Insurance Coverage and Safety Net Programs

Chapter 7

Background

Most North Carolinians have a source of insurance coverage, but the source of coverage varies across rural and urban areas. In 2011-2012, rural North Carolinians were more likely to be covered by Medicare (21%) or Medicaid (18%) and were less likely to be covered by employer sponsored insurance (40%), than people in urban areas (15%, 11%, and 48% respectively).[a]

In 2011-2012, 20.2% of *nonelderly* North Carolinians, or 1.6 million people, were uninsured.[b,1] Rural residents were about equally likely to be uninsured (20.8%) as urban residents (19.5%).[2] However, there is significant variation among counties in the percentage of the population who is uninsured. In some rural counties (e.g. Alleghany, Avery, Duplin, Jackson, Robeson), more than one in four nonelderly residents are uninsured. Approximately 80% of uninsured adults in North Carolina reported in 2012 that they were uninsured for more than one year, and over half (52%) reported being uninsured for five years or more.[3] Most of the uninsured in North Carolina report that they lack coverage because of costs (61.1%) or because they lost a job or changed employers (12.0%).[4]

Not having health insurance coverage is harmful to the health and well-being of children and adults alike. People who lack health insurance coverage have a harder time obtaining the care they need because of the costs. National studies show that people who are uninsured are less likely to obtain preventive screening or obtain care for their chronic conditions.[5] The uninsured are more likely to be hospitalized for preventable conditions, to be diagnosed with late stage cancer, and are more likely to die prematurely than those with insurance coverage.[5] North Carolina data confirm that adults without health insurance are more likely than those with insurance coverage to report being in fair or poor health,[c,6] but less likely to visit a doctor for a routine doctor's visit,[d,7] less likely to see a doctor when they need it because of the costs,[e,8] and are less likely to report having a personal doctor. [f,9] They are also less likely to have a

a Mark Holmes, PhD. Associate Professor, Health Policy and Management. University of North Carolina Gillings School of Global Public Health. Analysis of the Current Population Survey 1999-2012 by special request. May 15, 2014.

b When examining the uninsured, we focus on the nonelderly because almost ll people have insurance coverage once they reach age 65. In North Carolina, only 1% of the elderly (age 65 or older) are uninsured.

c In a statewide survey in 2012, the uninsured were more likely to report being in fair or poor health (26.1%) than are those with insurance coverage (17.5%).

d In 2012, North Carolina uninsured adults were much less likely to have seen a doctor in the last two years for a routine check-up (61.3%) compared to those with insurance coverage (90.4%).

e Almost half (48.6%) of uninsured adults in North Carolina reported in 2012 that they could not visit a doctor when they needed to because of the costs. In contrast, only 11.1% of those with insurance coverage had similar financial access difficulties.

f People who are uninsured were also less likely to report having a personal doctor (62.9%) compared to 14.4% for those with insurance coverage in 2012.

Bill Harrison, 50, and his family, have never had health insurance before. Bill is self-employed as a plumber and his wife's job doesn't offer coverage. Bill and his family lost everything in 2008 when the bottom fell out of the economy. He was hospitalized recently for panic attacks and then a heart attack. His wife had a strong family history of colon cancer and needed a colonoscopy for $1,200. Bill and his wife came into the Blue Ridge Community Health Services to talk to a navigator about subsidized insurance. Bill had heard of people that lost their insurance due to Obamacare, and he was skeptical about the government taking such a big role. When he walked out, having signed for heavily subsidized insurance for $2.38 per month for his family, he was no longer skeptical and had a new found security.

Blue Ridge Community Health Services, Hendersonville, NC

prescription filled because they cannot afford to pay for the medications.[g,10,11]

The lack of insurance coverage also impacts a person's finances. People who lack insurance coverage are more likely to report being contacted by a credit agency to collect outstanding medical bills, being unable to pay for basic necessities due to outstanding medical bills, and having no savings or assets.[5] Outstanding medical bills and/or health-related problems are among the major contributors to personal bankruptcy.[12]

Community Care of North Carolina, links individual practices to larger networks and is particularly helpful in rural and under-resourced communities, because the resources available at the network level can help address some of the provider shortages that exist in small rural communities.

