

MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING MINUTES
NC Medicaid Kirby Building Room 132, 1985 Umstead Drive, Raleigh, NC

Teleconference: Dial in: 888-363-4735 Access Code 9405409

May 17, 2019

The Medical Care Advisory Committee (MCAC) met via teleconference on Friday, May 17, 2019 (10:30 a.m. – 12:00 p.m.).

ATTENDEES

MCAC Members: Gary Massey, MCAC Chairman

MCAC Members via Telephone: Marilyn Pearson, MCAC Vice Chairman, Kim Schwartz, William Cockerham, Linda Burhans, Benjamin Smith, Samuel Clark, David Tayloe, Benjamin Smith William Cockerham, Stephen Small, Ivan Belov, Chris DeRienzo, Billy West, Thomas Johnson, David Sumpter, Paula Cox Fishman, Benjamin Koren, Jenny Hobbs

MCAC Interested Parties: Sarah Pfau, Mary Short, Jean Anderson, Bob Hardyman, Kristin Dubay, Chris Evans, Valerie Arendt, Lee Dobson, Jean Kirk, Martha Turner

DHB Staff: Jay Ludlam, Debra Farrington, Terri Pennington, Sharlene Mallette, Pamela Beatty

CALL TO ORDER

Gary Massey, MCAC Chair

Gary Massey, MCAC Chairman, called the meeting to order at 10:30 a.m. followed by the MCAC member roll call and introduction of staff and interested parties. Pamela Beatty declared a quorum. Chairman Massey welcomed and thanked everyone for their participation. Chairman Massey entertained a motion to approve the March 8, 2019 MCAC Meeting minutes. The minutes were approved by the Committee.

OPENING REMARKS:

Debra Farrington, Chief of Staff, NC Medicaid

Debra provided an update on recent events in Dave Richard's absence.

- Governor Roy Cooper released his recommended 2019-21 Budget. The House passed the budget and sent it over to the Senate who has not yet released their budget recommendations.
- The NC House budget included a significant decrease in the Medicaid rebase of approximately \$40 million lower than the Governor's budget. It also included a management flexible reduction which gives the State some ability to determine how that \$15 million reduction will be applied. The \$55 million reduction will have a big impact on our Medicaid budget. We are advocating for and certainly need the Governor's budget to be approved. Chairman Massey requested that the MCAC go on record in support of the Governor's budget. He also encouraged the Committee members to discuss the potential House budget cuts or underfunding of the Medicaid Program with members of the General Assembly, if given an opportunity.
- Debra reported that the provider physician rate increase is pending approval by CMS. However, we did get approval from CMS for the dental and the optical rate increases. Some of the changes have already been implemented on the visual side and we are working on finalizing those increases.

MEDICAID MANAGED CARE UPDATE

Jay Ludlam, Assistant Secretary, NC Medicaid

Jay provided a high-level overview of the following items:

Transition to Implementation Phase:

- The Division has published a number of policy papers and work pertaining to the innovations that we intend to bring to North Carolina Medicaid through the transformation of Medicaid. Those policies outline new operational platforms, an Advanced Medical Home (AMH) program, a robust quality strategy that is tied tightly to the value that the standard plans and ultimately tailored plans will provide.

- DHHS' priorities for transition to Managed Care:
 - Beneficiaries who have scheduled appointments will have the ability to see their own provider.
 - Beneficiaries' prescriptions will be filled by pharmacies.
 - The Division has an operational infrastructure that support calls to the Call Centers.
 - On November 2, 2019, our PHPs will have sufficient networks to ensure member choice and that our providers are paid for the services they provide to our members.

Current Managed Care Activities:

- The Division will go live with the Standard Plans within 175 days.
- Our focus is on the PHPs' readiness. Early this week, we sent notifications to the health plans informing them that we are scheduling readiness activities with them.
- Outreach and trainings have been scheduled with the DSS offices and county officials to explain how the changes will affect them. The focus right now is on Phase 1 counties which are 25 counties.
- The Division is working closely with Maximus, our enrollment broker. Maximus is putting a community engagement strategy in effect and have held community-based meetings and trainings. They are also in the process of developing/updating a website to guide beneficiaries at open enrollment through the process. Additionally, we have been working with Maximus' Office of Health Literacy to develop materials that are will go to beneficiaries.
- The Welcome Packet has been finalized, which is the first piece of information that the beneficiaries will receive regarding the enrollment process and inform members of assignments.

Ombudsman Update:

- The member Ombudsman RFP did not receive any potential bidders. Based on our analysis, we think that there were three areas that discouraged potential offerors:
 - The first one would be navigator issues (navigator services are services provided to support individuals in the marketplace)
 - The second potential issue that discouraged offerors was around the legal services component.
 - The third is related to oversight. We developed a large number of service-level expectations that we intended to put on the member Ombudsman to hold them accountable. As an example, holding them accountable included liquidated damages that could be issued for failure to return a voicemail and/or an afterhours call in a specified period of time. The liquidated damage amounts were not proportional to the amount of money that we expect this contract to be. Unintentionally, we leaned too heavily on the liquidated damages as the tool for accountability, putting the potential offeror at risk for what was disproportionate for the amount of money. We have tried to address the issues in our policy objectives and our expectations around oversight.
 - Debra asked if the Ombudsman would be awarded by open enrollment in July 2019. Jay stated it would not. Many of the services or functions that the member Ombudsman would have performed are supported, instead, by other players that are in the system like the Enrollment Broker. While it's not entirely independent, the State will have to develop mechanisms that do not discourage anyone from self-reporting an issue as well to which the State may have contributed.
 - Debra commented that the 90-day choice period that people have after go-live and the fact that people can change plans without any notice at their discretion, will help us respond to the delay in the Ombudsman coming up.

