

NC Department of Health and Human Services
DIVISION OF MEDICAL ASSISTANCE

MEDICAL CARE ADVISORY COMMITTEE MEETING
JUNE 3, 2016

MCKIMMON CENTER, 1101 GORMAN STREET (CONF. RM. #3) RALEIGH, NC 27606
TELECONFERENCE NO. 919-850-2820

The Medical Care Advisory Committee (MCAC) meeting was held at the McKimmon Center on Friday, June 3, 2016 at 9:00 a.m.

ATTENDEES

Members in Person: Samuel Clark, Dave Taloe, Marilyn Pearson, Paul Jean Cox, Derek Pantiel, Thomas Johnson, Ted Goins, Dave Sumpter, Jeff Horton, Sarah Pfau, Sandy Terrell, Roger Barnes, Trey Suttan, Rob Kindsvatter, John Stancil, Steve Tedder, Christal Kelly, Pamela Beatty, Teresa Smith, Kim Shore, and Mary Rhodes

Telephone: Mary Short, Kristen Dubey, Jamal Jones, and Paula Cox-Fishman

CALL TO ORDER

Gary Massey, MCAC Chair

- Meeting called to order at 9 a.m.
- Approval of April 15th and May 5th meeting minutes: Amendments: Derek Pantiel – Under the Medicaid Access Monitoring Requirements, the next to the last sentence should reference Medicaid not Medicare.
- With the amendment, the minutes have been approved.

OPENING REMARKS

Dave Richard, Deputy Secretary, DMA

- Thank you to every one for the efforts with the 1115 Waiver that has been sent to CMS on June 1, 2016 and is posted online. Inside the waiver you will see more contractual information versus administrative functions.
- Expansion was another big topic that had a significant impact on the secretary. All comments from the public have gone in the record and was shared with the General Assembly.
- The targeted comments from providers helped to instruct in ways to do things differently to work with providers and other stakeholders. The public comment period was tremendously helpful for the Waiver.
- CMS has confirmed that they have received the Waiver and we will have further conversations on the approval of the waiver process.
- The timeline of 18 months is based on what has happened in other states and the upcoming election. It could take longer to be approved or less time.
- Our expectation is to work with CMS to get the best possible product; the timeline is not what's important. What's important is getting what we do right and that it works for both CMS and the State.
- We recognize that the waiver does not address every public comment; we will continue to work with the community and beneficiaries as we work with CMS.
- The required 2015 FY Annual Report was posted June 1st, 2016.
- Jamal Jones added a quick reminder that the State has also released a summary of comment related and not related to the waiver on the website.

The minutes are a synopsis of the MCAC Meeting topics. All items are an update of the program area since the last meeting. Dates vary dependent upon reporting period. Available presentations may be viewed for more details on the DMA Medical Care Advisory (MCAC) web page at: <https://dma.ncdhhs.gov/get-involved/committees-work-groups>

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Prepared By: Mary K. P. Rhodes, DMA Policy & Regulatory Affairs

MEDICAID BUDGET UPDATE

Roger Barnes, Deputy Director of Finance, DMA

- Enrollment for the year was 1.897 as of the end of May of this year, 3% above and below the forecasting based on trends.
- Per Trey Suttan, the state forecasted and trended off of recent experiences of enrollment of drug experiences and other areas.
- We worked with SAS on our enrollment projections.
- Derek Pantiel – Has anyone looked into where patients are being seen when they can't see their PCP?
- Sandy Terrell – The State still needs to drill down to population but we are working with CCNC for this information. Claims are also being looked at for information.

LEGISLATIVE UPDATE

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

- Breaking news last night - the senate budget was passed. In the budget there are approximately 30 different special provisions, unique to the senate budget was a provision to have DMA contract collection of provider payments that are less than \$150.
- What did not appear in the House or Senate budget but did appear in the Governor's budget is our most critical one that complies with Federal Law – criminal background checks on high risk providers and now we can fingerprint those providers and receive results from the State Bureau of Investigation.
- Some high Risk providers are Behavior Health, PCS and DME providers.
- Fingerprinting is required for providers and anyone with a 5% direct or indirect interest in the provider.
- Other provisions are single stream funding, technical correction language and there have been some inconsistent slot expansion provisions.
- There has been a sunset in the cost of living disregard which has been repealed for Medicaid applicants in both the house and the senate. The provisions will be in the spread sheet and will be forwarded.

MEDICAID ACCESS MONITORING

Jeff Horton, Utilization Committee Chair, DMA

- We are still working on the Medicaid Access Monitoring Plan with is required under the 42.447 CFR.
- Some of that we are looking at are Primary Care, Dental, Physician Specialty Services, Neurology and Pediatrics.

MEDICAL HOME ACCESS & ED UTILIZATION

Kelly Crosbie, Executive VP & COO, NC Community Care Networks, Inc.

- CCN operates primary care case management systems, we provide and support medical homes across the state. We have over 1800 medical homes through initiatives, practice support and care management of complex patients.
- We monitor ED trends, expected utilization, historical utilization and more.

OBSERVATIONS & THOUGHTS FOR REFLECTION

TED GOINS

- I am concerned with recruitment and retention of the Medicare staff for all Medicare providers.
- Medicaid providers are having to compete with the higher minimum wage across the country – this should be analyzed in regard to those who have worked in the system for a long time and the new employees coming in at a higher wage.
- Dave Richard – Our commitment with great discussion to the Secretary is to develop a processing plan to address rates and will be presented by October 1st.

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WRITTEN REPORT INFORMATION

SANDRA TERRELL

- In the last article of the written report, the agency is in the process of complying with Federal regulations regarding the referring providers that are not enrolled in Medicaid.
- As of February 1st, we added into our Fiscal agent a report to see remittance information.
- Unless referring providers are enrolled in NC Medicaid you will have these claims suspended.
- The anticipation is that on August 1 we will turn this edit off. On August 1st, you must have your NPI on your claims.
- We are also working on residence and interns at hospitals enrolled in Medicaid. We are interested in keeping them to stay in NC and we are looking at alternatives to not require them to be enrolled.

PUBLIC COMMENTS

MARY SHORT

- I've had experience with IVD adults that were told by PCP that they needed to be prior approved for urgent care visits.
- If the PCP practice is a couple of counties away but there is an urgent care in the vicinity and a patient goes to the urgent care over the weekend then calls the office on Monday, they were told they should have gone to the ER. This sounds like patient dumping to the family.
- There is a case in IL, O.B. v Norwood, a Federal District Court judge ordered that IL Medicaid Agency need to "Take immediate and affirmative steps to provide the very in-home nursing services that they approved".
- I ask that there is a look at the clinical policies, the waiver and the different treatment of relatives and guardians in relation to provide services and the budgets for services and the application of policies.

CLOSING REMARKS

Gary Massey

- Gary closed the MCAC meeting with asking if anyone had any questions, there were no additional comments. The meeting was adjourned.
- The next meeting is September 16 at the McKimmon Center.

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