As noted earlier, many people in rural communities rely on Medicaid as their source of insurance coverage. North Carolina has historically linked Medicaid recipients to a primary care provider in a medical home. Medicaid recipients with chronic illnesses or other complex health problems also have access to care managers who help them coordinate their care. This system, called Community Care of North Carolina, links individual practices to larger networks, which helps with care coordination, pharmacy management, psychiatric services, and quality improvement efforts. This broader network is particularly helpful in rural and under-resourced communities, because the resources available at the network level can help address some of the provider shortages that exist in small rural communities. The North Carolina Department of Health and Human Services has proposed a major reform of the state's Medicaid program, as described in more detail below. This could have significant implications for the delivery of health services in rural areas.

For those who remain uninsured, there are many safety net organizations across the state with a mission or legal responsibility to serve the uninsured. Many of these organizations provide services to the uninsured for free or on a sliding scale basis. However, there are not sufficient safety net resources to meet all of the health care needs of the uninsured. Further, many of the uninsured are unaware of the resources that do exist.

The Patient Protection and Affordable Care Act

Congress enacted the Patient Protection and Affordable Care Act (ACA) in 2010.[h] The ACA was designed to address many of the challenges facing the United States health care system. It attempts to expand coverage to more uninsured, improve population health, improve quality of care, and reduce rising health care costs.[13] The Task Force on Rural Health focused on the new insurance coverage provisions that went into effect in 2014.

Insurance Mandate

Beginning in January 2014, individuals and families have new options to purchase health insurance coverage. The ACA requires most people to either have

g In 2010, North Carolina adults were asked about medication compliance. One-third of the uninsured (33.3%) compared to 29.2% of those with insurance coverage reported that there was a time when they had not filled a medication prescribed by a health professional. Of these, 68.6% of the uninsured and 27.7% of those with insurance coverage reported that they had not filled the medication because they could not afford to pay for it.

h Patient Protection and Affordable Care Act. Pub L no. 111-148

health insurance coverage or pay a penalty.[i,j] Most nonelderly North Carolinians will continue to receive health insurance coverage through their jobs or through a family member who has employer-sponsored insurance coverage. Older adults and some people with disabilities will continue to rely on Medicare as their primary source of health insurance coverage.

Medicaid and NC Health Choice (North Carolina's child health insurance program) provide coverage to some—but not all—low-income individuals in the state. Most uninsured children in the state qualify for either Medicaid or NC Health Choice (which provides coverage to children through age 18 if their family incomes are no greater than 200% the federal poverty guideline or "FPG"). However, because of certain eligibility restrictions, Medicaid only covers 28% of low-income nonelderly adults (with incomes below 100% FPG).[14] This is because current Medicaid eligibility rules require adults to meet certain categorical and income restrictions (and sometimes resource restrictions). For example, Medicaid eligibility is currently limited to adults who are 65 or older, disabled, or who are parents of dependent children under the age of 19 and who have incomes below a state-specified standard. Those who are elderly or disabled can qualify with incomes up to 100% FPG, but parents of dependent children can only qualify if their income is less than half (approximately 45%) of the FPG.[15] Because of the categorical eligibility requirements, most childless, nonelderly, and nondisabled adults cannot qualify for Medicaid.

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As originally enacted, the ACA required states to expand Medicaid to all citizens and many lawful permanent residents with family incomes below 138% FPG. The United States Supreme Court in National Federation of Independent Businesses v. Sebelius, 132 S. Ct. 2566 (2012), held that the mandatory Medicaid expansion was unconstitutionally coercive to the states. Instead, states have the option to expand Medicaid, but are not required to do so. In North Carolina, the Division of Medical Assistance estimated that this expansion, if offered, would provide coverage to approximately 500,000 adults with incomes below 138% FPG.[16] At the time this report was written, North Carolina has decided not to expand Medicaid.[k]

