

Health Care Reform: Patient Protection and Affordable Care Act

Overview of Implementation at DMA:

Medicaid and Health Choice

Medicaid Work Group – August 11, 2010

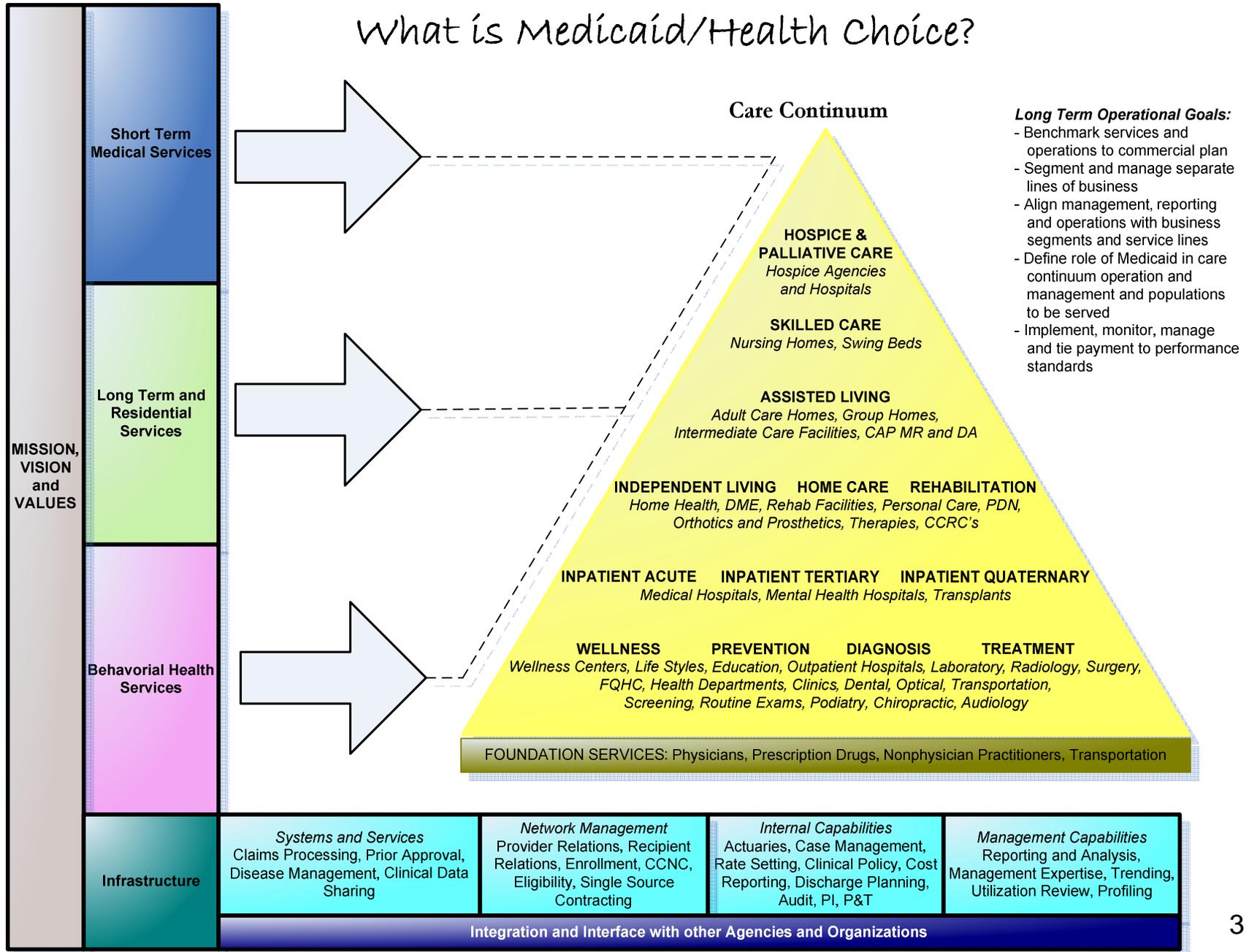


Setting the Stage in NC

- Recognition that Medicaid and SCHIP (Health Choice) are not the only players
 - Private Insurance Companies
 - Other State Agencies
- Many decisions to be made
 - Short term and long term
- Building off initiatives and vision of the State and Medicaid
 - Coordination among other activities such as Governor's Goals and Priorities, HIE, HIT, EHR, Project Excel goals, and Performance Budgeting
 - Balancing budget restraints, Medicaid sustainability and health care vision
- Very, very early in the process
 - Review and analysis
- All states and state agencies have questions
 - Weekly calls with CMS
 - Any mention of Health Care Reform in currently CMS discussions requires transfer to a different review process



What is Medicaid/Health Choice?



What is the Impact?

- Requires HHS (thus NC) to establish a system where individuals can apply for Medicaid, SCHIP, tax credits for coverage through the exchange or a State Basic Health Plan for people ineligible for Medicaid
- Establishes exchanges and are required to interface with Medicaid and vice versa
 - Requires that if individuals who are eligible for Medicaid/SCHIP apply for tax credits, they are enrolled in Medicaid instead.
 - Establishes training/outreach requirements to individuals
 - Coordinate enrollment procedures with other programs
 - Must consult with stakeholders, etc
- Modifies portions of Medicaid in order to ensure affordable health coverage
- Major categories
 - Eligibility
 - Services – basic package and Improvements of Coverage, Prescription Drugs
 - Enrollment Simplification
 - Funding – FMAP and Disproportionate Share Hospital Payments(DSH)
 - New Options to cover Long Term Services and Supports
 - Quality of Medicaid for Patients and Providers
 - Program Integrity



Impact on Medicaid/Health Choice

Eligibility

