JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

November 8, 2011
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Tuesday, November 8, 2011 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, Stan Bingham, Harris Blake, Jim Davis, Fletcher Hartsell, Martin Nesbitt, and William Purcell; and Representatives Martha Alexander, William Brisson, William Current, Mark Hollo, Pat Hurley, Bert Jones, Marian McLawhorn, Tom Murry, and Fred Steen. Also present were Representatives Marilyn Avila, Verla Insko and Angela Bryant

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

Chairman Pate called the meeting to order and welcomed members and guests. He took a moment to pay tribute to Senator Jim Forrester who passed away last week and called for a moment of silence in remembrance of Senator Forrester.

Chairman Pate recognized a group of students and faculty from the Health Policy and Management Department at UNC Chapel Hill's Gillings School of Global Public Health. He asked for a motion to approve the minutes from the October 11, 2011 meeting. The motion was made by Senator Hartsell and the minutes were approved.

Dr. Beth Melcher, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS and Kelly Crosbie from the Division of Medical Assistance (DMA) provided an update from last month's meeting on the Implementation Plan for the Statewide Expansion of the 1915 (b)(c) Medicaid Waiver. Points of interest during the presentation included:

- The Implementation Plan has been distributed to members and is posted on the DHHS website.
- All counties are aligned with a Managed Care Organization (MCO) with the exception of Wake County which is currently in negotiations with Durham County which will be an MCO.
- The DHHS is developing Intra-departmental Monitoring Teams (ITMs) with staff from the Divisions of Mental Health Developmental Disabilities and Substance Abuse Services and Medical Assistance. These teams will be assigned to each of the LME/MCOS and will be charged with monitoring the implementation of the waiver with reports to DHHS monthly.

- There will be an advisory group established. The purpose of this group will be to provide input and consultation on the implementation of and operation of the waivers by looking at reports, system goals and outcome measures as well as identification of problems and recommended solutions. This group will have Department staff but also representatives from consumer and provider groups (state and local), county commissioners, the NC Council of Community Programs and others. The group will likely be convened in January of 2012.
- Information on the development of consumer outcomes and system performance indicators of LME-MCOs will initially come from data collected and from current contracts which have specific outcomes and performance measures. In the future, the idea is to change the outcome measures to be more reflective of how lives are impacted and collect different data from which to report. A committee will convene in the Spring with stakeholders and consumers to determine what the measures should be moving forward with the objective of identifying those outcomes to be added to the contracts in July.

Chairman Dollar asked what the outreach strategies were to encourage individuals to sign up for Medicaid with particular interest in how information is being shared with Community Care of North Carolina (CCNC).. Kelly Crosbie with DMA answered that there were several initiatives and ongoing work groups looking at ways to help recipients enroll in Medicaid and in CCNC. DMA is working with DHHS, local DSS offices, and other behavioral health providers to help individuals sign up with CCNC at their behavioral health provider's office. She offered to get information on the number of people signing up. The Medicaid contract with the LME-MCOs requires monthly meetings with CCNC to exchange and share data on the individuals with the purpose of care coordination. Ms. Crosbie said items are being monitored at the State and local level and she would provide information on how those initiatives are developing. Regarding the aged, blind, and disabled population, Chairman Dollar asked when the completion date for signing up would be. Secretary Cansler answered that efforts had been increased to enroll this population and he would be monitoring the situation.

Chairman Dollar asked if the resource allocation process directed in H916 and cited in the Implementation Plan should be a priority and be established early in the implementation as opposed to the date listed in the Plan of July 1, 2013. Dr. Melcher responded that the date referenced is when all LMEs are to be MCOs creating statewide implementation. First, there must be the statewide implementation of the Supports Intensity (SIS) tool which starts January 2012. The July 1, 2013 date is reflective of all the steps that need to happen before that but the resource allocation would be implemented as quickly as possible. Chairman Dollar also asked about the input for the Strategic Implementation Plan from Piedmont Behavioral Health (PBH) and stakeholders. Dr. Melcher said that getting stakeholder involvement was always a challenge when trying to get representatives' feedback. Because time was short in developing the Strategic Plan, there was a broadcast message to get feedback as well as the use of established advocacy and stakeholder groups to get the information out. Dr. Melcher said they were open to making changes to the Strategic Plan as they move forward. PBH provided input and did not agree with all components of the plan. There will be ongoing communication as issues arise.

Chairman Dollar emphasized the Committees interest in consumer and family participation in the implementation of the expansion of the (b)(c) Waiver noting that "stakeholder" groups are often comprised only of those who represent large groups or provider agencies.