Health Insurance Marketplace

Many uninsured people will be able to buy insurance through the new health insurance marketplace. States were given the option of creating their own state-based marketplace or having the federal government operate one for the state.[l] In North Carolina, the federal government is operating the marketplace. In general, people can only enroll in the marketplace during an open enrollment

i The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016. Certain individuals are exempt from the mandate, including but not limited to those who are not required to pay taxes because their incomes are less than 100% of the federal poverty guideline (FPG), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.

j Patient Protection and Affordable Care Act. Pub L no. 111-148 §1501, 42 USC 18091

k North Carolina Session Law 2013-5.

l Patient Protection and Affordable Care Act. Pub L. no. 111-148 §§ 1311, 1321, 42 USC 13031, 18041

period. The initial open enrollment period ran from October 1, 2013 through March 31, 2014. The next open enrollment period will run from November 15, 2014 to February 15, 2015.[17] Certain individuals can enroll outside the open enrollment period if they have special circumstances (e.g. they lost their job and employer-sponsored insurance, got divorced, or had a child).

Subsidies are available to many families to help make health insurance coverage more affordable.[18] Individuals and/or families can qualify for subsidies if they have incomes between 100-400% FPG, do not have access to affordable employer-sponsored coverage, and are not eligible for publicly-funded health insurance (e.g. Medicaid, NC Health Choice, or Medicare). Subsidies are not available to most individuals with incomes below 100% FPG because, as the law was written, people living in poverty would be eligible for Medicaid (and if eligible for Medicaid, they were not eligible for the subsidies). The Supreme Court decision that made Medicaid expansion optional to the states created a coverage gap for the lowest income adults in states, like North Carolina, that chose not to expand Medicaid.

Individuals and/or families can qualify for subsidies if they have incomes between 100-400% FPG, do not have access to affordable employer-sponsored coverage, and are not eligible for publicly-funded health insurance.

Outreach, Education, and Enrollment Assistance

Most of the uninsured adults in North Carolina have little recent experience with commercial insurance coverage. As noted earlier, more than half of the uninsured adults in North Carolina reported being uninsured for five years or more, or had never had insurance coverage. Nationally, poll data from November 2013 showed that most of the uninsured knew little (33%) or nothing (38%) about the health insurance marketplaces.[19] And fewer than half of the uninsured polled reported any confidence in understanding most of the basic health insurance terms including: premiums, deductibles, copay, coinsurance, covered services, excluded services, provider networks, maximum annual out of pocket spending limits, or annual limits on services. Less than one-quarter of the uninsured reported that they understood all of these concepts.[20] Because of the general lack of understanding about how insurance works, and the fact that the health insurance marketplace is new, ongoing education, outreach, and enrollment assistance is needed.

Enroll America is a nonprofit organization created to "maximize the number of Americans who are enrolled in and retain health coverage."[21] The organization operates in 11 states, including North Carolina. Enroll America conducts outreach to the uninsured, helping educate them about the new insurance options available in the marketplace.[m] Enroll America also helps link uninsured people to in-person assisters when they need more information to understand their insurance options or to complete the steps to apply for coverage.

The ACA requires each marketplace to contract with "navigator" entities. These organizations get grants from the federal government to provide education,

m Sorien Schmidt, JD. State Director, North Carolina Enroll America. Email communication. February 11, 2014

outreach, and enrollment assistance. In North Carolina, four organizations or consortia of organizations, were awarded federal funding to offer navigator services: North Carolina Community Care Networks (a consortium of 11 organizations including Access East, Council on Aging of Buncombe County, Disability Rights North Carolina, Legal Aid of North Carolina, Legal Services of Southern Piedmont, MDC-The Benefit Bank of North Carolina, North Carolina Agromedicine Institute, NC MedAssist, Partnership for Community Care, Pisgah Legal Services, and Wake County Medical Society Health Foundation); Alcohol and Drug Council of North Carolina; Mountain Projects (serving Cherokee, Clay, Graham, Haywood, Jackson, Macon, and Swain counties); and Randolph Hospital (serving Randolph, Moore, and Montgomery counties).

