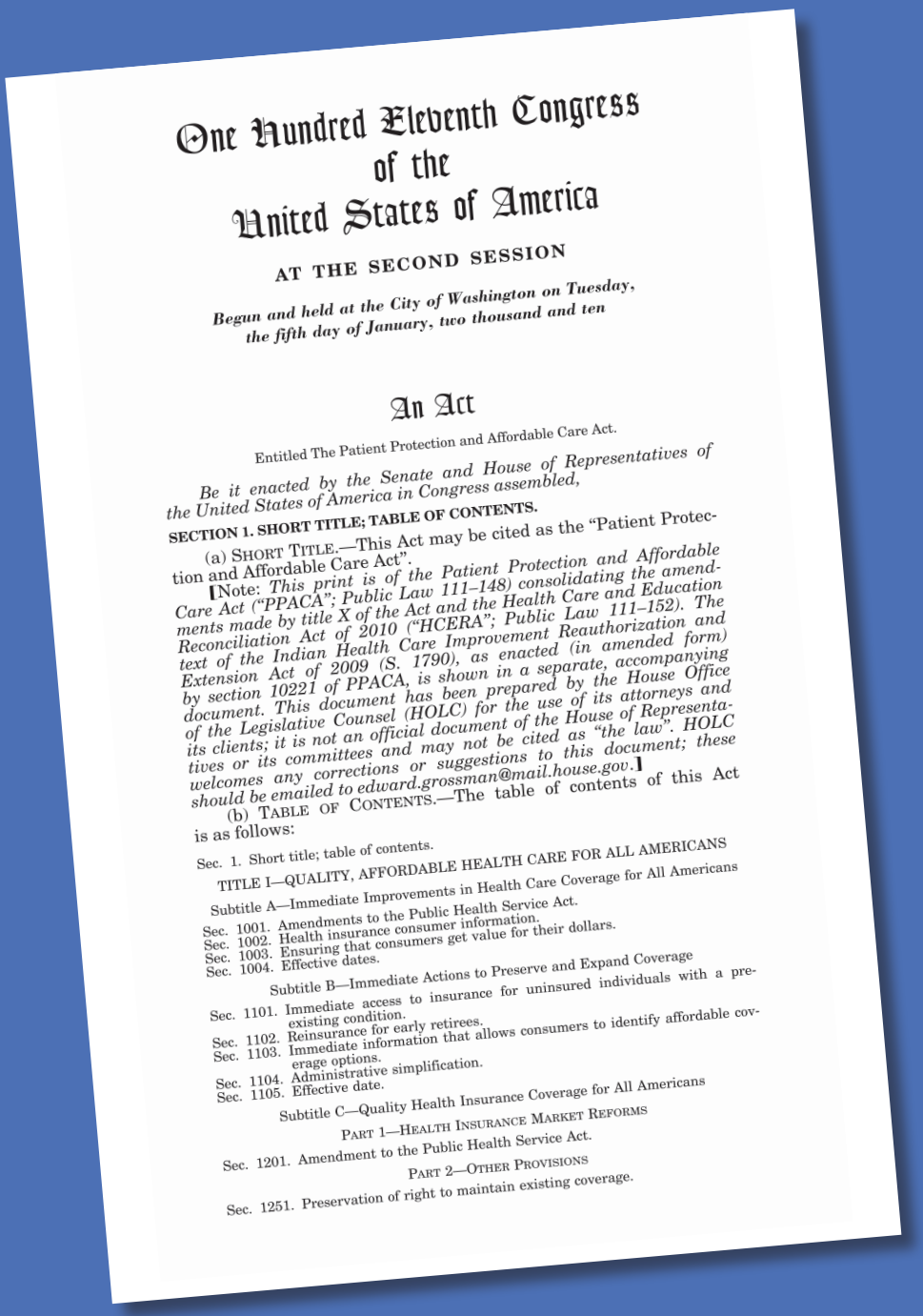

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

[Note: This print is of the Patient Protection and Affordable Care Act ("PPACA"; Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111–152). The text of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790), as enacted (in amended form) by section 10221 of PPACA, is shown in a separate, accompanying document. This document has been prepared by the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and its clients; it is not an official document of the House of Representatives or its committees and may not be cited as "the law". HOLC welcomes any corrections or suggestions to this document; these should be emailed to edward.grossman@mail.house.gov.]

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina

January 2013

Report by the
North Carolina Institute of Medicine

Submitted on Behalf of the North Carolina Department of Health and Human Services Department and the North Carolina Department of Insurance

NCIOM

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NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

EXECUTIVE SUMMARY

In March 2010, Congress passed national health reform,[1] referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rapidly rising health care costs. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, and places an increased emphasis on quality measurement and reporting. The ACA also has provisions to increase the supply of health professionals and strengthen the health care safety net.[2] The federal legislation also includes provisions aimed at reducing health care expenditures.

Health care accounts for a remarkably large portion of the United States' economy. In 2010, the United States spent $2.6 trillion on health care, an average of more than $8,000 per person (up from $1,110 in 1980).[3] The percentage of the gross domestic product (GDP) devoted to health care increased from 7.2% in 1970 to 17.9% in 2010. During this time, health care costs per person have grown an average of 2.4 percentage points faster than the GDP.[4] The increases in health care costs impact the ability for employers to offer insurance and for individuals to afford insurance. Rising health care costs also impact government programs such as Medicaid and Medicare, which are major parts of federal and state budgets. Increasing health care costs contribute to our federal deficit and reduce our ability to spend in other areas such as education, transportation, and economic development.

The ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs. At the same time, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations.

NCIOM WORKGROUPS

In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene stakeholders and other interested people to examine the new law to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole. The effort was led by an Overall Advisory Group, which was chaired by Lanier M. Cansler, CPA, Former Secretary, NCDHHS,[5] Albert Delia, Former Secretary, NCDHHS, and G. Wayne Goodwin, JD, Commissioner, NCDOI. The Overall Advisory Group included an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, and representatives of health care professional organizations, insurers, business, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the new act: Health Benefits Exchange; Medicaid; Safety Net; Health Professional

Workforce; Prevention; Quality; New Models of Care; and Fraud, Abuse, and Overutilization. (See Appendix A for a complete list of all Workgroup and Steering Committee members.)

Each workgroup was tasked with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions as well as examining federal funding opportunities in their area. The workgroups were guided by their co-chairs and the steering committee. The workgroups began meeting in August 2010 and met for 12-18 months. An interim report was published and is available online at http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf. Altogether, 260 people from across the state were members or steering committee members of one or more of the nine groups. In addition, the meetings were open to the public so that many others have participated in the meetings either in person or online.

Financial support for this effort was provided by generous grants from Kate B. Reynolds Charitable Trust, Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, John Rex Endowment, Cone Health Foundation, and the Reidsville Area Foundation.

This document is a compilation of reports from each of the health reform workgroups. Each report contains information about the applicable ACA provisions, findings, and recommendations. The recommendations of each workgroup was reviewed by the Overall Advisory Committee, and then sent to the NCIOM Board of Directors for final review. What follows is a summary of the NCIOM recommendations based on the work of the different workgroups and Overall Advisory Committee. The complete recommendations can be found in each of the workgroup chapters.

EXPANDING HEALTH CARE ACCESS TO THE UNINSURED

In North Carolina, there were approximately 1.6 million uninsured nonelderly individuals in 2010 (19%).[6] People who are uninsured are more likely to delay care and less likely to receive preventive services, primary care, or chronic care management. As a result, they are more likely to end up in the hospital with preventable health problems and more likely to die prematurely.[7] When the uninsured do seek care, some of the costs of their care are shifted to the insured population.

By 2014 the ACA requires most people to have health insurance or pay a penalty. To meet this requirement, the ACA builds on our current system of employer-sponsored insurance, individual coverage, and public coverage. Large employers (50 or more full-time equivalent employees) are required to offer employees coverage or pay a penalty.[8] Small businesses are not required to offer coverage, but the ACA provides tax credits to some small businesses to help offset some of their premium costs. Many North Carolina families will be eligible for subsidies to help them purchase private coverage, if they do not have access to affordable employer based coverage, cannot qualify for public coverage, and have incomes between 100- 400% of the federal poverty level.[9,10] In addition, the ACA gives states the option to expand Medicaid to cover more low-income adults.[11] In the first year alone, close to 800,000 uninsured people could gain coverage, if

North Carolina expands Medicaid. Of these, 41% will gain coverage through the private market, and 59% could gain coverage through Medicaid.[12]

Health Benefit Exchange Workgroup

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty. To help individuals who do not have access to affordable employer based coverage and small businesses, the ACA requires that each state have a Health Benefits Exchange (Exchange). Exchanges will offer information to help individuals and small businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own Exchange, the federal government will create one to offer coverage to individuals and small groups in the state. The Exchange was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The Exchange also can help promote competition on the basis of value, price, quality of care and customer service, and reduce competition based on risk avoidance, risk selection, and market segmentation. Qualified health plans (QHPs) offered through the Exchange must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[13] North Carolina's essential health benefits plan will be based on the health plan that is most commonly purchased by small businesses in North Carolina: the Blue Cross and Blue Shield of North Carolina Blue Options PPO.[14] The ACA also creates a "patient navigator" or in-person assister role to provide information to the public about health plan choices and to help them enroll.

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based Exchange. This bill did not pass the Senate in the 2011 or 2012 Sessions. Although the legislature did not pass legislation creating an Exchange, it did pass legislation stating its intent to create an Exchange within the state, and directing the NCDOI and the NCDHHS to continue to develop a state-based exchange.[15]

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Exchange. While the General Assembly indicated an interest to create a state-based exchange, it did not enact authorizing legislation in time to allow North Carolina to move forward with a state-based Exchange. North Carolina still has the option to create a state-based exchange in the future should it choose to do so; however, the state can only apply for federal funds to help build a state-based exchange through October 2014.

The effective and efficient operation of the Exchange will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the Exchange. The NCIOM believes that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government. Therefore, the NCIOM recommended:

RECOMMENDATION 2.1: STATE AND FEDERAL HEALTH BENEFITS EXCHANGE OPERATIONAL RESPONSIBILITIES

The North Carolina General Assembly should create a state-based Health Benefits Exchange (Exchange). The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management.

Under the ACA, Exchanges have the authority to modify QHP participation requirements if necessary to enhance Exchange operations. For example, the Exchange Board could limit the number or type of plan designs or take other steps necessary to facilitate consumer choice of health plans. However, the discretion to limit the number or types of plan designs should only be exercised if consumers have a reasonable choice of plans in the Exchange. Further, the Exchange should not make health plan oversight so prescriptive that it fosters innovations in plan design. In other words, one of the overriding goals of the Exchange should be to ensure that consumers have meaningful choices among competing insurers. In addition, the ACA requires health plans to meet state network adequacy requirements. The NCGA, NCDOI, or the Exchange Board should establish network adequacy standards, if needed to meet federal requirements.

RECOMMENDATION 2.2. HEALTH BENEFITS EXCHANGE BOARD AUTHORITY FOR EXCHANGE CERTIFICATION

The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority, beginning in 2014, to standardize terminology, benefit designs, or limit the number of plan offerings if needed to facilitate meaningful choice and promote competition among insurers, but only if the Exchange Board determines there is a reasonable level of choice in the Exchange market. The Exchange Board should also have the authority, beginning in 2016, to require or incentivize insurers to meet state standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services.

RECOMMENDATION 2.3. DEVELOP OBJECTIVE NETWORK ADEQUACY STANDARDS

If necessary to meet federal requirements, the North Carolina Department of Insurance (NCDOI) should develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the Exchange. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

In addition to the network adequacy standards, the ACA requires health plans to contract with essential community providers (ECP) in order to be certified.[16] ECPs are providers that serve predominantly low-income, medically underserved communities. The Exchange Board should monitor this provision to ensure that low-income and other vulnerable populations have access to all services without reasonable delay, and if necessary, further clarify how QHPs can meet this requirement.

RECOMMENDATION 2.4. MONITOR ESSENTIAL COMMUNITY PROVIDER PROVISIONS
The Health Benefits Exchange (Exchange) Board, in collaboration with the North Carolina Department of Insurance, should monitor insurers' contracts with essential community providers to ensure that low-income and other vulnerable populations have reasonable and timely access to a broad range of providers. If necessary, the Exchange Board should provide additional guidance to insurers about what constitutes a sufficient number or reasonable geographic distribution necessary to meet this requirement for qualified health plans offered in the Exchange.

Federal funding necessary to create and operate the Exchange is only available through 2014. Thereafter, the Exchange must be fully self-sufficient at the state-level. The ACA identifies certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[17]

RECOMMENDATION 2.5. ENSURE HEALTH BENEFITS EXCHANGE FINANCIAL SUSTAINABILITY
The North Carolina General Assembly should establish a Health Benefits Exchange (Exchange) Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the Exchange Trust Fund to pay for reasonable Exchange operations. The North Carolina General Assembly (NCGA) should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the Exchange Trust Fund. The NCGA should give the Exchange Board the authority to raise other revenues, within parameters established by the NCGA, if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for reasonable Exchange operations.

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. At the very general level, the Exchange and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll.

RECOMMENDATION 2.6. HEALTH BENEFITS EXCHANGE OUTREACH AND EDUCATION
The Health Benefits Exchange (Exchange), in conjunction with the North Carolina Department of Insurance, and North Carolina Division of Medical Assistance should develop a standardized community outreach and education toolkit and provide workshops so that interested organizations and individuals can disseminate information about public and private insurance options, the Exchange website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

The ACA also requires that the Exchange contract with navigator or with in-person assister entities to help people understand their different insurance options and facilitate enrollment into plans. The NCDOI operates a similar program for Medicare recipients, called the Senior Health Insurance Information Program (SHIIP). The Exchange should contract with NCDOI to help establish navigator and in-person assister training, certification, and oversight requirements.

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS AND IN-PERSON ASSISTERS.
The Health Benefit Exchange (Exchange) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator/in-person assister program. The NCDOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators and in-person assisters, and should create strong conflict of interest rules.

The state or Exchange can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the Exchange. Agents and brokers are in the best position to provide information and advice to small employers as employers need to weigh many factors in deciding whether to offer health insurance coverage and what type of coverage to offer. However, agents and brokers also need training to understand all the new public and private insurance options in order to provide the best information to individuals as well as small businesses and their employees. Additionally, the Exchange, in conjunction with the NCDOI, should examine current agent and broker commissions to reduce the financial incentives agents and brokers currently have to steer individuals and businesses to specific insurers.

RECOMMENDATION 2.8. REQUIREMENTS FOR AGENTS AND BROKERS SELLING COVERAGE IN THE HEALTH BENEFITS EXCHANGE
The Health Benefits Exchange (Exchange) Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the Exchange. The Exchange should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The NCDOI, in conjunction with the Exchange, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the Exchange, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage.

The ACA creates a "no wrong door" enrollment process. Individuals can apply directly to the Exchange, and if eligible for Medicaid or North Carolina Health Choice (NC Health Choice), North Carolina's Child Health Insurance Program, enroll directly into those programs. Conversely, people can apply for Medicaid or NC Health Choice first, and, if the person is

determined to be ineligible, he or she must be screened to enroll in a qualified health plan, and, if eligible, must be able to enroll "without delay." [18,19] Many of the low-income uninsured will first seek information about insurance options through their local Department of Social Services (DSS). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[20] Thus, the NCIOM recommended that DSS workers be trained and certified as navigators or in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or NC Health Choice to enroll into a qualified health plan offered through the Exchange.

RECOMMENDATION 2.9. "NO WRONG DOOR" ELIGIBILITY AND ENROLLMENT
Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice eligibility workers are cross-trained and certified as navigators or in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or NC Health Choice to enroll into a qualified health plan offered through the Health Benefits Exchange.

Medicaid Workgroup
Beginning in 2014, the ACA allows states to expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit.[21, 22] Children in families with incomes no greater than 200% FPL will continue to be eligible for Medicaid or NC Health Choice. Other people will gain coverage through private insurance offered through the Exchange. To qualify, a person must be a United States citizen or a lawfully present immigrant who has been in the United States for five years or more. Undocumented immigrants will not qualify for Medicaid coverage. If North Carolina elects to expand Medicaid eligibility, this change would be a major expansion to the North Carolina Medicaid program, especially for low-income adults.

A decision to participate in Medicaid expansion as put forth in the ACA would provide insurance coverage to approximately 500,000 North Carolinians, most of whom would remain uninsured without the expansion. Providing health insurance coverage will help people gain access to the care they need, which can help improve health outcomes. The gross service costs to the state would be $840.9 million and the new administrative costs would be $116.3 million between SFY 2014-2021. However, these new costs would be offset by pharmaceutical rebates ($60.9 million), redirecting existing state appropriations for other programs ($464.9 million), and the new tax revenues likely to be generated as a result of the increase in state domestic product from the infusion of $14.8 billion in new federal dollars ($496.9 million). Because of the high federal match rate, the offsets, and the new tax revenues, the state will actually experience a net savings of between $38 - $124 million/year from SFY 2014-2017. Beginning in SFY 2018, North Carolina will be required to contribute towards the costs of services to the newly eligibles. By, SFY 2021, the net new expenditure will be approximately $118.7 million to cover almost 540,000 people. Because of the large savings in the early years, North Carolina will be expected to save $65.4 million over the SFY 2014-2021 time period. Expanding Medicaid is also projected to create about 25,000 new jobs by 2016, which is expected to decline slightly to

18,000 sustained jobs (by 2021). The new federal funds would also help generate an additional $1.3-$1.7 billion in state domestic product per year.

RECOMMENDATION 3.1. EXPAND MEDICAID ELIGIBILITY UP TO 138% FPL
Based on North Carolina Division of Medical Assistance's projections of the number of people who may gain Medicaid coverage and the costs to the state, and the REMI analysis of jobs created, increase in the state's gross domestic product, and new tax revenues generated as a result of the expansion, the North Carolina Institute of Medicine recommends that North Carolina expand Medicaid eligibility up to 138% FPL.

Federal regulations prescribe most of the new eligibility and enrollment processes. States must implement the new eligibility and enrollment procedures for the existing Medicaid populations, even if the state does not choose to expand Medicaid. The state has some options which could further simplify the Medicaid eligibility and enrollment process.

RECOMMENDATION 3.2. SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES
The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage.

Further, it is likely that many individuals will move between Medicaid and the Exchange as their incomes fluctuate. Thus, the ACA includes provisions to streamline and coordinate the eligibility and enrollment processes between Medicaid, NC Health Choice, and the Exchange. Educating the public about these new requirements and the various health insurance options and insurance affordability programs is one of these provisions. Therefore, the NCIOM recommended:

RECOMMENDATION 3.3. DEVELOP A BROAD-BASED EDUCATION AND OUTREACH CAMPAIGN TO EDUCATE THE PUBLIC ABOUT NEW INSURANCE OPTIONS
The North Carolina Division of Medical Assistance, North Carolina Department of Insurance, and North Carolina Health Benefit Exchange should work together to develop a broad-based education and outreach campaign to educate the public about different health insurance options and insurance affordability programs.

Local DSS agencies will continue to play an important role in helping low-income people enroll in the appropriate health insurance coverage. Many people who have received assistance in the past through DSS are likely to continue to seek help there, regardless of whether they are eligible for Medicaid, NC Health Choice, or subsidized coverage through the Exchange. Thus, the NCIOM recommended:

RECOMMENDATION 3.4. RETRAIN DEPARTMENT OF SOCIAL SERVICES ELIGIBILITY WORKERS

The North Carolina Division of Medical Assistance, North Carolina Division of Social Services, and the North Carolina Association of County Directors of Social Services should provide training to county Department of Social Services (DSS) eligibility workers to help them understand the new eligibility and enrollment processes that will go into effect in the fall of 2013, and the new roles and responsibilities of DSS workers under the Affordable Care Act. Local DSS should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator or in-person assister in each DSS office.

