

Health Reform: Medicaid Workgroup
Wednesday, April 13, 2011
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Randall Best, Mary Bethel, Deborah Brown, Abby Carter Emanuelson, Steve Cline, John Eller, Lynn Hardy, Tracy Hayes, Joe Holliday, Tara Larson, Jennifer Mahan, Carla Obiol, Carla Pellerin, Kathie Smith

Steering Committee Members: Trish Farnham

NCIOM Staff: Lauren Short, Pam Silberman, Rachel Williams

Other Interested Persons: Jessica Bearden, Melanie Bush, Emily Carmody, Monica Jones, Betty Macon, Steve Owen, Sheila Platts, Nancy Rogers, Susan Ryan, Doug Sea, Chris Skowronek, David Swann, Rebecca Whitaker

Welcome

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

Dr. Gray welcomed everyone to the meeting.

Cost and Coverage Estimates from Interim Report

Steve Owen
Chief Business Operations Officer
Division of Medical Assistance
NC Department of Health and Human Services

Mr. Owen reviewed changes taking place in Medicaid due to health reform and the associated costs with those changes. In 2014, Medicaid eligibility will expand to those at 138% federal poverty level (FPL) and below. This expansion will create two categories: children and adults currently eligible for Medicaid but not currently enrolled (“woodwork” population) and adults that are newly eligible with incomes below 138% FPL. Woodwork individuals will receive all benefits currently available to Medicaid enrollees. Newly eligibles will receive fewer benefits, based on a “benchmark” plan. DMA estimates that more than 500,000 people will gain Medicaid eligibility as a result of this expansion. DMA estimates the costs to the state to be \$830 million in total between 2014 and 2019. The federal government will contribute more than \$15 billion to offset the Medicaid costs between 2014 and 2019.

Mr. Owen’s presentation can be found here: [Impact of Health Care Reform on Medicaid](#).

Selected questions and comments:

- The ongoing costs to the state will be approximately \$300 million per year to cover this new population.
- The federal government has not yet defined the benchmark plan for the new eligibles. Under the ACA, the benchmark benefits must consist of at least the minimum essential coverage, and this has not yet been defined. The Secretary of the US DHHS is expected to define the essential benefits package sometime this fall (2011).
- Q: Do the different benefit packages for woodwork individuals and newly eligibles mean there will be beneficiaries floating between benefit packages as a patient? A: Yes. This creates potential problems about coverage and costs. Also, patients switching between Medicaid and the HBE may have different coverage, or may need to change providers.
- Q: If the state wanted to sync the two Medicaid programs, would it need to add optional services to the benchmark plan to cover all the traditional Medicaid benefits? A: Yes (although there may be some services covered through the benchmark plan that are not fully covered in traditional Medicaid. For example, it is possible that coverage for behavioral health services through Institutions for Mental Diseases may be covered as part of the essential benefits, and by extension, the Medicaid benchmark plan.) The DMA cost estimates assumed that the state would only provide the mandatory benefits to the new eligibles.
- Most enrollees will get put into Medicaid when they are sick (i.e. visiting a doctor or hospital). Therefore, the Medicaid population could tend to be sicker than the rest of the population.
 - DMA assumed we would have an average population coming into Medicaid with these numbers.

Medicaid Lifestyle Initiatives

Health Homes

Tara Larson, MAEd

Chief Clinical Operations Officer

Division of Medical Assistance

NC Department of Health and Human Services

Ms. Larson discussed two initiatives, lifestyle incentives and health homes, which are options under the ACA. Section 4108, Medicaid Incentives for Prevention of Chronic Diseases (MIPCD), authorizes grants to provide incentives for Medicaid beneficiaries participating in prevention programs. The DMA has narrowed down possible incentives to two options: providing incentives to the aged, blind and disabled (ABD) population to participate in CCNC's Chronic Care Program or providing smoking cessation interventions for enrollees with two or three simultaneous chronic conditions.

