Adults without Dependent Children

2010 Regional Stakeholder Meetings Report

INTRODUCTION

The Colorado Health Care Affordability Act (the Act) has generated new revenue to expand public health insurance coverage to more Coloradans. The Adults without Dependent Children (AwDC) program is a new program funded by the Act. Starting in early 2012, the AwDC program will provide public health insurance to individuals up to 100% of the federal poverty level (FPL).

In 2010 the Department of Health Care Policy and Financing (the Department) conducted 12 community forums funded through a Health Resources and Services Administration (HRSA) multi-year, multi-million dollar grant known as the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). These forums were held throughout the state to present information about the AwDC program and to get input from potential clients, advocates, providers and other stakeholders. Seven of these forums were held in the spring, and five were held in the fall. Forums were held in Alamosa, Colorado Springs, Denver, Durango, Fort Morgan, Grand Junction, Greeley, Lafayette, Lamar, Montrose, and Steamboat Springs.

This report provides an overview of information presented by Department staff and combines feedback from all of the forums for each topic that was addressed. It is organized into three major sections: (1) program design; (2) outreach; and (3) next steps and ongoing activities. Please note, much of the information included in the "Information Presented by the Department" sections of program design and outreach was provided at the fall forums only. This is because the Department shared details about how federal health reform, or the Accountable Care Act (ACA), will impact the AwDC program and the ACA was not signed by President Obama until after the spring forums had concluded.

PROGRAM DESIGN

Eligible Populations

Eligibility: Information Presented by the Department

The AwDC program will provide coverage to those who:

- Are ages 19 - 64;
- Meet the income limit;
- Do not have a Medicaid eligible dependent child in the home;

- Are not entitled to Medicare Part A or entitled to or enrolled in Medicare Part B; and
- Are not described in another mandatory coverage group (e.g. parents, children, pregnant women).

As required by the ACA, Colorado will not have an asset test for this group, so the state will look only at an applicant's income to determine eligibility. Additionally, federal law prohibits premium/enrollment fees for individuals below 150% FPL who are in a mandatory enrollment category so AwDC clients will not have premium requirements. Individuals are eligible even if they have employer-sponsored coverage or other private insurance.

Under the state plan option—which is allowed for under the ACA—states cannot have wait lists for enrollment, nor can they target people by condition, level of need or by eligibility for another program (for example, Aid to the Needy Disabled). The ACA does allow states to enroll eligible populations in phases, so long as the lowest income populations are enrolled first. The Department is considering this approach because it will allow the state to keep the program within the budget allotment and ensure adequate development of provider networks and systems infrastructure. Other states that have expanded coverage to this population have reached, and even exceeded, enrollment targets in brief periods of time.

Eligibility: Stakeholder Comments

During the spring forums, stakeholders suggested a "phase-in" approach though many of the suggestions, for example prioritizing people by diagnosis or level of need, are no longer options due to the ACA requirements. During the fall forums, Department staff said they did not know what the initial income eligibility threshold would be but did ask attendees to discuss the ACA-allowed income phase-in approach:

- Several attendees suggested the Department start small by setting the initial income bar very low—even a 40% FPL threshold (the threshold for the Colorado Indigent Care Program's lowest category) could be too high a starting place. Attendees suggested this because:
    - They were concerned about lack of providers;
    - They were concerned there are too few eligibility technicians and enrollment staff to handle a large expansion (this was heard throughout the state); and
    - They believed that partnerships between the state and community-based organization would be more effective at providing outreach, education and support to a smaller group.
- Quite a few attendees said developing and getting out the message of the phased-in roll-out would be one of the biggest challenges. They were concerned that this phase-in approach could be confusing and create mistrust and anger. Attendees suggested that to combat this:

- The roll-out dates and income thresholds be clearly defined; and
- The state develop a process to track and notify individuals who did not meet the initial income threshold but might meet the higher income thresholds rolled out at a later date.

Eligibility: Follow-Up Questions and Answers

Q: How will income verification and eligibility verification criteria be integrated with the expansion populations?

A: The Department anticipates that verification guidelines will apply to the expansion populations in the same manner as they are applied to Family Medicaid. By the time the AwDC program is implemented, the Department's rules will allow for client self-declaration of income which will then be verified through the Income and Eligibility Verification System (IEVS). This rule change will allow an automated process to verify work income. The new process will reduce administrative burden to eligibility sites and simplify the eligibility process for clients.