In addition to expanding Medicaid coverage to more of the uninsured, the ACA gives states a number of options to expand home and community-based services (HCBS) to older adults or people with disabilities. Studies show that most people would prefer to remain in their homes or smaller community-based settings to receive services and supports rather than in a larger or institutional setting.[23,24] While supportive of expanding HCBS options for older adults or people with disabilities, the NCIOM was also cognizant of the state's fiscal constraints. Thus, the NCIOM recommended:

RECOMMENDATION 3.5. EXPLORE THE HOME AND COMMUNITY-BASED SERVICES MEDICAID EXPANSION OPTIONS

The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the costs and benefits of options to expand home and community-based services (HCBS), and should explore options to use existing state dollars to leverage federal Medicaid funding to expand HCBS. DMA should give priority to support caregivers or otherwise provide services to help the frail elderly or people with disabilities to remain in their homes, and should give priority to those who have been identified as at-risk through the Adult Protective Services system. DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.

Safety Net Workgroup

Many of the people who are expected to gain coverage under the ACA are already receiving some type of medical care from safety net organizations around the state. The safety net is composed of organizations that have a legal obligation or mission to provide health care and other related services to uninsured and underserved populations. Safety net organizations that have traditionally served underserved populations will be critical partners in meeting the health care needs of the newly insured. The ACA recognizes this and includes provisions to increase and strengthen the health care safety net.

In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers, school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations.

Research shows that many individuals who present in the emergency department have needs that could be met by health care providers outside of the emergency department. The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for underserved patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The NCIOM concurred and recommended:

RECOMMENDATION 4.1. DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT

The North Carolina College of Emergency Physicians (NCCEP) and partners should develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on dental complaints, chronic conditions, and behavioral health issues. NCCEP and partners should seek funding for the emergency care diversion project through federal sources. If adequate funding is not received from the federal sources, the North Carolina General Assembly should fund the emergency care diversion pilot project.

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health".[25] Therefore, the NCIOM recommended:

RECOMMENDATION 4.2. INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS

As part of the hospital and local health department community health assessments, these organizations should include input from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area. In implementing community health needs priorities, hospitals and local health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers. The savings the 340B program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the NCIOM recommended:

RECOMMENDATION 4.3. EXPAND 340B DISCOUNT DRUG PROGRAM ENROLLMENT AMONG ELIGIBLE ORGANIZATIONS

The North Carolina Division of Medical Assistance, Office of Rural Health and Community Care, North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage eligible hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.

The ACA requires that the Exchange establish a program to award grants to entities that serve as navigator or in-person assister coordinating entities. The duties of a navigator or in-person assister include public education; distribution of fair and impartial information; facilitation of enrollment in QHPs; provision of referrals for grievance, complaint, or question about their health plan; and provision of information in a manner that is culturally and linguistically appropriate to the needs of the population being served. In order to receive a grant, an organization must demonstrate that it has, or could readily establish, relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP. In addition, navigators and in-person assisters must meet standards to avoid conflicts of interest.

In North Carolina, safety net providers have established relationships with the diverse uninsured population that is traditionally hard to reach. These established relationships provide a unique opportunity for safety net providers to serve as navigators or in-person assisters for their patients.

RECOMMENDATION 4.4. ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS OR IN-PERSON ASSISTERS

The Health Benefits Exchange (Exchange) should train and certify staff at safety net organizations to serve as patient navigators or in-person assisters as long as these organizations meet the federal requirements for patient navigators or in-person assisters. As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. There is a continued need to coordinate the work of different safety net organizations to facilitate ongoing collaborations and communications. Therefore, the NCIOM recommended:

RECOMMENDATION 4.5. RECONVENE THE SAFETY NET ADVISORY COUNCIL

The Care Share Health Alliance should reconvene the Safety Net Advisory Council to identify communities with the greatest unmet needs; increase collaboration among safety net agencies; monitor safety net funding opportunities; make a recommendation and plan for integrating safety net tools including the North

Carolina Health Care Help website and the county level resources; and serve as a unified voice for the safety net.

Health Professional Workforce Workgroup

While the ACA includes provisions to increase the number of physical, behavioral, and oral health practitioners to address current and future workforce needs, and authorizes new programs to expand the number of health care providers, it does not include new appropriations to fund all of these provisions. Given limited federal funding for workforce initiatives, North Carolina policy makers, academic health institutions, and health professional organizations should focus on the steps it can take to ensure an adequate workforce to meet the health care needs of North Carolinians.

The increase in the number of North Carolinians with health insurance will increase demands for health care, particularly primary care.[26] In addition to high demands for physical health care, changes in insurance rules and access to health insurance are expected to increase demands for other services, particularly behavioral and oral health care. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, and behavioral and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. Furthermore, the provision of health care in the field is changing; therefore, education and training models must also change. Therefore, the NCIOM recommended:

RECOMMENDATION 5.1. EDUCATE HEALTH WORKFORCE USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE

The North Carolina Community College System, the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties should work together to create targeted programs and admissions policies to increase the number of students with expressed interested in primary care, behavioral health, and dentistry. AHEC should educate the existing workforce on new core competencies needed by the health care workforce including interdisciplinary team-based care, patient safety, quality initiatives, cultural competency, health information technology, and others.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[27] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health and may reduce costs. Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the NCIOM recommended:

RECOMMENDATION 5.2. SUPPORT AND EXPAND HEALTH PRACTITIONER PROGRAMS TO MORE CLOSELY REFLECT THE COMPOSITION OF THE POPULATION SERVED
The North Carolina Area Health Education Centers Program, the North Carolina Community College System, the University of North Carolina University System, private colleges and universities with health professions degree programs, and other interested parties, including the Alliance for Health Professions Diversity, should collaborate to create more intensive programs and coordinate efforts to expand and strengthen existing evidence-based health professions pipeline programs.

Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. The capacity to recruit and retain health professionals in rural and underserved areas across the state is critical to meet the health needs of North Carolinians. As part of the ACA, the National Health Service Corps (NHSC), a federal program for certain types of health care practitioners who receive loan repayments in return for practicing in a health professional shortage area (HPSA), received $1.5 billion in funding. Many states are competing to attract health professionals using NHSC funding. The Office of Rural Health and Community Care (ORHCC) plays a critical role in helping recruit health professionals and match them with qualified HPSAs. Recruiting health care professionals to rural and underserved areas also has a positive economic impact on local economies. Therefore, the NCIOM recommended:

RECOMMENDATION 5.3. STRENGTHEN AND EXPAND RECRUITMENT OF HEALTH PROFESSIONALS TO UNDERSERVED AREAS OF THE STATE
In order to support and strengthen the ability of the North Carolina Office of Rural Health and Community Care (ORHCC) to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina Department of Commerce should use $1 million annually of existing industry recruitment funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into North Carolina.

In addition to focusing on rural and underserved areas, there is a general need to strengthen the existing primary care, behavioral, and oral health workforces. To recruit more physicians, nurse practitioners, and physician assistants into primary care and to retain the workforce we currently have will require a rebalancing of how practitioners are paid, rewarding those health care professionals who practice in primary care. In order to encourage health care professionals to enter into primary care practices and to retain current practitioners, the NCIOM recommended:

RECOMMENDATION 5.4. INCREASE REIMBURSEMENT FOR PRIMARY CARE AND PSYCHIATRY SERVICES
Public and private payers should enhance their reimbursement to primary care practitioners and psychiatrists to more closely reflect the reimbursement provided to other specialty practitioners. For purposes of this recommendation, primary care practitioners include, but are not limited to: family physicians, general pediatricians, general internists, psychiatrists as well as nurse practitioners, physician assistants, and certified nurse midwives practicing in primary care.

Given the health care needs of the population, the role of the health care industry in North Carolina's economy, the amount of money the state invests in educating health care providers, and the state's role in financing the consumption of health care, there is a pressing need for North Carolina to identify workforce priorities and to create policies that ensure there are enough practitioners with the proper training to meet the health care needs of the population. Therefore, the NCIOM recommended:

RECOMMENDATION 5.5. SUPPORT COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS

The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. The North Carolina General Assembly should provide $550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.

IMPROVING POPULATION HEALTH

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA includes new funding to invest in prevention, wellness, and public health infrastructure. The ACA includes $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 for a new Prevention and Public Health fund to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina, which ranked 33 of the 50 states in 2012 based on a composite of 24 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[28]

Prevention Workgroup

The ACA included new requirements and options to cover clinical preventive services in public and private health insurance plans. In addition, the ACA includes new requirements, as well as new options for employers to promote employee wellness.

The ACA requires state Medicaid agencies to provide coverage for tobacco-cessation drugs and to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. The ACA also prohibits cost-sharing for these services. North Carolina's Medicaid program currently covers some tobacco cessation drugs and is already in compliance with the provision on pregnant women. However, barriers to treatment still exist. Therefore, the NCIOM recommended:

RECOMMENDATION 6.1. INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS

The North Carolina Division of Medical Assistance should provide all Federal Drug Administration (FDA) approved over-the-counter nicotine replacement therapy without a physician prescription as part of comprehensive tobacco cessation services and work to reduce out-of-pocket costs for such therapies. Primary care providers and Medicaid recipients should be educated about covered tobacco cessation therapies.

The ACA includes a provision that requires employers with 50 or more employees to provide reasonable break time and a private place (other than a bathroom) for an employee to express breast milk for nursing children for one year after the child was born. Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions.

RECOMMENDATION 6.2. SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

The North Carolina Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy. Small businesses should be encouraged to provide similar support to working mothers.

The ACA requires new employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for certain preventive services and immunizations. The state and partners will need to monitor health plans to ensure that coverage is provided, educate providers and patients on the covered services, and provide mechanisms in electronic medical record systems to promote the provision of these services.

RECOMMENDATION 6.3. PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. The North Carolina Department of Insurance should monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services. Electronic medical record systems offered in North Carolina should provide clinical decision support tools to identify and promote prevention services. Outreach should be done to educate providers and individuals about covered preventive services.

The ACA includes provisions that aim to improve population health through benefits provided by employers. The ACA also includes worksite wellness provisions which allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or

prevent disease. There is a need for education of employers and employees on these provisions, thus, the NCIOM recommended:

RECOMMENDATION 6.4. PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES
The Center for Healthy North Carolina and the North Carolina Division of Public Health should provide information to businesses on evidence-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.

The ACA also provided new funding opportunities to expand prevention efforts, prevent or reduce overweight and obesity, reduce tobacco use, improve maternal and infant health, and strengthen the public health infrastructure. The North Carolina Division of Public Health has been successful in competing for these funds. Most of the funding has been used to implement or strengthen programs at the local level.

While much of the initial ACA funding has been targeted to states, some funding opportunities are also available to local public health agencies. Larger public health agencies generally have the capacity to compete for these funds. However, smaller and/or poorer counties may lack the personnel or infrastructure to apply for grants or to implement new initiatives. These are often the counties with the greatest health needs. Therefore, the NCIOM recommended:

RECOMMENDATION 6.5. BUILD CAPACITY OF COMMUNITIES TO RESPOND TO FUNDING OPPORTUNITIES
The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should develop the infrastructure needed to allow communities of greatest need to respond to prevention-related funding opportunities.

As with other areas of the ACA, many of the provisions that include grant funding opportunities were authorized, but not appropriated. Therefore, the NCIOM recommended:

RECOMMENDATION 6.6. MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS
The state should monitor the federal appropriations process, as well as funding made available as part of the Public Health and Prevention Trust Fund, to identify additional funding of prevention provisions.

IMPROVING THE QUALITY OF CARE

The current health care payment system is structured to reward health professionals and providers based on the volume of services provided rather than based on the quality of care or health outcomes. The ACA begins to change the way that health care professionals and providers are reimbursed to emphasize the quality and value of the services provided.

Quality Workgroup

The ACA includes new provisions aimed at improving the quality of care provided by different types of health care professionals and providers. For example, the ACA requires the Secretary of the USDHHS to develop quality measures to assess health care outcomes, functional status, transitions of care, consumer decision-making, meaningful use of health information technology, safety, efficiency, equity and health disparities, and patient experience.[29] Health care professionals and providers will be required to report data on these new measures to CMS. Ultimately, these data will be made available to the public. In addition, the ACA changes the Medicare (and in some cases, Medicaid) reimbursement structure to reward providers and health care professionals, in part, on the quality of services provided.

Health care professionals and providers need to be educated about these changes, so that these groups can understand and be prepared to meet the new Medicare reporting and quality standards. In addition, consumers need to understand how to interpret the quality comparison data when they become available. Thus, the NCIOM made many recommendations about the need for education, including:

RECOMMENDATION 7.1. EDUCATE PRIMARY AND SPECIALTY CARE PROVIDERS ON QUALITY MEASURE REPORTING REQUIREMENTS
The Division of Medical Assistance and partners should educate primary care and specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults.

RECOMMENDATION 7.4. EDUCATE PROVIDERS ON ACA ISSUES
The North Carolina Area Health Education Centers and partners should educate physicians on new ACA requirements and provisions aimed at improving quality.

RECOMMENDATION 7.5. EDUCATE HOSPITALS ON ACA ISSUES
The North Carolina Hospital Association should provide education to hospitals on new ACA requirements and provisions aimed at improving quality of care in hospitals.

RECOMMENDATION 7.6. EDUCATE HOME AND HOSPICE CARE PROVIDERS ON ACA ISSUES
The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the ACA value-based purchasing provisions.

RECOMMENDATION 7.7. EDUCATE FACILITY PERSONNEL ON ACA ISSUES
The North Carolina Division of Health Service Regulation and partners should educate their constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value-based purchasing.

RECOMMENDATION 7.8. EDUCATE CONSUMERS ON AVAILABILITY AND INTERPRETATION OF PROVIDER QUALITY MEASURES
The North Carolina Healthcare Quality Alliance and partners should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.

Over time, health care professionals and institutions will be reimbursed, in part on the value of the services they provide. This will be measured by quality of care indicators or health outcomes. The ACA requires health care professionals and providers to report certain quality and outcome data to the federal government. In addition, many insurers are adopting similar reporting requirements. These new reporting requirements may become burdensome to health care professionals, if they are required to report the same, or similar data to multiple state and federal agencies and private insurers. Reductions in the reporting burden could be achieved through alignment of the state quality measure requirements (e.g., CCNC, DMA) with the federal measures. To reduce this reporting burden on providers and ensure that the state has access to information to drive state for state level quality improvement initiatives, the NCIOM recommended:

RECOMMENDATION 7.2. EXPLORE CENTRALIZED REPORTING
The North Carolina Health Information Exchange (NC HIE) Board should facilitate mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of North Carolina quality measures with federal requirements.

RECOMMENDATION 7.3. INVESTIGATE OPTIONS FOR DATA STORAGE
The North Carolina Department of Health and Human Services, working with the NC HIE and other stakeholder groups, should examine options to capture data automatically from electronic health records and then coordinate submission of data to the appropriate entities. Data should be made available at the state level for research and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.

The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. The goal of this focus is to improve quality and efficiency of care by improving transitions in care. Transitions in care refer to movement of patients between health care providers and health care settings. Problems with transition can occur when information about a patient's care or situation is not communicated adequately to other providers or to the patient. In order to improve transitions of care, the NCIOM recommended:

RECOMMENDATION 7.9. IMPROVE TRANSITIONS OF CARE

The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying, and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms to evaluate outcomes. Solutions utilizing transition principles should be applied to all patients regardless of payer.

RECOMMENDATION 7.10. REIMBURSE NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES

The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.

COST CONTAINMENT

The United States spends more on health care that any other developed nation (17% of the gross domestic product, or $7,960 per capita in 2009). Spending on health care is rising far more rapidly than other costs in our society. The ACA attempts to reign in health care costs by encouraging the development of new models of care that promote better patient outcomes and reduces unnecessary utilization, reducing payments to certain providers, streamlining administrative costs, and reducing fraud and abuse.

New Models of Care Workgroup

New models of care are essential to improve the value delivered by our health care system. The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and health care expenditures, while improving individual health outcomes and overall population health. The ACA gives CMS authority to test new models of care that expand access to needed services; incentivize providers to improve quality and individual and community health outcomes; involve patients more directly in their own care; reduce redundant, ineffective and inefficient utilization; and moderate rising health care costs.

North Carolina has many different pilots or demonstrations under development, both in the public and private sector, including, but not limited, to multipayer patient-centered medical homes, new payment models, value-based insurance designs, and broader population health interventions. Ongoing efforts are needed to catalogue the different initiatives and to disseminate information about successful efforts across the state. Therefore, the NCIOM recommended:

RECOMMENDATION 8.1. DEVELOP A CENTRALIZED NEW MODELS OF CARE TRACKING SYSTEM

North Carolina state government and North Carolina foundations should provide funding to the North Carolina Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state.

North Carolina needs to continually examine the way we provide and pay for health care services, to ensure that models being used are achieving optimal individual and population health outcomes, while providing care in the most efficient manner possible. Strong, independent evaluations that examine common quality, outcome, and cost metric—so that different models of care can be compared to one another—are needed to identify what works, for whom, and in what environment. Further, evaluation data should be shared publicly among insurers, other health systems, and the public. Thus the NCIOM recommended:

RECOMMENDATION 8.2. EVALUATE NEW PAYMENT AND DELIVERY MODELS

Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that others can learn from these new demonstrations. North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

There is a need for enhanced data to improve the functioning of the current health care system. State government, public and private payers, health systems, health care professionals, employers and consumers need information about diagnosis, utilization, costs, and outcomes in order to evaluate new delivery or payment models. To ensure that necessary data is captured in a way that allows for such evaluation, the NCIOM recommended:

RECOMMENDATION 8.3. CAPTURE DATA TO SUPPORT NEW MODELS OF CARE

The North Carolina Department of Health and Human Services should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to identify options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.

While public and private health care organizations in North Carolina have sought to take advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. A broader group of

stakeholders need to be involved in discussions to address potential barriers as well as solutions to overcome those barriers, including licensure boards, the North Carolina Department of Insurance, health professional associations, and health care systems.

RECOMMENDATION 8.4. EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS

The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models. The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or the otherwise effectively use of electronic health records. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.

Fraud and Abuse Workgroup

The ACA includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and CHIP. These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs).

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went in to effect in 2010 or 2011. Many requirements of the ACA provisions were already being addressed in North Carolina, including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. However, the state needed to enact new laws to implement other mandatory ACA requirements. The North Carolina General Assembly enacted these new laws in 2011 as Session Law 2011-399.

CONCLUSION

North Carolina currently faces significant health challenges, including the growing numbers of uninsured, poor overall population health, rising health care costs, and the need to increase access to care and improve quality. The ACA begins to address some of these problems. Greater emphasis will be placed on improving overall population health and the quality of health care services. Further, the ACA includes provisions aimed at lowering the rate of increase in health care expenditures.

The ACA does not address—or solve—all of the state's health care problems. For example, while the ACA includes provisions to expand the health professional workforce, the Act included little new funding. Thus there is likely to be workforce shortages to address the pent-up demand for health services in 2014 when many of the uninsured gain coverage. The ACA includes new provisions to change the way we deliver and pay for health care with the goal of improving quality and health outcomes while reducing escalating health care costs but, as of yet, most of these efforts are untested.

Further, there are still unanswered questions. The ACA directed the Secretary of USDHHS to implement many of the provisions of the new law. The Secretary has issued both proposed and final regulations implementing many of the sections of the law, but further guidance on other sections will be forthcoming.

While the ACA imposes significant new challenges, it also offers opportunities to increase affordable coverage to more North Carolinians, improve population health, and improve quality of care. Over the longer term, we may also gain new strategies to reign in escalating health costs. The recommendations included in this report are intended to help North Carolina implement the Affordable Care Act so as to best serve the state as a whole.

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[1] The ACA is actually a combination of two separate pieces of legislation. The Patient Protection and Affordable Care Act (HR 3590) was signed into law on March 23, 2010. This law was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4872), which was signed into law on March 30, 2010.

[2] A more complete description of the ACA is available in the May/June 2010 issue of the NCMJ. Silberman P, Liao C, Ricketts TC. Understanding health reform: a work in progress. *NC Med J*. 2010;71(3):215-231. http://www.ncmedicaljournal.com/archives/?issue-brief-understanding-health-reform-a-work-in-progress-3733. Accessed January 18, 2011. A review of the steps the state has taken to implement the ACA is available in the March/April 2011 issue of the NCMJ. Silberman P, Cansler LM, Goodwin W, Yorkery B, Alexander-Bratcher K, Schiro S. Implementation of the Affordable Care Act in North Carolina. *NC Med J*. 2011;72(2):156-160. http:// http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf. Accessed February 14, 2012.