Member Outreach Overview:

- Jay stated the Enrollment Broker (ER) is coordinating member education and outreach for enrollment events with local DSS offices. The schedule is still being finalized. They have responded to requests from counties, school nurses and individuals throughout the State. We are trying to get the ER to focus primarily on Regions 2 and 4 for go live; however, we are not precluding them to go into other regions. They are also in the process of scheduling open enrollment events across the various regions.
- Outreach events have taken place with Enrollment Broker, PHPs/PLE, and Ombudsman.
- Community events such as meet & greets, informational booth, and health fairs have taken place.
- PHPs and Enrollment Broker marketing materials including fact sheets and notices are available to community organizations and providers.

Member Communication Activities:

- Address verification letters were sent to Regions 2 and 4. We learned a couple of lessons around that. Kim Schwartz stated it is encouraging to hear that the beneficiary mailings in March were at 95% accuracy. Chairman Massey agreed.
- The PHPs have submitted their 30, 60 and 90-day deliverables. The value-added services were part of the 90-day deliverables. This is also a framework for us when we start to bring in the quality measures. The Division will soon start posting quality measures and how the health plans are doing on key metrics .

PHP Provider Contracting:

- We have established what we feel are clear network adequacy expectations and have established a MCAC Network Adequacy Subcommittee. We have asked that group to report to the full MCAC. We are also engaging an independent consultant to evaluate the number of providers who participate in NC Medicaid.
- Jay outlined categories of NC Medicaid's contract terms with the PHP providers.
- Debra stated that providers are saying they have not heard from the health plans. The Department will help facilitate connections by working with associations and placing information on our web page. Chairman Massey said the biggest pushback he has heard is folks are hesitating to sign anything with the PHPs without an understanding of what the rates are and so forth. Chairman Massey requested a final rates table at some point.
- Kim Schwartz advised the Committee that the Prospective Payment System (PPS) is a major component for Federally Qualified Health Centers (FQHC). There is major concern and anxiety about PPS in the FQHC world, Kim stated.
- Jay announced that the Division is continuing to host more webinars, working on virtual office hours in addition to meet and greet sessions. The meet and greets have been relatively successful.

Tailored Plan Design Activities:

- Debra Farrington shared that the Tailored Plan design is the last major area, aside from children in foster care, where we still need to make recommendations about how the plans will operate.
- Our initial work has focused a great deal on clarification as to who will fall in which plan. A great amount of work has been done on defining the eligibility criteria. The Secretary wants us to touch each person. We are doing a lot of work with reconciling at the member level with the LME-MCOs.
- We are continuing to define our quality measures. We plan to release policy papers pertaining to data management and how we will address care management in the Behavioral Health I/DD Tailored Plan. The MCAC Behavioral Health Subcommittee will meet in early June 2019. We will also look at the care management recommendations at that time.
- A webinar for BH I/DD Tailored Plans will take place at the end of May 2019 and is publicized on our webpage. We have been working with the County Commissioner Association to make recommendations to the Secretary on the Tailored Plan regions. We anticipate that recommendation will be coming any day now.
- Debra highlighted the flow process for the BH I/DD Tailored Plan Eligibility Request for individuals who are assigned to the Standard Plan, but believe they qualify for the Tailored Plan. An exemption form will be available for individuals who raise their hand to go into the Tailored Plan. We intend for this process to be implemented when we go live with Standard Plans. The form can be completed by the beneficiary, a provider, or a care manager. If a person is denied their request to move, they will have due process rights. We will finalize the form and send it to stakeholders for feedback prior to it being finalized.
- The Division is focusing its attention and working with the Enrollment Broker on materials to send to individuals to enroll people in the right plans. We do not want Innovations Waiver recipients choosing to go to the Standard Plan because that would not be in their best interest. We are doing everything possible to make sure that they have information to make the best choice for themselves. The exemption form will be presented to the Committee for feedback.
- Due to time, Chairman Massey asked Terri Pennington to table her presentation on Access Monitoring to the face-to-face on June 14, 2019 meeting. Billy West shared comments about his observation on the Access Monitoring Report. A lot of the penetration the report talked about saw decreases vs a steady state or increase, said Billy. Billy asked Terri to highlight why the decreases happened in her next report.

PUBLIC COMMENTS

- Mary Short commented on the May 6, 2019 article from *The Disability Scoop* entitled "Are Managed Care Providers Wrongly Denying Services to People with Disabilities?" The second paragraph of that article stated the U.S. Department of Health and Human Services (HHS) Office of the Inspector General said it will investigate whether managed care organizations are wrongfully denying services. In a letter to the HHS Inspector General, Senator Bob Casey, D. Pennsylvania cited reports from *The Dallas Morning News* and *The Des Moines Register* suggesting that some managed care companies have wrongly denied needed care.

CLOSING REMARKS

Chairman Massey announced the next MCAC meeting will be face-to-face and held at the McKimmon Center beginning at 9:00 a.m. Thanked everyone for their participation.

MEETING ADJOURNED