Advisory Committee Meeting

Thursday, July 28, 2016 | 11:00 a.m. – 2:00 p.m.
McKimmon Conference & Training Center | 1101 Gorman St., Raleigh NC 27606

Minutes

North Carolina Dual Eligibles Advisory Committee (NCDEAC) met Thursday, July 25, 2016, at 11:00 a.m.

ATTENDEES

Dee Jones (Division of Health Benefits/DHB) and Dave Richard (Division of Medical Assistance/DMA) – Department of Health and Human Services (DHHS) liaisons to the Advisory Committee

NCDEAC: Mary Bethel; Vickie Bradley; Conor Brockett; Hugh Campbell; Tonya Cedars (for Blair Barton-Percival); Kelly Crosbie; Corye Dunn; Cindy Ehlers; Keith Greenarch; Ken Jones; Genie Komives; Alan Kronhaus; Ken Lewis; Frances Messer; Carol Meyer; Benjamin Money; Carrie Palmer; P. Palmer (for William Lamb); JoAnne Powell; Sharon Scott (for Sharnese Ransome); Tim Rogers; Richard Scott; Linda Shaw; Craig Souza; Jeff Weegar

Audience: Kari Barsness (Community Care of NC); Melanie Bush (Cansler Collaborative Resources); Sam Clark (NC Health Care Facilities Assoc.); Tracy Colvard (Assoc. for Home and Hospice Care); Ronnie Cook (NC Hospital Assoc.); Dean Lee (Assoc. for Home and Hospice Care); Cooper Linton (Transitions LifeCare); Jamie Powell; Adam Sholar (NC Health Care Facilities Assoc.); Ed Turlington (Brooks Pierce); Kelly Vogel (KV Strategies); Chad Walker (Transitions LifeCare); M. Watson; Polly Welsh (NC Health Care Facilities Assoc.)

DHHS Dual Eligibles Planning Committee: Wayne Black; Donald Browning; Tabitha Bryant; Angela Diaz; Patricia Farnham; Nancy Henley; Jamal Jones; Sabrena Lea; Suzanne Merrill; Sandra Terrell

DHHS: Natasha Adams (DHB); Joseph Breen (Division of Aging and Adult Services); Julia Lerche (DHB); Jeff Mobley (Division of Services for the Deaf and Hard of Hearing)

WELCOME/INTRODUCTIONS

Dee Jones, Chief Operating Officer, DHB

- Meeting agenda overview. NCDEAC members, DHHS attendees and audience introductions.

ADVISORY COMMITTEE OPERATIONS

Dee Jones, Chief Operating Officer, DHB

- Provided a recap of the goals of the Advisory Committee discussed at the first meeting. The Department wants to set up the right program for the dually eligible population. The first step to do this is for the Committee to help define the population—who the people are and what services are available to them. The Committee will provide recommendations on how to cover duals under capitation. The Department wants to hear all aspects of that plan, including the pitfalls, challenges and program design. Workgroups will be used to help facilitate the work of the Committee.

ROLE OF THE STEERING COMMITTEE

Dee Jones, Chief Operating Officer, DHB

- Introduced the members of the Steering Committee.

- Explained the Department's expectations of the Steering Committee and how it will function in relation to the Advisory Committee. The Steering Committee will develop all future agendas for Advisory Committee meetings; will lead and organize any smaller working groups or subcommittees created within the Advisory Committee; will obtain any necessary information or data that the Advisory Committee may need from the Department; and will lead the drafting of recommendations to Department.

REVIEW OF COMMITTEE MEETING SCHEDULE

Dee Jones, Chief Operating Officer, DHB

- Steering and Advisory committee meetings will occur monthly. The Planning Committee meetings will occur in advance of the Advisory Committee meetings and are comprised of DHHS staff. The Steering Committee meetings will follow the Advisory Committee meetings so that the Steering Committee can set the course for the next Planning and Advisory Committee meetings.
- Reviewed all of the scheduled meeting dates and locations for the Steering and Advisory Committees.

REVIEW OF RECENT WEBINARS

Patricia Farnham, DMA and Jamal Jones, DHB

- Provided an overview of the three-part webinar series hosted by the Department in July. The first webinar provided an overview of the goals of the Medicaid reform legislation. The second webinar was an introductory session on the concept of managed care and long-term services and supports (LTSS). The third webinar provided a high-level overview of the 1115 waiver design. The intent of the series was to provide an educational opportunity for individuals using long-term services and supports (LTSS) and to provide an orientation on how Medicaid reform activities will impact them.

- The webinars were well attended with over 100 participants for each session. Participants received surveys following each webinar and provided the Department with positive feedback and constructive critiques.

