

HEALTH ACCESS STUDY GROUP

January 8, 2009

9:00-1:00

NCIOM

Meeting Summary



ATTENDEES:

Task Force/Steering Committee: Graham Barden III, Deborah Brown, Bonnie Cramer, Allen Dobson, Beverly Earle, Abby Carter Emanuelson, Angela Floyd, Toney Foriest, John Frank, Hugh Holliman, Eleanor Kinnaird, Tara Larson, Ken Lewis, Carolyn McClanahan, Barbara Morales Burke, Maureen O'Connor, John Perry, Mary Piepenbring, William Pully, Tony Rand, Robert Seligson, Richard Stevens, Brian Toomey, Tom Vitaglione, Gregory Wood

Interested Persons: Latasha Bennett, Mary Bethel, Danielle Breslin, David Bruton, Andrew Dugan, Maeve Goff, Jean Holliday, Robert Jackson, Jonathan Kotch, Ben Money, Karen O'Donnell, Shannon Smith, Walker Wilson

Staff: Mark Holmes, Julia Lerche, Jesse Lichstein, Thalia Shirley-Fuller, Pam Silberman

WELCOME

Allen Dobson, Jr., MD, FAAFP

President & CEO, Cabarrus Family Medicine, P.A.

Dr. Dobson welcomed attendees.

REVIEW OF RECOMMENDATIONS

The Study Group reviewed all recommendations. Comments and edits from the Study Group were incorporated into the recommendations.

PRIORITIZATION OF RECOMMENDATIONS

The Study Group selected eight of the 20 recommendations for prioritization. The priority recommendations include:

Low-Income Children

Recommendation 4.1 (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance should simplify the eligibility determination and recertification process to facilitate the enrollment of eligible Medicaid and NC Health Choice individuals. Specifically, the Division of Medical Assistance should:

- 1) Pilot test the use of North Carolina administrative databases to verify income, and if accurate, use administrative income databases to verify income for eligibility and recertification for all, or a portion, of the applicants and recipients.
- 2) Develop a system of presumptive eligibility for children.

- 3) Allow rolling recertification periods to enable individuals to return their recertification forms anytime within the three months prior to the end of their certification period.
 - 4) Use eligibility information from other public programs (eg, food stamps, WIC, free and reduced school meals) to determine Medicaid and SCHIP if those options become available with new federal legislation.
 - 5) Use other efforts to reduce the percentage of procedural closings during the eligibility and recertification process.
- b) The Division of Medical Assistance should expand outreach efforts to identify and enroll individuals who are eligible for Medicaid and NC Health Choice. Specifically, the Division of Medical Assistance should:
- 1) Ensure that Department of Social Services (DSS) eligibility workers are outstationed at DSH hospitals and FQHCs (as required by federal law), and at health departments or other community health providers that serve a large number of potentially eligible Medicaid recipients. Outstationed DSS workers should help individuals fill out Medicaid and NC Health Choice applications and recertification forms and determine eligibility.
 - 2) Train community organizations and other health professionals to assist potentially eligible individuals in filling out applications and recertification forms.
- c) The Department of Public Instruction and Local Education Authorities should actively work to promote health insurance coverage to children eligible for public programs, in coordination with the outreach efforts of the Department of Health and Human Services and local Departments of Social Services.

Recommendation 4.2 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should:

- a) Remove the cap on coverage of eligible children in the NC Health Choice program.
- b) Continue to implement Kids Care with coverage of children up to 250% of the federal poverty guidelines. If sufficient federal and state funds are available, Kids Care should be expanded to cover children up to 300% of the federal poverty guidelines.

Low-Income Adults

Recommendation 5.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly and the Governor's Office should work with the NC Congressional delegation to support Medicaid reform that provides fiscal relief to the states and gives states the flexibility and funding to expand coverage to low-income adults without categorical restrictions, along with other efforts to provide an economic stimulus to the state.

Recommendation 5.2 (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance should conduct outreach activities, and simplify the eligibility determination and recertification process to facilitate the enrollment of Medicaid adults. In addition to efforts undertaken for children, the North Carolina Division of Medical Assistance should explore other options applicable to adults, including, but not limited to: eliminating the resource limits for low-income parents or childless adults with incomes below

100% FPG and expand the allowable resource limits for other Medicaid eligibles, and expand the certification period from 6 to 12 months.

Recommendation 5.3 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid 1115 waiver to cover more low-income adults. The waiver should be implemented in two phases.

