STATE CONSUMER AND FAMILY ADVISORY COMMITTEE

MEETING MINUTES

Date: Wednesday, December 11, 2019 **Time**: 9:00 am **Location**: Division of Public Health, Building 3
5605 Six Forks Road, Raleigh, NC 27609

MEETING CALLED BY	Benita Purcell, Chair
TYPE OF MEETING	Public Meeting

ATTENDEES

COMMITTEE MEMBERS		**GUESTS**	
NAME	**AFFILIATION/CATCHMENT AREA**	**NAME**	**AFFILIATION/CATCHMENT AREA**
Ginger Booth	Trillium	Gillian Hookway-Jones	
April DeSelms	Eastpointe	Vincent Cella	
Jonathan Ellis	Trillium	Bob Crayton	Cardinal Innovations
Catreta Flowers	Trillium	Gerri Smith	The Arc of NC
Wayne Petteway	Trillium	Felicia Williams	Cardinal Innovations
Benita Purcell	Cardinal Innovations	Doug Wright	Alliance
Ron Rau	Sandhills	**CONFERENCE CALL PARTICIPANTS**	
Lori Richardson	Sandhills		
Susan Stevens	Cardinal Innovations		
Lorrine Washington	Eastpointe	**STAFF/PRESENTERS**	
CONFERENCE CALL PARTICIPANTS		**NAME**	**AFFILIATION**
Jean Andersen	Cardinal Innovations	Kate Barrow	DMH/DD/SAS- CE&E
Pat McGinnis	Vaya Health	Jennifer Bowman	DMH/DD/SAS- QM
ABSENT		Tonya Corso	DMH/DD/SAS- QM
Kenneth Brown	Alliance Health	Deb Goda	DHB- NC Medicaid
Ben Coggins	Partners	Bill Harris	DMH/DD/SAS- CE&E
Angelena Dunlap-Kearney	Cardinal Innovations	Deputy Secretary Kinsley	DMH/DD/SAS
Mitchell Gatewood	Vaya Health	Michelle Laws, PhD, MA	DMH/DD/SAS- CE&E
Deborah Page	Cardinal Innovations	Kathy Nichols	DMH/DD/SAS- Programs
Brandon Wilson	Vaya Health	Deputy Secretary Richard	DHB- NC Medicaid
		Suzanne Thompson	DMH/DD/SAS- CE&E

1. Consent Agenda & Approval of November Minutes

Discussion	The meeting called to order at 9:00 am. Jonathan Ellis motioned to approve the agenda, motion seconded by Wayne Petteway. Motion Carried; agenda approved. Lorrine Washington motioned to approve the minutes from the November meeting and State to Local Conference Call, Ron Rau seconded the motion. Motion carried; minutes approved without changes.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**

2. Public Comment

Discussion	Jean Andersen – Relationship to the Innovations Registry of Unmet Needs. Questions about how long the list is, frustrations about how long the wait times are. Counties that have a large provider, larger providers can take priority over folks who have been on the waitlist, take top waiver slots. List never moves. Benita confirmed that she had heard that too. Trying to get people from LME/MCOs and state to come to SCFAC about how numbers are calculated, process for getting on the registry and process for getting slots. Publicize and get people here. Deb Goda- requested the floor to respond. To allay fears- provider asking for a slot doesn't take precedents. Have some reserve capacity slots. Not first come first serve. Specific slots for MFP, for example, to discharge individuals from institutions. Certain number of slots for emergencies- DSS involvement, immediate placement, abuse and neglect. Slots for individuals who have moved from another state due to military. Reserve capacity for children in CAP-C who are aging out and eligible for a waiver. Turnover slots open when someone goes into a facility, someone passes away; slots assigned based on geographically. Contract with Mercer to assign slots. Providers aren't able to go and say "I'm your larger provider and I need a slot." Kenneth Bussell from IDD Medicaid will be invited to speak on the topic at a future meeting. Mark- is there a percentage? Deb responded that she can look it up. In renewals for waiver- get approved 5 years at a time. Jean- service gap: Teenagers with TBI (age 18)- go to adult trauma unit- placed on CAP-D waitlist because of overlap with CAPDA and CAPC, 18-21 going home without services because they are listed as adults. Parents don't know anything about CAPC. Kids and families penalized because they don't know about CAPC, age out, then have to go onto Innovations waitlist. These are people who are CAPC eligible when they leave the hospital. Not eligible for TBI Waiver because under the age of 22. Deb Goda- reach out to counterpart for CAPC and CAPDA to see how to educate people better on how to apply for it. Ginger- 5 slots for military families: who coordinates those 5 slots? Deb Goda: Has to be the same waiver (DD waiver), has to be a military family, and MCO has to ask for that slot. No CAP-DA age out slots for Innovations; appropriate for Innovations, CAPC services stop. CAPDA is skilled nursing level of care. Cost neutrality is against cost of skilled nursing vs. cost for facility. Bob Crayton- Impact. People with IDD can remain with LME/MCO, if slot on the waiver. Deb Goda: To get Innovations you have to be in the Tailored Plan. If choose Standard Plan have to give up Innovations Waiver slot first, then sign-up for
Conclusions	What are the responses, if any, from SCFAC?

