

Health Reform: Medicaid and Elder Justice Workgroup
Wednesday, November 3, 2010
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Steve Wegner (co-chair), Jon Abramson, Randall Best, Mary Bethel, Sherry Bradsher, Missy Brayboy, Joe Holliday, Richard Hudspeth, Rep. Verla Insko, John Lewis, Laketha Miller, Carla Pellerin, Kathie Smith, Dennis Streets, Curtis Venable, Tom Vitaglione, Leonard Wood

Steering Committee Members: Kari Barsness, John Dervin, Sabrena Lea, Trish Farnham, Julia Lerche, Suzanne Merrill

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Marie Britt, Ila Broyles, Cynthia Cason, Sam Clark, Analiese Dolph, Kerri Erb, Carla Hales Gordo, Lynn Hardy, Tracy Hayes, Jennifer Hillman, Kristi Huff, Tara Larson, Anne Lore, Jennifer Mahan, Gayl Manthei, Carolyn McClanahan, Renee Montgomery, Larry Nason, Steve Owen, Diane Poole, Dave Richard, Tim Rogers, Chris Skowronek, Flo Stein, Craig Souza, Rebecca Whitaker, Amy Whitted, Marci Wilding

Welcome and Introductions

Craigan Gray, MD, JD, MBA
Director, NC Division of Medical Assistance
North Carolina Department of Health and Human Services

Steve Wegner, JD, MD
President
NC Community Care Network
Access Care, Inc.

Dr. Gray welcomed everyone to the meeting.

Overview of New Home and Community Based Waiver Options under ACA

Tara Larson

Chief Clinical Operations Officer

Division of Medical Assistance

NC Department of Health and Human Services

Ms. Larson gave an overview of how the 1915(i) home and community based services (HCBS) option will be affected by the Affordable Care Act (ACA). The ACA gives the state more flexibility to develop specific HCB service packages for different target populations. If a state elects to expand HCBS using the 1915(i) option, then the program becomes an entitlement for eligible individuals and the program must operate statewide. North Carolina will initially submit a 1915(i) state plan amendment to provide personal care services for people living in adult care homes. Because of the state budget crisis, the Division of Medical Assistance does not have any immediate plans to expand the 1915(i) state plan amendment to other populations. However, the state is considering other ways in which it could amend the state plan in the future to cover other target populations. Further, the state may be able to receive an enhanced federal match for HCBS using either the 1915(i) option or the Community First Choice option. Her presentation can be found here: [1915\(i\) HCBS Option](#).

Selected questions and comments:

- Q: The Community First Choice (CFC) Option and the state balancing initiative will increase the Federal Medical Assistance Percentages (FMAP) rate by six percent and two percent, respectively. Do we have any clarification on how the enhanced federal match rate will be calculated or how much North Carolina might receive? A: No, we do not have clarification on what services those apply to yet. We also do not know if those percentages are based on today's FMAP rates.
- Q: If a person only needs assistance with respite services, can that state design a program so that the person would only be eligible for respite benefits without gaining eligibility for all of the other Medicaid covered services? A: Medicaid generally operates as an "all or nothing" program. If a person is eligible for any Medicaid services, the person generally is eligible for all services (not just a subset of services). However, we have not asked specifically if benefits can be limited to just respite services.
- Q: Are there any limits to the number of amendments or time limits to amend the 1915(i) option? A: No.
- Q: What services have been requested for the 1915(i) option in adult care homes? A: Personal care services.
- Comment: We should explore ways to use existing state dollars from other state programs to serve as the state match to cover HCBS through the Medicaid program. If we do that, we can draw down federal funds to help pay for some of the services.

Comment: The 1915(i) option does not give us the option of limiting the provider network. All the providers that meet the service standards can be enrolled.

- Q: Is there a definition for the number of days respite benefits would cover? A: It depends on how you define the package. The state has the flexibility in defining covered HCBS.

Costs and Quality of HCBS and Institutional Care

Steve Owen

Chief Business Operations Officer

Division of Medical Assistance

NC Department of Health and Human Services

Mr. Owen compared state costs of the community alternatives program for persons with intellectual or other developmental disabilities (called the CAP-MR/DD program) for people who would otherwise need the level of care provided through state developmental centers or private intermediate care facilities for people with intellectual and other developmental disabilities (called ICFs-MR). He also compared state costs of the community alternatives program for children/disabled adults (CAP-C & -DA), state owned nursing homes, and non-state owned nursing homes. Although the data for these entities is extremely rough and needs to be statistically adjusted, it helped give the workgroup a baseline on costs of community care versus facility care. His presentation can be found here: [Facility and Community Based Care](#).