[3] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[4] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[5] Secretary Cansler served as co-chair during his tenure as Secretary of the North Carolina Department of Health and Human Services. Secretary Delia became co-chair when he was appointed as Acting Secretary.

[6] United States Census Bureau. Current Population Survey, Annual Social and Economic Supplements. Table HIB-6. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65: 1999 to 2010. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html. Accessed February 15, 2012.

[7] The Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. Washington, DC: The Henry J. Kaiser Family Foundation.; 2010. http://www.kff.org/uninsured/upload/7451-06.pdf. Accessed February 8, 2011.

[8] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513.

[9] 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 line (FPL), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.

[10] The constitutionality of the individual mandate along with the Medicaid expansion is being challenged in the United States Supreme Court. The Supreme Court accepted two cases to consider the constitutionality of different provisions of the ACA, *National Federation of Independent Business v. Sebelius*, and *Florida v. Department of Health and Human Services*. The different challenges will be considered in late March. A decision is expected before the close of the Supreme Courts current term in June, 2012. Kaiser Family Foundation. A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law. http://www.kff.org/healthreform/upload/8270-2.pdf. Published January 2012. Accessed February 23, 2012.

[11] As originally passed, the ACA required states to expand Medicaid to all individuals with family incomes below 138% of the federal poverty guidelines, or lose federal funding. In June 2012, the Supreme Court ruled this was unduly coercive to the states and changed it to an optional expansion of Medicaid.

[12] Milliman I. North Carolina Health Benefit Exchange Study. Table 1.2. http://www.nciom.org/wp-content/uploads/2010/10/NCDOI-Health-Benefit-Exchanges-Report-Version-37_2012-12-9.pdf. Published December 9, 2011. Accessed February 14, 2012.

[13] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1302(a).

[14] The Center for Consumer Information and Insurance Oversight prepared a summary of the proposed North Carolina essential health benefit benchmark plan. The summary is available at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf. Accessed December 10, 2012.

[15] Sec. 49 of NCGA Session Law 2011-391.

[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.

[17] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(d)(5).

[18] Patient Protection and Affordable Care Act, Pub L No. 111-148, §2201, enacting §1943(b)(1)(C) of the Social Security Act, 42 USC 1396w-3(b)(1)(C).

[19] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.1200(g).

[20] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.908.

[21] The ACA requires states to expand Medicaid to cover nonelderly individuals with modified adjusted gross income of no more than 133% FPL, however the legislation also provides a 5% income disregard. Because of this disregard, individuals will be able to qualify for Medicaid if their income is not more than 138% FPL, assuming they meet other program rules.

[22] The federal poverty levels, established by the federal government, is based on family size. It is usually updated annually based on the changes in the Consumer Price Index. In 2012, the federal poverty levels for a family of one was $11,170; for a family of two ($15,130), family of three ($19,090), and family of four ($23,050). The federal poverty levels increase by $3,960 for each additional family member. United States Department of Health and Human Services. http://aspe.hhs.gov/poverty/12poverty.shtml. Accessed February 14, 2012. Because the federal poverty levels are updated annually, it is likely to be higher by 2014.

[23] National Institute of Mental Health. United States Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health; 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Published 1999. Accessed September 22, 2010.

[24] Bayer A.H., Harper L. American Association of Retired Persons. Fixing to Stay: A National Survey of Housing and Home Modification Issues. Washington, DC: AARP Independent Living Program; 1995, 2000. http://assets.aarp.org/rgcenter/il/home_mod.pdf. Accessed February 8, 2011.

[25] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007(a), enacting Sec. 501(r)(3)(B)(i) of the Internal Revenue Code of 1986, 26 USC 501(r)(3)(B)(i).

[26] Hofer AN, Abraham JM, Moscovice I. Expansion of coverage under the patient protection and Affordable Care Act and primary care utilization. *Milbank Q.* 2011;89(1):69-89.

[27] North Carolina Institute of Medicine Primary Care and Specialty Supply Task Force. Providers in Demand: North Carolina's Primary Care and Specialty Supply. Morrisville, NC: North Carolina Institute of Medicine; 2007. http://www.nciom.org/projects/supply/provider_supply_report.pdf. Accessed December 10, 2008.

[28] United Health Foundation. America's Health Rankings 2012: North Carolina. http://www.americashealthrankings.org/NC/2012. Accessed January 31, 2013.

[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3013-3014.

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 1: INTRODUCTION

In March 2010, Congress passed national health reform,[1] referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of uninsured, rapidly rising health care costs, poor overall population health, and uneven quality of care. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, places an increased emphasis on quality measurement and reporting, and tests new models of delivering and paying for health care to reduce unnecessary expenditures.

PROBLEMS WITH THE CURRENT HEALTH CARE SYSTEM

Growing Numbers of Uninsured

In 2010, when the legislation was passed, 18.4%[2] non-elderly Americans did not have health insurance. At the same time, 19.6% of nonelderly North Carolinians, or 1.58 million, were uninsured.[3] Not having health insurance coverage is harmful to the health and well-being of children and adults. People who lack health insurance coverage have a harder time affording necessary care. In a statewide survey of adults, nearly half of the uninsured in North Carolina reported forgoing necessary care due to cost, compared to 11% of individuals with insurance coverage.[4] More importantly, the lack of coverage adversely affects health. The uninsured are less likely to get preventive screenings and ongoing care for chronic conditions. Consequently, the uninsured have a greater likelihood than people with coverage of being diagnosed with severe health conditions (such as late stage cancer), being hospitalized for preventable health problems, or dying prematurely. [5]

The chief reason that people lack coverage is cost. Rising health care costs over the past decade have led to decreases in the number of employers offering health insurance and the number of employees who can afford the premiums when health insurance is offered.[6] In 2010 the average annual total premium cost for individual coverage through an employer in North Carolina was $4,992, with the employee picking up 22% of the cost.[7] Family coverage cost, on average, was $13,221, with the employee picking up 28% of the cost.[8] Between 2003 and 2011, average total premiums for employer-sponsored family coverage rose nationally by 62% (from $9,249 to $15,022). During that same time, the average employee premium contribution rose by 74% (from $2,283 to $3,962) and average per-person deductibles more than doubled (from $518 to $1,123).[9] Individuals who do not have access to employer-based coverage and who are not eligible for public insurance rely on the limited non-group coverage market for health insurance. The premium costs for non-group coverage can be extremely high and the individual must pay the full cost of the premium, with no contribution from their employer. Furthermore, in most states, insurers can deny coverage completely, impose limits on coverage for those with preexisting conditions, or charge higher premiums based on health status, occupation, and other personal characteristics. Uninsured North Carolinians report that the main reason they do not have health insurance is they cannot afford the premiums.[10]

Rising Health Care Costs

This rapid growth in premiums stems from an increase in underlying medical costs. High costs and utilization of medical technology and prescription drugs have fueled the increase in health expenditures. Additionally, the growing prevalence of chronic illnesses contributes to escalating premiums.[11] In addition, there is significant waste in our health care system, including fraud and abuse,[12] as well as unnecessary expenses due to poor delivery of health care services, fragmented and disjointed care, and overtreatment.[13]

Health care accounts for a remarkably large portion of the United States' economy. In 2010, the United States spent $2.6 trillion on health care, an average of more than $8,000 per person (up from $1,110 in 1980).[14] The percentage of the gross domestic product (GDP) devoted to health care increased from 7.2% in 1970 to 17.9% in 2010. During this time, health care costs per person have grown an average of 2.4 percentage points faster than the GDP.[15] As discussed, the increases in health care costs impact the ability for employers to offer insurance and for individuals to afford insurance. Rising health care costs also impact government programs such as Medicaid and Medicare, which are major parts of federal and state budgets. Rising health care costs contribute to our federal deficit and reduce our ability to spend in other areas such as education, transportation, and economic development.

Poor Overall Population Health

Americans are generally in poorer health than our counterparts in the developed world. This may be why we spend more than most other countries yet have similar—or worse—health outcomes. As population health worsens, costs to both individuals and the health care system as a whole continue to rise. National rankings show the United States ranks 30th out of 34 OECD countries in terms of premature mortality and in the bottom third for infant mortality and mortality due to heart disease. The United States has more obese adults than any other OECD country.[16] Examining 50-state data shows that North Carolina often ranks near the bottom of the states on measures of population health. In 2012, North Carolina was ranked 33rd in overall health (with 1 being the highest).[17] North Carolina ranks poorly on many health outcomes, health behaviors, access to care, and socioeconomic measures.

Poor or Uneven Quality of Care

While the United States spends significantly more than other countries on health care, our countries' performance on measures of health care quality is mixed. The United States ranks in the bottom third on measures of asthma and chronic obstructive pulmonary disease (COPD) hospitalization, obstetric trauma, and childhood vaccinations.[18] The United States ranks in the top third for five-year survival rates for patients with three types of cancer, and near the middle on measures of in-hospital, case specific mortality for three conditions.[19] These findings suggest that there is much room for improving the quality of care delivered within our health care system.

When compared to other states, North Carolina ranks 25th on potentially preventable use of hospitals and costs of care.[20] In a national comparison of health system performance, which includes 63 measures across five domains including access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives, North Carolina ranked 41st in 2009 (with 1 being the highest performing state). This low ranking was due, in large part, to significant health

disparities and poor performance on health outcome measures. While North Carolina performs better in health care performance than in health outcome measures, there is still considerable room for improvement. For example, the analysis suggests that 131,627 more adults with diabetes in North Carolina would have received recommended clinical services to prevent disease complications if North Carolina performed as well as the best state. Similarly, North Carolina would have experienced 23,384 fewer preventable Medicare hospitalizations saving close to $146 million.

The Affordable Care Act

The ACA was enacted to address these fundamental problems with our current health care system as well as to increase the supply of health professionals and strengthen the health care safety net.[21] The federal legislation also includes provisions aimed at reducing health care expenditures. While the ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations. In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and the North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene workgroups to examine the new law and gather stakeholder input to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole.

NCIOM Workgroups

At the request of NCDHHS and NCDOI, the NCIOM convened stakeholders and other interested people to examine the new law and to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole. The effort was led by an Overall Advisory Group, which was chaired by Lanier M. Cansler, CPA, Former Secretary, North Carolina Department of Health and Human Services,[22] Albert Delia, Acting Secretary, North Carolina Department of Health and Human Services, and G. Wayne Goodwin, JD, Commissioner, North Carolina Department of Insurance. The Overall Advisory Group included an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, and representatives of health care professional organizations, insurers, business, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the new act: Health Benefit Exchange; Medicaid; Safety Net; Health Professional Workforce; Prevention; Quality; New Models of Care; and Fraud, Abuse, and Overutilization. (See Appendix A for a complete list of all Workgroup and Steering Committee members.) Altogether, 260 people from across the state were members or steering committee members of one or more of the nine groups. In addition, the meetings were open to the public so that many others have participated in the meetings either in person or online.

Each workgroup was tasked with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions as well as examining federal funding opportunities in their area. The workgroups were guided by their co-chairs and the steering committee. The workgroups began meeting in August 2010 and met for 12-18 months. Each workgroup developed recommendations based on the information they were tasked with studying. An interim report was published in March of 2011 with the recommendations of the

workgroups at that time. (The interim report is available online at http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf.) The workgroups continued to meet and develop their final recommendations, which are contained in this report. The final recommendations of each workgroup were reviewed by the Overall Advisory Committee, which was charged with overseeing and coordinating the work of all the workgroups. The Overall Advisory Committee reviewed and revised the recommendations, then sent the recommendations to the NCIOM Board of Directors for review. The NCIOM Board of Directors reviewed, revised, and approved of the recommendations within this report.

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[1] The ACA is actually a combination of two separate pieces of legislation. The Patient Protection and Affordable Care Act (HR 3590) was signed into law on March 23, 2010. This law was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4872), which was signed into law on March 30, 2010.

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[22] Secretary Cansler served as co-chair during his tenure as Secretary of the North Carolina Department of Health and Human Services. Secretary Delia became co-chair when he was appointed as Acting Secretary.

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 2: HEALTH BENEFITS EXCHANGE

OVERVIEW

In 2011 one in five non-elderly North Carolinians lacked health insurance coverage. In some counties in North Carolina more than 25% of adults lack health insurance coverage (See Appendix B.) Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (Exchange). The ACA requires that each state have an Exchange that will offer information to help individuals and businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own Exchange, the federal government will create one to offer coverage to individuals and small groups in the state.

Beginning in 2014, the ACA requires most people to have minimum essential health insurance coverage or pay a penalty.[1,2] 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 level (FPL), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.[3] Larger businesses, with 50 or more full-time equivalent employees, must also offer minimum essential coverage or pay a penalty for their full-time employees.[4]

The Exchange was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The Exchange may also help promote competition on the basis of comparative value, price, quality of care, and customer service, and reduce competition based on risk avoidance, risk selection, and market segmentation. The Exchange may also help increase transparency in the marketplace; add to consumer education efforts; promote meaningful choice; and assist individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions. The goal in establishing the Exchange is to reduce the number of uninsured, promote improved competition in the health care marketplace, and engage consumers in care and coverage choices.

Individual and small group plans, including qualified health plans (QHPs) offered through the Exchange, must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[5] Each state had the opportunity to define its own essential health benefits package (using benchmarks defined by the US Department of Health and Human Services (US DHHS)) that includes coverage of these services. States were given until December 26, 2012 to make their selection.[6] The proposed regulations specified a default plan for states that did not selected their own essential health benefits plan which will be the benchmark for 2014 and 2015. North Carolina did not select its own plan so it will rely on the default plan. The default plan is the largest Blue Cross and Blue Shield of North Carolina

small group product, which is a Blue Options PPO plan.[7] In addition, the plan must be supplemented with pediatric oral and vision coverage, as well as habilitative services. The default plan for pediatric oral and vision services is coverage offered through the Federal Employees Dental and Vision Program. In addition, all insurance plans that are not grandfathered[8] must provide coverage of the clinical preventive services recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee for Immunization Practices with no cost sharing.[9] Insurers must also provide additional preventive services for infants, children, adolescents, and women.[10]

The ACA specifies that the essential health benefits package can be offered in one of four levels of coverage, including bronze (defined as having a 60% actuarial value of covered services), silver (70% actuarial value), gold (80% actuarial value), and platinum (90% actuarial value).[11] To meet the requirements for minimum essential coverage, an individual must have a health plan with at least a 60% actuarial value. That means that on average, the insurer pays for 60% of the total costs of covered benefits. The individual (or family) would be responsible, on average, for the other 40% of the costs of covered services in addition to their premium. (Typically, individuals or families would pay their 40% share through a combination of deductibles, coinsurance, and/or copayments.) Insurers that offer QHPs in the Exchange must offer at least the silver and gold level of coverage, but can also choose to offer the bronze and platinum levels. In addition, insurers can offer catastrophic plans to young adults under age 30 as well as to individuals exempt from the mandate to purchase coverage.[12]

The ACA includes subsidies to make health insurance coverage more affordable through the Exchange. The subsidies are available to single individuals or families with modified adjusted gross income (MAGI) of between 100 - 400% of FPL, if they do not have access to affordable employer-sponsored insurance (ESI) and do not qualify for public coverage such as Medicaid.[13,14] (Table 2.1) In North Carolina, almost 900,000 of the 1.6 million uninsured North Carolinians had family incomes between 100-400% FPL. (See Appendix B.) Families that qualify for subsidies may be eligible for an advanceable premium tax credit to help pay for health insurance coverage. The premium tax credit is based on the essential health benefits portion of the premium for the second lowest cost silver plan offered in the Exchange. As long as the family purchases the second lowest cost silver plan then the maximum that the family generally would have to pay is based on a percentage of their income (ranging from 2% for lower income families to 9.5% for those whose incomes are between 300-400% FPL).[a] Families who choose to purchase a higher cost plan would pay the specified percentage of their income, plus the difference in the premium cost between what they chose to purchase and the second lowest cost silver plan. Conversely, families that purchase a lower cost plan would pay less.

Lower income individuals and families, those with incomes below 250% FPL, also receive subsidies to help pay for their out-of-pocket costs (such as deductibles, coinsurance, or copayments) for the essential health benefits if they enroll in a silver plan. American Indians

[a] Individuals or families may have to pay a higher percentage of their income in premiums if they purchase a more expensive policy (e.g., one that costs more than the second lowest cost silver plan); they purchase coverage that includes additional services beyond the essential health benefits; or the individual or any family members smoke. The subsidies do not apply to covered services that are not part of the essential health benefits or to the tobacco surcharge (if any).

with incomes below 300% FPL pay no cost sharing.[15] The federal government will pay the premium tax credits and the cost-sharing subsidies directly to health plans. All families with incomes below 250% FPL that receive a subsidy who purchase a silver plan also qualify for reduced out-of-pocket annual limits. Eligible families must purchase their health insurance coverage through the Exchange in order to receive the premium tax credit and cost-sharing subsidies.

Table 2.1
Sliding Scale Premium Tax Credit and Cost-Sharing Reduction
Based on Second Lowest Cost Silver Plan

Individual or Family Income (as percent FPL)	Maximum premium for second lowest cost silver plan (Percent of family income)	Out-of-pocket cost sharing, on average[€]	Out-of-pocket cost-sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost-sharing limits)[¥] [β]
Families eligible for subsidy			
100-133% FPL[χ]	2%	6%	$2,250 (individual)/ $4,500 (more than one person) (1/3 HSA limits)
133-150% FPL	3-4%	6%	$2,250/$4,500
150-200% FPL	4-6.3%	13%	$2,250/$5,500
200-250% FPL	6.3%-8.05%	27%	$5,200/$10,400 (4/5 HSA limit)
250-300% FPL	8.05-9.5%	30%	$6,400/$12,800
300-400% FPL	9.5%	30%	$6,400/$12,800
Families not eligible for subsidies			
400%+ FPL	No limit	30%	$6,400/$12,800 (HSA limit)

[χ] Immigrants who are lawfully present in the United States for less than five years can qualify for a subsidy if their income is less than 100% FPL. Citizens and immigrants who are lawfully present in the United States for five years or more are not eligible for subsidies unless their income is at least 100% FPL. Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1401(c)(1), enacting Sec. 36B of the Internal Revenue Code of 1986.

[€] Out-of-pocket cost sharing includes deductibles, coinsurance, and copays.

[¥] Out-of-pocket limits do not include premiums, costs associated with non-covered services, or costs incurred from out of network providers. Annual cost sharing limited to $6,400 per individual or $12,800 per family in 2014 dollars (current Health Savings Account or "HSA" limits). Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1312(d), 1501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1002. United States Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014. Proposed Rule. *Fed Regist* 2012;77(236):73117-73218. December 7, 2012. http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf. Accessed January 23, 2013.

[β] The Center for Consumer Information and Insurance Oversight released Actuarial Value and Cost-Sharing Reductions Bulletin which indicated the United States Department of Health and Human Services' intent not to

reduce out-of-pocket limits for those with incomes between 250-400% FPL. http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf. Accessed April 13, 2012.

In addition to the subsidies available to individuals, the ACA also includes tax credits to help small businesses purchase health insurance coverage.[16] Small businesses with 25 or fewer employees, with average wages of $50,000 or less, are eligible for sliding scale tax credits if they offer health insurance coverage to their employees and pay at least 50% of the premium. The tax credits are currently available to small businesses that meet these criteria. However, beginning in 2014, small businesses will only be able to obtain tax credits if they purchase health insurance coverage through the Exchange.

The North Carolina Department of Insurance (NCDOI) contracted with Milliman, Inc., an actuarial consulting firm, to develop estimates of the number of people who might gain coverage in the Exchange and examine other Exchange operational and design issues. According to Milliman, approximately 715,000 North Carolinians are expected to obtain their health insurance coverage through the Exchange beginning in 2014.[17] (Table 2.2) Of these, slightly more than 51,000 people are expected to be covered by small businesses purchasing insurance for employees and their dependents through the Exchange; more than 660,000 people are expected to purchase nongroup coverage through the Exchange. Approximately 300,000 of the individuals who are expected to enroll in the Exchange in the first year are expected to have been uninsured in 2013. The remaining 360,000 estimated Exchange enrollees will have had health insurance coverage in the past, and the majority of these are expected to qualify for subsidies to purchase coverage through the Exchange.