Community health centers also received funding to hire staff to help with outreach, education, and enrollment assistance. Other organizations, such as hospitals, community clinics, or other nonprofits, can apply to help people enroll into the marketplace by becoming certified application counselors (CACs). Aside from navigator organizations and community health centers, approximately 60 other organizations have been certified as CACs (as of January 31, 2014).[22] Navigators, certified application counselors, and community health center outreach and enrollment staff must all be trained and certified by the federal government before they can help people enroll. Agents and brokers, once trained and certified, can also help people enroll into coverage in the marketplace.

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In addition, local departments of social services (DSS) have a legal responsibility to help people with the enrollment process. Local DSS offices must take applications for people interested in applying for Medicaid, NC Health Choice, or for subsidized coverage through the marketplace.[23]

Helping People Enroll into Insurance Coverage

Because open enrollment began recently, no studies evaluating different outreach, education, and enrollment assistance practices have been conducted to determine the most effective practices in helping the uninsured enroll in new insurance options. But past studies have identified best practices from state and national efforts to enroll uninsured children through Medicaid and/or Child Health Insurance Programs (CHIP);[24-28] from state health insurance programs (SHIP) that help Medicare recipients select Medicare supplement, Medicare Advantage and Medicare prescription drug plans;[25] and from Massachusetts as it implemented Mass Health Reform in 2006.[29] Unfortunately, because most states and communities have implemented multiple outreach, education, and enrollment strategies simultaneously, it is difficult to fully assess which of these strategies is most effective.[26,27] Thus, most of the past studies have been based on state officials' and/or other stakeholders' perceptions of which strategies are most effective and/or based on limited evaluations linking increases in enrollment to specific outreach and enrollment strategies. These studies suggest that certain marketing, outreach, and enrollment practices may be effective in

helping people understand their insurance options and enroll into coverage.[n] In addition to the past studies which have tried to identify best practices, some early studies and reports have described ACA marketing, outreach, and enrollment efforts in particular states.[23,28]

Marketing, Outreach, and Education

Mass media is important initially to help people learn about the new coverage, but thereafter, it is more effective to target marketing and outreach efforts to harder to reach populations.[24,25,27,28,30]

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- Make written materials accessible to people with low health literacy and limited English proficiency. Materials should be written at a literacy level that is appropriate for the target population and offered in multiple languages. It is not sufficient to translate English materials word for word into other languages. Rather, all materials should be reviewed by members of the target population to ensure that the messages are culturally and linguistically appropriate.[24,28-30]
- Develop simple messages and avoid using technical terms. The materials should emphasize a limited number of key messages, such as how the new insurance coverage will help people pay for preventive services or doctor's care, and will provide financial security in the event of an unanticipated medical emergency. It is also important to emphasize that financial help is available to make the coverage more affordable.[24,27,28]
- Use different approaches to reach a diverse population, including written materials, websites, online tools, telephone hotlines and in-person assistance.[25] Use web-based outreach and education to augment other efforts. These materials should be accessible to mobile devices, including smart phones and tablets as research shows that lower-income people are more reliant on these devices for internet access than higher income individuals.[26,30,31]
- Partner with trusted community-based organizations to help with the outreach and education at enrollment sites. Such organizations may include, but not be limited to: faith-based organizations, human services organizations, health care providers, schools, child care centers, family resource centers, food banks and, Goodwill.[24-28,30] In addition, work with

n The studies also focused on other elements needed for successful outreach and enrollment, such as a simple application form; an online eligibility and enrollment system that can verify eligibility through searches of federal and state databases; and decision supports to help people sort and compare health insurance options. These studies also noted the importance of having telephone hotlines staffed by knowledgeable staff who can answer consumer questions with accurate information. Having a simple recertification procedure was also noted as important. While all of these elements are important to ensure the success of the ACA enrollment efforts, they are primarily the responsibility of the federal government. North Carolina policymakers, agency staff, foundations, and community-based organizations have little impact on these elements. This chapter focuses on outreach, education, and enrollment assistance efforts that can be undertaken throughout the state or in local communities.

