

Tuesday, August 23, 2016 | 11:00 a.m. – 2:00 p.m.

McKimmon Conference & Training Center | 1101 Gorman St., Raleigh NC 27606

Minutes

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 (NC Coalition of Aging); Vickie Bradley (Eastern Band of Cherokee Indians); Conor Brockett (NC Medical Society); Sally Cameron (NC Psychological Association); Hugh Campbell (NC Association of Long Term Care Facilities); Corye Dunn (Disability Rights NC); Chris Egan (NC Council on Developmental Disabilities); Abby Emanuelson (National Multiple Sclerosis Society); Keith Greenarch (The Adaptable CIL); Genie Komives (NC Academy of Family Physicians); Pam Palmer for William Lamb (Friends of Residents in Long-Term Care); Ken Lewis (NC Association of Health Plans); Frances Messer (NC Assisted Living Association); Carol Meyer (The Carolinas Center for Hospice and End of Life Care); Jo Anne Powell (Roanoke Chowan Community Health Center); Sharnese Ransome (NC Association of County Departments of Social Services); Linda Shaw (PACE); Adam Sholar for Craig Souza (NC Health Care Facilities Association); Lynette Tolson (NC Association of Local Health Directors)

Audience: Kari Barsness (Community Care of NC); Melanie Bush (Cansler Collaborative Resources); Sam Clark (NC Health Care Facilities Assoc.); Brian Carle (Affinity Living Group); Daniel Back (Troutman Sand org); Bob Konrad (FOR-LTC); Sahn Lee (DMA); Suzanne Merrill; Ryan Minto (UHG), Jay Peters (NCALTCF); Yolanda Stith (NCALTCF); Mike Watson (Sandhills LME); Kelly Vgel (PLPCC)

DHHS Dual Eligibles Planning Committee: Donald Browning; Tabitha Bryant; Angela Diaz; Patricia Farnham; Nancy Henley; Jamal Jones; Sabrena Lea

DHHS: Anne Braswell (ORH); Badia Henderson (DHB); Angela Howard (DHB); Julia Lerche (DHB)

WELCOME AND INTRODUCTIONS

Dee Jones, Chief Operating Officer, DHB

- Meeting agenda overview. NCDEAC members, DHHS attendees and audience introductions.
- **Bethel.** Inquired about changing the Sept. 23 meeting time due to conflicts.
 - **Diaz.** Department previously reached out to members about moving date, but will investigate whether or not meeting can be moved to a different time on the same day.

PROPOSED SCHEDULE AND TIMELINES

Dee Jones, Chief Operating Officer, DHB

- Reviewed Department's projected timelines and milestones for Jan. 31 report to Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC)

MEETING GOAL

Dee Jones, Chief Operating Officer, DHB

- Advisory Committee will break into groups to discuss and answer (1) How should duals be incorporated into managed care (strategies, plans, structures, offerings)? (2) Which duals populations should be included in or excluded from managed care? (3) When should targeted population be incorporated into managed care in relation to 1115 waiver implementation? (4) What are specific challenges related to duals populations?

NORTH CAROLINA MEDICAID REFORM | DUAL ELIGIBLES ADVISORY COMMITTEE

STATE AND ADVISORY COMMITTEE FEEDBACK

Angela Diaz, Operations Manager, DHB (moderator)

- What is working well
 - Wide-range of services and supports are available to dual eligible to include emergency department, specialists, primary care physicians, etc.
 - Ability to access services with little or no cost due to coverage by both Medicare and Medicaid
 - Strong network of health care providers
- What could be improved
 - Care coordination and management
 - Better integration across Medicaid and Medicare services
 - Access to behavioral health services
 - More focus on preventive care and addressing social determinants
 - Better access to health information and education
 - Service coordination for clinical and social support
 - Appropriate access to HCBS and facility-based care
 - Flexibility for providers to develop compensable, person-centered solutions
 - Provide improved health outcomes through whole person care

DATA REQUEST FOLLOW-UP

Julia Lerche, DHB

- **Note:** Draft NC dual eligibles data exhibits are sourced from DHHS data warehouse, and are for discussion purposes only; results are being validated and may be revised
- **Assumptions:** Enrollments adjusted to mitigate duplication and include Program of All-inclusive Care for the Elderly (PACE). Numbers are rounded. January 2016 enrollment summary is separated by eligibility group: Medicaid only, full duals, partial duals and total.
- Provided Advisory Committee with requested data: Eligibility group descriptions; population by region and rural/urban status; population by living arrangement and explanation for Medicaid-only disabled enrollment.
 - Of 77,000 partial duals, roughly 69,000 are eligible for only Medicare Part B premium payment; remaining 8,000 are also eligible for Medicare Part A premium (when applicable), Medicare copays and deductibles, and the first twenty days in a nursing home
 - Enrollments fluctuate throughout the year; dual eligibles are more likely to live in rural areas
 - 61% of full dual eligibles are enrolled in a medical home, with more disabled than aged; medical home enrollment is voluntary for dual eligibles
 - Disabled eligibility determined by Social Security standards; Social Security disabled income (SSDI) made available to workers who have accumulated a sufficient number of work credits; supplemental security income (SSI) disability benefit available to low-income individuals who have not worked or have not earned enough credits to qualify for SSDI
- Outstanding requests are diagnosis/co-morbidity data, which may only include FFS data; additional detail on HMO premiums; number of duals using LME-MCOs services