Action Items	**Person(s) Responsible**	**Deadline**

1. Children in Foster Care

Deb Goda, *Behavioral Health Unit Manager*
NC Medicaid- Division of Health Benefits, DHHS

Discussion	Deb Goda provided a presentation on the topic of Children in Foster Care & Managed Care. She reviewed the power point distributed prior to the meeting and mentioned that a concept paper will be out soon. The Foster Care Plan will be separate from the Tailored Plan and Standard Plan, with services still coming from the county of eligibility. This is a coordinated effort around kids.

	- Design an RFP, similar to Tailored Plan and Standard Plan with pediatric expertise, psychiatric needs - Want <u>all</u> feedback: staffing, quality measures, procedures, medication management; complex system and want the best possible care for this population There is no timing on Foster Care Rollout just yet. Catreta Flowers commented that as a former foster parent, we need to do better for these children. The group discussed how this plan would save the state money in the long-run and improve quality of life. Ginger Booth mentioned that she is concerned there will be a provider issue with pediatric mental health. Related issues: Children in Foster Care because their parent is in the justice system; Youth Services in Juvenile Justice; Raise the Age Need provider education on becoming provider through Medicaid for children. Pat McGinnis mentioned that the Cherokee in the West- DSS taking children from parents wrongly. - Put families back together, heal - Behavioral Health Treatment - Train DSS workers; DSS come in to do a presentation; build up on both sides - Same issue happening with children of parents with developmental disabilities Questions: 1. Will this be contingent on the budget? a. Response: Not about "if" but "when." Managed Care more flexible, pay for outcomes, not just services. 2. Why single out Foster Care? a. Kids move, have to change providers. Kids have trauma. Need providers that understand that these kids have trauma. 3. Does state have capacity to meet these needs, especially in rural areas? a. Plan providing- will have to recruit and maintain providers. 4. Carved out plans across the country; any data that's encouraging? a. Will bring back data. 5. With these plans through transformation, will it be more attractive to be a Medicaid provider? a. Moving to a centralized credentialing vendor 6. What role does DSS Play? a. Placement and coordinating with MCO and PCP. Still work tightly with DSS. A psychiatric nurse present at the meeting discussed some challenges obtaining licensure.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**

2. Working Lunch

Discussion	Benita Purcell addressed the issue of SCFAC Member attendance and leaving early. She reiterated the importance of showing-up, being present, and contributing as a working committee. The members discussed writing a Thank You letter to Secretary Cohen and DHHS for work on Medicaid Transformation. Mark Fuhrmann asked members to review the letter in the packet. MAC discussion on combined CFAC and MAC. Deputy Secretary Dave Richard to discuss. Consumer and Family committee that would have the same current functions and roles but would encompass the MACs. Includes the SP PHPs?
Conclusions	