Dr. Melcher was asked if there was concern over the ability of guardianship to be provided by the new entities. She responded that moving into the MCO environment boundaries have to be created between MCOs being guardians of the same individuals whose care they are managing. Proposals will be made by the Department to the HHS Oversight Committee prior to the Short Session to address the issue. Resources to support guardianship are a larger issue and a court ruling which does not allow PBH to contract out guardianship will also need to be addressed during the Short Session.

Chairman Dollar asked if LMEs could contract out case management. Dr. Melcher said that Medicaid funded targeted case management no longer exists. Some of the functions of case management can be contracted out if the LME/MCOs choose to do so. The Department has not encouraged or discouraged the MCOs in what to contract out. Ms. Crosbie added that under the federal authority of the Medicaid contract, the LMEs are required to provide care management and care coordination for special health care populations but they are required to identify the individuals, and assure that they have assessments to any kind of special care beyond behavioral health. Chairman Dollar asked for an extensive list of services that the LME has the potential to contract out.

Senator Hartsell asked what impact the closing of New River would have on the plans for development of Smokey Mountain. He also asked what the status was of the audit and the contracts from New River, and when the audit would be available. Dr. Melcher answered that Smokey Mountain had stepped in to see that other providers have been able to take over the service provision once delivered by New River. She said there had been good conversations between Smokey Mountain, the counties, and the auditors and there should be a positive resolution. Ms. Crosbie said she would check on the timeframe of the audit.

Melanie Bush, Assistant Director of Administration, Division of Medical Assistance (DMA) provided an explanation of the Medical Care Advisory Committee's (MCAC) purpose, membership and the process that DMA uses to move forward on the recommendations of the MCAC. (See Attachment No. 3) Points of interest included:

- MCAC provides a public forum to discuss the Medicaid program in its entirety not limited to clinical policy or a specific issue but crosses all aspects of the Medicaid program.
- All members of the MCAC have experience with the Medicaid program, bring a unique perspective, and are diverse in terms of location and experience.

Dr. Karen Smith, Chair of the Medical Care Advisory Committee explained the functions of the MCAC. (See Attachment No. 4) Additional points of interest were:

- This year, meetings have been opened to hear more public insight and MCAC is pleased with information being received from other entities.
- Guiding principles were developed as to how to approach each of the programs and budget issues that needed to be addressed and options were reviewed for the short term budget issues.
- Regarding the Guiding Principles, it was important to have a consensus on how to review each of the programs.
- A key principle is to make sure that access and quality are maintained, and continue to have consistency recognizing that the provision of medical care has become so complicated that it must be made simpler for implementation.

Chairman Dollar added that it is important to note that the Medicaid budget situation being faced this year does not require changes that will be recurring. The solution may be found largely in the application of onetime money for the current year. He said a lot of the problem is being driven by liabilities from past years that now must be paid. Chairman Dollar asked how much of a consensus there was within the Medical Care Advisory Committee in making the recommendations. Dr. Smith responded that regarding the short term recommendations, the group came to a consensus of the "no across the board rate reductions." She said that the group recognized the value and importance of each of the recommendations and recognized that the clinical restrictions on mental health drugs for instance, is a broad discussion that needs to be evaluated before it can be fully implemented and some recommendations deal with future issues that we need to be prepared for in the Medicaid system. She also emphasized the value that has been placed on the Community Care network. Chairman Dollar asked that the HHS Oversight Committee be provided the details behind the recommendations made by the MCAC. Dr. Smith was also asked to provide a copy of the case rates and global rates information she referenced in her presentation.

Representative Avila asked what impact would be felt by modifying the private duty nursing rates. Dr. Smith said the group did look at the impact on the family, the patient, and the community as part of their role but would ask DMA to assist with a response.

Secretary Lanier Cansler, from the Department of Health and Human Services (DHHS) and his staff provided an update on several budget issues. Staff members present were: Jim Slate, Director, Budget and Analysis, Steve Jordan, Director, Division MH/DD/SAS, Luckey Welsh, Director, State Operated Healthcare Facilities, Dr. Jeff Engel, State Health Director and Director, Division of Public Health, John Price, Director, Office of Rural Health and Community Care, Sherry Bradsher, Director, Division of Social Services, and Karen Tomczak, Chief Information Officer and Director, Information Resource Management.