- Emphasized that the series was just a first step by the Department to get more information out to the public on these topics. Requested that members provide advice on how to reach a broader audience. Each webinar is already posted to the Dual Eligibles website and the Department will post a FAQs document generated from questions at the webinars as well as a transcription of each session.

- The Department wants to not only use these webinars to reach the LTSS population, but is also working on translating the information to reach the larger community as a whole.

    - **Komives.** Suggested it would be helpful if the webinars clarified the people comprising the dual eligible population as well as the types of services that the people are utilizing.

REVIEW OF CURRENT DUALS POPULATION/COST INFORMATION

Julia Lerche, DHB and Patricia Farnham, DMA

- Emphasized that the data provided is only a first cut and is in draft form for discussion purposes only. The Department is still working to validate the data. Once validated fully, the Committee will receive a copy of the data information comprised by the Department on the dually eligible population.

- The data presented came from the Department's data warehouse and only pertains to individuals that are dually eligible for both Medicare and Medicaid. Individuals who are also eligible for private

insurance are not included in the data set. Cautioned that the Department tried to limit duplication as much as possible but some may still exist in the enrollment data.

- Provided a high-level overview of the enrollment data. When compiling the data, the Department split the approximate 1.9 million population of Medicaid beneficiaries into three categories: Medicaid only, Full Duals, and Partial Duals. Based on data from January 2015, 315,000 individuals were dually eligible and, of those individuals, 243,000 are full duals.

- Discussed the age distribution of the three population categories. For individuals who are Medicaid only about three quarters of them are aged 0-21; 23% are 22-54 years old; and only 3% are aged 55 or older. For the duals population (full and partial), more than 50% are aged 65 and older. For the full duals, almost one third are 22-54 years old. When comparing the full and the partial duals, the partial duals tend to be older than the full duals.

- Provided an overview of the service utilization of the dual population for particular services for SFY2015. The data was distributed by claims costs by service category. Approximately three quarters of the claims come from three types of services: long-term-care Skilled Nursing Facilities, HMO premiums (includes PACE and LME/MCO capitated premiums), and Personal Care Services. Emphasized that the information only represented claims paid by NCTracks covered by Medicaid. The information is not the full scope of the services the dual population is receiving—just what Medicaid is paying. The total costs for the claims data is approximately three billion dollars for the dual eligible population.

- Discussed the data related to the number of duals eligibles that utilized a service in each of the claims categories in SFY2015. The top three categories utilized most frequently were physicians, hospital outpatient, and dental services. The information excludes services provided by the LME/MCOs and PACE.

- When finalizing the data, members requested the Department examine and provide the following:
    - Enrollment Data:
        - Identify by diagnosis/co-morbidities (also falls into cost data)
        - Identify by those served by medical home and LME-MCOs
        - Distribution by rural/urban regions (would be by county)
        - Distribution by living arrangement
        - Income levels by people who qualify for “spend down”
        - Provide more up to date enrollment with regular updates
        - Add eligibility criteria to help define the population categories
        - Determine how many individuals are eligible through the “spend down”
    - Utilization Data:
        - Organize by mandatory vs. optional services
        - Look at utilization volume of services
        - Divide the HMO premiums into separate categories
        - Determine where the CCNC PMPM payments to physicians are located
    - Cost Data:
        - Subdivide MQBs into partial and full duals
        - Identify cost trends of “frequent flyers”/high utilizers/people with co-morbidities.

        - Include real numbers in chart
        - Clarify what timeframe is being analyzed within the data set
        - Have all costs of services available, including matching the dollar amount to each service
        - Provide more detail on HMO premiums i.e. PACE vs. LME-MCOs

    - General Information Requests:
        - Look at similar sized MCO states' utilization rates prior to and after capitation compared to NC
        - Break out data for beneficiaries enrolled in LME-MCOs
        - Obtain Medicare claims data for this population from CMS

KEY QUESTIONS

Dave Richard, Deputy Secretary, DMA

- Posed several questions to the Committee for discussion and to provide advice to the Department: How are other states covering these populations (i.e. managed care, fee-for-service, other)? What lessons can NC learn from other states? Which population should NC include (i.e. full duals, partial duals, or both)? What is the timeline for implementation in relation to the current Medicaid Reform initiatives? Emphasized that the Advisory Committee has the knowledge base and expertise to answer these questions for the General Assembly.

- **Shaw.** Indicated that Pennsylvania is trying to do work in the area of LTSS, despite facing some challenges, and suggested the Department look at their program.

    - **Richard** responded that the Department needs to engage with other states like Pennsylvania, but also wants the Committee to reach out to their contacts in those states as well and bring the information back to the group.

- **Bethel.** A previous LTSS workgroup looked at what other states were doing and believes that information would provide a good basis for the Committee.

