JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

January 25, 2012
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Wednesday, January 25, 2012 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Louis Pate, Representative Nelson Dollar, and Representative Justin Burr, Co-Chairs; Senators Austin Allran, Doug Berger, Stan Bingham, Harris Blake, Fletcher Hartsell, Eric Mansfield, Martin Nesbitt, William Purcell, and Tommy Tucker; and Representatives William Brisson, William Current, Mark Hollo, Pat Hurley, Bert Jones, Marian McLawhorn and Tom Murry. Senators Andrew Brock and Ralph Hise and Representatives Marilyn Avila, and Verla Insko were also present.

Lisa Hollowell, Denise Thomas, Donnie Charleston, Karlynn O'Shaughnessy, Shawn Parker, Theresa Matula, Amy Jo Johnson, Jan Paul, Susan Barham, Joyce Jones, Pat Porter, Rennie Hobby, Candace Slate, and Dina Long provided staff support to the meeting. A Visitor Registration Sheet is attached and made a part of the minutes (See Attachment 1).

Chairman Burr called the meeting to order and welcomed members and guests. He announced that Chairman Pate was tied up in traffic and would be in shortly.

Chairman Burr recognized Robert Cosway, Principal and Consulting Actuary, from Milliman. Mr. Cosway said that Milliman was retained by the Division of Medical Assistance to review the impact of the Community Care of North Carolina (CCNC) program. A copy of this presentation is attached. (See Attachment No. 2) Mr. Cosway explained the methods used in the analysis of care management for the Medicaid population by eligibility groups. Mr. Cosway said that according to their best estimates, CCNC had reduced North Carolina's Medicaid costs through the care management activities. There are uncertainties as with any analysis of this kind and recommended that DMA continue to monitor the cost and savings of the program. He said the focus was entirely on health care cost and not on other goals of care management such as outcomes.

Mr. Cosway was asked if there were any preliminary estimates in terms of savings or trends for 2010-2011. He said the next step was procuring data this year to update the study to include FY 2011. He was also asked if any state had an outcomes based system related to the Medicaid population. He responded that if it was related to clinical outcomes he did not know of any state doing any sort of analysis or reimbursement based on clinical outcomes. Dr. Craigan Gray, Director of DMA stated that Ohio just this year had introduced a plan for a value-based payment process that is measuring outcomes in payment appropriately as applied to the outcome measurement. Continuing, he added that North Carolina has a Pregnancy Medical Home which is a value-based outcome metric driven program which accomplishes that objective. A request was made to have a report on the status and structure of the Ohio program.

Dr. Allen Dobson, President and CEO of Community Care of North Carolina, Inc., addressed what CCNC is doing in communities across North Carolina to get the savings and discussed what is happening with community care intervention that is so credible to help manage the budget over time. He shared the list of interventions that CCNC is doing and putting into every community across North Carolina. A copy of his presentation is attached. (See Attachment No. 3) He said that CCNC is a healthcare provider for North Carolina with physicians and hospitals organized together to be accountable to build a better Medicaid program and that 1.2 million of the 1.5 million Medicaid recipients were being served by CCNC.

Dr. Dobson was asked to comment on what plans CCNC has regarding the expected population increase of Medicaid recipients (500,000) facing North Carolina in 2014. He said he thought many of the new patients were already in the community. They might be hourly workers who do not have coverage. CCNC's job is to make sure there is capacity to absorb them into community care to avoid excessive cost. What is more problematic are the persons in that group who do not qualify but have significant health issues who are uninsured. He said the complexities of their care could be an issue for the budget and an issue for bringing those patients under some insurance coverage without breaking the bank of the Medicaid program.

