North Carolina Association of Local Health Directors
Policy and Finance Committee Summary
October 18, 2017
Cardinal Room, DPH
10:00am – 11:00am

Welcome - Call to Order at 2:05

1. **Update of the NC Alliance for Health legislative agenda**

   Back in 2010 – We worked with the legislature in new ways about their concerns about the Bill making its way through at the time regarding smoke free restaurants and bars.

   We like to focus on key questions: What do you want, Who can give it to you, Who do stakeholders/legislators need to hear this from – it has been confirmed again and again, if the legislature does not hear about a public health issue from their local health directors, then they don't consider it a very critical issue. My pitch to you today is not a formal request but instead, a request about process.

   Our Department has not called for policy priorities yet, but some of our partners have been working on theirs. The Alliance top priorities with Bill Sponsors included (press release – wral.com teen tobacco prevention) for $7mm increase for tobacco prevention funds for young people due to our concern for the younger generation using vapor e-cigs. Video shows the sincere champions: Lambuth, Dobson, Adcock, Woffer

   They were not successful last year for the $7mm request but did get $500,000 NR for 2 years. We can do better partnering with you next year now that we have their attention and these champions. Glad to work together. In addition, we want to work together to fill more of the demand for tobacco cessation. The Department put forth an expansion request for $3mm with $250,000 to train clinicians on how to treat tobacco. Regionally-based trainers can deploy. They work

on systems change and treatment options – can integrate training into clinics.

In the expansion budget request this year, we put enough funding to reduce our need to request more and more every year for the Quit Line. We have cut back on all insured populations… they only get one call instead of the evidence-based four calls with the Quit Line. In the expansion request, we have funding to promote cessation and mass communication reach in your local communities.

$250,000 for "You Quit To Quit" – and some funding is available for LHDs to work on continued calls. Think about inviting the Alliance for Public Health to November or December meeting. Justus Warren Task Force updates will be available by then. If you choose to add these things to your legislative agenda, it is a lot easier to have synergy and success by working together.

Funding for Prevention and Funding for Cessation are the two primary policy priorities from the Alliance for Public Health. They always look at tobacco tax options and also monitor any threats to current policy that is working.

HB276 "Lambuth Bill" - attempted in 2011/2012. The ask this year is around $7mm with $6.2mm going locally.

It's nice that this falls into the strategic investments for prevention…

Happy to come back and talk with you all any time about 6|18.

Master Settlement funds from tobacco … we advocate those funds going back into public health "as originally intended" rather than seeing them go into the general fund. $140mm annually every April comes from Master Settlement funds. Community Economic Development and tobacco communities.

The part that fell out of it all was the 'health' part. Tobacco is the leading preventable cause of death. Jim asked Sally to provide the

language that the NC Alliance for Health has for their health priorities. **Another suggestion was made to invite the Alliance to the next meeting.**

2. **NCALHD Legislative Agenda - $7.5 Communicable Disease Funding**

The last time we asked for $7.5mm for communicable disease, things became confusing at the legislature based on the fact other public health groups were also asking for similar amounts but for different health-related things. (e.g., community health center grants).

In this request amount, every county gets $75k with intent and purpose for full time CD nurse. Is this the priority for this year? Lillian from Davidson and Emily from Stokes County came to Jones Street to become familiar with the location and legislators.

Champion? Representative Dobson – would be interested in talking with us.

Is this a priority? If so, what is our strategy? Lynette requests a small group to work on this. CD education is needed for legislators.

DPH leadership team and NCALHD leadership worked together on this to determine the amount of funding and request – keeping it simple is key **– but also keeping it distinctive to public health is important –** we do need operating resources to avail the CD nurse.

Other priorities we had from last year and have discussed:

- Syringe Exchange
- LHD ability to charge for well water testing in migrant camps
- Restore funding for W & C block grant
- Raise the state tax on tobacco
- Expand Medicaid
- Regulate body art

Sub Committee to work on this policy priority – include those who have key Representatives and Senators – talking through local issues and our policy/funding priority is important.

Battle Betts: Albemarle
Dorthea Wyant: Cleveland
Dianne Creek: RPM
Emily
Doug Urland: Catawba
Sue Lynn Ledford: Wake
Lillian Henderson: Davidson
Jim Bruckner: Macon
John Morrow: Pitt
Karen
Dennis Joyner: Stanly
Jane Murry: Iredell

If you want to hear more about 'tobacco 21' – Sally and Jim can come back to share more about that. A big issue around that is enforcement.

In the last few minutes…
Steve Smith provided a brief update that included we did not seem to learn a lot in yesterday's meeting with DMA. The Medicaid spend in NC is $12B - $13B. They're talking about a RFA in spring and then respond quickly.