Table 2.2
Changes in Insurance Coverage (2013-2014)

		Market Changes in 2014							
				Employer Sponsor		Ind. Market			
Market in 2013	Total Pop.	Medicaid/ CHIP[χ]	Other Govt. Program	Exchange	Non-Exchange	Exchange	Non-Exchange	Un-insured	Undoc Un-insured
Medicaid/ CHIP	1,418,183	1,415,697	0	14	1,994	144	15	317	0
Other Govt. Pgm	734,760	84	731,453	171	2,744	186	121	0	0
Employer Sponsored Ins.	4,609,264	5,497	381	50,793	4,480,365	68,591	1,117	2,519	0
Individual Market	444,422	16,530	0	8	1,719	294,612	131,403	149	0
Uninsured	1,258,153	466,755	0	163	18,435	299,539	61	473,200	0
Undocumented Uninsured	215,014	0	0	0	0	0	0	0	215,014
Total	8,679,795	1,904,564	731,835	51,149	4,505,258	663,073	132,718	476,185	215,014

[χ] Milliman prepared the estimates of the number of people who may gain coverage through the Medicaid expansion before the US Supreme Court decision in *National Federation of Independent Business vs. Sebelius*. As is discussed more fully in Chapter 3, the US Supreme Court held that the Medicaid expansion is voluntary to the states. Thus, the number of people who may potentially become eligible for Medicaid will be largely dependent on whether, and if so, when North Carolina chooses to expand Medicaid to cover low-income people with incomes up to 138% FPL.

Three quarters of the people who purchase coverage directly through the Exchange are expected to be eligible for the premium tax credit and cost-sharing subsidies. Of all the individual market enrollees in the Exchange, Milliman estimated that 3% of enrollees will have incomes of less than 138% FPL; 5% will have incomes between 138-149% FPL; 21% will have incomes between 150-199% FPL; 30% will have incomes between 200-299% FPL; and 16% will have incomes between 300-400% FPL.[18] Only 25% are estimated to have incomes above 400% FPL.

The number of people expected to obtain coverage through the Exchange is expected to grow from roughly 715,000 people in 2014 to more than 900,000 people by 2016. Over time, more people are likely to obtain health insurance coverage as they learn about their different insurance options and the amount of the potential penalty for failing to have coverage increases.

EXCHANGE REQUIREMENTS

The ACA requires Exchanges to perform certain functions to facilitate selection and enrollment into a health plan. For example, Exchanges must:

- Certify, recertify, and decertify qualified health plans, Co-op plans, and federally approved multi-state plans as specified by the Secretary.[19, 20]
- Operate a toll-free telephone hotline to respond to requests for assistance and to provide eligibility and enrollment in person, via phone or fax, or electronically.[21, 22]
- Develop and maintain a website that provides standardized comparative information on plan options including costs, quality, and provider networks.[23, 24]
- Assign a quality rating to each qualified health plan offered through the Exchange using criteria developed by the Secretary.[25 , 26]
- Determine eligibility for the premium tax credit and cost-sharing subsidies.[27, 28]
- Conduct outreach and education to inform people about eligibility requirements for Medicaid and North Carolina Health Choice and, if eligible, enroll them directly into these programs.[29, 30]
- Establish and make available an electronic calculator for determining the costs of coverage after applicable premium tax credits and cost-sharing reductions.[31, 32]
- Certify individuals who are exempt from the requirement to purchase health insurance.[33,34]
- Provide information to the Secretary of the USDHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions and the level of coverage.[35]
- Provide the Secretary of the Treasury with information about anyone who is exempt from the individual mandate, anyone who is receiving a subsidy who works for an employer required to offer insurance, and information about individuals who change employers and who cease coverage under a qualified health plan.[36]
- Provide information to employers of any employee who ceases coverage under a qualified health plan.[37]
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.[38,39]
- Consult with relevant stakeholders to carry out required activities.[40 , 41]

- Publish average costs of licensing, regulatory fees, and other payments to the Exchange and administrative costs.[42, 43]
- Report on activities, receipts, and expenditures annually to the Secretary of the USDHHS.[44]
- Consider information from employers that contest the imposition of penalties.[45]

States can create one Exchange that covers both individuals (nongroup) and small businesses, or can create two Exchanges. In general, the requirements for the Exchange covering individuals and families (nongroup) and the Small Business Health Options Program (SHOP) Exchange covering small businesses are the same. However, the federal regulations included some requirements that are exclusive to the SHOP. For example, under the regulations the SHOP must allow qualified employers to select a "metal" level of coverage (e.g., bronze, silver, gold, platinum) so that their qualified employees could choose any plan within a specific tier.[46] The SHOP can offer other employee choice options to employers (e.g., single option, defined set of options within or across metal levels, or full choice). The SHOP must also provide an option for premium aggregation services for small businesses that choose to offer their employees a choice of plans.[47] This reduces the administrative burden on small businesses, as they will only need to remit one combined premium check to the SHOP instead of multiple premium checks to different insurers. The SHOP Exchange will then aggregate the premiums from the different employers and submit premiums to the appropriate insurers.

The federal government will pay for expenses associated with the establishment and operations of a state-based Exchange until 2015 for state-based Exchanges established for plan year 2014 operations (with the exception of Navigator grants, discussed more fully below). However, the Exchange must be financially self-sufficient beginning January 1, 2015, or after the first year of operation if established later than the 2014 plan year.[48,49] The ACA envisions that the Exchange would charge assessments or impose user fees to participating health insurance issuers, or the state must otherwise be able to generate sufficient funds to cover operating costs.[50]

States that choose to operate their own Exchange in 2014 must have submitted a letter of intent and their blueprint to the Center for Consumer Information and Insurance Oversight (CCIIO), within the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services by December 14, 2012.[51,52] States must then have a conditionally approved plan by January 1, 2013, and then be able to demonstrate operational readiness sometime before October 1, 2013 (at a date to be specified by the federal government).[53] CCIIO provided states guidance as to what will be required to show operational readiness.[54] To be certified, Exchanges must show their ability to perform the following core functions:

- *Consumer Assistance,* including education and outreach, navigator management, call center operations, website management, consumer support assistors, and written correspondence with consumers to support eligibility and enrollment.
- *Plan Management,* including plan selection, collection and analysis of plan rate and benefit package information, issuer monitoring and oversight, ongoing issuer account management, issuer outreach and training, and data collection and analysis for quality.
- *Eligibility,* including the ability to accept applications, conduct verifications of applicant information, determine eligibility for enrollment into a qualified health plan and

insurance affordability programs, connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP, and conduct redeterminations and appeals.
- *Enrollment*, including enrolling consumers into qualified health plans, transactions with QHPs and transmission of information necessary to initiate advance payment of the premium tax credits and cost-sharing reductions.
- *Financial management*, including user fees or assessments, or other arrangements to assure financial solvency, financial integrity, support of risk adjustment, reinsurance and risk corridor programs.

States that have decided not to operate the full Exchange in 2014 have other options. They can choose to assume responsibility for some consumer assistance functions, plan management functions, or both on behalf of the federally-facilitated Exchange.[55,56] These states must notify the federal government of their decision to operate a partnership plan by February 15, 2013.[57] States that decide not to operate their own Exchange in 2014 may also choose to operate a state-based Exchange at a later date, as long as they submit a blueprint by November two years prior to the first plan year and receive approval from DHHS one year prior to the assumption of the Exchange. However, the last application date for federal funding to help create a state-based Exchange is in October 2014.

STATE DESIGN ISSUES

The state has many options in implementing the Exchange provisions of the ACA. **First and foremost, the state must decide whether it wants to create its own Exchange or leave it to the federal government to implement.** The effective and efficient operation of the Exchange will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the Exchange. The Health Benefits Exchange (HBE) workgroup and Overall Advisory Committee believe that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government. In its interim report, the HBE workgroup and the Overall Advisory Committee recommended that the North Carolina General Assembly (NCGA) create a state based Health Benefits Exchange. The workgroup also recommended that the legislature create a separate quasi-state agency (public corporation), rather than house the Exchange within an existing state agency.[58]

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based Exchange. This bill did not pass the Senate in the 2011 or 2012 Sessions. Although the legislature did not pass legislation creating a Exchange, it did pass legislation stating its intent to create a Exchange within the state, and directing NCDOI and the North Carolina Department of Health and Human Services (NCDHHS) to continue to develop a state-based Exchange. The statute, Sec. 49 of Session Law 2011-391, directing NCDOI and NCDHHS to continue its work reads as follows:

> "**DEPARTMENT OF INSURANCE AND AFFORDABLE CARE ACT**
> **"SECTION 23.3.** It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010,

> Public Law 111-152, collectively referred to as the Affordable Care Act (ACA). The Department of Insurance (DOI) and the Department of Health and Human Services (DHHS) may collaborate and plan in furtherance of the requirements of the ACA. DOI may contract with experts, using available funds or grants, necessary to facilitate preparation for an Information Technology system capable of performing requirements of the ACA.
>
> The Commissioner of Insurance may also study the insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. If the Commissioner of Insurance conducts such a study, the Commissioner shall submit a report to the 2012 Regular Session of the 2011 General Assembly containing recommendations resulting from the study."

Based on this legislation, NCDOI submitted a Level I establishment grant to the federal government in June 2011. North Carolina was successful in obtaining a $12.4 million dollar grant. Level I grants provide funding for one year (with an opportunity for extension) to begin the process of creating a state-based Exchange. North Carolina's Level I grant period was extended by a year and now runs from August 15, 2011 through August 13, 2013. NCDOI submitted an application in November 2012 for a second Level I establishment grant to continue to prepare for an Exchange. The grant has not yet been awarded.

Since the NCGA did not implement legislation creating a state-based Exchange in the 2012 session, the state will not be able to meet the requirements to show operational readiness by January 1, 2013. Thus, the federal government will operate a federally-facilitated Exchange for North Carolina beginning in January 2014. However, North Carolina has chosen to move forward with a partnership plan assuming some consumer assistance and plan management functions on behalf of the federally-facilitated Exchange (discussed more fully below).[59] This leaves the option for the state to pursue a full state-based Exchange sometime in the future.

The state can submit a proposal for a Level II implementation grant to pay for further development, as well as start up and initial operational costs (through 2014). CMS extended the deadlines for Level I and Level II grant applications through 2014.[60] In order to apply for a Level II grant, the state must have authorized the creation of the Exchange with an appropriate governance structure. In addition, the Exchange must submit a budget through 2014, and an operational plan that includes—at a minimum—plans to provide consumer assistance, prevent fraud and abuse, and ensure financial sustainability beginning in 2015.[61]

When NCDOI received the first Level I establishment grant, it was still operating under the assumption, based on Sec. 49 of Session Law 2011-391, that North Carolina would be creating its own state-operated Exchange beginning 2014. Thus, the Level I establishment grant was used to develop plans to build some of the key components needed to show operational readiness, including developing requirements for the necessary information technology (IT) systems, and strengthening the existing consumer assistance program. The North Carolina Level I establishment grant has been used to do the following, among other activities:

- Engage stakeholders and perform policy analysis on policy issues.
- Develop requirements to expand NCDHHS eligibility IT system to include needed Exchange functionality and expanded user base.
- Develop requirements to build or procure non-eligibility IT systems.
- Establish capacity to provide assistance to individuals and small businesses seeking health insurance.
- Develop comprehensive work plan and budget through 2015 to support anticipated future Level II grant application.

NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the Exchange policy and design issues. NCDOI has created a separate Market Reform Technical Advisory Group (TAG) to consider the market reform issues—particularly those that will impact on insurance coverage or rating inside and outside the Exchange. The two groups were charged with examining different implementation and design issues. (Table 2.3) In general, the HBE workgroup considered those issues unique to the Exchange, and the NCDOI TAG considered those issues which affect health plans both inside and outside the Exchange. The NCIOM HBE workgroup completed its work in April 2012; the work of the NCDOI TAG is ongoing. The first phase NCDOI TAG work was provided to the NCGA in a report in May 2012.[62]

Table 2.3
Design Issues Considered by NCIOM HBE Workgroup and NCDOI Technical Advisory Group

NCIOM HBE Workgroup Issues	NCDOI TAG Issues
• Whether to operate a state-based Exchange or create a partnership Exchange • High level QHP certification options • Exchange sustainability options • Preliminary evaluation planning necessary for a Level II implementation grant • The roles, training, and certification requirements for agents, brokers, navigators, volunteer counselors and other community based organizations • Preliminary discussion of the essential community providers requirements	• Whether to merge the individual and small group market risk pools • Whether to allow groups of more than 50 to purchase QHPs in the Exchange in 2014 • Whether to change the North Carolina laws regarding self-funding and stop-loss coverage for small group plans • Whether to modify North Carolina small group insurance laws to comply with federal definitions for small group (e.g., whether to include groups of one, definition of employee) • The role of the state, if any, in administering the risk adjustment and reinsurance programs, and preliminary plans for program development if applicable • Mechanisms for assuring a level playing field inside and outside the Exchange (i.e., to mitigate adverse selection) • Geographic rating areas and other rating factors • Analysis of essential health benefits options for North Carolina • Operationalizing the essential community provider requirements

RECOMMENDATIONS

The HBE workgroup met 16 times from August 2010 to April 2012. In addition, a subcommittee met on four occasions to examine options for the navigator program. The information in this chapter will be most relevant to the state if the NCGA chooses to create a state-operated Exchange sometime in the future. Even absent this determination, much of this information will be useful to the state if it chooses to move forward with a partnership option. This information will also be presented to the Exchange Board (if created).

State-Based or Partnership Exchange

As noted earlier, the ACA gives states the authority to create its own Exchange or leave it to the federal government to operate an Exchange on the state's behalf. However, in subsequent regulations and policy guidance, the USDHHS set forth a proposed hybrid approach—called a "partnership" Exchange option.[63] With the partnership option, USDHHS gave states flexibility to assume some functions that they want to provide directly and those which they want the federal

government to assume. The partnership option is considered a federally-facilitated, and not a state-operated Exchange. Table 2.4 gives a brief overview of the different Exchange operational options: state operated, federally facilitated, or partnership. More detailed information is provided below.

Table 2.4
Overview of Different Exchange Operational Arrangements

	State Operated Exchange	Federally Facilitated Exchange	State-Federal Partnership
Consumer Assistance	State	Federal, with some harmonization to state laws	State option to develop and operate in person assistance program and help manage federal Navigator program
Plan Management	State	Federal, with some state interaction	State Option
Eligibility	State, with option for federal support	Federal, with state option for final Medicaid/CHIP determination	Federal, with state option for final Medicaid/CHIP determination
Enrollment	State	Federal	Federal
Financial Management	State, with option for federal risk adjustment	Federal, with option for state reinsurance	Federal, with option for state reinsurance
Sustainability	State option	Federal user fees	Federal user fees

Although workgroup members recommended that North Carolina create and operate its own Exchange, it did consider the partnership option. At the point that the workgroup considered this option, it was unclear which operational functions could be assumed by the state under the partnership option. Therefore, the workgroup examined all of the Exchange core functions to determine which functions would best be handled by a state agency or state-based Exchange, and those that would best left to the federal government.

Consumer assistance. The workgroup recommended that the state provide consumer assistance directly to enrollees. A state-based Exchange would be better equipped to provide outreach and education to North Carolinians, as a state organization would already have knowledge of the state, the insurance industry, key consumer and small business groups, and other consumer support and eligibility sources such as those provided by the NCDHHS and local social services agencies. In addition, NCDOI already operates a successful consumer assistance program—Health Insurance Smart NC (Smart NC) —which helps consumers with insurance related questions, complaints, appeals, and external review. Not only does Smart NC provide key services to North Carolinians, but the information it collects as part of the complaint process is essential for NCDOI's regulatory responsibilities. The workgroup also recommended that the Exchange contract to operate the call-center in state, as North Carolinians have a better understanding of the state's health insurance marketplace and health care infrastructure. In addition, workgroup members recommended operating a state-based call center so that the state would benefit from the new jobs created. Some of the HBE workgroup members thought the

federal government might be in the better position to create the "shop and compare" interface for the Exchange website, but they also recognized that the federal government would need to get a lot of the underlying data from the NCDOI. Thus, there was more of a consensus that the state-based Exchange take responsibility for creating the shop and compare website.

Plan management. The workgroup recommended that the responsibility for certifying and decertifying qualified health plans be done at the state level. NCDOI traditionally monitors the operations of insurers, including plan licensure and solvency. Many of the Exchange plan management functions will be similar to traditional regulatory oversight functions, and are integral to the oversight of health plans offered through the Exchange. Further, the NCDOI will continue to regulate insurers outside the Exchange. Thus the state should also regulate and oversee plans operating within the Exchange. To minimize the possibility of conflicting rules operating inside and outside the Exchange, the workgroup recommended that a state-based Exchange (if created), along with NCDOI, assume responsibility for plan management. In addition, the workgroup recommended that the Exchange rely on the NCDOI for several of the Exchange functions, including, but not limited to, rate approval, evaluation of plans against the QHP certification standards (e.g., accreditation, quality, etc.), analysis of data submitted to identify discriminatory benefit design, and market regulation, as NCDOI regularly performs these functions as part of it regulatory oversight of plans. This will help streamline the certification process, and reduce duplicative regulatory oversight of insurers.

The Exchange imposes new responsibilities that may not be fully addressed as part of the current NCDOI regulations. For example, the Exchange must establish network adequacy standards to ensure that the QHP offers a sufficient choice of providers.[64] If the state does not have its own network adequacy standards, the federal government will create standards for plans operating in the Exchange.[4] While NCDOI does not have specific network adequacy rules; it requires health plans with networks to develop their own standards and measures the plans against those standards.[65] Additionally, there are protections in place for consumers who are not able to access network providers.[66] Based on the final Exchange regulations, it appears that North Carolina's current network adequacy standards will be sufficient. If North Carolina's existing network adequacy requirements are not considered sufficient to meet federal requirements, the workgroup recommended that the state create its own specific network adequacy standards, as it has a better understanding of the availability of health care professionals and providers across the state, as well as consumer access issues reported through NCDOI. Absent adoption of statewide standards, the Exchange Board (if created) should have the authority to adopt standards for qualified health plans offered in the Exchange. In addition, the workgroup also recommended that the state assign quality ratings to the different plans, within the criteria established by the USDHHS. One of the advantages of having North Carolina assign quality ratings is that North Carolina would then have access to the underlying quality data. This would help ensure that the state has access to data that could drive state-level quality improvement activities, if it so chooses.

Eligibility for subsidy determinations. The workgroup recommended that a state-based Exchange take applications and help consumers with the verification process if questions arise. Workgroup members believed that this function could be handled better through a state-based Exchange that could more easily establish working relationships with community based organizations serving

as navigators, departments of social services, and local agents and brokers. Further, North Carolina should maintain its role in making final Medicaid/CHIP determinations, as the state is responsible for a share of the Medicaid and CHIP costs. While the workgroup members believed that the state should have primary responsibility for taking and processing the applications and making the final Medicaid/CHIP eligibility determinations, workgroup members did recommend that the federal government take the lead in determining eligibility for the premium tax credit and cost-sharing subsidies. Eligibility for the premium tax credit and cost- sharing subsidies is based on the IRS rules for MAGI. The IRS has responsibility for reconciling the amount of the premium tax credit that the individual received through the Exchange with the amount they are ultimately eligible to receive based on year-end taxes. As the IRS will be responsible for this reconciliation function, work group members thought it made more sense for the federal government to also make the initial eligibility decision about the premium tax credit and cost-sharing subsidy. Similarly, the workgroup members recommended that the federal government determine whether a person is exempt from the mandate, as for many people, the person's MAGI will be critical to this determination.

In addition, the workgroup recommended that the federal government assume responsibility for determining whether an employer is offering minimum essential coverage. In order to make this determination, the Exchange will need to obtain a copy of the employer's health plan offering to determine if the coverage meets the 60% actuarial value standard and whether the coverage is affordable to all of the full-time employees. The workgroup members believed it made more sense to let the federal government make this determination for North Carolina businesses, if this option is offered to states. This will be difficult for a state-based Exchange to determine, as it has no mechanism to collect health plan information from employers (particularly for self-funded employers). The federal government will need to collect this data in other states (for federally-facilitated Exchanges).

