

Health Reform: Medicaid and Elder Justice Workgroup
Tuesday, October 19, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Workgroup Members: Steve Wegner (co-chair), Randall Best, Mary Bethel, Sherry Bradsher, Missy Brayboy, Deborah Brown, Abby Carter Emanuelson, Mark Casey, John Eller, Kimberly Endicott, Com. Johnnie Farmer, Ted Goins, Richard Gottlieb, Joe Holliday, Richard Hudspeth, Rep. Verla Insko, John Lewis, Laketha Miller, Lydia Newman, Carla Obiol, Carla Pellerin, Robert Rich, Dennis Streets, Curtis Venable, Tom Vitaglione, Leonard Wood

Steering Committee Members: Julia Lerche, Carolyn McClanahan, Suzanne Merrill

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Julia Adams, Kari Barsness, Marie Britt, Melanie Bush, John Dervin, Lee Dixon, Annaliese Dolph, Kerri Erb, Allen Feezor, Catharine Goldsmith, Tracy Hayes, Harry Kaplan, Markita Keaton, Tara Larson, Ann Lore, Jennifer Mahan, Steve Mann, Earl Merritt, Tonya Oakley, Elaine Pleasant, Diane Poole, Melissa Reed, Chris Skowronek, David Swann, Joe Vincoli, Margaret Watts, Amy Witted

Welcome and Introductions

Steve Wegner, JD, MD

President

NC Community Care Network

Access Care, Inc.

Dr. Wegner briefly welcomed the group and the meeting participants introduced themselves.

Eligibility and Enrollment Process

What is the Role of Local DSS in 2014?

Overview of ACA Provisions

Pam Silberman, JD, DrPH

President and CEO

NC Institute of Medicine

Dr. Silberman reviewed the provisions in the ACA relating to Medicaid and CHIP coverage as well as HBE. Her presentation can be found here: [ACA Provisions](#).

Selected questions/comments:

- Q: If a hospital presumes eligibility and the patient is not eligible, are there some payments that can be recouped or not paid? A: People who have been determined to be presumptively eligible have a certain period of time to file their regular Medicaid application. If the person does not file the regular Medicaid application within the specified time period, then their presumptive eligibility will expire. Providers will only get paid for Medicaid covered services provided when the person was presumptively eligible, or if the person is later determined through the regular Medicaid process to be eligible. Providers will not be paid for services if the services are not normally covered, if the provider does not follow regular Medicaid billing or coverage provisions, or if the individual is not eligible when the services are rendered (i.e., the presumptive eligibility period has expired).
- Q: Will the Division of Medical Assistance (DMA) establish criteria for hospitals to be able to presume eligibility? A: Yes. There will be a formal process and established rules.
- Q: Can we proactively enroll all eligible residents into Medicaid, even if they refuse to apply? A: No, this is a voluntary system. However, some states are considering options for more active enrollment—e.g., sending out Medicaid eligibility cards to people who the state determines should be eligible (i.e., using past tax records). If the individual/family uses the card, then they are assumed to accept the coverage (and any terms of participation). Q: The patient navigator and outreach components are going to be important for those who are not computer literate and/or those without access to the internet. How does that fit into the Medicaid enrollment process? A: A person can speak with a patient navigator and the navigator will go online and lead them through the process. A navigator can also give them instructions on how individuals can apply themselves. DHHS wants to maximize what efforts are already underway and make navigator functions widely available. There can be formal navigators and informal navigators. Formal navigators will reach out to people not coming into care while informal navigators can be a doctor or nurse who assists those coming into care with enrollment. There is an intention to identify navigators in hospitals and provider offices and train them to assist patients. However, the state has to also consider the costs of navigator services, as the Health Benefits Exchange will have to pay navigators; and these costs may lead to increased premiums.
- Q: If people can apply online, what role will local DSS play? A: DSS may be morphed into an entity which helps people enroll when eligibility cannot be determined online. There are going to be glitches in the system and DSS will help those individuals who get caught in those glitches (i.e. income lower than reported income in system due to loss of job). DSS recognizes its role is going to change and is looking at what the new role will be and what skills its employees will need to have in the future. DSS directors will need a new business model.

- Q: Are hospitals going to have to contract with DOI to provide navigators? A: DOI would like to train hospital staff to ensure that they are providing accurate enrollment information to prospective enrollees. Large hospitals that already have staff focused on reimbursement structures will need to be expanded to understand new provisions and HBEs. An advantage of formal navigators is they will have the most up-to-date information as it is available.
- Comment: Advocates have requested an efficacy study to combine Medicaid and CHIP now instead of waiting for reform. Combining them now could save the state money and care for children would be improved.
- Comment: Populations that do not understand the process may still try to apply through DSS (i.e. non-English speakers, low literacy, etc.).

DMA's Current Simplification Efforts

Carolyn McClanahan

Chief

Medicaid Eligibility Unit

Division of Medical Assistance

Ms. McClanahan outlined DMA's plans to simplify Medicaid procedures. Plans include integrated eligibility, revising the reenrollment process, creating a single application for all programs and simplifying other procedures. A handout for her overview can be found here: [Eligibility Simplification, Medicaid Income/Reserve Limits](#).

