

HEALTH REFORM: MEDICAID WORKGROUP
Wednesday, October 13, 2011
North Carolina Institute of Medicine, Morrisville
9:00 am-12:00 pm
Meeting Summary

ATTENDEES

Workgroup Members: Craigan Gray (co-chair), Steve Wegner (co-chair), Jon Abramson, Mary Bethel, Sherry Bradsher, Missy Brayboy, Amelia Bryant, Abby Carter Emanuelson, Allen Feezor, Ted Goins, Lynn Hardy, Tracy Hayes, Rep. Verla Insko, John Lewis, Laketha Miller, Sen. William Purcell, Kathie Smith, Chuck Willson, Leonard Wood

Steering Committee Members: Trish Farnham, Carolyn McClanahan

NCIOM Staff: Pam Silberman, Jennifer Hastings

Other Interested Persons: John Dervin, Marita Keaton, Andy Landes, Sheila Platts

NEW FEDERAL REGULATIONS: MEDICAID ELIGIBILITY AND ENROLLMENT PROCEDURES, HBE ELIGIBILITY AND ENROLLMENT PROCEDURES

Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman presented a summary of the proposed federal regulations outlining the new Medicaid eligibility and enrollment procedures. Eligibility for most Medicaid program categories, CHIP, the Basic Health Plan (if the state chooses to develop this option), and advance payment of the premium tax credit and cost sharing subsidies will be based on a person's modified adjusted gross income (MAGI). The proposed regulations governing the Medicaid eligibility and enrollment provisions were published in 76 Fed. Register 51148-51199 (August 17, 2011).

The federal government also published other proposed regulations governing eligibility and enrollment into the HBE, premium tax credit and cost sharing subsidies, and operational requirements for HBEs and qualified health plans (QHP). The proposed regulations governing eligibility and enrollment provisions for the individual market and SHOP exchanges were published in 76 Fed. Register 51202-51237 (August 17, 2011). The proposed regulations governing the health insurance premium tax credit were published in 76 Fed. Register 50931-50949 (August 17, 2011). The proposed regulations governing HBE and QHPs were published in 76 Fed. Register 41866-41926 (July 15, 2011).

Dr. Silberman's presentation can be found here: [Medicaid Eligibility – Notice of Proposed Rule Making](#). She also handed out an overview of the other federal regulations governing the HBE and premium tax credits. That handout is available at: [Overview of all NPRM](#).

Selected questions and comments:

- Q: Do states have the ability to change reimbursement rates?

A: The federal government recently issued other proposed regulations which require states to look at access to every type of provider. If the state identifies access problems (eg, access is not reasonably equivalent to access for people in the commercial market), then the state has to develop an action plan. One possible option in a corrective action plan is to increase reimbursement rates—but that strategy is not mandated by the federal government. The proposed Medicaid regulations addressing access can be found at: [CMS Methods for Assuring Access to Covered Medicaid Services](#).
- Q: Can prisoners receive health insurance coverage?

A: Prisoners are not eligible for insurance coverage through the HBE or Medicaid while in prison. Medicaid is suspended while incarcerated. Prison care is 100% state-funded unless the individual comes out of the prison to be hospitalized. Then in this case, they can receive Medicaid to pay for the hospitalization if they are otherwise eligible for coverage. Family members of incarcerated individuals can still be eligible for Medicaid, CHIP, or subsidized coverage in the HBE.
- Q: Will “churning” continue to be an issue under the ACA?

A: In the past, many people moved into and out of Medicaid eligibility as their income changed. Often, when they lost Medicaid coverage, they would become uninsured. Under the ACA, people could lose Medicaid eligibility but then be eligible for subsidized coverage through the HBE (or they could gain employer based health insurance coverage). One study showed that a high proportion of people will transition between Medicaid and the HBE throughout the year. Even though someone could potentially retain some type of health insurance coverage, this lack of continuity could still create health problems. For example, if a person with a chronic illness is enrolled in the Community Care of North Carolina (CCNC) program, they could be receiving care management services to help them manage their health problems. They may lose this service if they move to a commercial insurance product through the HBE. The ACA statute does not provide states the option for 12-month continuous eligibility for the adult populations enrolled in Medicaid. However, states can base ongoing Medicaid eligibility on annualized income—so that small fluctuations in a person’s income will not constantly move people between Medicaid and the HBE.
- Q: How can local DSS offices handle all the new eligibles? How can the state train all the new workers who will be needed to help with eligibility and enrollment?

