North Carolina Department of Health and Human Services

2001 Mail Service Center • Raleigh, North Carolina 27699-2001

Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable William Purcell, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

Our letter dated March 3, 2008 explained that we needed additional time to explore several options for implementing cost sharing requirements across several programs prior to submitting the report. I am pleased to present the report at this time.

Please direct all questions concerning the report to Tara Larson, Acting Deputy Director for Clinical Policy and Programs at the Division of Medical Assistance at (919) 855-4260.

Sincerely,

Dempsey Benton

DB:tl

Attachment

cc: Dan Stewart
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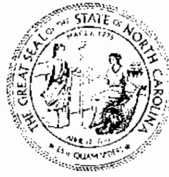
Michael Lancaster, M.D.
Leza Wainwright
Sharnese Ransome
Jennifer Hoffmann
Legislative Library (2)



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Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Doug Berger, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 622, Legislative Office Building
Raleigh, NC 27603

Dear Senator Berger:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Beverly M. Earle, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

Dear Representative Earle:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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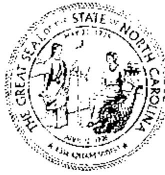

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2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Bob England, M.D., Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 2219, Legislative Building
Raleigh, NC 27601

Dear Representative England:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Verla Insko, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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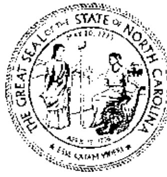

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Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Martin Nesbitt, Jr., Co-Chair
Joint Legislative Oversight Committee on MHDDSAS
North Carolina General Assembly
Room 300B, Legislative Office Building
Raleigh, NC 27603

Dear Senator Nesbitt:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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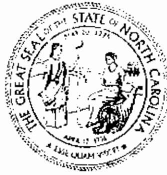

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Michael F. Easley, Governor

Dempsey Benton, Secretary

March 19, 2008

The Honorable Verla Insko, Co-Chair
Joint Legislative Oversight Committee on MHDDSAS
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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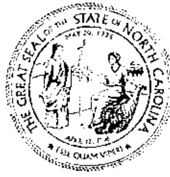

North Carolina Department of Health and Human Services

2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

March 18, 2008

Lynn Muchmore, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Mr. Muchmore:

Section 10.45 of S.L. 2007-323 (House Bill 1473), "Families Pay Part of the Cost of Services Under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income," required DHHS to "develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit." The legislation required the Department to submit a report on the related cost-sharing requirements by March 1, 2008.

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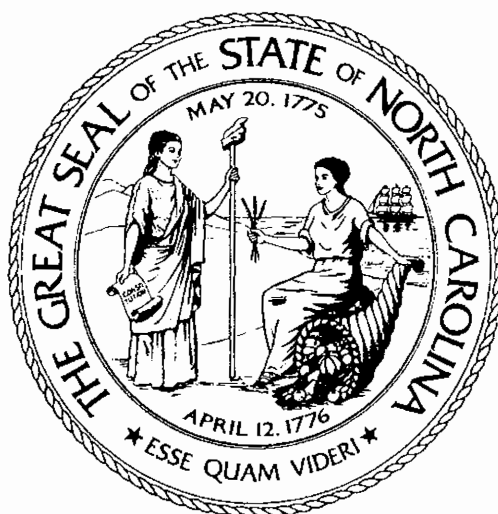
Families Pay Part of the Cost of Services under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income

Report to the 2007 General Assembly



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

March 2008

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Executive Summary

Section 10.45 of Session Law 2007-323 (2007 Appropriation Act, House Bill 1473), entitled "Families Pay Part of the Cost of Services under the CAP-MR/DD Program and the CAP-Children's Program Based on Family Income" requires the Department of Health and Human Services, Division of Medical Assistance (DMA), to develop a schedule of cost-sharing requirements for families of children with incomes above the Medicaid allowable limit to share in the costs of their child's Medicaid expenses under the Community Alternatives Program for Mental Retardation and Developmentally Disabled (CAP-MR/DD) and the Community Alternatives Program for Children (CAP-C). This report provides an overview of the options considered and the Department's recommendation.