Dr. Gray was asked if DMA had contracted with a company to assist in the process of signing up people with CCNC and he was asked where in the process are we in getting additional populations discussed signed up. He said that there were 6 and then 10 additional people hired on a temporary status and trained to help with the process. He said there was approximately 25% - 30% of the aged, blind, and disabled (ABD) category who chose to "opt out" of CCNC. Steve Owen, Chief Business Operating Officer, DMA, added that at the beginning of the year they had enrolled approximately 50% of the ABD population. As of December about 64% of that population had been enrolled.

Dr. Dobson was asked what the status was in the linkage of community care with the LMEs and the 1915 (b)(c) Waiver. He responded that a lot of the CABHAs are engaged in community care and that CCNC is meeting with LMEs on a regular basis. There are a lot of conversations on how to better coordinate the care management activities that LMEs do with the medical side. There are also discussions on how to connect care management functions with the LMEs through the provider portal in order to have accurate information on patients.

Melanie Bush, Assistant Director, Administration, DMA provided an update on the requested Medicaid State Plan Amendments (SPA). (See Attachment No. 4) Ms. Bush explained the Medicaid State Plan contract with the Federal government and reviewed two charts, the first of which depicted the internal process that DMA must do before submitting an SPA to the Federal government. The second chart reflected what happens once DMA has submitted a State Plan amendment. She also provided a list of all the outstanding and completed State Plan Amendments. There are currently 5 SPAs from calendar year 2010 that are outstanding. For 2011, there were 58 Medicaid SPAs and 1NC Health Choice SPA that were drafted. Of those, 57 were submitted to CMS, 27 were budget reduction SPAs, and 42 have been approved to date. One SPA has been submitted this year. State Plan Amendments #1152 and #1153 were approved this morning.

Chairman Pate said that in 2007 Congress directed states to implement asset verification for applicants of Medicaid. The deadline for North Carolina to comply was calendar year 2011. He said that he understood the process had been stalled within DHHS and that the CMS directed Request for Proposal had not yet been released to help our State help find a vendor to meet the requirement of law. Chairman Pate said in a recent briefing he learned that North Carolina's estimated savings by

rooting out this fraud and abuse would be approximately $100M - $150M per year. These savings would be achieved by insuring we only provide benefits to those who meet the income and asset requirements. Since our State's Medicaid program is facing a $150M deficit this year alone, he asked when DHHS planned to release the RFP and how long it would take to have the program up and running. He said according to these savings estimates, we are missing out on the opportunity to save North Carolina taxpayers between $275,000 and $400,000 per day. Secretary Cansler said he met with vendors yesterday about this issue. He said that no state had met the deadline yet. At this time DHHS is engaged in strategies to address the issue. Ms. Bush said that one of the SPAs approved by CMS yesterday and that DMA had just learned of today was the Asset Verification System.

Chairman Dollar provided a summary prepared by the Office of State Budget (OSB) on the Medicaid shortfall for 2010-2011. (See Attachment No. 5) He said the information provided would offer a better perspective on the projected Medicaid shortfall in the current fiscal year. Chairman Dollar offered to address questions but said that Pam Kilpatrick from OSB would be available to address questions at the February meeting. Chairman Dollar was asked what the plan was to find the money to cover the shortfall we have now; apparently the figure now is different than the one indicated on the handout. Chairman Dollar said it was a work in progress but the figures demonstrate that a far larger gap was closed last year. He said the information helps people understand what the gap was last year, what the drivers where, what happened with the budget and what we did by the end of the fiscal year to address that. The General Assembly will assess the situation in May and will address what the shortfall looks like at that time.

Jan Paul from Research summarized the legal implications of the recent court decision on Personal Care Services. Ms. Paul said that in the case of Pashby v. Cansler, the plaintiffs sought a preliminary injunction to prevent the Department from implementing a rule regarding the provision of Medicaid-covered Personal Care Services for adults over twenty-one years of age, and specifically the provisions of the In-Home Care for Adults (IHCA) Clinical Coverage Policy 3E (Policy 3E) that would adversely affect eligibility for in-home care for Medicaid recipients that were eligible for such care prior to the implementation of Policy 3E.