Selected questions/comments:

- Q: Are the rules being looked at by DMA both statutory and regulation? A: Yes. A workgroup is identifying which areas fall under federal laws (statutes or regulations), and which areas fall under state statutes and regulations. We need to know which rules we have some flexibility with (state statutes and administrative rules) and which ones we do not (federal laws).
- Q: States could qualify for an enhanced bonus from the federal government if they implement five of eight simplifications. North Carolina currently has implemented four of the required simplifications. Have we implemented any other recognized simplification effort, which would help us qualify for the bonus? A: No; however the express lane recertification could be that fifth option.

NC FAST

Anthony Vellucci

Program Director

Division of Information Resource Management

NC Department of Health and Human Services

Mr. Vellucci gave a presentation about the NC FAST program. This technology is being developed to integrate the eligibility and verification, case management, and prescreening functions for all of the different NC DHHS programs and services (including child care, food and nutrition services, Medicaid and NC Health Choice, Work First, energy assistance, Special Assistance, Refugee Assistance, child welfare, and adult and family services). This new eligibility and enrollment system was scheduled to be phased in over time. Because of the ACA, eligibility and enrollment, verification, and prescreening for Medicaid and NC Health Choice was moved up in the implementation schedule so that it will be fully implemented by January 2014. In addition, NC FAST will be interoperable with the electronic application web portal developed for the HBE, so that the application, eligibility and enrollment process between Medicaid, NC Health Choice, and the HBE will be coordinated and seamless to the individual. His presentation can be found here: [NC FAST](#).

Selected questions/comments:

- Comment: The intent of this system is that everything remains seamless for the recipient. There is no wrong door into the system because individuals can enter through ePASS (electronic Pre-Assessment Screening Service),¹ the internet or face-to-face contact. Applications are automatically sent to where they need to go whether it's Medicaid, HBE or links to private insurance.
- Q: Can a provider find out if a person is enrolled in a private insurance plan in order to identify potential third party liability? A: It depends on how the technology is set up. The system has the capability to do that but we would need the cooperation of the insurers.
- Q: If the HBE could contract with the Division of Medical Assistance to create the electronic application and enrollment system (i.e., through NC FAST), why create a separate web portal for the Health Benefits Exchange? A: NC DHHS does not have the time or resources to develop a new enrollment and eligibility system for the HBE. Instead, we can accomplish the same goals by developing a different HBE web portal that is interoperable with NC FAST. Q: If an individual qualifies for Medicaid, can the NC FAST system certify the case or will the case still have to be reviewed by DHHS? A: If you are eligible according to the system then the system will make the determination. The case does not have to be reviewed by DSS eligibility workers to be certified. If the case is flagged and determined ineligible, then the case will go to DSS and be handled by a person.
- Q: Will the data between the exchange and NC FAST be compatible? A: Yes. Unique identifiers, which have been a problem in the past with exchanging data, will not be a problem because this new system can translate identifiers across systems.

¹ ePASS will be "a secure, web-based, self-service tool that enables NC residents to screen for potential eligibility for a range of NC benefits and services programs." (Vellucci presentation, October 19, 2010).

- Q: If a person with Medicaid becomes ineligible and loses coverage but then becomes eligible again, will the system detect it? A: All information stored on the system for that case is time stamped. If the case is active and circumstances change then yes the system will catch that; however, if the case is inactive it would only catch it if we decide we want to allow the system to do that.
- Q: Can people be moved mid-year from exchange into Medicaid (i.e. if a person applies for Medicaid and is determined ineligible but then applies later for food stamps and they have been laid off and are now eligible for Medicaid)? A: Assume the answer is yes because it is mandatory eligibility and there cannot be any waiting lists.
- Comment: The reason for people rotating on and off Medicaid is a big question. We spend a lot of time re-certifying people after becoming ineligible and then eligible again. We need to reassess why we are making people ineligible and determine if it is necessary. Usually people who rotate in and out of Medicaid are deemed ineligible for administrative reasons, not because their situation has changed. Solving this problem will save time and costs.
- Comment: Anyone who applies for enrollment will have the right to appeal a denial.

Group Discussion

The workgroup discussed what new role DSS will play with the new eligibility and enrollment process; what legislative issues need to be addressed; and what clarifications the workgroup needs from CMS. Below is a list of the group's questions and comments.

- Role of providers and DHHS
 - How do we ensure continuing coverage?
 - Should there be a link to private insurers?
- Pending legislation issues to address
 - Costs of covering children
- Further clarification from CMS
 - How to ID newly eligible vs. currently eligible?
 - What preventive services are going to be covered by Medicaid?
 - What happens if income changes mid-year?
 - What if a person given presumptive eligibility falsifies information?
 - What are the quality control requirements for enrollment?
 - Can the state require persons given presumptive eligibility to file an application at the same time?