A list of questions submitted to DHHS by the General Assembly's Division of Fiscal Research was distributed with the Department's response. (See Attachment No. 5) Secretary Cansler said DHHS had been working diligently with the budget overall to accomplish the goals in this fiscal year. Outside of Medicaid, DHHS should be able to achieve the budget targets. He said DHHS was working on a number of ways to try to reduce costs and create savings that are not mandated by the budget. For example, he said DHHS was working with the State Facilities to reduce and eliminate unessential agency staffing, reduce the overtime, and hire staff which could save $2M per year. There is a Financial Management system in place that will generate data by January 1, 2012 that will identify how the hospitals and facilities compare with one another and indicate what is working and what is not working. Changes based on this information will be made which will save money. DHHS is working with the Controller's Office to replace the manual timekeeping system in the facilities with an automated timekeeping system which could generate $6M in savings.

Jim Slate addressed the first question regarding position eliminations and operating reductions and provided a summary of the DHHS Vacancy Report. (See Attachment No. 5a) Secretary Cansler said the reason there were so many vacant positions in the Division of Mental Health\State Facilities was due to the fact that the money in those positions was used to fund overtime and agency staffing in order to keep the facilities staffed at the required level. He

added that about 70% of all positions have some federal funding and there were a total of 157 FTE positions eliminated this budget cycle.

Regarding the nonprofit reductions, the Secretary said that a lot of the nonprofit money is in three areas: CCNC /Per Member Per Month, Piedmont Behavioral Health (PBH), and Smart Start, none of which are good places to take money. DHHS is trying to determine all the other nonprofits from which to take the money with the least amount of detrimental impact. He said they would achieve the $5M savings.

Secretary Cansler then addressed the issue of Medicaid. Points of interest included:

- One of the four areas of unbudgeted liabilities was the quarterly repayment of $10M from unbudgeted funds for the over $300M that was improperly drawn down from the federal government. Payments must be made on time or funds will be taken from the next federal payment to be received.
- DHHS is still waiting on appeals to be heard by OAH on Personal Care Services. This OAH delay is costing DHHS about $1.6M per month in service costs. OAH is beginning to have mediation on some of the appeals. Several hundred appeals have gone to mediation since the last meeting. There are about 2,000 appeals that have been filed.
- The cuts or projected cost savings in the first year of the biennium are at issue since legislation says the Secretary must reduce rates across the board by another 2 percent and/ or reduce services to make up the shortfall. For instance, it is estimated that only $51M cost savings will be realized by CCNC this year instead of the projected $90M. It is believed that over the biennium the projected total savings by CCNC would exceed the two year target by $20M. Secretary Cansler said he thought it was a one year problem and he was concerned that any reductions in rates now would destabilize a unified effort by providers to help reach the targets. He said he may need guidance from the General Assembly moving forward.
- Provider reimbursement rates – Anticipating approval, DHHS went ahead and implemented the provider adjustment rate November 1 of this year. If approval is not granted, providers will have to be reimbursed for whatever rate adjustment that was made that was not approved.
- There is a $139M shortfall both budgeted and unbudgeted. DHHS is working hard to reduce the amount. There are two ways to cover the shortfall in the Medicaid budget - an across the board rate reduction of 18% or virtually eliminate all optional services other than pharmacy, which still would not reach the $139M. In order to pursue these options, the Secretary said he would need to know right away. Chairman Dollar, speaking for the group, said those options would be too problematic. He said he felt this was essentially a one-time funding issue driven by payments that have to be made for liabilities that were incurred prior to the current administration and prior to this General Assembly. He said the Committee would work with the Department to see if a sufficient number of one-time funds could be found to resolve any cash problems for the current fiscal year in order not to affect the quality of the Medicaid program.

Regarding question number 6 on inflationary increases, Chairman Dollar asked for background on the actual numbers behind the $12M inflationary figure for nursing homes. Secretary Cansler explained that the $12M was not a problem at this time. He said DHHS was using analytical software for the first time this year in trying to develop a budget and the figure of $12M is part of that determination. He said they are not going to modify the case mix for the $12M. Depending

on the case mix strategy, they may not need the $12M or there could even be a surplus. Chairman Dollar also asked why the CAP/MR provider assessment had not yet been submitted to CMS. The Secretary replied that he was not sure if the State Plan Amendment (SPA) had been submitted or not. He said there was a development process in submitting a SPA to be approved by CMS and there has only been one other state that had submitted an assessment on CAP/MR-DD providers. He believed there were only a couple of State Plan Amendments that had not been submitted at this point and it was just a development process to get those done.

