUESTION AND ANSWER SESSION

Question: Will one stop enrollment for providers through NC Tracks continue?

Answer: DHHS envisions a one stop credentialing system, but where that will reside, and what role NC Tracks may play, has not yet been determined.

Question: Will the provider monthly newsletter continue?

Answer: Yes.

Question: Will the eligibility portal used by DSS and the beneficiary include plan information, provider information, etc. to help the beneficiary make choices about the plan, the provider (PCP), etc.?

Answer: The enrollment broker will have this information and the DSS and beneficiary will have access to that information during the enrollment process.

Question: Since PHPs will be paid “per member per month” does that mean that effective dates of coverage will be delayed until the 1st of the month?

Answer: Effective dates are being discussed, but the PMPM that is paid will reflect whatever is decided.

Question: About the requirement that providers must submit claims within 90 days to get paid by the PHP, where did the 90 days come from?

Answer: DHHS is suggesting 90 days to help with the administration of the capitated rate setting which is incumbent upon timely and up-to-date claims payment data from the PHPs.

Question: What happens to a claim submitted beyond 90 days?

Answer: Clean claims will still be paid appropriately under Medicaid standards.

Question: The design paper mentioned that PHPs will pay interest on claims that are not paid in accordance with the program standards for prompt pay, but this would appear to conflict with the March 2016 Legislative Report from DHHS.

Answer: DHHS will research this issue and obtain clarification.

Question: What feedback is DHHS receiving on the design paper (white paper), particularly from the behavioral health community.

Answer: DHHS is getting positive feedback on the paper in general, including respondents asking questions which are generating more review by the transition team, especially around detail. And no one is saying that BH integration is a bad idea.

Committee members offered the following additional comment in response regarding BH Integration; it is a challenge to explain integration to beneficiaries and get their buy-in/commitment. This will be critical to success for beneficiaries, providers, plans and DMA.

Question: What are we asking the MCAC to do and/or assist with regarding the paper?

Answer: We will be taking pieces of the plan and taking a deeper dive with the MCAC and will be asking for their input/feedback. These meetings will also include the public should they wish to attend and they will be able to give feedback time at meetings during the time dedicated to public comments.

The Chair suggested that the MCAC may want to establish sub-committees so that members can focus on areas which are of interest to them.

Dave Richard asked staff to bring a vision of what the sub-committees might look like to the September 22nd In-person meeting of the MCAC.

Question: May the committee get a copy of all public comments received on the design paper?

Answer: DHHS is synthesizing the comments and will provide a high-level summary of the comments at the meeting on the 22nd.

Question: Will an attorney at DHHS be reviewing PHP/Provider contracts?

Answer: New staff has been added to DHHS/DMA/DHB to help oversee transition efforts and the transformed Medicaid program. DHHS' goal is to identify the right skill set of staff for the transformed Medicaid program and expect to put the right resources in place to establish a quality program. Part of that will be establishing a contract between the state and PHPs (and likewise between the PHPs and providers) that reflects that goal and focuses on outcomes.

Question: Who will review RFP responses?

Answer: We will follow state and federal requirements around that process, and our goal is to have a non-biased, fair process that is free of objections from respondents.

Question: Will the Ombudsman program be internal to DHHS or external? If internal, there may be some perverse incentive to protect the State's interest rather than the beneficiaries.

Answer: The Ombudsman program is currently envisioned to be an outside organization.

Question: The design paper mentioned accountability of PHPs, but did not include a lot of detail. Is the plan to have accountability beyond what was included in the design paper?

Answer: We expect to design a robust compliance program to evaluate plans' compliance with the contracts and our expectations/requirements.

Question: The design paper mentioned "targeted stakeholder engagement" which sounds like DHHS is only engaging the stakeholders they have selected (targeted = selected), and such targeted audiences do not always give a full picture – especially beneficiaries' views. Encourage that direct beneficiary feedback should be included.

Answer: DHHS agrees and we want comments from beneficiaries.

Question: The design paper mentioned standardized provider contract language, when will those standard provisions be made public?

Answer: As this will likely be part of the RFP, by the time the RFP is issued.

PUBLIC COMMENTS

Meeting opened for public comments; there were none.

MEETING ADJOURNED

