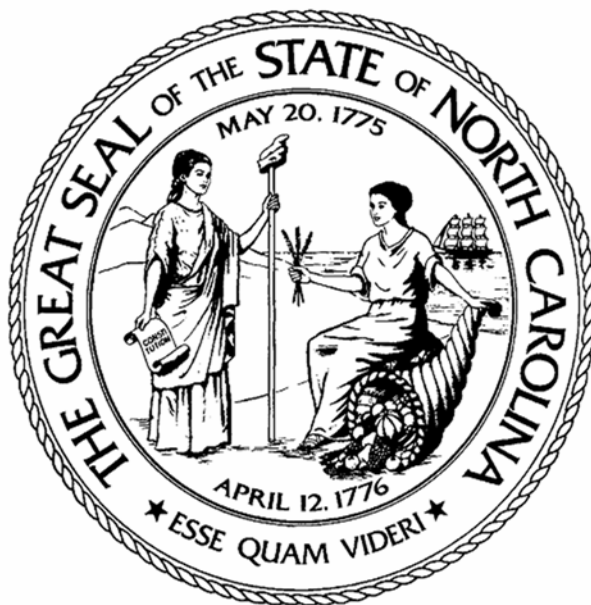


**MEDICAID COUNTY OF ORIGIN
PROGRESS REPORT**



Session Law 2014-100, Section 12H.35

State of North Carolina

**Department of Health and Human Services
Division of Medical Assistance**

February 1, 2015

OVERVIEW

Session Law 2014-100, Section 12H.35 directs the Department of Health and Human Services to address issues that arise when Medicaid beneficiaries move from one county to another and when beneficiaries move from one Local Management Entity/Managed Care Organization (LME/MCO) catchment area to another. Medicaid “county of origin” refers to the county where Medicaid eligibility determination was originally made. The county of origin is used to assign beneficiaries to LME/MCOs, as well as determine which county is responsible for providing the county share of State/County Special Assistance payments.

There are three primary populations affected by issues caused by the Medicaid county of origin assignment: 1) foster children, 2) beneficiaries living in intermediate care facilities, and 3) beneficiaries receiving Special Assistance payments.

1. FOSTER CHILDREN

Beneficiaries are often unable to receive timely access to behavioral health services in the new county of residence because the beneficiary’s assignment to an LME/MCO continues to be based in the county where Medicaid eligibility was originally determined. It can be difficult for an LME/MCO to coordinate behavioral health services in counties outside their catchment areas due to a lack of familiarity with the resources and providers in the new county of residence.

The 4,103 children in foster care are especially at risk of breaks in service and treatment because placements often change and can be geographically dispersed. Medicaid cannot move with the child because the child remains a ward of the county of Medicaid origin. Service providers in the area of the foster care placement may not be enrolled with the child’s LME/MCO. This can create difficulty in timely access to services.*

2. BENEFICIARIES LIVING IN INTERMEDIATE CARE FACILITIES

Beneficiaries living in intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) outside the catchment area of the LME/MCO where Medicaid eligibility was determined face similar issues as foster children. The ICF-IIDs must coordinate with multiple LME/MCOs on behalf of their residents, instead of the one LME/MCO in whose catchment area the facility is located, causing administrative burdens and potential gaps in services.

Moving the county of eligibility to the current county of residence is possible, but would have a significant impact on the per member/per month (PMPM) Medicaid capitation payments to the LME/MCO, and would require the LME/MCOs to make significant changes in administrative procedures. Latest enrollment figures show that 5,136 of beneficiaries living in ICF-IIDs may be affected.

* Medicaid eligibility county of origin assignment was previously an issue for children adopted from the foster care system in North Carolina as well. Now the child’s Medicaid moves with the child to the county of the adoptive family.

3. BENEFICIARIES RECEIVING STATE/COUNTY SPECIAL ASSISTANCE

The issues created by Medicaid county of origin assignment is the most complex for the 21,120 Medicaid beneficiaries receiving Special Assistance financial support. Beneficiaries receive State/County Special Assistance (SA) payments to cover room and board expenses in adult care homes/assisted living, family care homes, and group homes/supervised living homes. The SA/Medicaid county of origin is the county in which the individual last resided in a private living arrangement. SA payments are paid with 50 percent county and 50 percent State funds. Counties also bear the responsibility of the staffing and the Medicaid match for the administrative costs. Individuals eligible for SA may move to a facility outside of their county of SA/Medicaid origin for various reasons including the lack of availability of an appropriate setting within their county. Should the policy change to require the SA/Medicaid county of origin to be the physical location of the individual, counties with a large number of SA facilities would incur tremendous additional cost.

