

Health Reform: Medicaid Workgroup
Wednesday, January 19, 2011
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Steve Wegner (co-chair), Missy Brayboy, Abby Carter Emanuelson, Steve Cline, Tracy Hayes, Joe Holliday, Tara Larson, John Lewis, Jennifer Mahan, Laketha Miller, Carla Obiol, Kathie Smith, Curtis Venable, Tom Vitaglione, Leonard Wood

Steering Committee Members: Trish Farnham, Suzanne Merrill

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Marie Britt, Chris Collins, Lee Dixon, Analiese Dolph, Nancy Rogers, David Swann

Welcome and Introductions

Craigan Gray, MD, MBA, JD
Director
Division of Medical Assistance
NC Department of Health and Human Services
Co-chair

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

Dr. Wegner welcomed everyone to the meeting.

Health Homes

Chris Collins, MSW
Deputy Director, Office of Rural Health and Community Care
Assistant Director, Division of Medical Assistance—Managed Care

Section 2703 of the ACA creates a state option to develop health homes for Medicaid beneficiaries with chronic conditions. The health home must provide interdisciplinary care that includes mental health, primary care, and community-based social services to qualified eligibles. Qualified eligibles must have two or more chronic conditions, one chronic condition and at high risk for a second chronic condition, or a serious mental health condition. Chronic conditions include, but at the discretion of the Secretary will not be limited to, mental health disorders, substance abuse disorders, asthma, diabetes,

heart disease and/or being overweight (Body Mass Index 25+). Designated providers, teams of health care professionals linked to a designated provider, or a designated health team must administer the health home services.

Health homes are expected to lower emergency room use, reduce hospital admissions and readmissions, lower health care costs, reduce reliance on long-term care, and improve quality of care. The state option to provide health home services went into effect on January 1, 2011. States that applied to the Centers for Medicare and Medicaid Services (CMS) for title XIX funds will receive \$500,000 to develop a state plan amendment (SPA) to state Medicaid statutes for establishing the health homes. States that apply for this grant and provide health home services to Medicaid patients with chronic conditions will receive a 90 percent Federal Medical Assistance Percentage (FMAP) rate for the first eight fiscal quarters that the SPA is in effect. States are required to report evaluation data and quality measures to the state.

North Carolina is looking at CCNC networks and Carolina Access networks as a health home. The state wants to align services by identifying how other providers in the networks fit into the health home model to ensure coordination of care. The state wants to move from a targeted case management program to a per-member-per-month (PMPM) payment model and is also looking at ways to use health homes as a way to improve overall population health, identify high-risk individuals, and improve transitions of care.

Selected questions and comments:

- Q: About how many Medicaid recipients have only one chronic condition? A: We believe a majority of Medicaid recipients with chronic illnesses have two or more especially if you add in mental disorders. The most difficult part will be defining “at risk.”
- The pregnancy home model and this new model have the same goal for better outcomes. Sharing outcome data with providers has helped give more structure to the medical home and has helped at a local level.

ACA Workgroup Legislation

Tara Larson, MAEd
Chief Clinical Operations Officer
Division of Medical Assistance
NC Department of Health and Human Services

Ms. Larson presented draft legislation the NCIOM workgroups are proposing. Her presentation can be found here: [ACA Workgroup Legislation](#).

Selected questions and comments:

- Under the new legislation, all Medicaid providers must have a corporate compliance program. This is an area where associations could be helpful to their members, especially small providers, by creating a model program.

- The federal government is requiring states to identify high-risk providers. High-risk providers can be either a category of provider or individual providers due to performance issues. The state can go beyond the federal minimum requirements.
- Q: In 2014 children enrolled in Health Choice with incomes at 138% or less than the federal poverty level will go into Medicaid. Would it be wise to go ahead and make that switch now? It could potentially save the state money. A: All the logistics to do that would be overwhelming. More time needs to be spent on the planning side.

Review of Interim Report

The workgroup briefly reviewed a draft of the NCIOM's interim report Implementation of the Patient Protection and Affordable Care Act.

Selected questions and comments:

- Q: Should there be more emphasis on budget justification in this section of the report or in another section? Things such as health homes are going to save a lot of money. A: Some can be put into this section particularly pertaining to cost shifting. Areas where there will be cost savings were specified. Additional savings that cannot be accurately calculated will be included in another section.
- Q: Is there a study that can be cited to support the money savings from using home and community based services? A cost estimate will be done to determine if the state will save money.

Public Comment Period

No further public comments were given.