

MEDICAID AND ELDER JUSTICE
Wednesday, August 11, 2010
North Carolina Institute of Medicine, Morrisville
9:00-12:00

Workgroup Members: Craigan Gray (co-chair), Steve Wegner (co-chair), John Abramson, Mary Bethel, Missy Brayboy, Abby Carter Emanuelson, Kimberly Endicott, Richard Hudspeth, Rep. Verla Insko, John Lewis, Laketha Miller, Maureen Morrell, Lydia Newman, Carla Obiol, Carla Pellerin, Sen. William Purcell, Robert Rich, Kathie Smith, Curtis Venable, Leonard Wood

Steering Committee members: Julia Lerche, Larry Nason, Suzanne Merrill, Sabrene Lea, Carolyn McClanahan

Staff: Pam Silberman, Catherine Liao

Interested Persons: Melanie Bush, John Dervin, Lee Dixon, Mary Edwards, Kerri Erb, Tracy Hayes, Tara Lawson, Rick Pilato, Ben Popkin, Chris Skowronek, Rebecca Troutman

Welcome and Introductions

Craigan Gray, MD, JD, MBA

Director, NC Division of Medical Assistance

North Carolina Department of Health and Human Services

Steve Wegner, MD

President

NC Community Care Network

Access Care, Inc.

Dr. Craigan Gray welcomed everyone and thanked them for the important work they were about to undertake. Dr. Wegner also gave his introductions, and then other workgroup members and guests introduced themselves.

Overview of Health Reform, Structure of the Workgroups, and the Charge of this Workgroup

Pam Silberman, JD, DrPH,

President and CEO

North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Health Reform overview](#).

Overview of Workgroup’s Specific Provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

Pam Silberman

Dr. Silberman gave a more detailed presentation of the health reform provisions related to Medicaid and Elder Justice. Click here to view the presentation: [Workgroup overview](#). Click here to see the specific sections of the Affordable Care Act which the workgroup will review: [ACA Medicaid and Elder Law provisions](#).

Selected comments/questions:

- Q: Do we know how much it will cost the state to implement the provisions of the Affordable Care Act?
A: Dr. Gray reported that the Division of Medical Assistance estimates that between 500,000-800,000 people will gain Medicaid coverage between (2014-2019) at an estimated cost to the state of approximately \$800 million (total over five years). Dr. Silberman noted that while the Medicaid expansion would cost more to the state, that there were cost offsets. For example, from 2015-2019, the federal government will increase NC's CHIP match rate by 23% (up to approximately 98%). This will bring new revenues to the state. North Carolina has not yet conducted a comprehensive assessment of the net costs (or revenues) from all the different ACA provisions.
- Q: Who pays for the subsidies to people with incomes below 400% of the federal poverty levels?
A: The federal government.
- Q: Will people still need to go to DSS to apply for Medicaid or CHIP?
A: No. People will still be able to go to DSS to apply, but they will not need to. Enrollment can be taken electronically over the internet, so enrollment can take place anywhere. The law requires the health benefits exchange (HBE) to contract with patient navigators to help explain insurance options and help people enroll. In addition, community health centers, hospitals, and others will all be able to help enroll people in Medicaid. The law mandates a "no-wrong door" approach. Thus, if someone who applies for Medicaid is determined to be ineligible, but is eligible for the subsidy through the health benefits exchange, the person should be enrolled into the premium subsidy program to purchase private coverage. Similarly, if someone applies for the subsidy, but is determined to be eligible for Medicaid, the person should be enrolled into the Medicaid program.
- Q: Who will pay for the development of this electronic enrollment system (that coordinates between Medicaid and the HBE)?
A: There are new federal funds available to the states to create the HBE, but the state will also take advantage of enhanced federal Medicaid funding to help support the HIT infrastructure.
- Q: What happens to COBRA coverage? Are there subsidies for COBRA?
A: We are not sure how this bill affects COBRA coverage, if at all.
- Q: How will we educate the public about the new coverage options and other changes in the ACA?
A: This is a cross-cutting issue that we will bring to the attention of the Overall Advisory group.
- Q: How will preventive services be covered in Medicaid?
A: This is unclear in the bill. In one section, coverage of adult preventive services appears to be optional to the state. The ACA will provide an enhanced federal medical assistance payment (FMAP) to states that provide all the recommended adult preventive

services and immunizations without cost sharing. However, in another section of the bill, it implies that the states must cover all the essential health benefits (which also includes preventive services). We will seek further clarification of this.

Update on NC Division of Medical Assistance's Current Implementation Efforts

Tara R. Larson

Chief Clinical Operations Officer, Division of Medical Assistance

North Carolina Department of Health and Human Services

Ms Larson gave an overview of what the Division of Medical Assistance has been doing to implement the federal health reform provisions. Click here to view the presentation: [Division of Medical Assistance update.](#)

Selected comments/questions:

- Q: The new law requires states to keep track of people who would have been eligible under the old eligibility rules (“existing eligibles”) and those who are new eligible (ie, would not have qualified under the old eligibility rules). The federal government will give the state an enhanced federal matching payment for people who are newly eligible, but not for the existing eligibles. The ACA also streamlines the eligibility process for most individuals by eliminating the assets tests for most groups. How will the state know if a person would have been an “existing” eligible or “new eligible” without also verifying assets.
A: We heard that the federal government may do a sampling of cases (using the old eligibility rules) to determine the percentage of people who might have been eligible under the old rules. The state is still waiting for further clarification on this issue. Some groups will still be required to verify resources (assets) including the medically needy.
- Q: How does this new electronic enrollment interchange between Medicaid and the Health Benefit Exchange relate to the Department of Health and Human Services (DHHS) ongoing efforts to coordinate enrollment among all of the DHHS programs (such as food stamps, Medicaid, TANF, etc.)
A: DHHS has been working for several years to develop a common electronic application and enrollment process for different DHHS programs, including Food Stamps, Medicaid, NC Health Choice, child care subsidies, TANF, etc. The internal system was called NC FAST. Because of the ACA, DHHS has changed the order in which programs will be brought online under NC FAST, so that now Medicaid and NC Health Choice will be among the first programs that become operational.
- Q: The ACA includes new funding to expand Aging and Disability Resource Centers (ADRCs). How many currently exist in North Carolina?
A: There are eight existing ADRCs that cover 11 counties. There are already plans to expand the number of ADRCs to an additional 13 programs (covering 28 counties). There state is developing a strategic plan to expand the number of ADRCs to cover the entire state.
- Q: Can the federal coverage of preventive services be expanded to include paying pharmacy copays for aged, blind and disabled population?
A: The ACA preventive coverage does not include pharmacy benefits.

- Q: How do we help to remove the historical stigma attached to the Medicaid program?
A: This is an important question that the workgroup will consider. It is important to ensure that Medicaid is considered a regular insurance option, not a handout. One option may be to change the name of the program, but we will also need to change the way the program is administered so that it is no longer perceived as a welfare program.

Next steps

1. We may want to create a smaller subcommittee with members from both the HBE and the Medicaid workgroups to help examine the requirements for a coordinated electronic enrollment system.
2. In the next meeting, we will focus on those provisions which the state is required to implement in the next six months. Some provisions are optional and some are mandatory. We will also work with DMA to get cost estimates of the new provisions, and will identify the changes that need statutory or regulatory changes.
3. We also need to focus on what role DSS will play in the future in determining eligibility if there's an electronic enrollment system that supports the no wrong door approach.
4. We also need to think about how we frame this new program so that it's not perceived as an old welfare program.
5. The workgroup will also be asked to examine the different options to expand home and community-based services.