- Creates a MANDATORY eligibility group that expands Medicaid to 133% FPL without regards to categorically eligibility effective 1/2014
 - *NC Medicaid currently has approximately 15 eligibility categories ranging from 100% FPL to 185%*
 - *Excludes individuals if eligible for one of the existing mandatory groups- if enrolled or not*
- Increases mandatory eligibility of children 6-19 yrs to 133% FPL
 - *Will impact Health Choice since eligibility for HC is 101 to 200%*
- Allows the states implement the new eligibility category options effective 4/2010 but at the original NC FMAP- not the current enhanced FMAP.
 - *Not implementing this option*
- Allows option to expand coverage above 133% FPL up to the highest eligibility either through waiver or State Plan.
- Can phase in but must provide mandatory before implementing the other options. NC is not exercising the early implementation option at this point.



Projected Impact to Medicaid/Health Choice Eligibility in 2014

• Expanded Eligibility		• Children Moving from Health Choice
Children	77,072	
Childless Adults	246,956	57,714
Parents	<u>175,329</u>	
New Enrollees	499,357**	

These estimates include individuals who will become eligible because of mandatory Medicaid expansion (i.e. “expansion” population), and people who are currently eligible but not enrolled (i.e. “woodwork” population).

** Depending on the source, this number has been as high at 700,000 new eligibles.

*Current Medicaid monthly averages 1.4 million active cases up to approx 1.8 million per year



Services for the 133% FPL category

- Being defined by CMS but must include
 - Ambulatory Patient
 - ER and Hospitalization
 - Maternity and newborn care
 - MH/SA screening and treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory Services
 - Preventative/wellness and chronic disease management
 - Pediatric, including oral and vision care
 - Family Planning
- *NC Medicaid currently covers some level of all the mandatory package.*
- *Does allow for differences in the benefit package for eligibility category*
 - *Can be benchmarked like Health Choice*
- *Can change existing benefit package in Medicaid*