- a) The first phase should be to expand Medicaid coverage to low-income adults with incomes below 100% of the federal poverty guidelines.
 - 1) The Division of Medical Assistance should develop a limited benefit package that emphasizes prevention, primary care, chronic disease management, a limited formulary and limited hospitalizations.
 - 2) Adults covered under this initiative should be enrolled in Community Care of North Carolina.
 - 3) The Division of Medical Assistance should seek to identify other state funds already being used to provide services to this population that could be used as part of the state match for this new Medicaid coverage.
- b) The second phase should be to expand coverage to adults with incomes between 100-200% federal poverty guidelines.
 - 1) The adults covered through this waiver should receive the same benefit package and be enrolled in Community Care of North Carolina.
 - 2) The Division of Medical Assistance should develop a sliding scale for premiums and cost sharing for this group. However, in no event can the combined premium or cost sharing exceed 5% of the families' gross income.
- c) The North Carolina Division of Medical Assistance should develop a premium assistance program to enable Medicaid-eligible recipients to use Medicaid funds to pay for employer-sponsored insurance or private non-group insurance purchased in the private market.
- d) In order to expand the availability of coverage in the small group market, the Division of Medical Assistance should work with North Carolina Community Care Network Inc. and private insurers to explore the potential for a lower cost insurance product for small businesses that were previously uninsured utilizing the Community Care of North Carolina network. Medicaid-eligible recipients who work for employers who enroll in this lower-cost public private partnership plan shall also be eligible for premium assistance. The product may include the following features:
 - 1) Connecting all enrollees with a medical home
 - 2) A more limited benefit package, emphasizing prevention, primary care and chronic disease management
 - 3) Ensuring that enrollees with chronic diseases or complex health problems have access to care management and disease management through CCNC networks
 - 4) An emphasis on wellness, health promotion and personal responsibility
 - 5) Provider reimbursement for low income populations with incomes <200% FPG at lower levels than commercial rates
 - 6) A requirement that small businesses that purchase health insurance coverage through this public private partnership also offer Section 125 plans.

Recommendation 5.4 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid 1115 waiver or implement other Medicaid options to provide interconceptional coverage to low-income women with incomes below 185% FPG who have given birth to a high risk infant. (For purposes of this recommendation, high risk infants are defined as weighing less than 1500 grams, born less than 34 weeks gestation, born with a congenital anomaly, and/or who has died in the neonatal period (first 28 days of life) within the past two years).

- a) Interconceptional care should be limited to two years following the birth, or until the subsequent birth, whichever occurs sooner.
- b) DMA should develop a benefit package to improve interconceptional care in order to decrease poor birth outcomes in subsequent pregnancies.
- c) DMA should explore whether the cost savings from improved health outcomes will offset the cost of providing Medicaid coverage to this targeted population.

Safety Net

Recommendation 7.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should increase funding to expand safety net capacity. The North Carolina General Assembly should:

- a) Appropriate \$8 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the Community Health Centers Grants program. Funding should be used to expand the safety net infrastructure so that safety net organizations can hire staff to establish community-based medical homes and expand the availability of preventive, primary, chronic disease management, specialty, dental, behavioral health, and/or pharmacy services for the uninsured. Some of the funds should be targeted to support safety net organizations that are providing a disproportionate share of care to the uninsured.
- b) Appropriate \$2.2 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the HealthNet programs. Funds should be used to sustain existing community collaborations to care for the uninsured and expand networks to other parts of the state.

Workforce

Recommendation 8.2 (PRIORITY RECOMMENDATION)

In order to maintain and expand access to health care services for low-income and underserved populations, the North Carolina General Assembly should:

- a) Continue to support the Community Care of North Carolina (CCNC) program.
- b) Continue to tie Medicaid reimbursement to physicians at 95% of the Medicare rates.
- c) Direct the Division of Medical Assistance to increase the payment for primary care practitioners practicing in health professional shortage areas either by increasing reimbursement rates or establishing a higher per member per month (pmpm) CCNC payment.

- d) The North Carolina General Assembly should appropriate \$1,915,600 million in recurring funds in SFY 2010 to the NC Office of Rural Health and Community Care (ORHCC). Of this amount:
- 1) \$350,000 should be appropriated to provide technical assistance to communities to help identify community needs and practice models that can best meet these needs and to provide technical assistance to small practices or solo practitioners practicing in medically underserved communities or serving underserved populations;
 - 2) \$1.5 million should be appropriated to pay for loan repaying and financial incentives to recruit and retain primary care physicians, physician assistants, nurse practitioners, and certified nurse midwives, psychiatrists, psychiatric physician assistants, psychiatric nurse practitioners, general surgeons and dentists to rural and underserved communities; and
 - 3) \$65,600 should be appropriated to expand the number of ORHCC staff who recruit practitioners into health professional shortage areas.
 - 4) ORHCC should place a special emphasis on recruiting and retaining underrepresented minority, bilingual and bicultural providers to work in underserved areas or with underserved populations.