Enrollment. In general, the workgroup members recommended that the state-based Exchange maintain responsibility for enrolling and disenrolling people in QHPs. Workgroup members believed that a state-based Exchange could provide better customer service helping people enroll and disenroll. Further, the Exchange and NCDOI need data on enrollment and disenrollment as part of regulatory oversight. NCDOI needs to monitor plan growth to assure adequate reserves. Conversely, if too many people are disenrolling from a plan, it may be an indication of underlying quality or service problems necessitating Exchange or NCDOI review.

Financial management. Workgroup members supported having the state-based Exchange have primary responsibility for financial management of the Exchange, specifically setting and collecting any assessments. This option is only available if the state chooses to operate a state-based Exchange. CCIIO recently published guidance on the fees it will charge participating insurers to support the operational costs of the federally-facilitated Exchange.[67] In 2014, the proposed user fee is 3.5% of the premium costs for plans sold through the federally-facilitated Exchange; however, the final user fee may be changed to closer align with fees charged by other state-based Exchanges.[68] If the state operates the Exchange, it has greater control over the costs

of the Exchange and how the Exchange is financed. The operation of risk adjustment and reinsurance programs is also part of the financial management function. Due to their technical nature and impact both inside and outside the Exchange, these programs were discussed with NCDOI's TAG.[69]

Based on the HBE workgroup's analysis, the NCIOM recommended:

RECOMMENDATION 2.1: STATE AND FEDERAL EXCHANGE OPERATIONAL RESPONSIBILITIES

a) The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the Exchange Board is created, the Board should consider whether the state, or the federal government, is in the best position to:
   - **i. Determine eligibility for advance payment of the premium tax credit and cost-sharing subsidies**
   - **ii. Determine whether individuals are exempt from the coverage mandate**
   - **iii. Determine whether employers are offering coverage that meets minimum essential coverage.**

b) In making this determination, the Exchange Board should consider the costs of providing these functions through a state-based versus federally facilitated Exchange, which entity would be able to most effectively provide these services, and the impact of the decision on consumer access, consumer protections, and the rest of the North Carolina insurance marketplace.

QHP Certification Requirements

The workgroup also explored the issue of whether the Exchange should have any discretion to modify QHP participation requirements if necessary to enhance Exchange operations. Specifically, the workgroup explored the question of whether the Exchange Board should have the authority to: limit the number or type of plan designs, require insurers participating in the Exchange to offer all four tiers of health plans, require insurers to meet certain quality standards beyond what is already required in the ACA, or require insurers to meet additional requirements intended to foster innovation. The workgroup also discussed whether the Exchange should have the flexibility to give health plans more time to meet the ACA's accreditation standards, and whether the NCGA, NCDOI, or the Exchange should establish network adequacy standards.

With some caveats, the workgroup members reached consensus about giving the Exchange Board the authority to either impose new requirements or to incentivize health plans to meet additional standards if needed to improve plan competition, enhance the functioning of the Exchange, meet the needs of consumers, reduce adverse selection into the Exchange or among different insurers, or promote health plan innovation that could reduce costs or improve quality. However, HBE workgroup members only felt comfortable giving the Exchange Board the authority to impose additional requirements if the Board was broadly constituted and included representation from consumers, employers, insurers, agents, providers, and other knowledgeable individuals.

The workgroup was aware of the dramatic changes and considerable uncertainty that the Exchange environment poses to insurers in what is already a difficult market. Accordingly, the workgroup urged that the Exchange Board should pursue an "evolutionary approach" to the Exchange environment to the extent that the ACA permits. To this end, the workgroup urges (as noted later) that the board delay consideration of any additional or higher plan standards until 2016 (at the earliest), and that where possible, incentives be considered rather than mandates. Before imposing new requirements on health plans, the Exchange Board should consider the likely impact of those requirements on administrative costs and premiums, consumer choice (including the ability of consumers to understand and compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the Exchange, participation of health plans in the Exchange, appropriate competition among plans, adverse selection into the Exchange and/or among participating plans in the Exchange, the overall functioning of the Exchange, and the impact of any changes on the non-Exchange health insurance market.

Notwithstanding the above, the workgroup agreed that the Exchange Board should have the authority to standardize terminology, definitions, benefits design or array for QHPs offered in the Exchange in 2014 (or thereafter), if it is determined to be helpful to improve consumer understanding or more enlightened or comparable choice. Further, the workgroup recommended that the Exchange have the authority to limit the number of plan or benefit designs within each level that an individual insurer can offer, based on its judgment as to what best serves meaningful consumer engagement and choice, or improves competition among plans. In recommending that the Exchange Board have authority to limit benefit design, the workgroup was not recommending that the Exchange Board have the authority to limit differences in co-pays nor products that use different (more cost-effective or high performing) provider networks.

A more detailed description of the workgroup's recommendations is provided below.

Limiting the number or types of plan design. One of the advantages of the Exchange is providing consumers and small businesses with a choice of health plans—in terms of premium levels, out of pocket costs, and plan design. To facilitate meaningful choice, the Exchange website should have a good preference testing or sorting mechanism to help consumers first decide what decision elements are most important to them, and then to compare health plans. For example, the Exchange website should include, but not be limited to, sorting mechanisms based on premiums, deductibles, and other point-of-service cost sharing levels, participating providers, open or closed networks, and quality ratings. Even with a good sorting mechanism, workgroup members recognized that unlimited choice of different health plan designs may make the plan choice process difficult for consumers. Limiting the number of choices, standardizing terminology, definitions, and/or standardizing some of the plan designs can make it easier for consumers to make meaningful comparisons among health plans. Further, limiting the number of plan choices or variations could help spur competition in costs (rather than small variations in plan design) and would also help reduce administrative costs to the Exchange. However, if the Exchange imposed strict limits on the number or types of plan design, it could reduce consumer choice, and potentially create barriers to the introduction of innovative insurance models.

Thus, workgroup members recommended that the Exchange Board have the authority to standardize terminology, definitions, benefit design or array, or limit the number of choices or plan designs if needed to assure meaningful choice and proper functioning or based on consumer or employer feedback. The Exchange Board needs to balance any potential limits on the number or variety of health plans with: the need for a reasonable level of choice; ability to introduce more cost-effective or high performing insurance plans; and the need to increase meaningful competition based on value, quality, and/or cost among health plans. While the workgroup recognized that the Exchange Board may choose to limit the number or types of different health plans offered by any insurers, the group did not recommend that the Exchange exclude any insurer from participating in the Exchange if it otherwise met the certification requirements.

Require insurers participating in the Exchange to offer three or four of the metal plans. The ACA requires all issuers participating in the Exchange to offer the silver level plan (70% actuarial value), and the gold level plan (80% actuarial value). In addition, issuers can—but are not required to under the ACA— offer bronze level plans (60% actuarial value), or platinum level plans (90% actuarial value). Workgroup members discussed whether the Exchange Board should have the authority to require issuers to offer the bronze and/or the platinum level plans in addition to silver and gold to help maximize consumer and employer choice and mitigate risk segmentation across insurers. Requiring issuers to offer three or four levels of plans could limit participation among insurers (particularly small insurers who may have a harder time developing bronze or platinum level plans). Further, there are very few platinum level plans available in the commercial non-group market today; some workgroup members questioned the rationale of forcing insurers to offer plans that are not currently available in the commercial market. Richer benefit packages (e.g., platinum level plans) tend to attract people with more significant health problems. The ACA prohibits insurers from pricing plans based on the health status of the enrollees or an individual's utilization of health services. Thus, it is possible that the higher costs of people enrolled in the platinum level plans would be passed along in higher premiums for those who enroll in bronze, silver, or gold plans. Members also raised the concern that requiring health plans to offer all four levels could force insurers to offer uncompetitive plans to meet Exchange participation requirements but which would attract few enrollees. While there were significant concerns raised about requiring health plans to offer all four of the metal level plans, the workgroup members did reach consensus that the Exchange Board should have the authority to require health plans to offer 3 or 4 levels if needed to reduce risk segmentation across insurers or if needed to provide consumers and employers greater choice (based on consumer and employer feedback). This should not be a requirement for health plan participation in 2014; the earliest that the Board should be able to require this is 2016.

Require insurers participating in the Exchange to meet quality standards in addition to those required by the ACA or Secretary of the US DHHS. The ACA requires that all plans be accredited, implement a quality improvement strategy, report certain quality measures, and limit contracts to providers that meet specified quality standards.[70] Exchanges must assign a quality rating to each plan on the basis of relative quality and price.[71] The Secretary of USDHHS will establish standards for the quality rating system, and will also collect enrollee satisfaction information on all health plans.[72] In addition, the ACA directs the Secretary to develop strategies to further reward quality of care through market based incentives.[73]

The HBE workgroup discussed whether the Exchange should have the authority to impose any quality standards in addition to those standards specified in the statute. Workgroup members recognized that North Carolinians may have specific health problems that are not addressed as part of national quality standards. In addition, some members wanted the Exchange to have the authority to remove poor quality plans from the plan offerings, as low-quality, lower-cost plans could reduce the value of the advanceable premium subsidies. These workgroup members were concerned that if the lowest quality plans are also the lowest cost plans, and subsidies are set at the second lowest cost silver plan, many North Carolinians could be forced into lower quality plans because they may not be able to afford a higher quality plan. While some members of the group believed that the Exchange should have flexibility to require that insurers meet additional quality standards, the group could not reach consensus on this point.[74] Some members of the group argued that the federal standards will greatly enhance current quality standards, and that imposing additional requirements would increase costs to the plans. Instead, the group agreed that, beginning in 2016, the Exchange should have the authority to incentivize, rather than mandate, insurers to meet higher standards (for example, by giving those plans that meet the higher standard special recognition on the Exchange shop and compare website).

Require insurers participating in the Exchange to meet other requirements, such as customer service, improved health outcomes, or reduced costs, in addition to those required by the ACA or Secretary of the US DHHS. For the reasons stated above, the workgroup believed that, beginning in 2016, the Exchange should have the authority to incentivize health plans to meet higher standards, but not mandate any additional requirements in addition to those required under the ACA and supporting regulations.

Phasing in accreditation standards. The federal regulations give Exchanges the authority to establish the length of time in which an insurer must receive outside accreditation following initial certification in the Exchange.[75] The workgroup recommended that insurers be given two years to obtain accreditation if the insurer can show they are making reasonable progress towards that goal. Members were concerned that in the early years, the accreditation bodies may be overloaded with health plans seeking accreditation, and that this could slow down the normal accreditation process (typically 12-18 months). Therefore, the workgroup also recommended that the Exchange Board, in exceptional circumstances, have the flexibility to provide plans with additional time beyond two years to obtain initial accreditation.

Network adequacy standards. The federal regulations require that Exchanges establish network adequacy standards to ensure that enrollees have a sufficient choice of providers. The Secretary proposed that these standards be established at the state level, rather than at the federal level, because states have a better understanding of the geography, local patterns of care, array and distribution of health care professionals and providers, and market conditions.[76] Qualified health plans must meet the state established network adequacy standards.[77] If the state does not have or create a network adequacy standard that meets federal requirements, the federal government will do so. As noted earlier, North Carolina's existing procedures may be sufficient to meet the federal network adequacy standard. If not, the workgroup discussed whether the Exchange should establish standards for plans offered in the Exchange, or whether NCDOI should establish standards for all commercial insurers. The workgroup recommended that if needed, NCDOI establish objective minimum network adequacy standards that satisfy the requirements of the

ACA, and that these standards should be the same for plans operating inside and outside the Exchange. The workgroup also recommended that NCDOI include some flexibility in the network adequacy standards, if needed to test innovative or quality-driven delivery models. This issue of creating minimum network adequacy standards both inside and outside the Exchange was referred to the NCDOI TAG for further consideration.

Essential community providers. In addition to the network adequacy standards, the ACA requires health plans to contract with essential community provider (ECP) in order to be certified.[78] ECPS are providers that serve predominantly low-income, medically underserved communities. They include, but are not limited to federally qualified health centers (FQHCs), family planning entities receiving federal funds, Ryan White grantees, black lung clinics, comprehensive hemophilia diagnostic treatment centers, public health entities receiving funding for sexually transmitted diseases or tuberculosis, disproportionate share hospitals, children's hospitals, critical access hospitals, free standing cancer centers, rural referral centers, sole community hospitals, and other state agencies or nonprofits that provide the same types of services to the same population.[79] The intent of this provision is to "strengthen access in medically-underserved areas and for vulnerable populations,"[80] and link to the general network adequacy standards, which are intended to ensure that there are a sufficient number and types of providers to "assure that all services, including mental health and substance abuse services, will be accessible without unreasonable delay."[81] The final Exchange regulations state that a "QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards."[82] There are also special contracting and payment rules for contracts with Indian health providers.

While the ACA requires QHPs to contract with essential community providers, it also states that QHPs need not contract with ECPs if such provider refuses to accept the generally applicable payment rates.[83] However, the ACA includes special payment requirements for FQHCs. If the QHP contracts with FQHCs, it must pay FQHCs "not less than the amount of payment that would have been paid to the center [under Medicaid's prospective payment system rate] for such item or service,"[84] or another payment rate if mutually agreed upon by the FQHC and QHP, and at least equal to the generally applicable payment rate of the QHP.[85]

The workgroup members agreed that the Exchange Board should monitor this provision to ensure that low-income and other vulnerable populations have access to all services without unreasonable delay, and if necessary, further clarify how QHPs can meet this requirement.

After examining the different options, and assuming that the Exchange Board is broadly constituted with diverse membership, the NCIOM recommended:

RECOMMENDATION 2.2: HEALTH BENEFIT EXCHANGE BOARD AUTHORITY FOR EXCHANGE CERTIFICATION

a) The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority to:
   - **i. Require insurers offering qualified health plans in the Exchange to standardize terminology, definitions, benefit design or array, or limit the number of plan offerings or types of plan designs if needed to facilitate health plan selection or promote meaningful competition among insurers, but only after the Exchange determines that there is a reasonable level of choice in the Exchange market. Any restrictions in benefit design should not limit simple differences in co-pays or limit the use of products that use more cost-effective or high performing provider networks.**
   - **ii. Require that the insurers offer the bronze and/or the platinum level plan, in addition to the silver and gold level plans, if needed to reduce risk segmentation across insurers, and/or to give consumers and employers greater choice.**
   - **iii. Incentivize insurers to meet state set quality standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services (USDHHS).**
   - **iv. Incentivize insurers to meet other state standards, such as customer service, participation in health information technology, improved health outcomes, or reduced costs in addition to those required by the ACA or Secretary of the USDHHS.**

b) The Exchange Board should not have the authority to exclude insurers from participating in the Exchange if they otherwise meet the certification and other ACA requirements.

c) Aside from allowing the Exchange Board to standardize terminology, plan design, or limit the number of different plan designs per level (Sec. a.i. above), the Exchange Board should not impose any other new requirements earlier than 2016. Thereafter, before imposing new requirements on health plans, the Exchange Board should consider the likely impact of those requirements on the overall functioning of the Exchange, the needs of consumers and/or employers purchasing in the Exchange, administrative costs and premiums, consumer choice (including the ability of consumers to compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the Exchange, participation of health plans in the Exchange, adverse selection into the Exchange and/or among participating plans in the Exchange, and, in consultation with the North Carolina Department of Insurance, the impact of any changes on the health insurance market operating outside the Exchange.

d) The Exchange Board should give insurers applying to become qualified health plans that are not already accredited two years to meet the accreditation standards assuming that the insurer can show that it is making reasonable progress in obtaining accreditation. The Exchange Board can choose to extend this time for extenuating circumstances, for example, if the accreditation agencies are unable to make timely accreditation decisions.

RECOMMENDATION 2.3: DEVELOP OBJECTIVE NETWORK ADEQUACY STANDARDS
The North Carolina Department of Insurance should study and, if applicable, develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the Exchange. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

RECOMMENDATION 2.4: MONITOR ESSENTIAL COMMUNITY PROVIDER PROVISIONS
The Health Benefit Exchange Board, in collaboration with the North Carolina Department of Insurance, should monitor insurers' contracts with essential community providers to ensure that low-income and other vulnerable populations have reasonable and timely access to a broad range of providers. If necessary, the Exchange Board should provide additional guidance to insurers about what constitutes a sufficient number or reasonable geographic distribution necessary to meet this requirement for qualified health plans offered in the Exchange, and/or provide incentives to encourage insurers to contract with a greater number of essential community providers.

After the work of the NCIOM HBE workgroup was completed, the NCDOI TAG considered and made recommendations to the NCDOI about how to operationalize the essential community provider provisions. Summaries of the NCDOI TAG recommendations and deliberations are available on the NCDOI website: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx.

Exchange Sustainability Options
Federal funding necessary to create and operate a state-based Exchange is only available through the first year of operations (2014 if the Exchange is state-based in the first year). Thereafter, the Exchange must be fully self-sufficient at the state-level. The ACA identifies certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[86] The federal regulations parallel the statutory requirements by noting that states may fund Exchange operations by charging assessments or user fees on participating insurers, or otherwise generate funding for Exchange operations.[87] As noted earlier, HHS proposed rules state that HHS will charge a user fee of 3.5% of premium costs for plans sold in the federally-facilitated Exchange in 2014.[88]

Milliman Inc. prepared a preliminary estimate of the ongoing operational costs beginning in 2014 of a North Carolina state-based Exchange. Milliman estimated that the North Carolina Exchange operations would cost approximately $23.8 million in 2014, $25 million in 2015, and $26.7 million in 2016.[17] This equates to roughly 0.5% of Exchange premiums in 2014. The Milliman estimates were among the first estimates developed across the country, and did not reflect subsequent regulations and guidance or the experiences of some of the early adopter states. In addition, Milliman's estimates do not include the initial start-up costs. The estimates were based on the Exchange providing bare minimum services, including functions related to Exchange operations (such as plan administration, call center, eligibility processing, enrollment reporting, and plan performance and quality reporting), marketing (including Exchange

marketing, navigator program, outreach and education, and public relations), information systems, and finance (including actuarial analysis, accounting/financial reporting, and infrastructure).

Milliman noted, however, that this estimate could change depending on the Exchange's design and operational features. Because Milliman prepared its estimate before the preliminary regulations were issued, it did not include all of the Exchange operational requirements specified in the federal regulations. For example, the Milliman estimate does not include the costs of premium aggregation for small businesses (an Exchange requirement specified in the federal regulations). Further, the HBE workgroup was concerned that some of the estimates may be too low—including the estimates of the volume and duration of calls which the call center would field in the initial years.

NCDOI asked one of its consultants, Public Consulting Group (PCG), to examine Milliman's initial assumptions underlying their estimates in light of the new guidance the state received from the federal government. In addition, PCG was asked to examine other states' Exchange cost estimates. Table 2.5 reflects the information provided to the HBE workgroup from PCG.

Table 2.5
Comparison of North Carolina Estimated Exchange Costs with Other States

	NC	IL	MA	DE	WY	MD	AL
Estimated Administrative Costs	$25.2 M	$56.2M	$27.5M	$7.8M	$4.2M	$41.8M	$44.5M
Average Estimated Enrollment*	807,212	589,000	190,000	66,433	30,500	312,244	330,000
Per Member Per Month Cost	$2.60	$7.95	$12.04	$9.74	$11.46	$11.16	$11.24

*The estimated enrollment was not reported consistently across states. Some states provided estimated enrollment for one year, others for multiple years. Thus, PCG produced an average estimated enrollment for each state. In North Carolina, for example, enrollment was averaged over three years (2014-2016).

PCG cautioned that it was difficult to compare the Exchange cost estimates across states, as the states did not include all the same expenses in their estimates. For example, some of the states included the IT costs, whereas others did not. Nonetheless, North Carolina's Exchange operational expenses appear to be disproportionately lower than other states, after adjusting for expected enrollment. The average of the other states that were reviewed was approximately $10 per member per month, whereas the Milliman cost estimate for North Carolina was only $2.60 per member per month. NCDOI is working with PCG to develop a more detailed cost estimate as part of its current grant activities.

In order to obtain a Level II grant, the state must have a detailed budget and plans to assure financial self-sufficiency in 2015. Thus, the workgroup examined options for different ways to raise the necessary revenues to support the Exchange operations. The group recommended that any new premium tax revenues generated as a result of the implementation of the ACA be put into a trust fund and designated for the Exchange operations. This would include premium tax

dollars raised as a result of the new people gaining coverage as well as the increase in costs of health insurance premiums due to ACA implementation.