    - **Farnham** responded that the Department is still vetting the information from the LTSS workgroup and is working to have it available for the next meeting.

- Members want the Department to take into account what NC is doing correct because the state has an extensive menu of services already. Believes this process should focus on the beneficiaries and that any changes should be based on what is good for them. Do not want the Department to assume, at the beginning of this process, that all LTSS should be under a managed care system if the system is not broken.

    - **Richard** responded that the Department knows the charge of the Committee based on the law, but he does not want the Committee's conversation to be limited. The Department wants what is best for the people of NC.

- **Komives.** Suggested it would be helpful to provide the Committee with a clear understanding of the rationale for the General Assembly's decision to move the dually eligible population into managed care.

- **Money.** Indicated that there is a lot to learn from PACE program in terms of capitation and asked the Executive Director of PACE, Linda Shaw, to provide some background on the program.
- **Shaw.** Stated that the PACE program provides all services that are medically necessary to their participants. PACE is a full-risk model. They function as the insurer and the provider of care. The program seeks to take an all-inclusive look at an individual's medical situation. To be eligible, an individual must require a nursing home level of care. PACE will provide care, as long as the person remains enrolled, up until the time of the participant's death. Typically, individuals only dis-enroll because they move out of their service areas. The goal the program is to keep participants out of long-term care facilities, however, if that becomes necessary the program will pay for those expenses.

    - Members asked several follow-up questions of Ms. Shaw regarding the functions and operations of the PACE program including questions related to care coordination, the eligibility process, enrollment, program resources, program outcomes, and how the program handles financial losses.

    - **Richard.** The Department will provide a factsheet on the PACE program to the Committee.

- **Money.** Suggested the Committee look at whether there could be a pilot project that mirrors or aligns with PACE's approach to see what capitated services for dual eligibles would look like.

- **Campbell.** Discussed the General Assembly's goal of budget predictability, the required medical loss ratio, NC's robust continuum of LTSS services and expressed concern for how the shift to managed care will achieve the monetary goals set forth by the General Assembly.

    - The Department recognizes that the dual eligibles are a vulnerable population and wants to ensure that this process is managed properly. The Department believes there are benefits to moving duals into a managed care system and will continue to engage stakeholders throughout the process of figuring out how to bring them into a capitated environment. There are models that other states are trying and North Carolina can learn from them.

- **Dunn.** Wants an explicit value of the Committee to be that people will have a meaningful choice to stay in their homes for as long as they want by ensuring that community based services are available.

- **Ehlers.** Suggested the Committee form a workgroup for dual eligibles who have an SPMI, IDD/DD, and/or SU diagnosis.

- **Lewis.** Stated that the Medicaid Reform legislation tasks the managed care plans with coordinating care for beneficiaries. Believes that the managed care companies have been doing the same types of things that the PACE program has been doing, and that there is no one way to do this for everyone. The managed care plans want to work alongside of whatever model NC chooses, to make the system better.

- Questioned the Committee on how it should go about accomplishing the Committee's work. The Department believes that workgroups will assist in the process, but wants the Committee to decide and/or put forth other ideas.

RECOMMENDED WORK SESSIONS

Dee Jones, Chief Operating Officer, DHB

- Provided an overview of what topics could be useful for the Committee to discuss if the decision is made that they will subdivide into workgroups including: the key questions that were previously provided as well as feedback on what approach should be used to answer each of them; LTSS-related waiver goals and provide feedback on those goals as related to dual eligibles; what is working well in the current system and provide feedback on what could be retained under a reformed system; feedback on what could be improved in a reformed system; recommendations on how the Steering Committee should identify and organize upcoming meetings; and recommendations on how the Committee should develop and submit the formal recommendations to the Department.
- Members discussed the feasibility of workgroups and when the Committee should form them. Some members stated it was too early to set up workgroups and that they would like more information from the Department prior to making a decision. Members stated that it would be helpful to have information on what is working now and what could be done better; the additional data on the dual eligible population that was requested earlier in the meeting; information on what other states have done for duals; and NC's current LTSS service array prior to forming workgroups.
- **Lewis.** Suggested bringing in some of the managed care plans to present to the Committee to explain what they do and what they provide the state for the duals population.
    - **Richard** responded that the Department will have a follow-up discussion with Ken Lewis, Executive Director of the NC Association of Health Plans, about having some of the plans present to the Advisory Committee regarding what they do, what they have done in other states, and what they could provide in NC.
- Requested that Advisory Committee members send Angela Diaz (Angela.Diaz@dhhs.nc.gov) information regarding each member's concerns for their constituency as well as their concerns regarding the dually eligible population as a whole. The Department will synthesize the information and develop common themes to present to the group at the next meeting for discussion.

ADJOURNMENT

The meeting adjourned at 1:25 p.m.