The legislation (see Appendix) envisions consideration of various approaches for implementing cost sharing requirements and a number of related issues, including establishing cost sharing based on a sliding scale of family income; taking into account the impact on families with more than one child in the CAP programs; taking into consideration how other states have implemented cost-sharing in their CAP programs; and providing a public hearing and other opportunities for individuals to comment on the imposition of cost sharing under the two CAP programs or waivers.

The purpose of the legislation is to require families who have the means, to share in the cost of services provided to their minor children, defined under Medicaid regulations as individuals under the age 21. The Department recommends parents share responsibility for their child's care by paying a monthly premium, the amount of which will be based on the family's income.

A monthly premium, as opposed to other cost sharing approaches, such as co-payments, deductibles or coinsurance, is recommended to facilitate administration. Although implementing the cost sharing requirement via a premium should make implementation and administration easier, information system modifications will be required regardless of the approach. DMA cannot implement a premium requirement in its legacy Medicaid Information Management System (MMIS), because the system does not have the necessary functionality. Modifications to the Eligibility Information System (EIS) will also be required to collect and track family income and cost sharing requirements and to ensure proper reporting of eligibles.

The Division of Medical Assistance (Division) considered purchasing a stand alone premium tracking system to support this program as well as other initiatives that require similar cost sharing. Design, development and implementation costs, including those associated with establishing the necessary interfaces with EIS and MMIS are expected to exceed $10 million. As such DMA does not believe implementation via a stand alone premium collection system is cost effective, particularly in light of the planned replacement of MMIS. Therefore, the Department recommends implementation of cost sharing requirements for the CAP-MR/DD and CAP-C programs be delayed until after the replacement MMIS is operational.

Delaying implementation will also allow sufficient time to develop a schedule of premiums, consider public input and suggestions, educate recipients and their families, develop operating

procedures and policies, and seek the necessary federal approval. Cost sharing **cannot** be required in the CAP-MR/DD or CAP-C programs without the approval of the Centers for Medicare and Medicaid Services (CMS).

In State Fiscal Year 2006-2007, there were 5,150 children under the age of 21 that received CAP services under CAP-MR/DD and CAP-C waivers. It is unknown how many families will be impacted and required to pay a premium. Currently, the Division does not collect this data, because only the child's income counts in determining eligibility under the waivers.

As part of the development of this report, DMA researched information from other states, including Iowa, California, and Kansas. The Division consulted with Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) to ensure the development of a comprehensive project.

A public hearing, as well as other opportunities for families to discuss the impact of cost sharing, still needs to be held. The first opportunity for public input will occur in May 2008 during a public forum on the CAP-MR/DD program.

Concept for Proposal

The special provision requires families to share in the cost of their child's Medicaid expenses under the CAP-MR/DD and CAP-C Medicaid waivers. At the present time, only the child's income is used to determine eligibility for CAP-MR/DD or CAP-C, because the parent's income is disregarded under the waivers. The legislation will require families who have the means, to share in the cost of services provided to their children. The Department recommends parents share responsibility for their child's care by paying a monthly premium, which will be assessed based on the family's income.

A monthly premium, as opposed to other cost sharing approaches, such as co-payments, deductibles or coinsurance, is recommended to facilitate administration. In contrast to premiums, which are paid up front by recipients on a monthly basis, co-payments, deductibles and coinsurance are assessed at the point of service delivery and paid by the recipient directly to the provider. A co-payment is a specified dollar amount for which the recipient is responsible that is not tied to the cost of the service. Coinsurance is a specified percentage of the allowable charge for which the recipient is responsible. Co-payments and coinsurance are applied to specific types of service (e.g. physician visits, diagnostic tests or outpatient care) each time that service is delivered. A deductible is a specified amount of money that must be paid by the recipient before Medicaid coverage pays for any services, or it may apply to only specific types of services (e.g. inpatient hospitalization). If these approaches are used, in lieu of or in addition to premiums, it will be necessary to establish out of pocket maximums to ensure that a recipient's share of the cost of services is equitable relative to the income sliding scale.