Steve Jordan addressed MH/DD/SAS questions.

- Costs that have carried over for the past 3 years have created slow payment issues to the LMEs. Payments are running one month behind in service dollars and administration.
- Cash flow problems began in 2008 when two hospitals lost federal funding due to inspection issues. The hospitals continued to be operational through State funds. An appeal was won with one of the hospitals and DHHS was able to get the funding back. Millions of federal dollars were lost and required state dollar replacement causing the current cash flow issue.

Luckey Welsh addressed the initiative to determine whether the state could save money and maintain quality by consolidating and privatizing the operation of the psychiatric hospital of Forensic Unit.

- Analysis does not indicate a significant amount of savings in consolidating services however; further questions need to be answered before a determination can be made.

John Price addressed questions regarding the Health and Wellness Trust Fund.

- Of the $22M transferred to the Division on Public Health from the Health and Wellness Trust Fund, roughly $3.7M was transferred to the Office of Rural Health and Community Care (ORHCC) to administer three programs.
    - Medication Assistance Program (MAP) – ORHCC continues to grant funds to the 53 former Health and Wellness Trust sites around the State. Since funding began 3 months ago to those 53 sites, services have been provided to over 19,000 patients and have pulled down over $21M in pharmaceuticals from the pharmaceutical manufacturer's Free Drug Program.
    - ChecKmeds NC Program - $350,000 that came from the funding to ORHCC has been identified to match federal Medicaid dollars to help implement the pilot ChecKmeds program as directed in the budget for CCNC.
    - Roanoke-Chowan Community Health Center – A contract is now in place with them for $293,000 and monthly invoices have begun to be received as they spend the money down.
- The only program that has ongoing support possibly for 2012 is MAP because a grant was received from the Kate B. Reynolds Charitable Trust for $550,000 of which $200,000 has been used to fill in some missing gaps in the funding this year. The Trust indicated the funding could be used next year if it is not all spent this year but that would cover only about 10 sites next year.

Dr. Jeff Engel continued with the Health and Wellness Trust Fund transfer to the Division of Public Health.

- Attachment C in the handout details the remainder of the $22M spent on programs. The first category represents programs that were under existence under the pre-existing

Health and Wellness Trust Fund that were transferred to the Division and were continued. The second category represents unspent or unobligated Health and Wellness Trust Fund dollars that went into programming in the area of tobacco, prevention, and control.

Secretary Cansler said that 70% of all money in DHHS comes from federal funds and grants. He noted that several major Block Grants could be affected by modifications being made in Washington. Jim Slate provided an update on Block Grant funding.

- The Preventive Health and Health Services Block Grant (PHHSBG) was eliminated with an impact on the State of about $3.1M but through a federal level competitive grant process the State has been awarded a Community Transformation Grant. It will not replace all the items the PHHSBG was used for but will minimize the impact. Through this competitive grant, North Carolina received the 4th largest grant in the country.

Sherry Bradsher addressed issues concerning the Low Income Energy Assistance Program (LIEAP) and the Crisis Intervention Program (CIP).

- It is estimated that with the $11.8M available in the LIEPA that nearly 30,000 households will be served providing relief of about $400 per family for the 4 coldest months of the year.
- In preparation for changes to the programs, all the automation and reporting changes have been made, all 100 DSS offices have been trained on the new policies, and a public release was issued to all DSS offices and all media informing them of the changes.

Secretary Cansler provided an update on NCFAST. He explained how this technology would help counties integrate services, tear down silos and be more effective in the way things are done. It will facilitate statewide case management so people can move from one county to another with more ease, and will provide more global services to make sure the right services are being applied to achieve the goal. Eligibility can be determined by one entry and avoids duplication at the local level. He said the project was on time and on budget.

Karen Tomczak briefed the Committee on the continuation review for the Division of Information Resource Management (DIRM). Several additional points of interest included:

- The handout details the 5 contracts specifically in relation to the business functions they support and some of the receipts that come from those systems.
- The first contract, Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), was implemented in 1999 with key system functions that include patient management and patient billing. The contractual maintenance costs cover the provision of continual software upgrades (e.g. for health care and billing), including necessary enhancements for compliance with various State and federal requirements.
- The second contract is a staffing contract for the DHHS Client Services Data Warehouse (CSDW) and DMH Consumer Data Warehouse (CDW). This contract covers the IT staffing support for ongoing operations and maintenance for the warehouses. The CSDW Warehouse is currently used by seven divisions and houses over 5 billion records.
- With the expansion of CSDW in 2011 to incorporate the Health Information System (HIS) data, HIS data can now be matched or cross-walked to other DHHS business divisions' data (e.g. DSS) to meet ad-hoc cross program(s) reporting needs.