nontraditional partners that may have more name recognition among targeted populations, such as sports franchises.[26,28,30] Train different staff in health care organizations, including front-office staff, nurses and health care providers, to understand basic information about ACA eligibility and enrollment so that they can provide appropriate referral information to their patients and/or encourage them to apply.[23,28,32]

- Develop a network of community-based organizations that are helping with outreach and enrollment efforts. Community coalitions can help identify and address gaps in outreach and enrollment.[23,27]

Enrollment Assistance

- Offer people different options to file applications, including online, telephone, mail, or in person.[24] Provide access to in-person assisters to help people decide whether or not to enroll, get the necessary information needed to file the application, apply for financial assistance, understand official notices, choose a plan, and, if necessary, file an appeal.[25,28,29] Adequate resources are needed to ensure that there are sufficient numbers of in-person assisters who can work with all the people who want assistance, and that technology is available to help people apply online in appropriate venues.[25,29]

Develop a network of community-based organizations that are helping with outreach and enrollment efforts.

- Develop strategic partnerships with other state and local governmental agencies that interface with uninsured people, including but not limited to social services, local health departments, and employment security agencies.[26] In addition, outstation in-person assisters into hospitals, federally qualified health centers (FQHCs), health departments, or other places where the uninsured are likely to seek services.[24,27]

- Develop in-reach strategies. Hospitals, FQHCs, and other health professionals may be able to examine their own data systems to identify people who are uninsured and potentially eligible.[32]

- Change the culture of DSS eligibility workers to more actively help people enroll into health insurance coverage.[24]

Post Enrollment

- Provide ongoing help to people who need help understanding how to use their insurance once they have enrolled. Newly insured are likely to need additional help understanding provider networks, formularies, and cost sharing.[25,29]

- Provide help to people who need to report changes that could affect their eligibility for or amount of subsidies.[25]

- Offer help to people in the next open enrollment period in deciding whether to stay in their existing plans or to change to a new plan.[25]

Rural Outreach and Enrollment Efforts

Past studies have looked at marketing, outreach, education, and enrollment generically across different states, but have not focused on issues that may be specific to rural areas. Rural beneficiaries may experience other barriers that are unique or more prevalent in rural areas. For example, studies indicate that people living in rural areas have less access to the internet.[33] Rural beneficiaries also are more likely to report transportation barriers, which could make it more difficult for them to get to central locations for enrollment events.[34] Further, the receipt of public benefits carries a stigma for many rural families, which is arguably larger in rural areas than in urban areas.[35] It is not yet clear whether the subsidies available through the marketplace will carry the same stigma as does the receipt of public benefits. In addition, even though the proportion of people who are uninsured may be larger in many rural communities than urban, there are fewer people who are uninsured (because population density is less in rural areas than urban). Thus, many of the existing outreach, education, and enrollment efforts have focused initially on urban areas.[36]

Between October 1, 2013 and April 19, 2014, more than 350,000 people selected a marketplace plan in North Carolina (and more than 8 million nationally).

North Carolina Outreach, Education, and Enrollment Assistance in Rural Areas

Although open enrollment for the new health insurance coverage officially started on October 1, 2013, problems with the functioning of the federal website (www.healthcare.gov) made it difficult to enroll until mid-to-late November.[37] Thus, enrollment started slowly. However, enrollment accelerated later during the open enrollment period. Between October 1, 2013 and April 19, 2014, more than 350,000 people selected a marketplace plan in North Carolina (and more than 8 million nationally).[38] North Carolina had the fifth largest number of individuals selecting a marketplace plan during this time period.

As noted earlier, North Carolina received federal grants to support navigator activities among four different organizations (or consortia of organizations). In addition, 31 FQHCs received funding to hire outreach and enrollment specialists.[39] These FQHCs serve 62 counties, including 51 counties that are rural.[o] There are also other CACs across the state.[22]

While there are organizations that ostensibly serve the entire state, the Task Force heard from several organizational representatives that there were not sufficient in-person assisters to meet all the needs across the state, and in particular in rural communities. Organizations like Enroll America initially concentrated its efforts in urban areas. Legal Aid of North Carolina—which serves the entire state—has most of its branch offices (physical presence) in urban settings. While these organizations also try to reach rural areas, they do not have sufficient resources to serve everyone needing assistance. Local, state, and national funders helped to augment the navigator and FQHC funding, but

o Alice Pollard, MSW, MSPH. Outreach and Enrollment Specialist – Eastern North Carolina, North Carolina Community Health Center Association. Email communication. August 1, 2014.

these efforts have been largely targeted to communities with community or hospital foundations willing to contribute, and/or urban areas with the largest numbers of uninsured.[p] The only statewide philanthropic organization that targeted its funding to rural communities was the Kate B. Reynolds Charitable Trust.