The court first determined that the named Plaintiffs could bring the lawsuit as a class action, and determined the class to consist of:

> "all current or future North Carolina Medicaid recipients age 21 or older who have, or will have, coverage of PCS denied, delayed, interrupted, terminated, or reduced by Defendant directly or through his agents or assigns as a result of the new eligibility requirements for in-home PCS and unlawful policies contained in ICHA Policy 3E."

After reviewing and analyzing the eligibility criteria, the court concluded that Policy 3E violates Medicaid's comparability requirement by treating differently recipients with similar levels of need. Specifically, it permits PCS for Medicaid recipients living in adult care homes with far less strict eligibility requirements than the eligibility requirements for in-home PCS under the In-Home Care for Adults Program. The court also concluded that the implementation of Policy 3E would place qualified individuals under the Americans with Disabilities Act, who have been successfully living in their own homes, at risk of segregation in the form of institutionalization, in violation of the U.S. Supreme Court's holding in *Olmstead v. L.C.* Finally, the court held that the Department's notice to the Plaintiffs contained language that failed to provide detailed reasons for the proposed termination, in violation of procedural due process.

As a result of its findings, the court granted the Plaintiffs' Motion for Preliminary Injunction, thus prohibiting the Department from implementing any part of IHCA Policy 3E.

The Department has filed a motion for Judge Boyle to stay his Order for a Preliminary Injunction, and appealed his decision to the U.S. Court of Appeals for the Fourth Circuit. Briefs are due in the Fourth Circuit the first week in March. Ms. Paul noted that Tracey Hayes from the Attorney General's Office is here today, and can answer any specific questions about the court case.

There are cost implications as a result of the court's ruling, including coding and billing changes. She said the next presentation by Steve Owens of DMS would address these considerations.

Steve Owen addressed the potential budget implications in a handout detailing how DMA came up with their assumptions. (See Attachment No. 6) He said the impact in State dollars for 2012 should be about $9.4M and $32.8M for 2013. Mr. Owen stated that the dollars calculated for FY 2012 assume that claims will start being paid in April 2012. This allows for the claims lag in terms of the program changes being completed, providers beginning to file claims and once claims actually begin to be paid.

Mr. Owen was asked to provide information on how the $41M - $42M shortfall would be addressed. He responded that DHHS had identified a $149M shortfall for this year which includes the $9.4M and an approximate $243M projected shortfall for 2013 has also been identified. He was not sure how that would be made up. Secretary Cansler said there was a projected $139M cash flow issue this year, and this adds $9M more to that problem for the current year. The remaining $32.8M is in the next fiscal year which adds to the problem of funding. Secretary Cansler added that DHHS has effectively had two different PCS programs which DHHS had operated in accordance with a CMS - approved State Plan Amendment. Now, because of interpretation of comparability rules, it has raised issues about PCS. The change that the Judge says DHHS cannot implement, had been implemented for 6 months but now will have to be reversed in trying to deal with the policy change that came about as a result of legislation passed by the General Assembly.

Senator Nesbitt asked staff how much money was put in the Medicaid program and what percent of that is $140M. Denise Thomas from Fiscal Services responded that the total general fund appropriation for Medicaid was $2.9B. So, the $9M this year is much less than one half of one percent. Next year's appropriation is $2.9B with a $38M impact on next year's budget.

Chairman Pate asked for a motion to approve the minutes from the December 13, 2011 meeting. The motion was made by Senator Blake and the minutes were approved.

After lunch, Chairman Pate asked Beth Wood, State Auditor, to address the audit of the Medicaid Management Information System (MMIS). (See Attachment No. 7) Auditor Wood explained the issues addressed in the Replacement MMIS Implementation audit, the findings – the causes of the delays, the impact of those delays, the lack of clear documentation, and the poor communication that existed with the vendor.