Action Items	Person(s) Responsible	Deadline

3. QM: Network Adequacy & Accessibility Analysis

Jennifer Bowman, *Team Lead for Quality Management*
Div. MH/DD/SAS, DHHS

Discussion	Jennifer Bowman provided an overview of the network adequacy and accessibility analysis. Recommend that members look at local NAAA, recommend that Local CFACs do that as well. This is a joint effort between the Division and NC Medicaid. Jennifer review the purpose of the analysis, the timeline, and what was included in the analysis. She reviewed the exception requests and explained some of the challenges that the LME/MCO encounters. Benita asked about why there are so many exception requests? Some of it is because of rurality, have to offer an alternative service. Less coverage in rural areas. Where does a consumer find more information about the exception request is? Jennifer- can be found in the annual report. Corrective action plan to meet need. Single case agreements, for example. Didn't ask for exception or not approved? Thought LME/MCOs would be further along. Access to care- describe access to care. SDOH play into; Included an environmental scan of SDOH. Pulled excerpts from each LME/MCOs on SDOH. Kate will send out. Special Populations- TCLI, co-occurring diagnosis for children with special health care needs, and people with TBI. She reviewed the SDOH for the TCLI population. Reluctance of people to participate because of fear of losing benefits. Benita- housing and coming out of the justice system is a huge issue. Parking lot: DSS guardianship issue in reluctance to move from adult care home into the community. Overview of Gaps Analysis and Performance Improvement Projects Network Access Plans- ask to identify gaps and plans for improving gaps identified by consumers and families.
Conclusions	

Action Items	Person(s) Responsible	Deadline
Get SDOH reports from LME/MCOs reports to send to SCFAC.	Jennifer Bowman and Kate Barrow	
Send links to LME/MCO reports.	Kate Barrow	December 18, 2019

4. Division Updates

Kody Kinsley, *Deputy Secretary for Behavioral Health and IDD*
DMH/DD/SAS, DHHS

Discussion	Deputy Secretary Kinsley recapped the Medicaid Transformation suspension due to not having the right budget. He mentioned the suspension letter that was sent out to individuals who have enrolled and those who were targeted. Communication and messaging- making sure its working well.

	State CFAC and MCACs rumor- not true. Deputy Secretary Richard will be here later. Mark- How did the rumor get started? MCAC is requirement for CMS process, SCFAC is requirement for legislation. Finishing up the Division of 2020 goals. Used SCFAC Annual Report to inform policies. In January, DS Kinsley will talk through what the Division is planning at the January meeting. Internal and external policies changes. Video recording has been suggested to give clarification on the suspension. Secretary Cohen was on WRAL for about 30 minutes. Shared through social media; very informative. Thursday presentation at Pinehurst- having more beds is not the answer. Need better community supports. How do you support people getting the right care at the right time. Numbers to share: 25% of public bed days (bed available) went to capacity restoration- criminal justice process, need to be provided services in psychiatric services, but to teach justice system. Build new programs for those services not just in psych hospitals. Private beds (Holly Hills, etc.) that of all the licensed beds we have only 80% are operating. Of all beds being operated only 80% being used. Only 64% of beds in use. That is often because of payor. Points back to Medicaid expansion problem. When sold Dix, would not have spent that money on building more beds; would have spent $$ expanding community-based services. Pat- please repeat statistics on people dying… Community Psych beds, trying to get much used. Medicaid Expansion would be a game changer. Focus more on what is needed in the community. Refocus the funding- stop focusing on hospitals.
Conclusions	Will bring Pinehurst presentation back in January.

Action Items	**Person(s) Responsible**	**Deadline**

5. Tailored Plan RFA Q&A

Dave Richard, *Deputy Secretary for NC Medicaid*
NC Medicaid, DHHS

Discussion	Deputy Secretary Dave Richard gave a background on the Medicaid Transformation suspension and how the budget would have made a significant impact on DHHS that would have resulted in the termination of programs. DS reiterated the importance of Medicaid Expansion for people receiving services for Behavioral Health and Substance Use Disorders. He explained how the tax system works to fund Medicaid Expansion. When suspension is lifted, individuals will have to go through Open Enrollment again, choose another plan. Will still have 90 days to go through the process- choose a new plan, prior to auto assignment. 1. Will this be statewide or regional? a. Deputy Secretary Richard- not sure, can't speculate. Contract: Staff for Medicaid working close with DSS, Public health, and DMH/DD/SAS; didn't increase the number of staff to do this. Did a lot of this work through contracts. Will continue to lose contract staff if no budget is passed in January. Had a one-time fund to access the funds. When the budget didn't pass, no ability to draw from funds until next fiscal year. Have to wind down expenses. Suspension is a longer-term impact. Tailored Plan: Close to finalizing request for application to get into procurement team's hands. Meet procurement standards. Target date for releasing RFA is late winter (late February/March). If GA comes back and there is no movement on budget, no movement on SP, then impacts TP. Don't want rollout of both. Stand up SP before stand-up TP. Nothing has changed but it could change. Thinking about the Foster Care Plan. Finalizing that- timeline of that considering everything else. Want to get everything right. There will be some white papers that come out over the next 3 weeks- Care Management, (Catch All Paper) things about TP that need response on.