A: If the system works the way it is supposed to, the new eligibility and enrollment system will automatically conduct data matches to verify most of the eligibility requirements. For example, the system will obtain income information from the IRS or the Employment Security Commission, citizenship from the Social Security Administration, and immigration status from the Department of Homeland Security. In addition, people will be able to apply online or by telephone, so local DSS offices will not need to help every person who applies for Medicaid, CHIP, or subsidized coverage through the HBE. However, some people will need additional assistance in determining eligibility, including those who prefer to apply in person or those who encounter problems with the administrative data match. Local DSS offices will provide troubleshooting services. The state will need to provide additional training to DSS staff, as DSS

staff will be expected to help people enroll in Medicaid, CHIP, or the HBE (whichever coverage is applicable to the specific individual). In addition, the HBE will be required to contract with entities that can serve as patient navigators who can also assist people in applying for public or private health insurance coverage through the HBE. Thus, DSS staff will not be the only people who provide assistance with the eligibility and enrollment process. Nonetheless, it is possible there will be a bottleneck during the first year during—especially during the initial peak demand period. Local DSS staffing issues will be pretty significant and DSS is trying to streamline policies now between other programs, such as SNAP and TANF, in order to free up administrative time.

- Q: What is the cost difference between Medicaid and HBE?

A: The state has no financial responsibility to pay for people who enroll in the HBE. Thus, for it is less expensive to the state budget for people to enroll in insurance coverage through the HBE than Medicaid. However, for individuals, it would be more expensive to enroll in a subsidized plan through the HBE than Medicaid, since there are no premiums in Medicaid. People do not have a choice of whether or not they want to enroll in Medicaid or receive subsidized health insurance through the HBE. If a person is eligible for Medicaid or NC Health Choice, they are not eligible for the premium tax credit or cost sharing subsidies through the HBE.

ROLE OF DSS IN MEDICAID, CHIP, AND HBE ELIGIBILITY AND ENROLLMENT

Carolyn McClanahan

Medicaid Eligibility Unit

Division of Medical Assistance

NC Department of Health and Human Services

Ms. McClanahan discussed the effects of ACA on Medicaid/NC Health Choice enrollment and eligibility. Once all systems are fully operational, individuals will be able to apply in person through DSS, or can apply online, by phone, mail, or fax. The NC Department of Health and Human Services is in the process of developing NCFAST. When fully implemented, NCFAST will determine eligibility for all DHHS programs (eg, SNAP, TANF, Medicaid, NC Health Choice, child care subsidies), and for the premium tax credits and cost sharing subsidies in the HBE. The Medicaid, NC Health Choice, and HBE portion of NCFAST is scheduled to become operational in the summer of 2013.

The state must use a single application form for Medicaid, NC Health Choice, the Basic Health Program (if the state creates a Basic Health Program), or for the tax credit and cost sharing subsidies through the HBE. The Centers for Medicaid and Medicare Services (CMS) is in the process of developing this form. The ACA and proposed regulations requires states to verify eligibility for insurance affordability programs based on data matches at the federal and state level. Medicaid must continue to use current income and not most recent tax year to determine initial eligibility. The state will need to convert existing income limits to MAGI (modified-adjusted gross income). MAGI applies to all Medicaid applicants except those who receive Medicaid because they are receiving SSI, elderly or disabled who also receive Medicare, those applying for the medically needy program, or those who are seeking assistance with long-term care or home and community-based services. The ACA also eliminates the asset test for the MAGI groups.

Selected questions and comments:

- All the work the NC Department of Health and Human Services is doing to simplify enrollment is dovetailing very nicely with the work that needs to be done to get ready for January 2014, which is when most of the ACA eligibility provisions become effective. The goal is to streamline eligibility criteria across program categories.
- DSS cannot require documentation for information that can be obtained online through data matches from the IRS, SSA, Department of Homeland Security, etc.
- DSS will submit comments on the proposed regulations by October 31.
- Q: What if the North Carolina General Assembly passed a law mandating drug testing for Medicaid eligibility?
A: The state cannot impose new eligibility requirements in the Medicaid program. Drug testing is not an allowed eligibility requirement; imposing a new requirement would violate federal maintenance of effort requirements.
- Q: We go through stringent audit processes on the days Medicaid recipients spend in the hospital. Will that change under the ACA?
A: No.
- The purpose of changes to the application procedure is to make it simple and seamless for the consumer. There are provisions that say we need to simplify, but we also have to balance this with financial integrity.