Senator Davis asked about the possibility of integrating data. The Secretary responded that the focus in technology, as the new MMIS for Medicaid and other payments is being built, is to make sure information is being pulled from multiple sources.

Chairman Dollar asked if the study performed by the Milliman Group with respect to saving with CCNC had been completed. Secretary Cansler responded that he thought the report would indicate a substantial savings in 2010 by CCNC efforts and that Dr. Dobson would provide an update.

Dr. Allen Dobson, President, Community Care of North Carolina provided the cost savings strategy related to this biennium budget. Dr. Dobson began with a brief overview and how CCNC operates. (See Attachment No. 6)

- Community Care is a delivery system. The State manages the benefits but CCNC is an organized delivery system partnered with the State to manage a very difficult population.
- CCNC makes sure Medicaid patients have primary care physicians and support around them.
- The statewide program has 1,360 locations representing 94% of all the primary care work force in North Carolina. Those not currently in the work force are mostly in the urban areas. Of the total Medicaid population, there are currently 1.3M Medicaid recipients enrolled in the program and receiving medical home services and additional services.
- The more opportunities CCNC can find to manage, the State will begin accruing those savings this year and beyond.
- There is one psychiatrist in each Network whose job is to coordinate the medical community with the mental health community unlike the CABHA psychiatrist. The psychiatrist does not offer clinical services but rather is the leader in helping collaborations to occur.
- Efforts will continue the rest of the fiscal year to work with the Department to find additional opportunities to manage the program. As initiatives are found and implemented the numbers will be updated.
- The Milliman Group has engaged in a review of CCNC cost savings. Dr. Dobson notes that the report of their review will be available within the next two weeks.

Senator Purcell asked if there was a way patients could come from the Emergency Department (ED) to the primary care doctor's office as they were once able to do. Dr. Dobson answered that a federal statute made it very difficult to send a patient out of the ED without an evaluation. There is now an electronic method of notifying the CCNC Network and every primary care doctor to let them know when a patient is in the hospital, and care managers are in the hospitals to educate the patients.

After listening to Dr. Dobson's presentation, Chairman Dollar said the media tends to report on the challenges of Medicaid but need to take note of the fact that there are several solutions being worked on and the progress is being made with CCNC, DHHS, with all the providers, and all in the health care community. He said the media needed to take note of a number of things including quality care but in particular regarding the budget, the projected CCNC savings for the second year of the biennium are expected to be $150M which is 66% more than the General Assembly had budgeted. If there is a savings of $150M in State funds you are actually saving $450M or more in total federal and State funds.

Senator Purcell commented on the fact that DHHS was struggling to meet payments, that there is a looming possibility that more optional services could be cut and provider rates could be cut. He asked if at some point the Committee would feel a responsibility to tell the Appropriations Chairs that more money is needed. Chairman Pate responded that the last thing they would want to do is cut optional services or go against providers. He said the Chairs would continue to work with the Secretary to see what funding can be found together to get back on track. Chairman Dollar added again that the issue was one-time money which is being driven by liabilities that were accrued in past administrations. He said as we move forward in the budget year, the General Assembly would work with DHHS to find ways to come up with the one-time funds that are needed to see that those liabilities are covered in the overall HHS budget. Additional savings are possible through the efforts of CCNC and DHHS is continuing to work on a number of efforts within the Medicaid program and other areas. Chairman Dollar said there was a broad agreement that they were going to resolve the issue for the current fiscal year but would not be lowering reimbursement rates and would not reduce optional services beyond those in the original budget from the Governor and DHHS. Senator Purcell asked if there was a point that additional revenue would be requested. Chairman Dollar responded that the budget was in the hands of the Governor and she had to manage the budget and be in balance by the end of the fiscal year. He said he felt the Governor would achieve that objective and that they would be working with the Governor.

Chairman Pate announced that there would be a Governance Subcommittee formed and that members of the subcommittee would be announced in the next couple of weeks. He also announced that the next meeting on December 13th would be a joint meeting with the IT Oversight Committee.

There being no further business, the meeting adjourned at 3:05 PM.

_____
Senator Louis Pate, Co-Chair

_____
Representative Nelson Dollar, Co-Chair

_____
Representative Justin Burr, Co-Chair

_____
Rennie Hobby, Committee Clerk