Q: Will there be guaranteed eligibility for six months or one year for this population?

A: There is currently no federal authority to provide guaranteed eligibility for adults (except to pregnant women for up to 90 days following delivery). The authority allowed for in Section 1902(e)(12) of the Social Security Act only covers children up to age 18.

Q: Can you do a quarterly review of income since many likely enrollees are seasonal workers whose income fluctuates from month to month?

A: There is no federal authority to do a quarterly review of income for clients. The Department will continue with its current policy of requesting that clients report changes in income within ten days. If there is a change in federal authority that would allow this approach, the Department would consider it.

Q: How does this program relate to the Colorado Indigent Care program (CICP)? Can you just enroll people who receive services through the CICP into the AwDC program? Will the CICP be needed after the AwDC is implemented?

A: The CICP provides funding to clinics and hospitals so that medical services can be provided at a discount to Colorado residents that meet the eligibility requirements. The CICP is *not* a health insurance program. In contrast, the AwDC program is a public health insurance program like our current Medicaid and CHP+ programs. As such, individuals enrolling in the AwDC program will have to be determined eligible according to federal requirements; they cannot be deemed eligible based on participation in the CICP.

The state anticipates that the CICP program will still be needed after the AwDC program is implemented because there will continue to be individuals without insurance.

Benefits

Benefits: Information Presented by the Department

During the fall forums, Department staff explained that the benefit package for the AwDC program will differ from the standard Medicaid package. Per the ACA, the Department will develop a "benchmark" or "benchmark equivalent" package.

A benchmark package is one that is:

- The same as the state employee health benefits package;
- The same as the federal employee health benefits program Blue Cross/Blue Shield plan;
- The same as the largest HMO in the state; or
- Approved by the Secretary of the U.S. Department of Health & Human Services. The secretary may approve any other health benefits coverage she determines provides appropriate coverage to meet the needs of the population.

A benchmark equivalent package must have an actuarial value that is equivalent to one of the benchmark benefit packages above. The actuarial value is a summary measure of a health insurance plan's benefit generosity; it means the percent of medical expenditures the package is likely to pay. In addition, the benchmark equivalent package must include the following categories of services:

- Inpatient and outpatient hospital services;
- Physician surgical and medical services;
- Laboratory and X-ray services;
- Prescription drugs;
- Mental health services;
- Well-baby and well-child care, including age appropriate immunizations;
- Emergency services;
- Family planning services and supplies; and
- Other appropriate preventive services designated by the Secretary of the U.S. Department of Health & Human Services.

Effective 2014 there are some additional benefits that must be included. These additional benefits include maternity care, substance use disorder services and rehabilitative and habilitative services and devices.

The ACA requires that the majority of clients receive a benchmark or benchmark-equivalent benefit package. Federal law also states that some populations, such as pregnant clients, medically frail clients, and terminally ill clients are exempt from this

and must be enrolled in the standard Medicaid benefit plan. States can give exempt individuals the option of enrolling in the benchmark package.

Benefits: Stakeholder Comments

Attendees were asked to identify the benefits most needed by this population. They told Department staff to consider for inclusion:

- Mental health and substance abuse treatment services—this was universally mentioned. In addition, several attendees expressed concern that the benchmark benefit packages (which are tied to private insurance benefits with limited benefits in this area) will not meet the anticipated high needs of this population;
- Prescription drugs, including medications used to manage mental health and substance abuse diagnoses, are essential because lack of medication often leads to additional health problems for this population. Some stakeholders suggested a temporary approval process for medications so that people can be stabilized while awaiting Medicaid approval;
- Dental services such as teeth cleaning and cavity filling (this was mentioned at every forum);
- Vision and hearing services (testing, glasses and hearing aids);
- Preventive health care services including family planning services;
- Nutritional counseling and obesity related services;
- Specialty care;
- Transportation, which is particularly needed in rural and frontier areas where there are both fewer providers and limited public transportation options;
- Consumer Directed Attendant Support Services (CDASS);
- Durable medical equipment;
- Imaging services (CAT scans and MRIs); and
- Case management. Universally, attendees told the Department that case management/care coordination is essential because clients will likely have multiple chronic conditions and have difficulty navigating the system, keeping appointments and understanding their benefits and how to use them.