Currently, all insurers pay a 1.9% premium tax. Aggregate health insurance premiums are expected to increase significantly in 2014 as a result of the ACA, resulting in more premium tax revenue than would otherwise be expected. This is the result of several factors. First, Milliman estimated that approximately 350,000 more people will have commercial health insurance coverage in 2014 relative to the number that would have been covered in 2014 absent the ACA. Second, Milliman estimated that average fully-insured health insurance premiums across the individual and group markets would increase by 16.5% from 2013 to 2014. This is about 6% higher than what would have been expected if the ACA were not in place. The increase in average health insurance premiums over and above the usual expected annual increase is primarily a result of changes in the individual market. These changes include the coverage of additional benefits, as well as insurance reforms that will lead to a disproportionate number of higher cost individuals entering the market in 2014. These changes include guaranteed issue requirements, elimination of medical underwriting, and the provision of subsidies to make health insurance more affordable.

The workgroup recommended that the annual increase in premium tax revenue resulting from the expected annual increase in premiums over the baseline year of 2013 that would have occurred in the absence of the ACA would go into the state's General Funds. However, the increase due to implementation of the ACA should be set aside into the Exchange Trust Fund starting in 2014. Based on the average premium and enrollment estimates from Milliman, the increase in premium tax revenues in 2014 attributable to the ACA is estimated to be approximately $62 million.[89] Note that Milliman's estimates were not expressly prepared for the purpose of calculating premium tax revenue, and estimates are very sensitive to the assumptions. For example, if there are only 200,000 new entrants to the individual market in 2014 as a result of the ACA, the premium tax revenue increase would be only $41 million (assuming no change to average premiums in the individual market Exchange).

Capturing the increase in premium tax revenues from 2013 as a result of the new ACA coverage requirements is similar to the process that the NCGA established when it created Inclusive Health, North Carolina's high risk pool. The NCGA created a special trust fund and deposited an amount equal to the growth in net revenue from the increase in all premium taxes collected between SFYs 2007 and 2008.[90] For the first two years, the North Carolina Health Insurance Risk Pool received 100% of the growth in premium tax revenues collected (above what the state had collected in SFY 2007). Beginning in SFY 2010, the High Risk Pool only received 30% of the increase. The high risk pool funds have come from existing premium tax revenues.

In contrast, the HBE workgroup recommended that the Exchange receive only the new health insurance premium tax revenues generated as a result in the growth in the number of covered lives and the increase in costs of health insurance premiums due to the ACA over the 2013 baseline year. Because of the concern that this may not prove adequate to meet the Exchange's budget requirements, the HBE workgroup also recommended that the NCGA pass through the revenues it uses to support Inclusive Health. After the workgroup finished its work, staff at Inclusive Health reported that they did not receive any premium payment support in SFY 2012

because premium collections for all types of insurance products collected that year were less than the base fiscal year amount from 2006-2007.[91] First quarter SFY 2013 projections are comparable to SFY 2012 projections, which means that it is unclear there will be any payment in SFY 2013. Beginning in 2014, individuals who were receiving coverage through the state or federal high risk pool will gain coverage through the Exchange. Inclusive Health will no longer be needed to provide coverage to these high risk individuals. Thus, any remaining funds should be transferred to the Exchange to support operations, net the reserves needed to pay outstanding health bills.

One of the primary advantages of financing the Exchange operational costs through the premium tax dollars is that this financing structure is already in place. Most of the initial financing will come from the increase in covered lives, which was unlikely to occur absent the ACA coverage and financing provisions. The workgroup believed that another potential advantage would be that the federal government could cover much of this cost for those who are eligible for the premium tax credit. As noted earlier, people who are eligible for subsidies pay premiums based on their income (e.g., not based directly on the costs of the premiums). The federal government subsidizes the difference between the individual's required premium (as a percentage of their income) and the second lowest cost silver plan. Effectively, this means that the federal government will pay for the increase in premium costs associated with the premium tax (for those eligible for the subsidy).

Workgroup members recognized that the funding resulting from any increase in health insurance premium tax revenue could be highly variable, and funding levels would be dependent on some market forces outside the control of the Exchange. Thus, workgroup members also recommended that the Exchange be given other mechanisms to raise needed funding if the Exchange trust fund does not generate sufficient revenues to cover the Exchange's operational expenses from the premium taxes.

The workgroup members recognized that there were advantages and disadvantages of different financing mechanisms. For example:

- *Advertising fees*. These fees may not generate significant revenues. Further, the administrative costs of collecting and selling advertising would reduce the revenues that could be used for Exchange operations. In addition, advertising health plans that were offered through the Exchange could reduce the effectiveness of the Exchange shop and compare website, if consumers are given the impression that the website is trying to promote one plan over another. Thus before accepting advertising revenues, the Exchange board should establish criteria for the types and placement display of potential advertising.
- *User fees on insurers operating within the Exchange*. Workgroup members discussed the imposition of additional user fees on insurers operating within the Exchange. Some members were concerned that adding additional user fees on insurers offering coverage within the Exchange might discourage health plans from participating in the Exchange (depending on the size of the user fee). In addition, because insurers are required to charge the same premium for health plans offered inside and outside the Exchange, an additional user fee charged to health plans operating in the Exchange might result in

higher premiums outside the Exchange. On the other hand, it is possible that imposing an additional fee on insurers would be built into the premium costs, and therefore passed onto the federal government for people eligible for a subsidy. The workgroup members also discussed the possibility of charging additional user fees on health plans that offer more than a specified level of health plan options per level, in order to discourage insurers from offering large numbers of plan designs in each level. The additional fees would also help offset the additional administrative costs in certifying and overseeing all of the new plans offered within the Exchange.

- *User fees on individuals purchasing within the Exchange*. Workgroup members also discussed the possibility of charging a user fee to individuals who purchased coverage within the Exchange, if allowed under federal law. However, workgroup members were concerned that imposing a fee on users in the Exchange would discourage people from purchasing coverage in the Exchange. Further, many individuals could be gaining the benefits of the Exchange (for example, by using the shop and compare website to examine the costs and quality of different health plans), even if they ultimately choose to purchase coverage outside the Exchange. Thus, workgroup members also discussed the option to charge fees for individuals both inside and outside the Exchange.
- *Foundation funding*. The Exchange should have the authority to seek foundation or other funding, particularly in the first few years, to support navigator grants (see discussion of navigators below). However, the workgroup members did not believe the Exchange should rely on foundation funding to support ongoing operational expenses, as foundation funding is typically time limited.

After considering the different financing mechanisms, the workgroup members recommended that the Exchange Board be given the authority to exercise different options to help pay for reasonable operational costs. Most, if not all of the funding should come through the premium tax revenues. If that was insufficient, then the Exchange Board should have the authority to allow advertising or charge user fees on insurers or individuals. The workgroup was also supportive of using any of the funds that may remain in the Inclusive Health Trust Fund after it closes down operations for Exchange operational costs.

Thus, the NCIOM recommended:

RECOMMENDATION 2.5: ENSURE HEALTH BENEFITS EXCHANGE FINANCIAL SUSTAINABILITY

a) The North Carolina General Assembly (NCGA) should establish an Exchange Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the Exchange Trust Fund to pay for reasonable Exchange operations.
   - **i. The trust fund should include premium tax revenues generated as a result of the increase in the number of people who purchase health insurance coverage inside and outside the Exchange from a base year of 2013.**
   - **ii. The trust fund should include the premium tax revenues generated as a result of the increase in the costs of the premium due to the implementation of the ACA.**

b) The NCGA should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the Exchange Trust Fund.

c) The NCGA should give the Exchange Board the authority to raise other revenues if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for the reasonable Exchange operations. These additional revenue sources should include, but not be limited to:

- **i. Fees on individuals or insurers who offer or purchase coverage in the Exchange, up to a maximum threshold established by the NCGA.**
- **ii. Fees on insurers who offer more than a specified number of health plans per level.**
- **iii. Advertising revenues.**
- **iv. Grants from foundations or other philanthropic sources.**

Education, Outreach, Navigators, and Enrollment Assistance

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. There are separate, but similar, requirements for the Exchange and Medicaid agency. At the very general level, the Exchange and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll. To make it easier for people to apply, the ACA and federal regulations specify that people can apply online, in person, by telephone, or by fax.[92,93] Individuals can always seek informal help from family or friends. However, the ACA also envisions that there will be other sources of trained enrollment counselors such as In-Person Assisters, Navigators, DSS workers, agents and/or brokers. Subsequent to the work of the HBE workgroup, the federal government also gave states that will be providing consumer assistance under a partnership option the authority to train and pay in-person assisters. This is discussed in more detail below. Further, the new law creates a "no wrong door" enrollment process. Individuals can apply directly to the Exchange, and if eligible for Medicaid or CHIP, enroll directly into those programs, and conversely, people can apply for Medicaid or CHIP, and if ineligible, be screened and, if eligible, enrolled into a QHP in the Exchange.

The HBE workgroup created a subcommittee to consider education and outreach efforts; training for nonprofits and other groups who can refer individuals to appropriate assistance; navigator training, certification, compensation and accountability; the role of agents and brokers; and how to create the "no wrong door" eligibility and enrollment process. The subcommittee reported its recommendations to the full committee.

Education and Outreach. The Exchange is required to conduct education and outreach to inform the public about the Exchange.[94] In addition, the Exchange must provide for the operation of a toll-free hotline to answer questions and help people enroll.[95] The ACA also imposes new outreach requirements on state Medicaid agencies. The agency is required to conduct outreach to vulnerable populations "including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS."[96]

The HBE workgroup recognized that the Exchange might need to enlist the support of different groups to provide education and outreach to the nongroup market and the small group market. For example, while nonprofits, human services agencies, community-based organizations, and

faith groups may be enlisted to provide education and outreach to individuals, the Exchange may need to enlist the support of Chambers of Commerce, professional associations, small business resource centers, community banks, or other organizations to reach small businesses.

Regardless of what organization or entity provides the education and outreach, the HBE workgroup recommended that these organizations receive similar information so that there is a consistent message about new potential insurance opportunities. The HBE workgroup recognized that these materials may need to be tailored somewhat to a specific target audience, but the underlying information should be similar regardless of the audience. Therefore, the HBE workgroup recommended that the Exchange work with the NCDOI, North Carolina Division of Medical Assistance (DMA), and other appropriate organizations to develop a standardized community outreach and education toolkit so that interested organizations and individuals can disseminate similar outreach and education materials. The toolkit should provide basic information about public insurance options (including Medicaid and North Carolina Health Choice), nongroup coverage available through the Exchange, eligibility for the premium tax credit and cost-sharing subsidies, different insurance options for small businesses, the small business tax credit, the eligibility and enrollment website, and appropriate referral sources where people can get individualized help with eligibility, enrollment, and other insurance issues.

General training. As noted earlier, individuals can seek help in the enrollment process from many different sources. Individuals can obtain help from certified navigators, in-person assisters, agents, or brokers (discussed more fully below). However, an individual can seek help from other sources as well. The new federal regulations state that the Exchange must accept applications from the applicant, an authorized representative, or someone acting responsibly on behalf of the applicant.[97]

The HBE workgroup recognized that some individuals will first learn of the new insurance options through their health care providers or through other nonprofit or community-based organizations. It is important to offer basic training to these organizations so that they understand the new insurance options and can make appropriate referrals. Thus, the HBE workgroup recommended that the Exchange, in conjunction with NCDOI and DMA, offer workshops or other training opportunities to provide basic information about public and private insurance options, the Exchange website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

To implement the information, outreach, and assistance provisions of the ACA, the HBE workgroup recommended:

RECOMMENDATION 2.6. HEALTH BENEFITS EXCHANGE OUTREACH AND EDUCATION

a) The Health Benefits Exchange (Exchange), in conjunction with the North Carolina Department of Insurance (NCDOI), North Carolina Division of Medical Assistance (DMA), and other appropriate organizations, should develop a standardized community outreach and education toolkit so that interested organizations and individuals can disseminate similar outreach and education materials. The toolkit should provide basic information about public insurance options (including Medicaid and North Carolina Health Choice), nongroup coverage available through the

Exchange, eligibility for the premium tax credit and cost-sharing subsidies, different insurance options for small businesses, the small business tax credit, the computerized eligibility and enrollment system, and appropriate referral sources where people can get individualized help with eligibility, enrollment, and other insurance issues.

b) The Exchange, in conjunction with the NCDOI and DMA, should offer workshops and other training opportunities to other groups, including providers, nonprofits and community-based organizations to provide basic information about public and private insurance options, the Exchange website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

Navigators. The ACA requires the Exchange to provide grants to navigator *entities* to help people understand their insurance options and enroll into coverage in the Exchange. To be eligible to receive a grant, the navigator entity must have existing relationships or show that they can establish relationships with individuals or small businesses likely to enroll in a QHP.[98] The regulations clarify that the Exchange must contract with at least two of the following categories of eligible *navigator entities* to receive the navigator grants, including: consumer and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry organizations, ranching and farming organizations; chambers of commerce; unions; resource partners of the Small Business Administration; licensed agents and brokers (if they do not receive compensation directly or indirectly from insurers); and other public or private entities which may include Indian tribes, tribal organizations, and state or local human service agencies.[99]

The HBE workgroup recognized that there is a difference between "navigator entities" and individual navigators. Navigator entities are organizations that can serve as local coordinating bodies—working with and overseeing the work of individually trained navigators. For example, a community-based organization may serve as the navigator entity and receive a small navigator grant to help pay for operational expenses (see navigator compensation discussion, below). This entity would serve as the coordinating body for individuals who are trained and certified as navigators. The individual navigators may or may not work for the navigator entities. Navigators are best suited to work with individuals in the nongroup market. As discussed more fully below, the HBE workgroup recommended that small groups that seek information or enrollment assistance be channeled to licensed agents or brokers.

The state or Exchange can establish licensure or certification requirements for individual navigators. Navigators must be able to provide impartial information about different health plans, and, therefore, cannot have a conflict of interest.

Navigators must be able to perform specific responsibilities:

- Conduct public education activities to educate the public about coverage offered through the Exchange.
- Distribute fair and impartial information about enrollment into QHPs, and the subsidies available through the Exchange.
- Help people with enrollment into qualified health plans.

- Provide referrals to applicable health insurance consumer assistance, ombudsman programs, or other appropriate state agency or agencies that can address consumer questions or complaints.
- Provide information in a manner that is culturally and linguistically accessible.[100]

The HBE workgroup used NCDOI's Seniors' Health Insurance Information Program (SHIIP) as a successful example of a navigator program. SHIIP counselors help provide information to older adults and people with disabilities about Medicare, Medicare Advantage plans, Medicare supplement plans, Medicare Prescription Drug Plans, and long-term care insurance. NCDOI contracts with 109 SHIIP coordinating organizations across the state. These organizations help coordinate the work of more than 900 volunteer SHIIP counselors. To serve as SHIIP counselor, individuals must complete required training and pass a competency exam. Currently, the training is provided online, includes 13 different modules, and takes approximately 24 hours to complete. SHIIP counselors must also meet continuing education requirements, and be recertified annually. Individual SHIIP counselors must also report certain information to NCDOI and must meet minimum activity thresholds (such as providing a minimum number of one-on-one counseling sessions) to be recertified. SHIIP also has a complaint system so that people can provide feedback to NCDOI about specific SHIIP counselors, and individual volunteers can be terminated for cause. SHIIP counselors may not provide advice to individuals about plan selection, they only provide information so that individuals can make their own choice of Medicare Advantage, Medicare Prescription Drug Plans, Medicare supplement, or long-term care insurance plans.

Individual Exchange navigators will play a similar role to SHIIP counselors. They will help individuals and families understand plan options, insurance concepts, and how to access and navigate the website (including sorting plans on the basis of premiums, cost sharing, providers, quality, or other factors important to the individual consumers). However, navigators—like SHIIP counselors—are not licensed to provide advice on plan selection. Thus, navigators can help individuals understand their plan choices, but should not offer advice or steer the individual or family to a particular health plan. If an individual or family needs help selecting a health plan, then that person should be referred to a licensed agent or broker.

In order to ensure that individual Exchange navigators have the training and competency to assist individuals in understanding their plan choice, the HBE workgroup recommended that the Exchange contract with NCDOI to develop a process for training and certifying navigators, including the requirement to pass a competency exam. Navigators should be required to complete continuing education requirements and meet minimum activity thresholds. In addition, navigators should be required to provide certain information to the state, including, but not limited to, information on the number of people served and types of services provided. Navigators should be required to meet these requirements—including continuing education, minimum activity thresholds, and reporting, to obtain their annual recertification. Navigator entities should have a designated person who serves as the navigator coordinator. These coordinators must also be certified as navigators, but will have additional responsibilities and training to serve as the coordinator and oversee the work of individual navigators.

As noted earlier, the ACA requires navigators to give impartial information and advice. To ensure that navigators can provide impartial information, the ACA directs the Exchange to have procedures to avoid "conflicts of interest." Neither the ACA nor the draft regulations give additional detail about how to avoid conflicts of interest, except that individuals may not directly or indirectly receive compensation from health plans. Further, there are very specific rules about potential conflicts of interest for agents and brokers (discussed more fully below). Thus the HBE workgroup discussed mechanisms to prevent navigator conflicts of interest that could inappropriately steer people towards a specific health plan.

Both the safety net workgroup (see Recommendation 4.4 in Chapter 4) and members of the HBE workgroup recognized the important role that safety net organizations could play in helping the uninsured enroll in appropriate health plans. Thus, the workgroup was concerned about creating too strict a definition of conflict of interest that could preclude staff from safety net organizations from serving as certified navigators. The workgroup recommended that the Exchange create conflict of interest rules that would preclude an *entity* from serving as a coordinating navigator entity if they would derive financial benefit from steering an individual to a particular health plan or health insurer. Under this definition, any health care provider that receives differential reimbursement from different insurers would not be eligible to serve as a certified navigator entity or receive navigator funding. However, it was acknowledged that there may be certain situations where the employees of these provider organizations could appropriately serve as certified navigators, such as those who work for: (1) safety net providers such as free clinics, FQHCs, rural health clinics, and health departments that provide primary care services to the uninsured and other vulnerable populations; and (2) hospitals or other types of health care organizations in rural or other underserved communities if the Exchange or NCDOI certifies that there are insufficient navigators in those communities to meet the need for navigator services and that additional capacity is needed. Employees of these organizations or other individuals can serve as individual navigators as long as the individual, and his or her immediate family members do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not based on the health plans which individuals select. The Exchange should adopt rules, guidance, education, and conflict of interest disclosure requirements, and should specifically monitor these provider-linked navigators to ensure that they comply with the ACA's prohibitions against steering patients to particular plans.

While the Exchange is required to provide grants to navigator entities, the Exchange may not use federal funds that the state received to establish the Exchange for that purpose.[101] The prohibition on the use of federal funds will cause difficulties in the first few years of Exchange operations. The Exchange will begin to accept applications in October 2013, for initial enrollment on January 1, 2014. The federal regulations specified that the initial enrollment period will run from October 1, 2013 to March 31, 2014.[102] The Level II federal Exchange grant can only be used to pay for all of the initial Exchange set up and operational costs through the first year of operation. Depending on the funding source, the Exchange may not have separate operational funds until 2014 (at the earliest) or 2015. Thus, while the ACA and accompanying regulations require the Exchange to provide grants to navigator entities, it restricts the use of federal funds for this purpose.

The HBE workgroup discussed possible funding sources for the first two years, as well as ways of structuring grants to navigator entities. Although the Exchange cannot use federal funds to pay for navigator services, it can use Level II federal funds to develop the navigator training and certification. In addition, outreach and educational expenses are legitimate uses of Exchange funding. Thus the workgroup recommended that the Exchange use federal funds to pay for training, continuing education, and certification. In addition, the Exchange should provide small grants to community-based organizations, social services agencies, professional associations, navigator entities, and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers. The Exchange Board should also seek funding from state philanthropic organizations or other sources to help pay small grants to navigator entities to help offset the administrative costs to coordinate and oversee the work of local navigators. Initially, the Exchange should pay each navigator coordinating entity a flat rate, based on size of the targeted population. After the first year, however, the navigator grants should be based, in part, on outcomes so that navigator entities are rewarded for doing a good job with education, outreach, and enrollment facilitation. The workgroup suggested that the Exchange Board explore the question about whether individual navigators should receive any compensation for their services.