Funding

- “Newly eligible” Expansion Population – 101% to 133% FPL category
 - 2014 through 2016 100% FMAP
 - 2017 95% FMAP
 - 2018 94% FMAP
 - 2019 93% FMAP
 - 2020 and beyond 90% FMAP
- Enrollees at or below 100% FPL “Woodwork Population” – regular FMAP
- There is a Maintenance of Effort (MOE) on standards, methodologies and procedures – can’t become more restrictive
- New reporting requirements to CMS for this population
- Extends Health Choice for 2 years through 9/30/2015
 - *Makes additional changes to existing legislation*



DSH allotment reduced by 40% initially, further reductions based on changes in rate of uninsured

Enrollment and Eligibility

- New formula for determining financial eligibility
 - *MAGI (modified adjusted gross income)*
 - *Equivalent income test*
 - *Eliminates assets test for new category but not for existing categories*
 - *New training requirements for eligibility workers*
 - *New manuals and rules*
 - *Legislative changes?*
- Excludes existing categories such as SSI, ABD, Medically Needy,
 - *There will continue to be multiple methodologies for determination*
- Permits states to offer premium assistance and wrap around benefits to **ALL** Medicaid recipients
 - *NC currently has “similar” options (HIPP and Ticket to Work) but not to the extent outlined.*
- S-CHIP Enhanced Support
 - *CMS discussing moving the 0 through 5 back to Health Choice from Medicaid*
- Creates new MANDATORY category effective 1/2014 for individuals under the age of 26 who were in foster care and enrolled in Medicaid when they turned 18.

NC added optional coverage through 20 for foster children – policy decision when to add 26



Enrollment Simplification

- Creates an additional option (Community First Choice Option) to provide habilitation services or attendant services through the State Plan instead of only waivers
 - *150% FPL*
 - *Consumer directed*
 - *Integrated setting based upon needs*
 - *NC's waivers have moved in the above direction*
 - *Waiting for further guidance from CMS*
- These requirements should look very familiar
 - *Enrollment through website ensuring high level of security features*
 - *Single application process for multiple programs*
 - *Expanded outreach efforts to targeted groups*
 - *Express lane eligibility*
- Analyzing comparison to NC's existing simplification activities
 - *What changes need to happen to NC FAST and what interfaces need to be built into the health exchange*
- Allows hospitals to make presumptive eligibility determinations
 - *Expands current out-stationed workers (FQHCs and hospitals)*
 - *Allows for others to conduct eligibility determination other than the local DSS*



Improvements to Medicaid and Options for Long-Term Services and Supports

- There are changes happening with Medicare. Since many Medicaid rates, Third Party Liability reimbursement rules and even parts of provider enrollment are tied to Medicare, there is impact to Medicaid. When Medicare makes a change, Medicaid follows.
 - *Provider practices*
 - *Provider rates*
- Coverage of Freestanding Birth Center
 - *NC currently covers- continuing the analysis process*
- Family Planning Services
 - *NC currently covers under State Plan and through 1115 Waiver. Analysis underway to determine full impact of changes*
- Definition of Medical Assistance added. Historically, Medical assistance or medical necessity has been locally defined and service defined. This increases the Medicaid's agency responsibility on ensuring access to health care.
 - *Policy change for medical necessity*
- Amends 1915i options (state plan) to parallel with HCBS waivers (eligibility, services and target groups). Can't limit participants and requires independent assessment
 - *Received guidance from CMS August 9th*



Improvements to Medicaid and Options for Long-Term Services and Supports (cont)

- Removal of barriers to HCBS waivers (CAP programs)
 - *Income limit to 300% of SSI*
 - *Dual enrollment in waivers*
 - *Eligibility changes including financial determination*
 - *Target populations*
- Extends Money Follows the Person funding (MFP)
 - *NC received \$16 m*
 - *Received CMS guidance effective July 26th. Have moved forward with changes in transition coordination, shorter residency requirement in eligible facilities, extends funding through 2019 and increases federal funding to 100% for administrative infrastructure for Medicaid agency*
- Prescriptions
 - *Changes in federal upper limit to 175%*
 - *Eliminates exclusion of certain drugs*
 - *Impacts on rebates*
- Expansion of ADRCs
 - *Role with MFP transition, CAP programs, system navigators*