Attendees also suggested the Department consider:

- Incentives for good health related activities; for example, individuals would get a cell phone or minutes added to a plan card when appointments are kept;
- Ways to discourage enrollees from not showing for appointments such as charging no-show fees or terminating eligibility;
- Use of co-payments to promote client accountability (so long as they are reasonable); others felt that co-payments might be a barrier to services. One option would be to assess co-payments only on individuals at the higher income levels; and

- Higher co-payments for high emergency room utilization or for non-emergency visits to the emergency room.

Benefits: Additional Department Comments and Follow-up Questions and Answers

During the discussion, Department staff clarified that federal law prohibits the state from charging Medicaid clients no-show fees or terminating benefits to discourage appointment no-shows. While federal law allows the state to charge co-payments for non-emergency use of the emergency room, it does not allow co-payments for actual emergency services even if the client has high utilization of emergency services.

Q: Will other, non-AwDC Medicaid enrollees be eligible for this benefit package?
A: At this time the Department does not envision permitting non-AwDC enrollees to enroll in this benefit package though it could be considered at a later date.

Q: How will the program interact with the family planning waiver/women's health services waiver that the Department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment are pursuing?
A: The women's health services waiver program will cover individuals up to a higher poverty level (up to 200% FPL) but will cover fewer services than the AwDC program will. Though the Department is still determining the benefits package for the AwDC program, the Centers for Medicare & Medicaid Services (CMS) (the federal entity that oversees the Medicaid program), requires that family planning services and supplies for individuals of child-bearing age are covered.

Q: How does the new health reform expansion interact with HIFA waivers? Will HIFA waivers no longer be available?
A: In the past, states have used Health Insurance Flexibility and Accountability (HIFA) waivers to develop programs for individuals previously not eligible and to vary benefits and cost sharing. The ACA does not make changes to this option. The Department will not be pursuing a HIFA waiver; rather the Department will be using the state plan option allowed for in the ACA.

Delivery System and Partnerships

Delivery System: Information Presented by the Department

The Department has not made any final decisions about the delivery system.

As stated above, stakeholders (and others who have expanded eligibility for this population) suggest that care-coordination is essential and the Department will likely use the Accountable Care Collaborative (ACC) program as the delivery system to

accommodate this need. The ACC program is a state-wide pilot program that will be implemented in the spring of 2011 in seven different regions. The ACC program is designed to:

- Improve health outcomes through a coordinated client/family centered system;
- Reduce costs by reducing avoidable, duplicative and inappropriate services;
- Provide a focal point of care/medical home for all clients; and
- Use data sharing components to improve coordination.

Delivery System: Stakeholder Comments

Attendees focused on potential beneficial partnerships and how these could help ensure an efficient service delivery model. They suggested that:

- Improved integration of mental health and primary health care (for example, through partnerships) would be very beneficial for this population;
- Integrated health centers could help; stakeholders encouraged the Department to think through reimbursement models that might encourage this and one stakeholder suggested the use of bundled payments; and
- Partnerships and collaboration with the Department of Corrections could help smooth transitions for people moving back to the community, particularly as it relates to access to necessary psychotropic drugs;

Many stakeholders said that expanding the pediatric medical homes model to cover adults in the program would be a good idea. As it relates to behavioral health services, some encouraged the Department to consider the managed care benefit in place for other Medicaid clients.

Delivery System: Additional Department Comments and Responses to Questions

Several attendees requested clarification on the meaning of medical homes since this is an important component of the ACC program. In general, having a medical home means having comprehensive, continuous, coordinated care that is family-centered, accessible, compassionate, and culturally competent. Typically, a medical home primary care provider is given an additional monthly payment for providing services that aren't usually paid for, such as coordinating care and health education. Within the medical home model, the primary care provider plays a greater role than is typical in coordinating and overseeing all of the patient's care, including specialty care and other supportive services.

Clients in the ACC program can change their primary care provider within the first 120 days of enrollment for any reason. After that they can switch for reasons of "good cause" and, for any reason, at their annual re-determination.

OUTREACH AND EDUCATION

Client Outreach and Education

Client Outreach and Education: Information Presented by the Department

Department staff shared that there is an outreach team providing assistance to program design staff. The outreach team will be working to develop an effective outreach plan for the AwDC program.

Client Outreach and Education: Stakeholder Comments

There was consensus across the state that intensive and effective outreach efforts are necessary for the success of this program and that additional financial resources and dedicated staff will be needed. Stakeholders felt this type of outreach was necessary to help clients understand:

- That there is now a program available to them, and what it includes, because many in this population are unaccustomed to having health insurance; and
- The phase-in eligibility.