The federal government will contract with navigators under a federally-facilitated Exchange or a partnership plan. However, states that run their own Exchange or choose to assume the consumer assistance functions, under a partnership plan, can train and contract with "in-person assisters." For all ostensible purposes, "in-person assisters" will play a similar role as navigators. However, the states can use federal grant funds to help pay for in-person assisters as part of the general outreach and education function. NCDOI plans on developing a training and certification program for in-person assisters under the federal partnership model. This training and certification program will be modeled on the NCDOI successful NC SHIIP program, and will follow the recommendations set out in this chapter. NCDOI plans to contract with intermediary assister organizations or administrative entities, which will have the responsibility for identifying and monitoring the work of in-person assisters across the state.

Thus, to ensure that the state operate an effective navigator and/or in-person assister program, the NCIOM recommended:

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS/IN-PERSON ASSISTERS

a) **The Health Benefit Exchange (Exchange) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator/in-person assister program. In the absence of a state-based Exchange, NCDOI should develop and oversee an in-person assister program that meets the same functions.**
    i. **The NCDOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators or in-person assisters.**
    ii. **Individual navigators/in-person assisters should be recertified annually. To be recertified, the navigator/in-person assister should be required to:**
        A. **Complete continuing education requirements and meet minimum activity thresholds, as specified by the NCDOI, in conjunction with the Exchange.**

B. **Provide data to the state to ensure the overall functioning of the navigator/in-person assister system. Such data may include, but not be limited to, information on the number of people served and types of services provided.**

C. **Be connected to a specific navigator/in-person assister administrative entity.**

iii. **Individual navigators/in-person assisters can be terminated for cause.**

iv. **Navigator or in-person assister administrative entities should have a designated person who serves as the navigator/in-person assister coordinator. These coordinators must also be certified as navigators/in-person assisters, but will have additional responsibilities and training to serve as a coordinator and oversee the work of individual navigators/in-person assisters in their community.**

b) The Exchange Board (or NCDOI under a partnership model) shall create strong conflict of interest rules for individual navigators/in-person assisters and navigator/in-person assister administrative entities. The conflict of interest rules should:

i. **Preclude navigator/in-person assister administrative entities from serving as a coordinating entity if they would derive financial benefit from steering an individual to a particular health plan or health insurer.**

ii. **Allow employees of primary care safety net organizations (e.g., FQHCs, free clinics, rural health clinics, or health departments) or other individuals to serve as individual navigators/in-person assisters as long as the individuals, and their immediate families, do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not directly or indirectly based on the health plans which the individual selects. The Exchange Board can allow employees of hospitals or other health care organizations to serve as navigators/in-person assisters in rural or other underserved communities, but only if the Exchange Board certifies that there is insufficient navigator/in-person assister capacity in those communities to meet the needs of individuals seeking navigator/in-person assister assistance. The Exchange should adopt rules, guidance, education, and conflict of interest disclosure requirements, as well as reporting requirements, and should specifically monitor these provider-linked navigators/in-person assisters to ensure that they comply with the ACA's prohibitions against steering patients to particular plans.**

c) If allowed by the federal government, the Exchange Board/NCDOI should use federal funds to help pay for training, continuing education, and certification of individual navigator/in-person assister and navigator/in-person assister administrative entities. In addition, the Exchange should provide small grants to community-based organizations, social services agencies, professional associations, navigator/in-person assister administrative entities and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers.

d) The Exchange Board/NCDOI should seek funding from state philanthropic organizations or other sources to help pay small grants to navigator/in-person assister administrative entities to help offset the administrative costs to coordinate and oversee the work of local navigators/in-person assisters.

i. **In 2013, the Exchange/NCDOI should pay each navigator/in-person assister administrative entity a flat rate based on size of the targeted population.**

ii. **Thereafter, the navigator/in-person assister grants should be based, in part, on outcomes so that navigator/in-person assister administrative entities are rewarded for doing a good job with education, outreach, and enrollment facilitation.**

iii. **The Exchange Board/NCDOI may explore the option of compensating individual navigators/in person asssiter for their services.**

Agents and brokers. Agents, brokers, or other people who receive compensation directly or indirectly from insurers may not serve as navigators/in-person assisters, although the state or Exchange can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the Exchange.[103] However, agents and brokers also need training to help enroll individuals, small businesses, or their employees into a qualified health plan offered through the Exchange. Agents and brokers need to understand the different insurance affordability programs (including Medicaid, CHIP, and the insurance subsidies offered through the Exchange). In addition, agents and brokers need to understand the small business tax credit available through the Exchange. Thus, the workgroup recommended that agents and brokers receive training, be certified, and subject to continuing education requirements in order to be allowed to enroll individuals or small businesses into coverage offered through the Exchange.

Agents and brokers are in the best position to provide information and advice to small employers, as employers need to weigh many factors in deciding whether to offer health insurance coverage and what type of coverage to offer. For example, businesses need to understand the financial implications of offering group health insurance coverage in terms of tax deductibility. Businesses also need to consider whether to offer health insurance through a Section 125 plan, and whether it is more advantageous to purchase health insurance inside or outside the Exchange. And businesses need to understand the implications of whether to offer their employees one plan or a choice of plans in a particular level. Agents are licensed to sell health insurance coverage outside the Exchange, and many will also receive the training and certification to sell coverage inside the Exchange. Navigators/in-person assisters will not be trained to provide this level of information. Thus, the workgroup recommended that small employers who need more information or advice should be funneled to an agent or broker rather than a navigator/in-person assister.

While HBE workgroup members recommended that small businesses generally be referred to agents for assistance, the workgroup did recognize that there are some concerns in relying primarily on agents and brokers to service small employer groups. The ACA is very specific on reducing conflicts of interest among navigators, but the law does not specifically prohibit conflicts of interest if the agent/broker is not compensated as a navigator. Currently, there are many different ways in which agents and brokers are either directly, or indirectly, encouraged to steer clients to specific insurers. For example, carriers often limit the number of agents or brokers they appoint to represent them. As a result, agents can be "captive" to a particular insurer or group of insurers. Agents who are captive can only sell products for those specific insurers. Other agents are independent, but may still have a financial incentive to steer clients to a specific insurer. For example, some insurers pay higher commissions after an agent or broker places a certain level of business in that company.

Further, typical compensation arrangements make it financially prohibitive for agents and brokers to service the smallest employer groups (i.e., those with <10 employees). It often costs more to agents and brokers and insurers on a per person basis to provide services to small groups, as there are certain fixed costs that are spread among a smaller group of covered lives. In addition, small groups generally lack human resource staff, so look to agents and brokers to handle many of the functions that larger organizations handle internally. If agents or brokers are

paid a flat commission per covered life, the aggregate fee may be insufficient to cover the costs of servicing these small groups. To make it more difficult, some insurers pay agents or brokers progressively higher commissions, depending on the size of the group. The workgroup discussed the possibility of paying agents and brokers more for smaller groups, recognizing the higher costs in providing services to small employers. However, if insurers pay higher commissions for some groups over others, the additional commission rate will be spread over all of the insurers' small group business as insurers must essentially charge the same premium for different small businesses. (Beginning in 2014, insurers can only vary rates based on age and family composition of the covered individuals and geography. Insurers may not charge differential premiums based on differences in administrative expenses of covering different small employer groups).

Just as the HBE workgroup wanted to minimize the potential conflict of interest of individual navigators/in-person assisters or navigator/in-person assister administrative entities, the group wanted to also minimize the potential conflict of interest among agents who place business in the Exchange. In addition, the workgroup wanted to ensure that agents and brokers are adequately compensated for working with the smallest employers, as these groups are the least likely to currently offer coverage and often need more help in understanding their different insurance options operating inside and outside the Exchange. The workgroup made a number of recommendations to address these potential problems. First, the Exchange should not refer small businesses to agents or brokers who are "captive" agents, or who are restricted to selling certain limited number of plans. In addition, the HBE workgroup recommended that agents disclose if they receive differential commissions from different insurers.

In addition, the workgroup wanted to ensure that agents and brokers have no disincentive to place business in the Exchange. Thus, the HBE workgroup recommended that NCDOI require insurers to pay agents and brokers the same commission, whether placing business inside or outside the Exchange. The workgroup also recommended that the NCDOI, in conjunction with the Exchange, examine other options to reduce potential conflicts of interest—such as paying agents or brokers a standard amount per enrollee regardless of the insurer, and paying the same rate for individuals enrolled in nongroup coverage as for employees enrolled in a group health plan.

To encourage agents and brokers to educate and enroll small businesses that had not previously offered insurance coverage, the workgroup recommended that NCDOI and the Exchange examine whether agents should be paid differentially for enrolling small businesses that have not offered health insurance coverage within the last six months. The workgroup also recommended that the NCDOI and Exchange examine whether agents and brokers should be paid a higher rate per person for the smallest groups, and a lower rate per person as the size of the employer increases. Many of the above issues related to agents and brokers have been addressed by NCDOI's TAG, and information about the discussion and recommendations is available on the NCDOI website.[104]

The HBE workgroup also discussed barriers which discourage small businesses from offering coverage to their employees. The cost of health insurance coverage is typically cited as the primary barrier to offering coverage. However, some small businesses have difficulty meeting

insurers' minimum participation rates. Under current law, insurers set minimum participation rates—for example, that 75% of eligible employees must enroll in the insurance coverage—to prevent adverse selection into the plan. The ACA allows the SHOP to set minimum participation requirements for group coverage.[105] Some of the HBE workgroup members argued that there was less need to set minimum participation rates after the ACA is fully implemented, as more people will have insurance coverage and, therefore, there will be less possibility of adverse selection. Others argued that the mandatory insurance coverage provisions apply in the nongroup market, but do not change the dynamics in the small group market as small employers with fewer than 50 full time equivalent employees are not required to offer coverage. Thus, there is still a need for minimum participation rates to prevent adverse selection. Because this was an issue that affected small groups both inside and outside the Exchange, the workgroup recommended that the NCDOI TAG consider whether the state should eliminate minimum participation requirements.

To address these concerns, the NCIOM recommended:

RECOMMENDATION 2.8. REQUIREMENTS FOR AGENTS AND BROKERS SELLING COVERAGE IN THE EXCHANGE

- **a) The Health Benefits Exchange (Exchange)Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the Exchange.**
  - **i. The Exchange should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The training and certification should include, but not be limited to, information about the different insurance affordability programs (including Medicaid, CHIP, and insurance subsidies offered through the Exchange), how to use the Exchange website, and the small business tax credit.**
  - **ii. Small businesses that contact the Exchange or call center needing additional information and advice should be directed to an agent or broker rather than an individual navigator. However, the Exchange should only refer small businesses to independent agents or brokers who are able to sell any of the qualified health plans offered in the Exchange.**
- **b) The NCDOI, in conjunction with the Exchange, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the Exchange, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage. As part of this analysis, NCDOI and the Exchange should consider the impact of any changes in agent and broker compensation on overall agent/broker compensation, insurers' medical loss ratio, and on premium prices in the nongroup and small group market. As part of this analysis, NCDOI and the Exchange should consider whether to:**
  - **i. Pay agents and brokers a standard commission per enrollee regardless of the insurer.**
  - **ii. Require insurers to pay agents and brokers the same standard commission, whether placing business inside or outside the Exchange.**
  - **iii. Pay agents and brokers a standard commission for each individual whether enrolling in a nongroup plan or group plan.**
  - **iv. Require insurers to appoint all licensed agents and brokers in good standing who have been certified to offer insurance inside the Exchange as part of the insurers' panel.**

v. **Pay agents and brokers a higher per person commission or other compensation to encourage agents and brokers to enroll very small groups (e.g., groups of under 10 employees).**
vi. **Pay higher commissions or other compensation to encourage agents and brokers to enroll small businesses that had not offered health insurance in the last six months.**

c) **If the NCDOI, in conjunction with the Exchange, does not change agent and navigator compensation structure to prevent conflicts of interest or reduce the incentive to steer individuals or businesses to different insurers or plans inside or outside the Exchange, then agents or brokers who place business in the Exchange must disclose to their individual and small business clients if they receive differential commissions from different insurers.**

No wrong door. The ACA creates a "no wrong door" approach for eligibility and enrollment into any of the insurance affordability programs (i.e., Medicaid, CHIP, or subsidized insurance coverage offered through the Exchange). For example, the Exchange and Medicaid must both use the same streamlined application form.[106,107] The state must also create an eligibility and enrollment system that allows individuals to apply for any insurance affordability program to which they are entitled without delay.[108,109] In North Carolina, NC FAST is expected to serve as the eligibility system for Medicaid, North Carolina Health Choice, and subsidized coverage through the Exchange (should the state operate its own Exchange).

In addition to the specific role of navigators/in-person assisters, both the Exchange and Medicaid have a responsibility to assist people in applying for and enrolling into appropriate public or private health insurance coverage. The Exchange must first screen people to assess whether an individual is eligible for Medicaid or CHIP before they can be considered for the insurance subsidies in the Exchange. If the Exchange identifies people who are potentially eligible for Medicaid or CHIP, the Exchange must share information with the Medicaid agency so that an eligibility decision can be made without undue delay.[110,111]

The HBE workgroup recognized that many of the low-income uninsured will first seek information about insurance options through their local department of social services (DSS). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[112] In addition, if the person is determined to be ineligible for Medicaid, he or she must be screened to enroll into a QHP, and, if eligible, must be able to enroll "without delay."[113,114] Thus, the workgroup recommended that DSS workers be trained and certified as navigators/in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a QHP offered through the Exchange. To make it easier for DSS offices to serve as navigator/in-person assister administrative entities, the HBE workgroup recommended that the state develop data capture mechanisms so that all or most of the data needed for reporting and accountability to the state would be captured through the NCFAST system. Further, the Exchange Board should examine options to help offset some of the administrative costs for DSS workers in providing enrollment assistance to individuals who have been determined to be ineligible for Medicaid or North Carolina Health Choice.

The workgroup recognized that not every DSS office would want, or have the resources, to take on the additional workload that could be created by providing advice to people about Exchange insurance options. Thus, the workgroup wanted further clarification on what the federal government meant by ensuring that a person was eligible to enroll "without delay." The

workgroup members were concerned that absent immediate assistance, many of the people who seek services from DSS might fall through the cracks if they were directed to another agency for care. Assuming that there is some flexibility, the workgroup recommended that the Exchange Board create other mechanisms to ensure a "warm hand-off" so that people who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from a trained navigator/in-person assister or other trained staff outside of the local social services office.

To address these concerns, the NCIOM recommended:

RECOMMENDATION 2.9: "NO WRONG DOOR" ELIGIBILITY AND ENROLLMENT

a) Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice (CHIP) eligibility workers are cross-trained and certified as navigators /in-person assister so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the Health Benefits Exchange (Exchange).
   - **i. NCFAST should design the eligibility and enrollment system to electronically capture data needed for oversight of navigators.**

b) If allowed under federal law, the Exchange Board, working with the North Carolina Division of Social Services, North Carolina Division of Medical Assistance, and Social Services Directors Association should create other mechanisms to ensure that people who seek in person services from local DSS, who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from trained navigators/in-person assisters or other trained staff outside of the local DSS offices.

c) The Exchange Board should examine options to help offset some of the administrative costs for DSS workers in providing enrollment assistance to individuals who have been determined to be ineligible for Medicaid or North Carolina Health Choice.

REFERENCES AND NOTES

[1] 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. The maximum penalty that any individual or family would incur is the amount they would have had to pay if they had purchased the lowest cost bronze plan available in the nongroup market, or the cost they would have incurred to purchase an employer-sponsored plan. Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1501(b), enacting Sec. 5000A(c),(e)(1)(B) of the Internal Revenue Code of 1986, 26 USC 5000A.

[2] The constitutionality of the individual mandate along with the Medicaid expansion was challenged in the United States Supreme Court, in *National Federation of Independent Business v. Sebelius*, 567 US ___ (2012).. The Supreme Court held that the mandate that people purchase health insurance coverage or pay a penalty was a constitutional exercise of Congress' taxing authority. Available at: http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. Accessed November 7, 2012.

[3] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1411(b)(5); Patient Protection and Affordable Care Act, Pub L No. 111-148, §1501(b), enacting Sec. 5000A(d),(e) of the Internal Revenue Code of 1986, 26 USC 5000A.

[4] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513(a), enacting Sec. 4980H(c)(2) of the Internal Revenue Code of 1986, 26 USC 4980H(c)(2).

[5] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(a).

[6] United States Department of Health and Human Services. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Proposed Rule. *Fed Regist*.

2012;77(227):70644-70676. http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf. Accessed November 29, 2012.

[7] The Center for Consumer Information and Insurance Oversight prepared a summary of the proposed North Carolina essential health benefit benchmark plan. The summary is available at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf. Accessed December 10, 2012.

[8] Grandfathered plans—those that were in existence when the bill was signed into law on March 23, 2010, and which have not changed substantially since then. Over time, many insurance plans will lose their grandfathered status, and will be subject to the preventive services and minimum essential coverage requirements. United States Department of Health and Human Services. Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act; United States Department of Health and Human Services. Interim Final Rule and Proposed Rule. 75 *Fed Reg*ist. 34538-34570. June 17, 2010. Amendment to Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act. *Fed Regist*. 2010;75(221):70114-70122. To be codified at 26 CFR §54, 29 CFR §2590, 45 CFR §147.

[9] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

[10] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC 300gg.

[11] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(d), 42 USC 18022.

[12] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302(e), 42 USC 18022.

[13] The Federal Poverty Level (FPL) is based on family size. The 2012 FPL is: $11,170 /year (one person), $15,130/year (two people), $19,090/year (three people), $23,050/year (four people), and $3,960/year for each additional person. Thus 400% FPL would be: $44,680 (one person), $60,520/year (two people), $76,360/year (three people), and $92,200 (four people), and $15,840/year for each additional person.

[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1401(c)(1), enacting Sec. 36B of the Internal Revenue Code of 1986.

[15] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1402(d)(1)(2), 2901.

[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1421, 1501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §10105(e), creating Sec. 45R of the Internal Revenue Code of 1986.

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[19] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1301, 1311, 1321, 1322, 1334, 10104.

[20] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.1010, 155.1075, 155.1080.

[21] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

[22] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

[23] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).

[24] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.

[25] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).

[26] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200.

[27] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1401(f)(3), 1411, 1412, 10105, as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1001, 1004.
[28] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.300-155.355.
[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(F), 1411, 1413.
[30] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.
[31] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(G).
[32] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.205.
[33] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(H).
[34] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200(b), 155.705.
[35] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1401(f)(3), as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1004(c).
[36] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(I).
[37] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(J).
[38] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(K), 1311(i).
[39] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.210-220.
[40] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(6).
[41] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.130.
[42] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(7).
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[44] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1313.
[45] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10108(d)(2), 1411(f)(2).
[46] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(2)(3).
[47] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.240(c); 155.705(b)(4).
[48] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(a),(d)(5).
[49] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.160.
[50] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).
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[60] Center for Consumer Information and Insurance Oversight. Centers for Medicare and Medicaid Services. United States Department of Health and Human Services. Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges. Funding Announcement. CFDA 93.525.

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[66] NCGS §58-3-200(d).

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[71] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4).

[72] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c).

[73] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(g).
[74] For purposes of the HBE workgroup discussion and decision making, we limited "consensus" decisions to those that were supported by at least two-thirds of the members.
[75] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.1045.
[76] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 155.1050.
[77] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.230.
[78] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.
[79] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031 referencing 42 USC §§256(b)(a)(4), 1927(c)(1)(d)(i)(IV) for definition of essential community provider.
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[93] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.
[94] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205(e).
[95] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.
[96] PPACA Sec. 2201, amending Sec. XIX of the Social Security Act, 42 USC 1396w-3(b)(1)(F).
[97] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.20.
[98] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(2)(A).
[99] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.210(b)(2).
[100] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(3).
[101] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(6).
[102] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.410.
[103] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.220.