Developing a sliding scale premium schedule based on income will be easier to implement than establishing various out of pocket maximum amounts across income levels and family size, and attempting to track and manage cost sharing at the point of service delivery. Requiring monthly premiums irrespective of service delivery also alleviates the need for providers to seek payment from recipients.

It is important to note that regardless of administrative approach this provision cannot be implemented without the approval of CMS, the federal Medicaid oversight agency. This requirement alone will prevent implementation by July 1, 2008. In addition, changes or modifications to existing state information technology systems or new programming are subject to Office of Information Technology Services (ITS) requirements under SB 991 and will take several months to satisfy. The Department also recommends the schedule of cost sharing requirements be specified in the NC General Statutes or Appropriations Act, which will require legislative action.

Under the CAP cost sharing requirements, families with incomes below 100% of the federal poverty level will not incur a fee for their child's Medicaid expenses. Because the legislation indicates that cost sharing should apply to families with incomes above the Medicaid allowable limit, the Division is prepared to establish cost sharing requirements for families who have income over 100% of the federal poverty level, but recommends nominal premiums be set for families at lower income levels to ensure consistency with cost sharing requirements in the

regular Medicaid program. Collection will begin at 101% federal poverty level. This is the same Medicaid level the state uses in determining the child's eligibility under the current waivers. Families with income above 100% federal poverty level must pay the required premium or risk having their Medicaid coverage terminated.

There are additional details that need to be finalized prior to implementation; however, this report provides an overview of the cost sharing implementation process and how this process should be implemented by the State of North Carolina, Department of Health and Human Services, Division of Medical Assistance.

CAP Cost Sharing Options

This report presents four options considered by the Department for implementing cost sharing requirements for families and children with incomes above the Medicaid allowable limits.

Option #1 – Delay Implementation of Cost Sharing Requirements until Establishment of Automated Premium Collection Capability through the Replacement MMIS – Recommended Approach

DMA seeks the enactment of legislation to delay implementing premium collection until the replacement MMIS is functional. The Department is currently in the process of hiring a new vendor to develop the MMIS and expects to select a vendor by early fall.

Requirements for an automated premium collection system are part of the requirements listed in the Request for Proposal. Once a vendor is selected, there is the potential delay of three years or longer before implementation of premium collection could begin as the new MMIS is made operational to handle current day to day claims processing activities. Despite the potential length of the delay, if the General Assembly appropriate funds and directs the Division to pursue an RFP for a separate automated premium collection system (i.e. Option #3), the State will pay twice for the development of an automated premium collection system, and there is no guarantee that implementation will occur significantly sooner. Likewise, pursuing a manual premium collection program administered by the local departments of social services (i.e. Option #2) is also expected to take 18 months or more to implement.

Pros

- Collection of premiums will be handled by the MMIS
- Allows multiple state agencies adequate time to develop system requirements for MMIS, EIS and develop procedures with the Controller's Office
- No changes to the current MMIS will be required which eliminates the need for system changes to be made twice, saving more than $10 million
- Changes to Eligibility Information System (EIS) expected to be minimal
- Staff at local departments of social services will not have to collect premiums, thus eliminating the need of additional county staff (See Option #2)

Cons

- County staff will still need to conduct appeal hearings, if benefits are terminated or are reduced
- Implementation may take three years or longer

Option # 2 – Manual Premium Collection

Although less efficient than an automated system, premiums could be collected manually at the local level. Under this option, the county departments of social services will be asked to collect the monthly premiums after notifying families of the amount of the premium; the due date; and the consequences of not paying. This process would not be automated, and thus is resource intensive and is referred to as manual premium collection.