When asked about how to conduct the outreach to potential clients and what might be most effective, stakeholders offered the following ideas:

- Use hospital staff and post flyers and information on bulletin boards;
- Schools can be a very good place to target individuals transitioning from children's programs;
- Many enrollees have experience with Social Security and Veterans Affairs offices and these can be good venues for flyers and brochures;
- Community health centers and other CICP providers have been providing care to many likely enrollees, and their staff will be valuable resources. In addition, flyers and brochures should be available at these sites;
- Similarly, health fairs and community events are good outreach opportunities;
- Use college health centers and bulletin/information boards since many college kids will be eligible;
- Local soup kitchens and homeless shelters because they are currently providing services to many individuals who will be eligible;
- Resource centers and grocery stores often have community information boards;
- Target interventions and outreach to individuals moving out of correctional facilities to facilitate enrollment upon release;

- More and more enrollees have access to the internet; email and Twitter can be effective communication methods (other stakeholders disagreed and felt this would not be effective for this population since they do not have regular internet access);
- Flyers should be brief—1-2 pages—and contain the highlights about eligibility as well as ways to get more information; and
- Information should be accurately translated into needed languages and written such that individuals with low literacy levels can understand it.

Stakeholders universally agreed that, in addition to education about eligibility, clients will need education about the benefits and how to effectively use services (for example, make appointments with providers, keep those appointments and only use the emergency room for emergencies). As part of this discussion, stakeholders offered the following ways to conduct that orientation:

- Use the case managers/care coordinators;
- Educate clients on these topics immediately after enrollment or even during the eligibility determination process;
- Consider providing orientation as part of an existing event (for example, during lunch at a soup kitchen or at a health fair, since some clients might not be receptive to a government-sponsored event); and
- Have a 1-800 number to help with questions.

While stakeholders universally stressed the importance of intensive outreach and client education, they also voiced concern about the limited number of eligibility technicians and their capacity to work with so many new people. They were hopeful that the new PEAK online enrollment system will reduce enrollment time and required resources, but were concerned about clients' ability to access this tool due to computer illiteracy and limited access to the internet. Stakeholders believed that many clients would still need face-to-face assistance and that additional staff and financial resources might be necessary.

Finally, attendees at several sessions wondered how the AwDC program and Buy-in Programs for People with Disabilities will interact with one another and with current Medicaid programs, because individuals will be moving between programs that might have different benefit packages and provider networks. Attendees identified this as an important area for outreach and education as well as for policy and operations discussions with the Department during the development and implementation of these programs.

Provider Outreach

Provider Outreach: Information Presented by the Department

Experiences in other states and information gathered from the 2009 stakeholder sessions suggest that expanding the Medicaid provider network is very important. Department

staff shared that, as part of the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP) (the multi-year federal Health Resources and Services Administration (HRSA) grant awarded to the Department), a provider recruiter has been hired to enroll additional providers in the Medicaid program.

In light of this need, staff asked attendees to suggest who they should target and how they should conduct provider outreach.

Provider Outreach: Stakeholder Comments

Attendees had the following thoughts and recommendations:

- The state should target CICP providers who are not currently taking Medicaid for enrollment in the program. These providers are currently treating many likely enrollees and their involvement will help ensure continuity of care;
- Provider shortages are likely to get worse following the expansion and several communities reported an already low number of mental health and substance abuse providers who accept Medicaid (particularly in rural areas);
- Client education as described above could help attract and retain providers since it might result in fewer enrollees missing appointments; and
- Provider reimbursement rates are too low—increasing them would help as would reducing the administrative burden of serving as a Medicaid provider.

NEXT STEPS AND ONGOING ACTIVITIES

As of December of 2010, Department staff have begun working with a consultant to develop benefit design models and determine the appropriate income eligibility thresholds to be phased in. The stakeholder comments and information learned from these forums have been shared with the consultant and will be taken into consideration when determining the best program design features.

A Department contractor funded through the CO-CHAMP grant recently conducted focus groups around the state to help the state develop effective outreach strategies for this population. The Report is available on the Department's Web site.

Department staff will continue to reach out to stakeholders throughout the development and implementation phases and encourage people to contact **Susan Mathieu** at **303-866-3582** or **susan.mathieu@state.co.us** for additional information or to receive updates and information about the program.