Section 2703, State Option to Provide Health Homes for Enrollees with Chronic Conditions, allows states to submit a state plan amendment (SPA) to provide services for enrollees with chronic conditions to enhance coordination of care. Services must be provided by a designated health home provider, a team of health care professionals, or a health team. Federal support will be offered to states in the form of an enhanced federal medical assistance percentage (FMAP) rate for a total of eight quarters. North Carolina is planning on submitting two state SPAs. The

first SPA would be to enhance the existing CCNC care management (including efforts to integrate behavioral health and primary care). The second SPA would include tiered network incentive payments (based on outcomes such as reduced readmissions and reduced use of the emergency department); consolidating the Community Alternatives Program (CAP) for children and for disabled adults into CCNC; including HIV case management as part of CCNC; and expanding the LME behavioral health waivers to better coordinate behavioral health services for the Medicaid population.

Ms. Larson's presentations can be found here: [Medicaid Lifestyle Initiatives](#).
[Health Homes](#).

Selected questions and comments for Lifestyle Initiatives:

- Q: Is DMA seeking legislative support for the Medicaid Lifestyle grant or Health Homes this session? A: DMA has requested a special provision that gives it the authority to seek funding for innovations that will lead to lower health care costs.
- Q: Do we know what type of incentives will make a difference with Medicaid recipients? Committee members suggested the following:
 - Any incentives that can encourage community building or community health (i.e. a YMCA membership) would be good for the ABD population. Loneliness is a problem in that population.
 - A gift card to pregnant women who sees a doctor for prenatal care before a certain time.
 - Gas cards or transportation vouchers to help with transportation.
 - Purchasing of Wii's for the home to target obesity. People may like doing that instead of going to the gym. That could be especially helpful in rural populations with no access to a gym.
 - The state could create a point system where the Medicaid recipient could buy items such as shoes, exercise attire, or other things a person wouldn't usually buy for him/herself. This could operate like a rewards program. Blue Cross Blue Shield has Blue Awards which is similar to this. It could be helpful to look at that program and their experiences.
 - Most people know what they are supposed to do, but have trouble modifying their behavior. What does it take to modify behavior? That involves talking to the population and looking at evidence based practices.
 - Maybe incentives can be a gift that a participant can give to grandkids or others.

Selected questions and comments for Health Homes:

- Q: The idea here is to coordinate care. When there is a local management entity (LME) managing care and another entity delivering services, does that negate the whole idea of coordination? A: No. The enhanced FMAP is for case management and coordination functions, not the actual delivery of service.
- Q: How many Medicaid recipients are currently in the CCNC network? A: About 1.1 million out of about 1.5 million recipients are tied to CCNC. The only enrollees we cannot mandate into CCNC are dual eligibles, Native Americans, and children in foster care. We are modifying the state plan to have a more opt-out component rather than an opt-in component for those we can include these populations in CCNC.

- Q: What is the difference between these health homes and CCNC? A: We want to expand CCNC networks to include things such as co-located mental health and substance abuse programs and doing more in terms of care coordination.
- Q: Are you going to require using evidence based screening tools? A: Yes. When we identify screening tools they will be evidence based.
 - SBIRT trainings to primary care providers are already occurring.
- Q: The tiered incentive rates are based on provider quality measures. If a provider disagreed with the assessment of quality and the tier they have been placed in, is there some sort of appeal process? A: Right now CCNC has surveillance process in place through chart reviews. Evidence of quality will be based on real evidence, not based on third party observations.

Eligibility Simplification

Susan Ryan

Eligibility Policy Coordinator

Division of Medical Assistance

NC Department of Health and Human Services

Ms. Ryan explained efforts to simplify the complicated eligibility rules and paperwork. DHHS has been working to align its income policies among different programs including Medicaid, food and nutrition services, and NC Health Choice. Once NCFAST is available, it will further streamline the process of determining eligibility by creating one submission to determine eligibility for multiple state programs. DMA has adjusted its reenrollment process to be more active by reenrolling beneficiaries automatically unless a change has been reported. DMA is also reviewing its applications and policy manuals.

Ms. Ryan's presentation can be found here: [Eligibility Simplification](#).