To assist the counties in covering the local cost of implementation, the Department recommends funding be provided for at least one new position for each county department of social services with the state and federal government sharing the cost of the position. Alternatively, the counties could be allowed to retain all or a portion of the premium collected; however, this method may not adequately reimburse the county for additional staff, particularly if the number of families required to participate is low. In addition, Section 10.45.(c) states that savings realized due to this cost sharing shall remain in the CAP-MR/DD and CAP-C programs as applicable to fund additional CAP-MR/DD and CAP-C slots. Therefore, allowing the counties to keep premium receipts as administrative reimbursement may violate the legislative intent if the General Assembly did not assume savings would be determined after covering applicable administrative costs.

The Controller's Office, in conjunction with DMA, must develop policies and collection procedures for the counties to remit the premiums collected to the Controller's Office. The Division may also need an additional program manager in the Medicaid Eligibility Unit for development, implementation and ongoing maintenance of this process.

Pros

- No major MMIS changes are predicted to be needed at this time, unless a code for federal reporting requirements is needed
- Minimal changes to EIS are expected and include notification to MMIS of eligibility and a premium identification flag for the claims processing
- Implementation can occur with current MMIS

Cons

- Requires reliability on county staff to administer a requirement that should be the state's responsibility
- Policies and procedures must be developed for the county departments of social services
- Policies and procedures must be developed as it relates to the role of the Controller's Office
- Requires appropriation to support additional staff at the county level
- One hundred county staff must be hired to implement the manual premium collection which will be labor intensive

- The manual process may result in errors as the process will not be automated
- County staff will need to conduct appeal hearings, if benefits terminate or are reduced
- Additional state resources required to complete technology changes
- Implementation expected to take 18 months or longer given the need for federal approval, funding and staffing requirements, need for system changes and time required to develop policies and procedures

Option # 3 – Develop and Issue a Request for Proposal (RFP) for Purchase of Commercial Off the Shelf (COTS) System for Premium Collections

Under this option, DMA will issue an RFP for the purchase of a COTS system to manage the premium collection. This COTS premium billing and payment system must have the capability to interface with EIS and the current MMIS. This interface should include items such as accounting for collected premiums, returned checks, refunds, and reporting for CMS and DMA.

The Division considered purchasing a stand alone premium collection system to interface with MMIS and EIS in support of this program as well as other initiatives that require similar cost sharing, but design, development and implementation costs are expected to exceed $10 million.

Pros

- Establishes a centralized systematic process for premium collection which may be used by other programs, such as Ticket to Work, NC Kids' Care
- Staff at local departments of social services will not have to collect premiums, thus eliminating the need of additional county staff (See Option #2)
- State may not have to incur cost of hiring additional staff

Cons

- Significant technology design, development and implementation costs
- Requires significant EIS and MMIS changes to develop interfaces with stand alone system
- Funding may not be approved by CMS since the federal agency will share the cost of developing the replacement MMIS over the next few years, and this approach may be viewed as duplicative
- All state dollars may be required to purchase, develop, and implement COTS system if CMS denies use of federal funds to make the IT changes
- County staff will still need to conduct appeal hearings, if benefits are terminated or are reduced
- Implementation may take two years or longer given the need for federal approval, lack of funding, significant technology requirements and lengthy IT approval process

Option # 4 – Deductibles

DMA will establish a deductible similar to private insurance practices which will require families to pay a portion of their medical bills prior to Medicaid paying. For example, the State Employees Health Plan, depending on the Preferred Provider Option chosen, requires a member to cover $300 in medical bills before the state health plan insurance begins to pay. In the North Carolina Medicaid program for long term care services, this type of deductible is called a patient monthly liability (PML). This approach is successful with nursing facilities because the PML goes to the facility as the facility incurs enough charges to meet the deductible.