Ms. McClanahan's presentation can be found here: [DMA Medicaid Enrollment Eligibility](#).

QUESTIONS FOR WORKGROUP

Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman led a discussion with the workgroup around the potential eligibility options allowed in the proposed federal regulations.

- Q: Should we continue to count the pregnant woman as two people rather than two?
Discussion: Counting the pregnant woman as two helps more people gain Medicaid coverage. North Carolina is trying to reduce infant mortality through the CCNC pregnancy home managed care initiative. The pregnancy home initiative has the potential to positively influence birth outcomes through higher quality measures. The fact that Medicaid covers 72,000 births a year means it can have a profound influence with the care that is provided. North Carolina can positively impact on healthy births by maintaining existing eligibility coverage. Furthermore, this will not cost the state anymore because we will have better birth outcomes; the collateral benefits of the pregnancy home are healthier babies delivered on time with fewer developmental disabilities.

RECOMMENDATION: Continue to cover pregnant women as groups of two up to 185% of the federal poverty limit.

- Q: Should the state consider “reasonably anticipated” future changes in income in the eligibility determination process? For example, if someone is currently working, but just got a layoff notice, should the state have the flexibility to make them eligible?

Discussion: North Carolina needs to define “reasonably anticipated.” If this definition is not very clear and strict it could cause an increase in appeals. The state currently has more than 12,000 appeals a year. Examples of “reasonably anticipated” might be as follows: Hoping to get a job is not “reasonably anticipated,” but having a new job or getting a job lay-off notice could be considered “reasonably anticipated.” There are differing objectives the state should consider: continuity of care, minimizing cost to the state, program simplification so it is easier to administer, and ease of administration to the applicant. It will be important to make enrollees understand that they are responsible for notifying DSS when there are any changes. It is in the best interest of enrollees to alert DSS or the HBE with status changes because they might incur tax penalties if they receive subsidies that are too high. Periodic “pinging” in the NC FAST system will be necessary to identify individuals whose income status has changed

RECOMMENDATION: The state should strictly define “reasonably anticipated changes” and be allowed to factor this information into the eligibility determination process. Reasonably anticipated changes should include a new job, loss of a job, or change in the number of hours worked on a regular basis.

- Q: The state is required to use current income for initial eligibility determinations, but may use annualized income to determine ongoing Medicaid eligibility. Should the state use annualized income for ongoing eligibility (rather than current income)?

Discussion: Using annualized income to determine ongoing eligibility is important so that individuals don’t change eligibility status for small changes in earning (for example, for individuals who work fluctuating hours). This will help minimize administrative costs to the state and local DSS agencies. Also, it is difficult for health care providers to keep track of constantly changing insurance coverage. Many people work hourly or in short-term contracts. If we allow it to be something other than annual, then we open the door for people to fluctuate in and out of Medicaid eligibility every other month. This will cost the state more and put more of a strain on providers. Anything other than annual would cause a huge administrative burden.

RECOMMENDATION: Use annual income for ongoing eligibility.

Q: Should the state rely on self-attestation for residency and age and date of birth?

Discussion: The state currently uses self-attestation for date of birth. The state currently requires two forms of residency for Medicaid. In the past, the state was concerned that people would move to North Carolina from surrounding states to gain Medicaid coverage. That may be less of an issue with the standardized income eligibility threshold across the country. Further, we cannot impose a residency duration requirement because the Supreme Court has held that such time

limits are unconstitutional. The state should accept self-attestation of residency because it would decrease administrative burdens in trying to determine eligibility. In addition, it is very difficult to verify residency through online eligibility. Further, individuals who do not have utilities in their name would face a barrier. Currently, denials occur because people cannot bring in verification. However, relaxing residency verification could potentially increase costs to the state, and may require changes in the state legislation.

Proving residency is not the same as providing verification of citizenship or lawful immigration status. The ACA requires proof of citizenship (through the Social Security Administration) and immigration status (through the Department of Homeland Security).

RECOMMENDATION: The state should continue to take self-attestation for date of birth.

RECOMMENDATION: The question of residency verification is still an open question and will be discussed by the workgroup at an upcoming meeting.

- The group had additional questions which it will address at the next workgroup meeting:
 - How should the state define “reasonably compatible” for verification purposes?
 - Are there other sources of electronic verification which the state can use to verify eligibility?
 - What is the state’s outreach plan (the ACA requires state Medicaid agencies to conduct outreach to certain underserved populations)?
 - What is the state’s role to provide assistance?
 - What role, if any, should DSS play as patient navigators?