Selected questions and comments:

- Q: Will NCFAST include applications for long term care? A: No. People applying for long term care services will still use the current process. Applications for long-term care will be included in NCFAST later in the process.
- The \$9.5 million that is needed for NCFAST is not in budget. The requirements for 2014 won't be met if NCFAST doesn't happen.

Ideas to Help North Carolina Prepare for the 2014 Medicaid Eligibility Changes

Pam Silberman, JD, DrPH

President and CEO

North Carolina Institute of Medicine

Dr. Silberman gave a review of Medicaid expansion, exchange enrollment, and the challenges these pose to the state. Challenges include identifying Medicaid enrollees who are newly eligible versus those that were eligible before expansion; beneficiaries moving in and out of public and private coverage; differing benefit packages between new eligibles, traditional beneficiaries, and plans in the exchange; and different provider networks and quality reporting standards between Medicaid and the exchange.

Dr. Silberman asked the group to discuss what steps North Carolina should take to minimize loss of provider coverage as people move between public and provider coverage and if North Carolina should align quality reporting standards across all insurers.

Dr. Silberman's presentation can be found here: [Eligibility and Enrollment](#).

Selected questions and comments:

- DMA is under budgetary constraints in making eligibility changes that would increase costs to the state. Thus, for example, we could not expand continuous eligibility to adults, because it would increase the number of people on Medicaid.
- Q: What happens when a “newly eligible” person turns 65?
A: Those who are newly eligible that turn 65 and begin receiving Medicare will be governed by the traditional eligibility rules. That means that some people may lose coverage (i.e., those with incomes between 100-138% FPL); but those who continue to receive Medicaid will receive full Medicaid coverage.
 - Similarly, someone with disability who does not receive SSI or Social Security Disability may receive a different benefit package than those with social security. Any enrollment simplification work has to take all of these complexities from the statutes into consideration.
- Would a person have appeal rights if they are determined not to be eligible for Medicaid?
 - The HBE will screen for Medicaid eligibility. We do not yet know what appeal notices will need to be given, if—for example—a person is determined to be eligible for the HBE subsidy, but not for Medicaid.
- Q: Will it be a problem for providers to keep track of eligibility for billing?
A: Presumably, people will be issued “smart cards” so that providers can track eligibility and coverage. Ideally, the smart card record would include visit limits, but also information about drug utilization, number of images, providers seen, etc.
- Do we have to use the old eligibility rules for everyone? Under federal Medicaid law, when someone applies for Medicaid, DSS is supposed to determine eligibility for all programs to which they may be entitled. Theoretically, the state would have to determine eligibility for all the different Medicaid categories to give prospective enrollees’ an option of which plan is best for them. However, this defeats the purpose of simplified eligibility and enrollment. We are still waiting for further federal guidance on this issue.
- The current version of HB 115 (HBE legislation) requires most navigators to be licensed.
Q: Why would you have to license navigators?
A: To ensure a certain level of competence as insurance companies do with agents. Licensure creates a higher standard of performance. However, licensure creates barriers to the use of navigators.
 - I am concerned that brokers and agents may not spend the time helping low-income or underserved populations enroll in health plans or Medicaid.
 - Navigators get paid through a grant. There is nothing in the statute precluding a person from helping a person go online and enroll.
 - In order for our citizens to benefit, we have to do active outreach. 1) We don't want to take the humanistic part out of enrollment, but NCFASST will help guide consumers through the process based on eligibility pieces entered into that system

whether entered by them themselves or by a navigator. Also, the system will tell them which program will best suit them. 2) We should continue to look at what other states are doing instead of trying to reinvent the wheel. Florida already has a no wrong door of entry system with navigators and computer portals throughout the state. Eighty percent of those that apply do it online. The state contracted with other entities to be out in communities helping people navigate programs. Social Services is trying to reinvent itself.

Public Comment Period

- The homeless have the potential to be a costly group to any Medicaid plan. There are a lot of homeless individuals with chronic conditions that have sporadic health treatment and don't have consistent enough records to qualify as disabled. Currently, the homeless tend to over utilize emergency rooms and are admitted since there is nowhere to discharge them. After the new coverage options in 2014, homeless people will have new access to health care and will have a more complete health record.