Selected questions and comments:

- Comment: It is hard to compare the data because it isn't "apples to apples." The state historically has not collected good assessment data to determine the extent of a person's need for long-term services and supports. As a result, it is hard to know whether differences in costs are due to the person's level of need or where the person receives these services (ie, state developmental center, ICF-MR, or in the home).
 - Q: Is there a way to normalize the data for severity of need? A: The state has some information that could help, but no validated, reliable way to determine the level of a person's needs for services and supports across different populations.
 - Comment: It is hard to assess and monitor programs. Maybe it should be a recommendation to standardize data collection and measures.

The workgroup then heard from three panelists who discussed the needs for additional HCBS for people with intellectual and other developmental disabilities (I/DD), the frail elderly, and people with mental illness or addiction disorders. Because of the state's current budget shortfall, panelists were asked to discuss what their priorities would be for expansion of HCBS.

Panel: HCBS Options for Different Population Groups
People with Intellectual and Developmental Disabilities

David Richard
Executive Director
Arc North Carolina

Mr. Richard gave a presentation about the needs for additional HCBS for people with IDD. He noted that many different groups of people with I/DD could benefit from the 1915(i) state plan. However, because of the state budget crisis, he suggested that the state begin to expand Medicaid HCBS by serving people who are currently receiving state funds for residential supports in private ICFs-MR. In order to limit the number of people who could be served using this option, he also suggested that the state put a moratorium on new admissions to private ICFs-MR. His presentation can be found here: [Home and Community for People with ID/DD](#).

View from Governor's State Aging Conference

Dennis Streets
Director
Division of Aging and Adult Services
NC Department of Health and Human Services

Mr. Streets outlined the main themes that arose during the Governor's Conference on Aging and the priorities for the 2011 NC Senior Tar Heel Legislature. While the Governor's Conference on Aging discussed many topics (not all relevant to this workgroup), he did note that the Governor's Conference supported expansion of respite services and adult day care services. These services can help support families in taking care of frail elderly family members, thus keeping people out of long-term care facilities. His presentation can be found here: [Governor's State Aging Conference](#). A handout Mr. Street provided can be found here: [Summing Up](#).

People with Mental Illness or Addiction Disorders

Flo Stein
Chief
Community Policy Management
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Development
NC Department of Health and Human Services

Ms. Stein discussed the need for better long term services and supports (LTSS) for those with mental illness and/or substance abuse disorders. She explained that the ACA included HBCS options that could provide long-term services and supports to people with mental illness or addiction disorders. The new HCBS options, including the Community First Choice option and

the state balancing initiative can help support people to live as independently as possible in the community. Ms. Stein noted that the state of Georgia just entered a settlement agreement in an Olmstead lawsuit over the lack of community supports to enable people to move from institutional settings back into the community.

Selected questions and comments for the last three presentations:

- Q: Mr. Streets, what are the priority groups among the elderly that should receive priority if the state expand HCBS? A: Some of the priorities should include targeting the near poor and people with dementia, providing services to keep people at home for as long as possible, and offering options for consumer-directed care. The state should explore options to expand funding for respite and adult day care services (the Medicaid program currently pays for adult day health programs, but not adult day care. Adult day care may be a more affordable and efficient way to provide services to multiple frail elderly during the day).
- Comment: We need to use validated, reliable assessment instruments to determine the level of a person's needs. Good assessments are very important in looking at medical care, transitional care and community care because we have to manage them all as a team.

Group Discussion

The workgroup discussed the pros and cons to pursuing additional HBCS, the group's priority areas, the possible cost containment options, and the additional information that is needed. The group discussed more pros of pursuing additional HBCS than cons. Pros included targeting services to specific populations, serving more people with existing funds, enhancing quality requirements, keeping people in their communities, and the possibility of using the HCBS options to maintain existing services rather than experience major cuts. Cons discussed included potential new costs to the state, inability to limit the number of persons enrolled, inability to limit providers (except through quality control), and potential coercion in individual's homes.

The workgroup discussed what its priorities should be if the state were to expand HCBS. Some of the priorities included:

- Use existing state HCBS funds to pay for respite and adult day care services for individuals with incomes higher than traditional Medicaid (so that families can continue to provide services to their loved ones at home)
- Use existing state funds for people with I/DD being served in 122C facilities (limit program initially to people in 122C facilities so as to limit potential state liability)
- Provide HCBS to people who are currently being served through the Adult Protective Services system
- Examining options to pay for palliative care at the end of life

Additional information workgroup members would like to have included more accurate cost data, what other states are doing around HCBS, and what assistive technologies can be funded through the 1915(i) option.

Public Comment Period

No additional public comments were given.