

## Certified Application Counselor Stakeholder Meeting

facilitated by Jackie Edison

- **Date:** Thursday, December 18, 2014
- **Building:** MNSure
- **Time:** 2:30-4:00 p.m.
- **Conference room:** Minnesota
- **Participants:** Jackie Edison, David Van Sant, Christina Wessel, Alison Griffin, (MNSure), Joanna Justiniano (Cardon Outreach), Emily Arias (MedEligible), Farr Ahmed (Children's Hospital), Deborah Beaulieu (Cass Lake IHS), Jennifer Phoenix (Olmsted Medical Center)

### Topics

#### Discussion of roadmap for consumer assistance program policy review and update

- In the process of analyzing all assisters programs
- MNSure board is required to set permanent policies and procedures this year
- How does consumer assistance operate in Minnesota
- Any changes that would be proposed and approved would be implanted for FY 2017, which starts July 1, 2016

#### Discussion of CAC landscape analysis

Jackie Edison presented a preview of the CAC landscape review. See handout titled, "CAC Landscape Review Preview."

#### Data available through MNSure (as of 12/12/2014)

- 305 CACs from 47 CAC organizations
  - Only 10 CAC organizations have 10 or more CACs. These 10 CAC organizations have 192 CACs or 63% of all the CACs.
- 58 cities/towns in MN have CACs located there
  - Only 3 cities have more than 10 CACs (Duluth, Golden Valley, Minneapolis, Rochester, St. Louis Park and St. Paul)
- Vast majority of CACs in MN operate within hospitals or clinics

#### Summary points from literature review

- CACs are described as volunteers.
- There is no funding source through marketplaces for CACs.
- CACs are not required to: conduct outreach or comply with cultural and linguistic requirements that apply to other navigators.
- CACs can still assist consumers if they have conflicts of interest if they disclose those conflicts of interest.

- Nationally, most Federally Qualified Health Centers that have assisters are CACs, not navigators.
- Some states require HPE providers to also be CACs. This can be a problem for some third party vendors because HPE approvers must be hospital staff.
- Some states allow selected CAC organizations to certify their own staff following guidelines, including conducting their own background check.
- Some states charge fees for CAC organizations to access training and background checks.

**Discussion:**

- For analysis, it would be good to distinguish the type of facilities in which CACs operate – hospital vs clinic.
- It's important to note that CACs work with ill, uninsured consumers who need services immediately.
- There is a misperception that CACs only care about getting their organization paid rather than getting their consumers coverage. CACs help facilitate patients receiving care they need, discharge planning and follow-up care.
- Cardon Outreach has CACs in 43 states. Some of the differences noted, include:
  - The Assister Resource Center (ARC) is a unique resource in Minnesota. There is not special access for the CACs in other states. This is an excellent resource in MN.
  - MN is unique with the CAC stakeholder group feedback loop.
  - WI has done a great job rolling out Hospital Presumptive Eligibility (HPE) process.
  - Other states impose barriers to CAC certification:
    - Georgia requires fingerprinting.
    - Illinois requires version of an insurance broker training in addition to CAC training.
    - Wisconsin charges different fees to get established as CACs.
    - Other states have proctored training tests.
- Conflict of Interest
  - Currently, some CACs disclose free service, who they work for, and that their goal is to help the consumer secure coverage (issues can come up with QHP-eligible). Some pre-screen and then refer out to a broker if QHP eligible.
- Liability
  - Some CACs stated they need more training about the liability that they are setting up by putting their CAC ID on the consumer's application. Liability is covered in the data sharing agreements with CAC organizations. Putting a CAC ID on the application to be associated with a case does not make a CAC the consumer's authorized representative. One CAC organization stated that they have families sign disclaimers.
- HPE connect to CACs
  - It would be good to incorporate HPE statistics or presence into CAC analysis.
  - HPE approvers must be staff of an institution, not contract vendors. For example, MedEligible cannot approve an HPE application when working at Abbot. This creates a two-step process and some pieces of the application can get lost. Some issues occur when the paper HPE application is not turned in alongside the MNSure application.
  - There is variety in the type of worker who is acting as an HPE approver. There are nurses, public health nurses, PCAs, appointment departments, social work departments,

- long-term care facilities. Social workers are HPE approvers at regional hospitals (not the case in the metro).
  - There needs to be some way to track and grow information networks.
  - Long-term care facilities may have most growth potential for CACs.
- On reservations, Indian Health Service CACs often play roll of navigator in also providing outreach and education.

### **Opportunity to provide feedback on open enrollment experience**

- An increased amount of verification requests are being sent out. This may be in error.
  - MNSure is still investigating why this is happening.
  - Comply with the request if the consumer has the documentation readily available.
  - Hang tight through the 90-day window, as a solution may be identified soon.
- Pending apps
  - 1,000 in January 2014 now 1,800 in December 2014
  - Being the “CAC on the app” doesn’t seem to be getting some CACs access to find out about a consumer’s pending application.
- The ARC and Case Status Checks
  - Send via excel and email, calls are tying up wait times
  - Provide Name and DOB or what you have. SSN is not required.
- HCEO
  - Won’t assist CACs, even with MedEligible release that the counties accept
    - Requires DHS release, but have given 2 different versions
    - Can we create a CAC release?

### **Future meetings**

\*\*\*Next CAC Stakeholder meeting: January 15, 2014, 2:30 pm – 4:00 pm\*\*\*\*

\*\*\* Next Joint Stakeholder meeting: January 8, 2014, 1:00 pm – 3:00 pm\*\*\*\*