RECOMMENDATIONS

1. FOSTER CHILDREN

DHHS recommends that LME/MCOs be mandated to use a Single Case Agreement with the child's behavioral health providers, creating a streamlined agreement between a single provider and the LME/MCO to treat a single patient. These are streamlined agreements between a single provider and the LME/MCO. The enrollment requirements for this provider should be expedited, allowing for more timely access to necessary behavioral health services due to the decrease in administrative burden.

2. BENEFICIARIES LIVING IN ICF-IIDs

Overall administrative and service delivery system impact could be reduced if the change in Medicaid county of eligibility for residents of ICF-IIDs is delayed until July 1, 2017. By then, North Carolina will have consolidated its behavioral health system into four LME/MCOs and the administrative changes, PMPM capitation changes, and service disruption will be minimal.

In the interim, DHHS recommends that the LME/MCOs be mandated to use Single Case Agreements with the individual behavioral health providers that are outside of the catchment area of the LME/MCO. These are streamlined agreements between a single provider and the LME/MCO. The provider does not have to go through the complex process of becoming a network provider when the provider would typically not be serving more than one or two individuals.

3. BENEFICIARIES RECEIVING STATE/COUNTY SPECIAL ASSISTANCE

The question of changing the SA/Medicaid county of origin to the county in which the individual resides in an SA facility was examined by a NC DHHS taskforce and the NC Association of County Directors of Departments Social Services (NCACDSS) in 2013. Staff conducted analysis of the January 2013 caseload and the cost per county for SA beneficiaries with the current policy

compared to the cost per county were the policy changed to the county in which the individual resides in a facility. The analysis showed that the medium and larger counties with a greater number of facilities would shoulder the greatest increase in cost, while counties with few or no facilities would see a decrease in their costs. The DHHS taskforce and NCACDSS concluded that LME/MCOs in the county of origin should continue to have the responsibility of assuring that SA beneficiaries with mental health needs will have services provided through a contractual agreement with the LME/MCO covering the county in which the beneficiary resides.

DHHS continues to support the recommendation of the 2013 taskforce and NCACDSS. DHHS will work with both county DSSs and LME/MCOs where possible to further streamline access to services.

RELATED ISSUES AND RECOMMENDATIONS

Medicaid recipients have access to Emergency Departments and hospital facilities across the State, regardless of their county of Medicaid eligibility. Occasionally, issues arise when hospitals bill for beneficiaries who reside outside of the hospital's LME/MCO catchment area. LME/MCOs are contractually responsible for behavioral health, Emergency Department, and inpatient claims for all beneficiaries in their catchment area, regardless of the location of the facility providing the behavioral health, ED, or inpatient services. This issue will be addressed with stringent contract enforcement.

NEXT STEPS

1. Develop and enforce a streamlined Single Case Agreement process for the LME/MCOs.
2. Upon consolidation to 4 LME/MCOs, move the Medicaid county of origin for ICF-IDD residents to the county of the ICF-IDD.

Appendix: Session Law 2014-100

SUBPART XII-H. DIVISION OF MEDICAL ASSISTANCE (MEDICAID)

MEDICAID COUNTY OF ORIGIN

SECTION 12H.35.(a) The Department of Health and Human Services shall take measures to address issues arising when Medicaid recipients move residence from one county to another county and from one LME/MCO catchment area to another. The measures shall include the following:

- (1) Reduce administrative burden on intermediate care facilities (ICFs) which contract with more than one LME/MCO.
- (2) Engage the counties to create a plan to resolve issues related to the county of origin for social services and public assistance programs. The plan shall provide for uniform statewide policies for determining county of residence for Medicaid eligibility as well as for other social services and public assistance programs. The North Carolina Association of County Commissioners shall participate in the development of the plan.

SECTION 12H.35.(b) By February 1, 2015, the Department of Health and Human Services shall report to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services on the progress of the measures in subsection (a) of this Section. The report shall include the following:

- (1) For the issues related to intermediate care facilities (ICFs) which contract with more than one LME/MCO:
 - a. Identify measures taken to reduce administrative burden.
 - b. Describe the adequacy of the measures taken.
 - c. Identify any additional measures that need to be taken and provide an expected time line for implementation of additional measures.
- (2) For the county of origin issues:
 - a. Report the plan.
 - b. Propose necessary changes to law and policy.
 - c. Identify whether programming changes to NC FAST are needed and provide a detailed explanation of any costs associated with needed changes.
 - d. Provide an estimated time line for implementing the plan.