Improving Quality of Medicaid for Patients and Providers

- Creation of health care measurements for adults similar those in effect for children
 - *Reviewing in terms of Meaningful Use requirements of EHRs and other measures being implemented. Moves Medicaid faster to Metric driven service areas*
 - *All Medicaid services will have metrics*
- Prevention of payments for preventable health care acquired conditions
 - *Analogy to Never events and HACs currently for hospitals and mandated for DMA to implement in Budget Bill*
- Option for “health home” who have at least 2 chronic conditions or at risk. Will include mental health, substance abuse, asthma, diabetes, heart disease, overweight/obesity (January 2011)
- Health Home MUST provide: Case management and care management, health promotion, transition services from inpatient, patient/family support and referrals to community services
 - *CCNC and LME/CABHA- linkages between primary care and behavioral health*
 - *Provider qualifications – linkages with primary care, IT capability and capacity*
 - *Data sharing for coordination*
 - *Outcomes (care coordination, discharge planning, referrals and linkages and health information linkages.*
 - *Hospital readmissions, medication reconciliation, Hospital discharge planning*
 - *NC’s activities in consolidated case management, CCNC performance indicators, and CCNC/LME relationship and role definitions all move us ahead of the requirements*
 - *Increases match for the first 2 years to 90%*
 - *Expanding telehealth and telemedicine*

Improving Quality of Medicaid for Patients and Providers

- Demonstration projects- waiting for CMS guidance/requirements. Turn around time is quick
 - Integrated care around hospitalization
 - *Bundled payments*
 - *PACE (not a demonstration project)*
 - Payments based upon performance (*currently under development at Medicaid – not as demonstration projects*)
 - *NOVA Project – additional rate for maintaining “extra” criteria*
 - *Incentives for meeting certain criteria (Smart PA, demonstration of achieving metrics)*
 - *Pregnancy Home – exempt from PA and incentive payment for meeting criteria*
 - *CCNC PMPM and contract requirements*
 - *The plan: pay for delivery of evidence services and health outcomes – not for process and volume*
 - Pediatric Accountable Care Organizations sharing in savings due to implementation of performance guidelines



Reimbursements for IMDs between ages of 21-65 to stabilize emergency psychiatric condition
DIVISION OF MEDICAL ASSISTANCE

Program Integrity

- The Governor's Plan to address Medicaid Fraud, Abuse and Misuse moves NC in high gear to meet the requirements
 - *Analytical Software*
 - *Additional staffing and IT capabilities*
 - *Enhanced post payment review and prepayment review*
- Enhances screening procedures to be based upon risk factors
 - *Example: Frequency in Monitoring Tool used with DMA/DMH/LME*
 - *Outlier management*
- Enrollment or revalidation
 - *Uncollected debt*
 - *Payment suspension or billing privileges revoked*
 - *Exclusions from health care programs*
 - *Expands compliance programs*
 - *Sharing provider data among states and agencies*
 - *Adherence to state rules and requirements linked to Medicaid participation*
- Data reporting
 - *Sharing across federal/ state agencies (IRS, Revenue, DHSR, Licensing Boards)*
 - *Standards for states to report to CMS and penalties for failure to meet requirements*



Program Integrity

- Increases provider standards and disclosures (supports NC actions)
 - *Ownership*
 - *Failure to disclose or falsifying application*
 - *Bonds based upon size and volume of billing based upon risk*
 - *Exclusion from enrollment or re-enrollment when managers or entities have met certain “sanctions” or non-allowed activities – good standing rules*
- State data systems must identify areas of fraud, abuse, misuse
 - *NC’s analytical software*
 - *Prepayment reviews – stopping the payments up front*
- Data reporting requirements for recoupments, program integrity activities
 - *Program Integrity Dashboard: cases opened, cases closed, referrals, dollars recouped, time for case closure*