Secretary Cansler responded that much of the report was built around the issue of documentation and agreed that not all was documented as it should have been. He said that after the auditor's recommendation, staff had been directed to take action towards proper documentation. Secretary Cansler distributed a handout from DHHS reconciling the MMIS Replacement Project and Operations. (See Attachment No. 8) He explained the two pieces of the contract- the development,

design, and implementation piece which is what is being paid to build the system, and the operational piece which is what is to be paid to run the system in the coming years. The Development Phase is paid by 90% Federal dollars and 10% State dollars. Of the $186.6M for development cost, $18M is State dollars spread over several years. He said that with the total cost to build the system, and the total cost to operate the system it comes to a net $74M savings over seven years.

Auditor Wood was asked if there was any kind of a follow-up to the audit and if that information would be shared with the General Assembly. She responded that it was not the practice of the State Auditor's Office in the past to do follow-up audits. It is the practice of this administration to start follow-up audits. Once an agency develops a corrective action plan, they are given time to implement the plan and then there will be a follow-up audit.

Secretary Cansler was asked how all of this was able to transpire without any kind of accountability. He said that the project is the largest IT project the State has ever undertaken and it had never been audited before. Decisions were made and documented but minutes were not taken during negotiations to explain why decisions were made the way they were. He added that CMS would not allow DHHS to spend money they had not approved, or sign contracts that they had not approved. With the ever changing environment, there have been more changes than ever anticipated which drove costs up. Auditor Wood said it was critical to have accurate documentation to determine that decisions made were the correct ones. There is no way to do an analysis of where we are today without documentation of those decisions.

Auditor Wood was asked what the degree of difficulty was received in cooperation with the Department. She replied that there was a letter received from the DHHS asking them not to do the audit, that staff was committed to the project and could not help with the audit. When asking for information, the Auditor's Office was either given partial information or none and they were never able to get a meeting with management of the agency. So, they proceeded with the audit.

Chairman Dollar asked Dan Stewart, Assistant Secretary for Finance and Business Operations, DHHS, what kind of actions he took internally, management wise, as the direct line manager over the MMIS project. Mr. Stewart responded that there had been a number of meetings but there still remained a difference of opinion on several issues with the Auditor's Office. He said he was very pleased with the management of the MMIS office. He said he had worked with them for a number of years and the staff included an IT attorney that works on the contract. There are ITS attorneys, external IT legal attorneys that review the contracts. Mr. Stewart said there was a tremendous amount of documentation (thousands of pages) but that it may not have been in the format that the Auditor's Office needed. He said the detailed design work was over 100,000 pages and the RFP response from vendors was over 2,000 pages. Chairman Dollar further voiced his concern comparing NC FAST to MMIS and the fact that it took 10 years to get NC FAST up and running. Secretary Cansler responded that funding was first appropriated for NC FAST in 1998. In 2001 the plug was pulled on the project since the work being done was not where we wanted to go. About four years ago software was purchased and two years ago the development and integration of the system began. The system is on target. He said the two systems reform the way Health and Human Services works. Representative Insko suggested that it might have been helpful in the past to have known how changes made by lawmakers affected the system and perhaps in the future notification would be helpful especially as the budget process nears.

Secretary Cansler was asked once the system is in place how much would it cost to keep the system running in the future. He responded that currently the vendor was paid millions of dollars every year

for every change made. He said there were 700 plus changes made to the old system that have to be made to the new system. The operating cost will be reduced by half once the new system becomes operational because of the way the new system works and because of the way the contract is set up.