The NCIOM Task Force on Rural Health heard presentations from representatives of organizations working to provide outreach, education, and/or enrollment assistance in rural areas.[36] In addition, a panel of navigators and CACs discussed rural outreach and enrollment challenges and successes in a meeting of the "Big Tent" (a consortium of navigators and CACs that meet biweekly to discuss outreach and enrollment efforts).[40] Further, the Task Force obtained feedback from rural community members directly in eight rural community feedback meetings. Some common themes that were presented include:

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Successes

- Health care providers can be important outreach ambassadors. People trust their physicians, nurses, pharmacists, and other health care providers, so it is important to enlist the provider community to disseminate information about the ACA and appropriate referral sources to their patients.
- Educate the office staff in health care organizations so that they will engage the patients and help refer them to appropriate resources (either inside the organization or to other in-person assisters).
- Health care organizations should look at their own populations (in-reach) to identify people who are uninsured and who may benefit from the new coverage options. Once identified, the health care organization should reach out to those individuals to help them understand the new options.
- Find other trusted people in the local community to educate community members about the new insurance options and the possible Medicaid expansion option for the state. This can include the faith community, schools, businesses, local government, or other community leaders. Panelists at the Task Force meetings talked about the importance of reaching out to the faith leaders, schools, businesses, local government, and professional associations (such as the North Carolina Growers Association) to educate parishioners, employees without access to employer-sponsored insurance, farmers/farm workers, and the general public about coverage options in the marketplace and the potential Medicaid expansion option.[36]
- People often need to hear the information about the Affordable Care Act multiple times before they begin to understand and/or consider enrolling into coverage.

p Kellan Moore, Executive Director, Care Share Health Alliance. Email communication. February 11, 2014

- It is important to go to where uninsured people are, and not expect them to come to you. Aside from hospitals and health clinics, North Carolina agencies have had success reaching the uninsured in churches or other faith-based organizations, farms or livestock shows, cooperative extension, libraries, community colleges, and other gathering places in rural communities.
- Work with rural newspapers to disseminate information about local education or enrollment events. The local media look for local stories, so it is important to explain the local connection when talking to the media.

Challenges

- Many people in rural communities are unaware of the new health insurance options available through the ACA, the state option to expand Medicaid to low-income uninsured people, or existing safety net resources in the community.
- Many of the uninsured do not understand how health insurance works (in general) or the new health insurance options available under the ACA.
- Some people in rural communities have a general mistrust of government programs. Many rural people pride themselves on being self-sufficient and do not want a government handout. In addition, some people are afraid of, or distrust, "Obamacare" and think it is different than private insurance coverage.
- Even with subsidies, the premiums are not affordable to some individuals.
- Some rural people who are self-employed are ineligible for subsidies because they have so many deductions that reduce their countable income below 100% FPG.
- A number of uninsured people fall into the coverage gap (e.g. they are ineligible for Medicaid but not eligible for subsidies in the marketplace because their income is below 100% FPG). Several panelists talked about the difficulty in telling people who are ineligible that they are "too poor" to be helped by the Affordable Care Act. The panelists try to refer the people to safety net organizations, but in many communities, the safety net organizations are already at capacity and cannot accommodate many new patients or have long waiting times.
- Transportation can be a problem for people without their own vehicle. The lack of transportation is a particular problem in rural areas because rural areas are less likely to offer public transportation.
- The North Carolina navigator organizations and FQHCs created a statewide appointment scheduler to assist people in finding an in-person assister who can talk with them about enrollment and insurance options.