We would like for them to come back and provide the same presentation they did for the FQHCs. They have offered to have additional conversations but 2-3 months seem like a long time.

Transition into 11:00am meeting:

Steve Smith provided updates that Tim Gallagher is now working with us – we tied into that expertise. That vote occurred at the health directors' meeting in Asheville at NCPHA. Time is of the essence to find our talking points and our understanding around Medicaid Transformation.

DMA presentation on Tuesday of this week was lackluster. It was not what we expected = there was no presentation, but rather, very informal discussion.

Medicaid Managed Care - we don't know much more this week than we knew before this week. We need to hear a global perspective about what's important to you… conveying message to BOH, Commissioners, Partners will be critical.

Start with an example: Tim said something that resonated with me. We pushed Tim to help us understand some concepts about Medicaid Managed Care and how we talk about it moving forward.

Q: Operating in a connected way – what can we do consistently across all 100 counties. You have to communicated to MCOs and external partners that you are indeed a collective and united system. We know we have different services, capacities and different approaches

We still need to negotiate and talk to them as a system. BEHIND THE SCENES we can talk about services and lists of things we do and don't do (Primary Care for example). But it's really important to present a united front in some ways.

Don't hesitate to talk with MCOs and learn more, but perhaps **pause carefully before signing any contracts.** Each entity is going to seek / want statewide coverage. Integrated care / United / local health system…

Timeline: Right now we have an opportunity to tip this all more toward what we're asking versus what they're giving. Later we won't be able to do that.

Q: **How do we know these companies will even be given the contracts?**
A: **We don't – no decisions have been made or will be made until after the RFP is released and responded to.**

In NC, only Medicaid realizes we're health departments. In other insurance companies… not all see us any differently than our NPI number.

Companies like United are trying to build support and an ability to say they have 'LHD' 'support' in order to get the future contract.

We're proceeding with caution and trying to understand the new environment, its language, and how to work within it.

Carolina Complete is next… WellCare is sitting at our doors.

We're in the dating relationship with these companies right now and will be married later – keep in mind that what happens now and later may look different.

The merger of what we heard yesterday vs what we hear from Tim… regardless, **we need to develop <u>NOW</u> what it is we envision this being BEFORE the RFP lands on the ground.** The answer is in the questions… if we don't have some input as to what we are asking for (the most pivotal thing). The asking vs the taking.

DPH has been working with Medicaid about what services LHDs bring to the table to develop the RFP.

Basing decision about who you sign with around your services. We have to take action now as best we can… once the network materializes we can re-negotiate.

Performance measure rules are already in place… Rates are all the same?

Is there any danger that if one of us signs, it commits us all??
Not necessarily

DMA has not negotiated with ANY entity… they have only put the basement payment out. If DMA hears back from CMS about cost settlement and we are NOT included, we need to go back to the drawing board.

More white papers are coming out with details… we will have a chance to respond.

Some of Tim's algorithms look tough if cost settlement is not granted by CMS for LHDs.

For FQHCs, precedence has been set to cost settle – but those decisions are already made at the CMS level. Federal control over cost settlement is critical to decisions moving forward.

We should seek to make language from DPH / DMA right to preserve cost settlement.

Currently, some of our fees are improved compared to other providers. The floor moving forward is already established as the current Medicaid rate for private providers.

Need to influence the DHHS plan. There are different models we have to prepare for – with cost settlement and without.

Care management, cost settlement, and Medicaid fees…. One or all of these could go away.

CMS decision expected 'early winter' – we'll see if we can understand better how decisions are made at CMS.

Lynette: On Monday, had a meeting with Mel Phelps with the Medical Society. Interest in building a public / private partnership Pilot for social determinants of health. LHD, FQHC, Private providers, church, school, etc.

Officers realize that Medicaid Transformation is looming large and feels hard to understand and fit into the other work we are doing.

Comment: Remember, what we saw when Mental Health reform happened, the legislature will start to futz with things immediately.

A number of discussions and continued 'courtships' have included the hot-button topic of Medicaid Expansion.

Robert Martin was present for a brief overview of HIPAA Activity:

HIPAA Alliance: As part of the fall education conference, we had Jill Moore update us during a full day of training.

Implementation committee – standard walk-throughs helping with the physical and privacy security standards. The policy workgroup just met in Chatham County and came up with best practices for about 50 policies to share. December 8th – Duplin County will host a working session for HIPAA 101. Continuing to work on training for privacy and security officials in each LHDs. It's well worth the effort they are putting into this.

If we're going to ask for CD funds… intent is stated and language is already there to specify coverage of a CD nurse.