Senator Brock requested that a copy of the memo mentioned in the Auditor's report on page 10 be provided to all members. (See Attachment No. 9) He was interested to see if the content of the correspondence from Angeline Sligh, MMIS Program Director to John Mahoney, Manager of CSC could be construed in anyway as directing an impediment to the Auditor's investigation. The letter was distributed and the Secretary said he felt the letter was written because there was a true difference in opinion with CSC and not because something was trying to be covered. Ms. Sligh explained the circumstances and said that CSC was not asked to change the document but rather to correct it. When it was given to the Auditor's Office, it was noted that the document was a "draft work product and had not been reviewed by the State." The official document CSC submitted to the State did not have that comment included. It was suggested that in the future it was expected that agencies fully cooperate with the Auditor's Office and that it would be a good idea to have a Corrective Action Plan negotiated between the Auditor and DHHS.

Wil Neumann of Secure Exchange Solutions, Inc. introduced Doug Trotter, President and CEO who explained the basics of what a Medicaid smart card is, the technology and the terminology around a smart card. Mr. Neumann provided an update on the pilot established six months ago in Gastonia with four offices and how they have applied some cost savings to the State with the pilot. (See Attachment No. 10) Mr. Trotter said their system was not a card but rather a total system. It integrates the card technology without being tied to a rigid type of implementation. He said other types of implementation could be used or other types of cards. Mr. Neumann said that verifying individuals and their eligibility would have significant savings to the State, the Federal government and to providers. With other functionalities installed such as pharmacy, saving would increase. Mr. Neumann added that they would have a report out next week detailing the cost savings.

Mr. Neumann was asked if there were Federal dollars to help implement this process. He answered that there was currently a grant process with Federal money that is closing very soon but thinks that it may be reissued. He said there was a chance we could get some grants in collaboration with the State agency for implementation.

Sheila Platts from DMA explained that DMA had a smart card project that they were working on moving from a paper Medicaid card to a plastic Medicaid card. She detailed the objective, the status and the cost of the project. She said there had been eight vendor demonstrations since October with a lot of good information which DMA plans to utilize in the RFP in the Spring of 2012. Her presentation is provided. (See Attachment No. 11)

Ms. Platts was asked if the smart card was compatible with most hospital software and what is the timeline to begin the contracts. She said some of the cards in the demonstrations were able to use the current point of sale system, some require a scanner to scan the bar code, and some require a card reader, and that equipment is not included in the cost of the card. She said they were working on the RFP now and did not have the timeline at this point. Mr. Neumann said that his company would be ready to move forward in a 90 day implementation in a two county area and could implement the whole State within one year. The reissuance of cards is currently not built into the system but there would be discussion about that. There would not be a need to reissue every year as long as the card is working. Secretary Cansler added that the legislature would have to act on requiring Medicaid

recipients to have a card because DHHS does not have that power without legislative action. The Secretary was asked to provide an estimate of savings if smart card is implemented.

Ms. Platts was asked if there would be a multi-level system of identification for security for the patient and the provider, and would it expand into other fields such as pharmacy. She said those requirements would most likely be in the RFP to insure there is authentication for the card, and fraud detection in place, and also so that all information transmitted is protected between DMA and the provider. Ms. Platts was also asked what type of backup system was in place if the internet is down or power is lost. She responded that requirement would be in the RFP to ensure that the infrastructure is in place so there would be no disruption in services.

It was suggested that it would be helpful to see extrapolations in savings from multiple vendors in addition to the functionality in how the cards work, the cost range projected from the different companies – which ones had the $2 card and which ones had the $25 card, in order to get a complete picture.

In acknowledging that the Secretary would be leaving his position at the end of the month, Chairman Pate thanked Secretary Cansler for his years of service, his expertise and his guidance. Secretary Cansler said it had been a great honor to serve. He said there had been a lot of frustrations but also a lot of rewards. In closing, he said his parting advice would be that "politics are always going to be here but ultimately what is important is achieving the goals of this State and that means working together and setting politics aside."

There being no further business, the meeting adjourned at 3:45 PM.

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Senator Louis Pate, Co-Chair

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Representative Nelson Dollar, Co-Chair

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Representative Justin Burr, Co-Chair

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Rennie Hobby, Committee Clerk