Many people in rural communities are unaware of the new health insurance options available through the ACA, the state option to expand Medicaid to low-income uninsured people, or existing safety net resources in the community.

However, the scheduler does not include all of the other CAC agencies and does not have enough appointments listed to meet the needs of all the people who want to talk to in-person assisters.

- The number of people and the amount of time are both insufficient to reach all the people who are uninsured.

Medicaid Reform

The North Carolina Medicaid program serves approximately 1.8 million people in any given month.[41] Most Medicaid recipients are enrolled in the Community Care of North Carolina (CCNC) program. CCNC links Medicaid recipients to a primary care provider.[41] Primary care providers are currently paid on a fee-for-service basis for all the services they provide. In addition, they receive a small per-member per-month management fee that compensates them to coordinate care for their patients.

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CCNC includes 14 networks that are part of the North Carolina Community Care Network, Inc. (NCCCN) statewide organization. NCCCN receives a small, per-member per-month payment that helps pay for care coordinators, pharmacists, psychiatrists, quality improvement specialists, and a data analytics center that supports each of the 14 networks. Care coordinators are often housed in larger practices, and work closely with the primary care provider to help educate individuals about their health problems, and provide care management services when needed. The pharmacists, psychiatrists, and quality improvement specialists work in the network, but provide consultation to primary care practices.

Most providers who participate in the Medicaid program continue to be paid on a fee-for-service basis. That means that the providers are reimbursed every time they provide a service—whether or not the service was needed or led to health improvements. Many experts believe that our current fee-for-service system incentivizes providers to offer more services (volume), but does not reward providers on the basis of the value of the services they provide.[42] This, in turn, increases health care expenditures, but does little to improve overall quality. CCNC attempts to improve quality by measuring and reporting information back to providers on the quality of care they provide to Medicaid recipients. Yet in the past, provider reimbursement was not tied to the quality of care they provided.

The North Carolina Department of Health and Human Services (NCDHHS) has proposed a major overhaul of the state's Medicaid program, called Partnership for a Healthy North Carolina.[43] NCDHHS has proposed contracting with Accountable Care Organizations (ACOs). Within the Partnership for a Healthy North Carolina, a participating ACO will be a group of providers who agree to assume responsibility for all of the physical health needs of a group of Medicaid recipients. The goal of the Partnership for a Healthy North Carolina is to be

patient centered and promote whole-person care. The partnership also aims to secure budget predictability and cost savings, and partner with North Carolina's health care community to achieve these goals.

Medicaid recipients are assigned to an ACO based on whether their primary care provider is part of an ACO. ACOs must have a minimum of 5,000 Medicaid recipients to be eligible to participate in this initiative. By the end of the first year, the state aims to have 40% of Medicaid recipients enrolled in an ACO. This is expected to grow to 60% by the end of Year 2, 80% by the end of Year 3, and 90% thereafter.[47] If the ACOs lack capacity or geographic breadth to reach these targets, then NCDHHS will take such steps as are necessary (such as lowering payments to nonparticipating providers) to ensure the provider participation in the ACOs is sufficient to achieve these goals.

Many different types of safety net organizations provide health services to people who lack health insurance coverage in North Carolina.

By SFY 2016-2017 (the second year of implementation), the state expects the ACOs to reduce the rate of growth in Medicaid physical health expenditures by two-fifths of expenditures expected without this new program. If the ACO achieves certain quality standards and saves money, the ACO can share these savings with the state. However, if costs exceed the targeted amount, the ACO must share in the losses with the state.

The intent of this initiative is to move from "volume to value," by focusing not as much on the quantity of services provided as on the value of services provided. While a laudable goal, this model may not work as well in rural communities as in urban communities. Rural communities may lack the infrastructure or comprehensive provider network necessary to support an ACO. Further, some of the urban ACOs may choose not to contract with rural providers in order to avoid rural recipients who may be sicker than urban recipients. Thus, as the state moves forward to implement Medicaid reform, it is important to examine the potential impact of these efforts on rural communities.