- **Members** discussed capitating patients between different plans, understanding that population is important. LME-MCO does not represent true number of patients. Suggestion to get diagnosis first. Understanding how many people are served with PLEs. Questioned getting access to Medicare data and additional information.
 - **Lerche.** Getting individual Medicare data takes time and is not necessarily feasible. DHHS is working with consultants to get from other states that are using Medicare data and hopes to have by next meeting

DUAL ELIGIBLES SERVICE ARRAY

Trish Farnham, DHHS

- NC Medicaid eligibility group and Medicare status crosswalk to include such groups as aged, blind, disabled, etc. Duals whitepaper summary discussing different Medicare and Medicaid rules; the complex patient needs make it difficult to provide a comprehensive, seamless benefits package. Duals cannot be mandated to enroll in capitated or managed care plans for Medicare coverage. Many states use managed LTSS (MLTSS) plans to serve duals.
- MLTSS plans with capitated Medicare health plans (Medicare Advantage) generally have clearer path to cost savings and better beneficiary experience. Recommendations include plans could be extensions of PHPs, distinct entities or a mix of both; enrollment would be mandatory for full duals for Medicaid benefits coordinated with strong efforts to encourage companion D-SNPs in Medicare.
- Perspectives from other states include currently performing research and interviews on sample state MLTSS implementations to include strategic approach taken by sample states; consumer experience in sample states; lessons learned by sample states.

BREAKOUT SESSIONS

1. How should duals be incorporated into managed care? (Strategies, Plans, Structures, Offerings)

- **Group 1: Meyer, Shaw, Powell, Emanuelson, Cameron, Vogel**
 - Is current structure sufficient for duals?
 - More time will be needed, phase in
 - Look to PACE model for flexibility, pooling of funds
 - Expand PACE statewide
 - PACE innovation (Fed) person centered/broaden (could reduce #'s in Medicaid population)
 - Manage MCTSS Plan
 - Case management
 - Adequate funding
 - High cost
- **Group 2: Messer, Bethel, Sholar, Komives, Brockett**
 - Should there be a specialized plan
 - How do you change a care manager
 - If managed care is intended to better coordinate, why would exclude 15%
 - How do you ensure state has threshold regiments
 - Very carefully
 - Patients have lots of needs and involved in multiple systems of care
 - LME vs. Capitated vs. FFS
- **Group 3: Egan, Ransome, Dunn, Campbell, Konrad, Farnham**
 - Data driven exercise

- Gather data on these populations
 - Potential savings
 - What plans and offering do we need from the PHP's
 - Availability of care coordination and other types of services and providers
 - Need to find out how various programs fit in
- Incentive payments for high utilizers
- **Group 4: Jones, Tolson, Palmer, Bradley**
 - Include all eligibles

2. *Which duals populations should be included in or excluded from managed care?*

- **Group 1: Meyer, Shaw, Powell, Emanuelson, Cameron, Vogel**
 - Which duals to include/exclude from managed care
 - Separate out BH candidates from the severe with co-morbidity (e.g. diabetes)
 - Full duals only
- **Group 2: Messer, Bethel, Sholar, Komives, Brockett**
 - Other state experiences
 - Good discussion around partials vs. duals
 - Can they be phased in by program category
 - After the waiver is granted and there's some experience
- **Group 3: Egan, Ransome, Dunn, Campbell, Konrad, Farnham**
 - No one excluded eventually
 - What is the value of including vs. excluding
 - How does quality fit in
 - It is more about when not if
 - What benchmarks do our system need to meet before it is capable of managing this population
 - More about which services to include and how to add others over time
 - Assess LTSS success with Medicaid only folks before rolling in duals
 - How to build capacity of care managers to serve complex enrollees
 - Readiness review measures
- **Group 4: Jones, Tolson, Palmer, Bradley**
 - Integrate info, particularly the LME/MCO info

3. *When should the targeted population be incorporated into managed care in relation to the 1115 waiver implementation?*

- **Group 1: Meyer, Shaw, Powell, Emanuelson, Cameron, Vogel**
 - Expansion
 - After waiver is granted and there are some things established
 - At least 2 years of experience
 - Maybe wait until LME/MCO transition occurs
 - Phase in duals after 3-5 years of experience in MMC
- **Group 2: Messer, Bethel, Sholar, Komives, Brockett**
 - After the LME-MCO transition
 - Maybe save categories sooner

- Need to sustain network during the transition
- **Group 3: Egan, Ransome, Dunn, Campbell, Konrad, Farnham**
 - Not day 1
 - Develop readiness threshold
 - Roll in gradually
 - Readiness must include network adequacy across LTSS array
 - Alternative, pour resources into getting those with most intensive needs served first
 - Regional rollout

4. *What are the specific challenges related to the duals populations?*

- **Group 1: Meyer, Shaw, Powell, Emanuelson, Cameron, Vogel**
 - Fear
 - Go back to the assumptions
- **Group 2: Messer, Bethel, Sholar, Komives, Brockett**
 - Highly complex population is the challenge
 - Challenges
 - Huge variation in needs, many with high complexity
 - Need to isolate categories and go one by one then decide which would do best (phase in)
- **Group 3: Egan, Ransome, Dunn, Campbell, Konrad, Farnham**
 - Care Management
 - Financial alignment data
 - Complex needs
 - Effective staff management
 - Non-Managed
 - Medicare Alignment
 - How much efficiencies given (making too much)
 - If you fold Medicare in too soon can't assess efficiencies

Meeting adjourned 2:10pm