For individuals receiving services under the CAP waivers, there would likely be multiple providers to which the deductible must be paid, rather than a single provider like a nursing facility or hospital. Significant system changes to EIS and MMIS will be required to handle this approach. While this capability is part of the RFP for the new MMIS vendor, it will require significant development work.

Provider training will also be necessary as this approach differs from current policy whereby a provider is reimbursed for services if a Medicaid card is issued. Under this option, the provider will not know if Medicaid will pay until the claim is processed. The family must also understand that even if the provider accepted the Medicaid card, the family is still responsible for the payment of certain charges. Presently under the Medicaid program, if a provider accepts Medicaid as payment, he cannot charge the Medicaid recipient for any difference in what Medicaid pays and what the provider bills.

Pros

- A model currently exists with long term care services

Cons

- Requires significant changes to current MMIS
- Requires significant changes to EIS
- Additional state resources required to complete technology changes
- Requires extensive participant and provider education
- Providers could see this as cost shifting to them since some recipients may not be able to pay
- May result in families having to pay multiple deductibles. Currently if a child's income is above the Medicaid allowed income level, they are required to meet a spend-down deductible, before Medicaid will cover services. Unless the policy regarding the spend down is revised, this option will impose an additional deductible based on the parent's income
- County staff will still need to conduct appeal hearings, if benefits are terminated or are reduced
- Implementation may take 18 months or longer given the need for federal approval, lack of funding, and significant technology requirements

Recommendation and Conclusion

After considering the various cost sharing options in light of limited information system functionality, the Department recommends Option #1 to delay the implementation of cost sharing requirements until the replacement MMIS is functional. During this timeframe, DMA will proceed in developing a recommended schedule of cost sharing requirements, in consultation with DMH/DD/SAS, CAP program stakeholders and the public. The Division will also work with the Controller's Office, DIRM, and the new MMIS vendor to develop business rules, program policies and procedures, and define the technology requirements. The Department intends to seek legislative approval of the cost sharing schedule prior to submitting the proposal to CMS.

APPENDIX

Excerpt from SL 2007-323, House Bill 1473

FAMILIES PAY PART OF THE COST OF SERVICES UNDER THE CAP-MR/DD PROGRAM AND THE CAP-CHILDREN'S PROGRAM BASED ON FAMILY INCOME

Section 10.45.(a) Subject to approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services, Division of Medical Assistance, shall develop a schedule of cost-sharing requirements for families of children with income above the Medicaid allowable limit to share in the costs of their child's Medicaid expenses under the CAP-MR-DD (Community Alternatives Program for Mental Retardation and Developmentally Disabled) Program and the CAP-C (Community Alternatives Program for Children). The cost-sharing amounts shall be based on a sliding fee scale of family income and shall take into account the impact on families with more than one child in the CAP programs. In developing the schedule, the Department shall also take into consideration how other states have implemented cost-sharing in their CAP programs. The Division of Medical Assistance may establish monthly deductibles as a means of implementing this cost-sharing. The Department shall provide for at least one public hearing and other opportunities for individual to comment on the imposition of cost-sharing under the CAP program. Not later than March 1, 2008, the Department shall report on the cost-sharing requirements to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance, Abuse Services and Bridge Funding Needs, and to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services and the Fiscal Research Division. The report shall include a summary of comments the Department has received at the public hearing under this subsection, and shall also indicate any barriers to implementing the cost-sharing schedule.

Section 10.45.(b) This section becomes effective July 1, 2008, for children enrolled in CAP-MR/DD or CAP-C on and after that date. For currently enrolled CAP-MR/DD and CAP-C recipients, this section becomes effective at the recipient's first certification period following July 1, 2008.

Section 10.45.(c) The Division of Medical Assistance shall report on savings realized due to the cost-sharing implemented pursuant to this section. Savings realized from the implementation of cost-sharing shall remain in the CAP-MR/DD and CAP-C programs, as applicable, and shall be used to fund additional CAP-MR/DD and CAP-C slots. The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before March 1, 2009.