Safety Net Resources

Many different types of safety net organizations provide health services to people who lack health insurance coverage in North Carolina.[44] These include hospitals, community and migrant health centers, rural health centers, public health departments, free clinics, and other nonprofit organizations that have a mission or legal obligation to provide services to the uninsured. Because of the federal Emergency Medical Treatment and Active Labor Act (EMTALA),[45] hospitals with emergency departments have a legal responsibility to screen and stabilize anyone who presents, regardless of ability to pay.[13] However, hospitals can charge people for the services they provide, although most offer some charity care to people with lower incomes.[5,46] Community and migrant health centers (also referred to as federally qualified health centers or FQHCs) also provide primary care services on a sliding scale basis to people who lack insurance coverage, as do some health departments and rural health centers.[44] Free clinics

also provide services to the uninsured, but most free clinics rely on volunteer health care professionals and, as a result, typically operate more limited hours and are able to see fewer patients during a week than a traditional clinic. While primary care services are available to some uninsured people—either for free or on a sliding scale basis—access to specialists is far more limited.[47] Some communities have tried to address this problem on a volunteer basis. Many uninsured also have difficulty obtaining needed prescription medications, mental health or substance abuse services, or dental care.[47]

National studies have shown that most of the uninsured are unaware of existing safety net resources, and only a little more than half of the uninsured know about safety net resources that are located within five miles of where they live.[48] To help address this issue, the NCIOM created a website—www.nchealthcarehelp.org—that provides information about some of the safety net resources that exist within the state, but most people are unaware of this website. In addition, United Way created a website that includes information about nonprofit health and human resources that exist across the state, www.nc211.org. This website is augmented by two call centers that cover all but eight counties across the state.[q,r] The United Way website is maintained by local partners and is updated on a more regular basis than is the NCIOM website. Some, but not complete, overlap, exists between the information collected on both websites.

Most of the safety net organizations in these communities were operating at or near capacity and would not be able to serve many more of the uninsured absent new resources.

Despite the availability of these website resources, there is still a general lack of knowledge about existing safety net resources across the state. This general lack of knowledge of existing safety net resources was confirmed in the eight rural community meetings hosted as part of this Task Force. We heard from people in almost all of the community meetings that many of the uninsured were unaware of the safety net resources that operated in their communities (aside from the hospital). However, rural representatives at these meetings expressed concern about broadly advertising the availability of safety net resources. We heard that most of the safety net organizations in these communities were operating at or near capacity and would not be able to serve many more of the uninsured absent new resources.

Based on the feedback from the rural community meetings, presentations, and best practices from prior outreach and enrollment efforts, the Task Force recommends:

q Marti Morris, Director, NC 211. Verbal communication. March 12, 2014
r At the time this report was being written, www.nc211.org covered all but eight counties across the state. However, United Way has plans to include the last eight counties in the summer of 2014.

Recommendation 5: Educate and engage people in rural communities about new and emerging health insurance options available under the Affordable Care Act as well as existing safety net resources.

a) Existing navigator entities, certified application counselors, hospitals, departments of social services, health departments, local government, safety net organizations, businesses, the faith community, and other nonprofits, should continue to work together collaboratively at the local level to coordinate education, outreach, and enrollment efforts, and to identify gaps in necessary resources.

b) North Carolina foundations should support local education, outreach, and enrollment activities by targeting rural communities with high unmet needs. High unmet needs should be demonstrated by having large numbers or a large percentage of uninsured, with few navigators, CACs, or other enrollment specialists. Funding should be targeted first to those communities that have a coordinated effort in place to examine the need; identify existing resources and gaps in resources; and develop a plan to outreach to hard to reach rural populations.

c) The North Carolina General Assembly and North Carolina Department of Health and Human Services should examine the potential impact of any changes to Medicaid payment and delivery models on rural communities before implementing major system reforms.

d) The North Carolina Institute of Medicine should work with United Way's 211 line to transition the maintenance of www.nchealthcarehelp.org to www.nc211.org to better promote the availability of safety net resources across the state. North Carolina foundations should encourage that safety net grantees review and update information on the site at least once annually.

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