	No question about CFACs roll, state or regionally. Conversations have been had about MACs and how those work with CFACs. Perhaps rolling MACs into Local CFACs. Does it dilute the membership of the CFAC in a way it shouldn't be? Will come to State CFAC with a recommendation. If you create something new that does create conflict? Build on something that already exists and is working well. NC Medicaid- wants input from State CFAC. Benita- Where are PHPs in the process? Deputy Secretary Richard- not currently cutting contracts or scaling back staff. Still working on Provider Network Adequacy. Providers disappointed because they've worked hard to be part of SP and TP. Jean- no CFAC members on MCAC, invited to be on subcommittees, but not on MCAC. Wondering if there are any changes to be made to MCAC to include Consumers and Families are included? Deputy Secretary Richard- Members are chosen by congressional districts, at large members- might be opportunity to get more consumers and families; don't want to lose provider representations; need more representation of people with DD, MH and physical disabilities (co-occurring disabilities). Make sure public comment is available. Jonathan- feels like a token seat. Don't want to participate because it feels that way. How do we change 122-C to be more effective? Any positives to share? Got here through a compromise. Even though there is a pause, there is a lot of work on policies that recognize the importance of Social Determinants of Health and the impact those have on people.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**

6. Uninsured State Funded Approach

Kathy Nichols, *Assistant Director for Programs and Services*
DMH/DD/SAS, DHHS

Discussion	Kathy Nichols introduced herself to the group. No waitlist for State Funded Services, working on automating our Innovations waitlist. Capture more information about people on the waitlists- better track them and better serve them. Waitlist notifications. Deinstitutionalization Service array on the state funded side is not going to change as of right now except for the area of care management. People will not be able to be served by the medical home, state funded services…proposing to have an IDD care plan manager responsible for all IDD folks not on the waiver, BH person for people with complex MH and SUD folks, add a definition of case management. Targeted case management; options under that definition for evidenced-based case management. Case Management definition that helps people transition out of emergency department as a pilot site. Link to SDOH, low to no cost pharm availability. Proposing to expand TCLI. TCLI to help people with SMI living in adult care homes transition to community (Federal DOJ, violation of Olmstead). State Collaborative- what works well on the local level? If CFAC members have a suggestion and recommendation for what works at the local level, that is welcomed. Prevention- taking back block grant funds for prevention and hold them at the state level; have one contract work in the prevention space. No LME/MCOs have prevention staff. Hopefully will better manage dollars.

	Co-pays that match Medicaid. State Funded co-pays need to be mirrored to Medicaid. There will be more detail in the White Paper. Still a complaint and appeal process, monitoring of services and providers. Probably should have a waitlist for MH/SU side, but need to monitor Medicaid is an entitlement, should approve or deny based on medical necessity, for single stream funding- run out of $, do not have to pay for it. Autism services is a good example; have a shortage of BACA specialist. Less on acute side, more on long-term side. Hoping to have this paper out by end of the week, would like recommendations from. Update on the 7 PRTF pilot site? Kathy- good update for the spring. In-progress, results should be in. Community Crisis Plans per SB 630, was supposed to include consumers in development? When talk about community inclusion, refers primarily to adults with SMI and creating more adult collaboratives. Other Special Populations: Homeless Populations (In Reach and Diversion): TP should divert programs in placement and housing. Housing plans in addition. Criminal Justice Population- some work being done there. DMH is doing work with Public Safety. Juvenile Justice has grant to do housing. Step-down sites; bridge housing and we pay for WRAP around services. Reentry folks at Public Safety at Wake County Detention Center; step down and recovery housing. Part of that work would include getting ID, getting Medicaid turned back on, working on resources for landlords for background check for people. Would be good to have State funded side of TP take a bigger role- need to look at what's needed. Not a lot can be done right now. Application for Medicaid prior to release date. Eastern Band of Cherokee- participating in Managed Care. Working on part of plan as part 1115; only have about 7,000 folks. Not enough to take on plan of their own. Will be able to access same level of care LGBT- funding a pilot in Durham. Service would like to develop for across the state.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**
Have someone from DMH/DD/SAS come in from Justice Teams to talk about projects.	Kate Barrow with Dr. Laws	

Meeting Adjourned:	**Next Meeting:**
The meeting adjourned at 3:00. Mark Fuhrmann motioned. April DeSelms seconded. Meeting adjourned.	January 8, 2019