[104] North Carolina Department of Insurance. http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx. Accessed December 4, 2012.
[105] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(10).
[106] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.
[107] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.405
[108] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.
[109] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(b)(3).
[110] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4).
[111] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.
[112] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.908.
[113] Patient Protection and Affordable Care Act, Pub L No. 111-148, §2201, enacting §1943(b)(1)(C) of the Social Security Act, 42 USC 1396w-3(b)(1)(C).
[114] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(e).

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 3: MEDICAID

Many uninsured people in North Carolina will obtain coverage through Medicaid in 2014, if the state chooses to expand Medicaid, as allowed under the Affordable Care Act (ACA). As enacted, the ACA required that states expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit beginning January 1, 2014. States that chose not to expand Medicaid could have lost all of their federal Medicaid funds. However, the Supreme Court, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), held that this mandatory Medicaid expansion was unconstitutionally coercive to the states. The Supreme Court essentially struck down the enforcement mechanism leaving the Medicaid expansion as a voluntary option to the states.

While the Supreme Court overturned the mandatory Medicaid expansion, the rest of the coverage provisions remained intact. Children in families with incomes no greater than 200% of the federal poverty level (FPL) will continue to be eligible for Medicaid or North Carolina Health Choice (NC Health Choice), North Carolina's Child Health Insurance Program (CHIP). Other people, with incomes between 100-400% FPL who do not have access to affordable employer-sponsored insurance, can obtain subsidies to enroll in private insurance offered through the Health Benefit Exchange (Exchange) (discussed more fully in Chapter 2). It is likely that many individuals will move between these programs as their income fluctuates. Thus, the ACA includes provisions to streamline and coordinate the eligibility and enrollment processes between Medicaid, CHIP, the Basic Health Plan (if the state chooses to implement this option), and the Exchange. The Basic Health Plan is a state option to create a separate health insurance program for those with incomes above 138% FPL but not greater than 200% FPL.

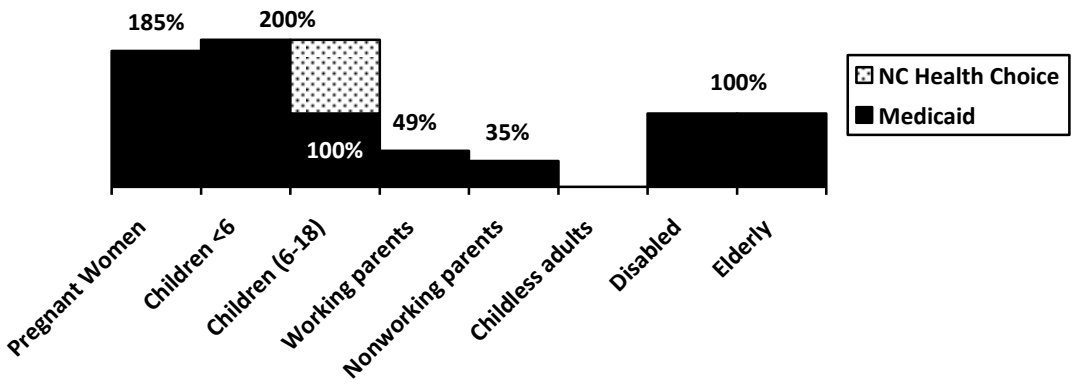
The Medicaid workgroup finished its work before the US Supreme Court decision. It focused on the new Medicaid expansion, eligibility and enrollment requirements, new benefit mandates or options, and options for home and community-based services. Medicaid also plays a critical role in almost all aspects of the ACA and is discussed in other sections throughout this report. For example, Community Care of North Carolina (CCNC), North Carolina's Medicaid primary care management program, is considered a national model of a patient-centered medical home. CCNC is a leader in testing new delivery and payment models (discussed more fully in the Chapter 8). The Division of Medical Assistance (DMA), which operates both the Medicaid and NC Health Choice programs, has implemented new policies aimed at improving health care quality and outcomes, and reducing fraud, abuse, and unnecessary utilization (discussed more fully in Chapters 7 and 9, respectively). Further, the ACA gives states a financial incentive to provide the same coverage of clinical preventive services in Medicaid as would be offered to the commercially insured population (discussed more fully in Chapter 6). DMA's payment policies also have a profound impact on the willingness and ability of health care professionals and other health care providers to participate in the Medicaid program. Thus, reimbursement rates must be adequate to ensure an adequate supply of health professionals to meet the health care needs of the newly insured (discussed more fully in Chapter 5).

COVERAGE EXPANSION

The ACA, as enacted, expanded Medicaid coverage to most nonelderly individuals with MAGI no greater than 138% of FPL beginning January 1, 2014.[1, 2] As explained in more detail below, the federal government will pay most of the costs of covering the new eligibles. To qualify, a person must be a United States citizen or a lawfully present immigrant who has been in the United States for five years or more. Undocumented immigrants will not qualify for Medicaid coverage. The ACA requires states to provide Medicaid coverage to all children with incomes below 138%.[3] This provision is mandatory to the states, and was not affected by the Supreme Court ruling in *National Federation of Independent Businesses v. Sebelius.* In North Carolina, this means that the state must move children ages 6-18 with incomes between 100-138% FPL from NC Health Choice, to the Medicaid program. Children ages 6-18 with incomes between 138-200% FPL will continue to receive NC Health Choice, and younger children with incomes up to 200% FPL will continue to receive Medicaid coverage. This requirement to cover children with incomes up to 200% FPL through either Medicaid or NC Health Choice is scheduled to stay in effect until 2019, when the federal CHIP program is scheduled to end unless Congress reauthorizes the program. At that point, children will either be enrolled in Medicaid or private insurance (through the Exchange or otherwise) depending on their families' income.

The Supreme Court ruling made the Medicaid expansion optional for states. Under the Supreme Court ruling, each state now has the option to expand Medicaid coverage to many low-income adults who are not currently eligible for Medicaid. Currently, to qualify for Medicaid, a person must be a citizen or lawful permanent immigrant in the United States for at least five years and must meet certain categorical, income, and resource requirements. Medicaid is generally limited to children of low-income families, or adults who are either pregnant, have dependent children under age 19 living with them, disabled (under strict Social Security disability standards) or elderly (65 or older). Even if a person meets these categorical eligibility rules, the individual must also have an income below a certain income threshold and have limited resources or assets to qualify. Childless, nonelderly, and nondisabled adults do not currently qualify for Medicaid, regardless of their income. Because of these eligibility restrictions, North Carolina's Medicaid program only covered 30% of all poor adults with incomes up to 100% FPL in 2010-2011.[4] (Figure 3.1)

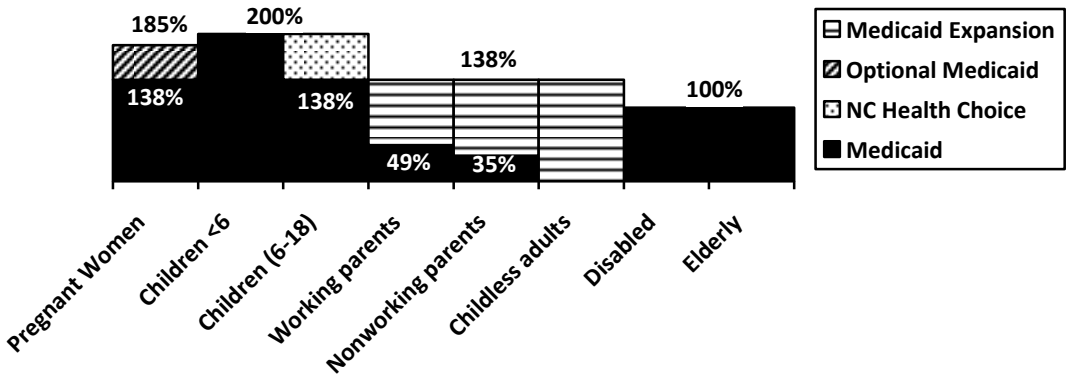
Figure 3.1
North Carolina Medicaid Income Eligibility (2012)



Source: Kaiser Family Foundation. Statehealthfacts.org. Parents eligibility based on a family of three (2012).

However, in 2014, the eligibility criteria will change, and states can choose to cover most adults with incomes up to 138% FPL. The ACA removes the categorical restrictions and resource limits for most adults. Instead, eligibility for children and most adults will be determined based on a person's citizenship (or lawful immigration status) and income (see Figure 3.2 and Table 3.1). The ACA does *not* expand Medicaid coverage to undocumented immigrants.

Figure 3.2
Medicaid Income Eligibility Including Optional Expansion (2014)



Source: North Carolina Institute of Medicine analysis of Medicaid expansion option.

To put this into perspective, a person working at minimum wage ($7.25/hour), 40 hours week, and 50 weeks/year would earn $14,500/year. The incomes of these low-wage workers are generally too high to qualify for Medicaid under North Carolina's current Medicaid eligibility rules.[5] As noted earlier, a single nonelderly adult who is not disabled cannot currently qualify for Medicaid in North Carolina regardless of income. Parents can qualify, but income limits are quite low. A working parent in a family of three would only qualify in North Carolina if his or

her income was less than approximately $9,350/year, equivalent to approximately two-thirds of what a person earns on minimum wage. However, beginning January 1, 2014, this adult would be able to qualify regardless of whether he or she has children if the person's income is no greater than 138% FPL (or ~$15,415/year for an individual) (See Table 3.1).

Table 3.1
Medicaid and NC Health Choice (NCHC) Eligibility for Different Family Sizes[¥] Using 2012 Medicaid Eligibility and Percent Federal Poverty Level (2012, 2014)

	2012 Income Eligibility/Year			2014 Income Eligibility[£]		
	Percent Federal Poverty Level	**Medicaid**	**NC Health Choice**	**Percent Federal Poverty Level**	**Medicaid**	**NC Health Choice**
Child age 0-5	200%	Family size: 1: ≤$22,340 4: ≤$46,100		200%	Family size: 1: ≤$22,340 4: ≤$46,100	
Child age 6-18	Medicaid:100% NCHC: 100-200%	1: ≤$11,170 4: ≤$23,050	1: $11-170-$22,340 4: $23,050-$46,100	Medicaid:138% NCHC:100-200%	1:≤$15,415 4: ≤$31,809	1: $15,415-$22,340 4: $31,809-$46,100
Pregnant woman[β]	185%	2:≤$27,991 4: ≤$42,643	Not eligible	185%[c]	2:≤$27,991 4:≤$42,643	Not eligible
Parent of dependent child <19 years old	1:39% 4:31%	1:≤$4,344 4: ≤$7,128	Not eligible	138%	1:≤$15,415 4: ≤$31,809	Not eligible
Adult without dependent children who is not disabled or elderly	Not eligible	Not eligible	Not eligible	138%	1:≤$15,415 2: ≤$20,879	Not eligible
Medicare eligible adult (elderly or disabled)	100%	1:≤$11,170 2: ≤$15,130	Not eligible	100%	1:≤$11,170 2: ≤$15,130	Not eligible

[¥] While the table generally shows the income limits for an individual (1) or for a family of four (4), the chart includes three exceptions. A pregnant woman is always counted as two people for Medicaid eligibility purposes. Thus, the information included for a single pregnant woman is based on a family size of two people instead of one person. Additionally, adults without dependent children, and elderly and disabled families are generally no larger than a family size of two people.

[£] The 2014 income eligibility limits are based on the 2012 FPL, as the 2014 FPL are unknown at this time. However, the actual income eligibility limits are likely to be higher, as they will be based on the 2014 federal poverty levels (which increase with the cost of inflation).

[β] In 2014, North Carolina has the option of reducing the income eligibility guidelines of pregnant women to 138% FPL and moving those pregnant women with higher incomes into private subsidized coverage (i.e., through the Exchange).

The income guidelines for an individual would be $15,415/year (single adult without dependent children) or $31,809/year for a family of four if based on 2012 FPL (See Table 3.1). (These income limits are likely to increase by 2014, as they will be based on the 2014 federal poverty levels.) Expansion of Medicaid to cover adults with incomes up to 138% FPL would be a major expansion and would provide coverage to many low-income adults. However, some individuals will be ineligible for Medicaid even if their incomes are below 138% FPL. For example, undocumented immigrants and lawful immigrants who have been in the United States for less than five years are ineligible for Medicaid coverage, regardless of their incomes. Others may decide not to enroll even though they are eligible. Low-income individuals who are not required to pay taxes are exempt from the insurance coverage mandate. Further, it is doubtful that everyone who is Medicaid eligible will enroll in the first year. Instead, Medicaid coverage is likely to grow over time as more people learn about the new Medicaid eligibility rules and coverage options. In addition, enrollment is also likely to depend, in part, in the state's outreach efforts.

The ACA distinguishes between those individuals who will be *newly eligible* (i.e., they would not be eligible for coverage if they applied today), from those who are *currently eligible but not enrolled* or *"woodwork"* individuals (i.e., they meet the existing eligibility rules, but are not currently enrolled). Both individuals may come in and apply for the first time after the new law goes into effect in 2014. But, the federal government will pay a different percentage of the Medicaid service costs, depending on whether a person is newly eligible or a woodwork individual. For example, the federal government will pay 100% of the Medicaid costs for newly eligible individuals for the first three fiscal years (2014-2016). After the first three years, the federal government will pay 95% of the costs in FFY 2017, 94% in FFY 2018, 93% in FFY 2019, and 90% thereafter.[6] In contrast, the federal government will continue to pay the state's regular Federal Medical Assistance Percentage (FMAP), currently approximately 65%, for woodwork individuals.[7]

There are other differences between the woodwork group and the newly eligibles. The state must provide the same coverage to the woodwork group that it provides to existing eligibles. Children will be eligible for coverage of all the same services offered to children already enrolled in Medicaid, and woodwork adults will be eligible for the same coverage available to adults in a similar eligibility category. The state must pay its share of the costs for the woodwork group who enroll in 2014 or thereafter. This is not optional to the states, even after the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*.

The state has more flexibility with regard to the newly eligibles. First, the state can choose whether or not to expand Medicaid to the newly eligibles. If the state does choose to expand Medicaid, North Carolina could create a more limited package of covered services for the newly eligibles. States must provide the newly eligible a benchmark benefit plan that is no less comprehensive than the essential benefits package, but not as expansive as the services covered in the existing Medicaid program.[8] (See Chapter 2 for a discussion of the essential benefit package.)

The ACA was written with the expectation that low income individuals would receive health care coverage through the Medicaid expansion. Therefore, subsidies to help low income individuals afford health insurance through the Exchange were limited to individuals with incomes between 100% - 400% FPL. Most of the uninsured with incomes below 138% FPL will not be able to obtain health insurance coverage if the state chooses not to expand Medicaid. Because of the high cost of insurance, few people living in poverty would be able to afford the full cost of coverage and they are not eligible for subsidies through the Exchange. For example, the average premium cost for an employer-based health plan in North Carolina was $5,230 in 2011 for a single employee, or $14,304/year for family coverage.[9] [10] This would comprise 48% of the yearly income for a single person living in poverty, or 64% of the yearly income of a family of four. In 2010-2011, approximately 355,000 uninsured adults in North Carolina (26.9% of uninsured adults) had incomes below 100% FPL. Another 183,000 uninsured adults (13.9%) had incomes between 100-138% FPL. North Carolina could choose to expand coverage to adults with incomes less than 138% FPL (e.g., up to 100% FPL), but it cannot receive the enhanced FMAP rate unless it expands coverage up to 138%.[11]

DMA developed estimates of the number of new people who would gain Medicaid coverage and the costs of providing coverage to these individuals from 2014-2019.[12] DMA prepared separate analyses for the woodwork and the newly eligible individuals. DMA used certain assumptions in developing its enrollment and cost projections:

- DMA used the North Carolina Office of State Budget and Management's population projections for 2014-2019.
- DMA used the most recent data on the percentage of the population that was uninsured and held that constant throughout the six year time period.
- DMA assumed that the basis for paying health care providers would not change over the six years. This assumption includes built in rate changes for the providers that have rates set based on costs, indexes, and on external factors. For example, North Carolina is required, under the federal Medicaid law, to pay federally qualified health centers and rural health centers using a cost-based formula.[a] Other key payment factors are for hospital outpatient, which is paid at 80% of cost, drugs, which are paid on indices such as the wholesale acquisition costs, and the nursing home case-mix adjustment. The North Carolina General Assembly (NCGA) establishes rates for other provider groups. DMA assumed for these purposes that the rates would remain constant for those providers who have rates set by the NCGA.[b]

[a] Under federal law, states must pay federally qualified health centers and rural health centers based on a prospective cost basis, and hospice services must be paid at no less than Medicare rates. North Carolina must also pay the Medicare Part B and Part D premiums for certain Medicare eligible individuals, and pays for prescription drugs based on wholesale acquisition costs (for brand name drugs), or state Medicaid costs (for generic drugs). Further, hospitals are paid 80% of costs for outpatient charges, and nursing home reimbursement contains an update factor for changes in case mix index. Steve Owen, Chief Business Operating Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services. Electronic communication. December 31, 2012.

[b] The North Carolina General Assembly sets the base rates for hospital inpatient and nursing home base reimbursement. Physicians are currently paid based on 95% of Medicare, but that percentage is adjusted based on how much the General Assembly appropriates for physician reimbursement. DMA assumed that physicians would continue to receive the same reimbursement as they currently receive, except for the required increase in rates for

- DMA assumed current utilization rates would remain constant, and based its costs for newly eligible adults based on the utilization and costs for the existing coverage of non-elderly, non-disabled adults with dependent children.
- DMA assumed a more limited benefit package for the newly eligibles. Because the NCGA had not yet established a Medicaid benchmark plan when they did their analysis, DMA used the State Employees Health Plan as the benchmark plan for covered services.[c] The State Employees Health Plan offers more limited benefits than the state's current Medicaid benefits, and is one of the approved Medicaid benchmark plans under the ACA.[13] While DMA used the State Employees Health Plan to define covered services, it assumed more limited cost sharing than is currently required as part of the State Employees Health Plan.
- DMA assumed a consistent federal match rate for the woodwork population of approximately 65% (based on the current FMAP rate).
- DMA assumed different "take-up" rates for different populations in the woodwork and newly eligible groups. For example, DMA assumed that a higher proportion of the newly eligible individuals who are currently uninsured would seek to enroll than those who are already eligible but not enrolled (woodwork).
- DMA estimated an annual "run rate" which is the projected annual costs after 2021. In general, DMA's projections for the run rate were based on 2021 projections, except when different federal laws applied. For example, the CHIP enhancement (described more fully below) ends in FY 2019 so was not included in the 2020 and 2021 cost projections.

Based on these assumptions, DMA estimated that approximately 564,000 people would enroll in Medicaid in SFY 2014 (including both the woodwork and newly eligibles). This would grow over time to approximately 624,000 by SFY 2021. Of the new enrollees in 2014, 12% would be woodwork individuals, and 88% would be newly eligibles. Determining the new costs to the state involved multiple steps:

1) DMA estimated the total service costs for both the woodwork group and the newly eligibles. (See Tables 3.2 and 3.3 and Appendix C.)
2) DMA identified the potential cost offsets for each population. For example, both the state and federal government get rebates from pharmaceutical manufacturers.[14] The drug rebates apply to both the woodwork and newly eligible groups. In addition, the ACA includes an enhanced federal match rate for the CHIP program of 23 percentage points in FFY 2016-2019.[15] This will reduce the net new state costs associated with providing coverage to the woodwork population. There are other cost offsets (described more fully below) for the newly eligible population. (See Tables 3.2 and 3.3 and Appendix C.)

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primary care procedures. Steve Owen, Chief Business Operating Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services. Electronic communication. December 31, 2012.

[c] North Carolina developed its costs estimates, using the State Health Plan as the Medicaid benchmark for the newly eligibles. However, the state has the option of providing full Medicaid coverage, or providing more limited coverage, as long as the coverage is no more limited that the essential health benefits package offered in the Health Benefit Exchange. As discussed more fully in Chapter 2, North Carolina's essential health benefit package will be based on the most commonly purchased small group health plan, Blue Cross and Blue Shield of North Carolina's Blue Options PPO plan.

3) DMA estimated the new administrative costs to the state for the expanded coverage and the changes required to the eligibility and enrollment system. (See Tables 3.2 and 3.3 and Appendix C.)
4) The new federal dollars that flow into the state will produce other economic benefits to the state, in terms of new jobs and new state tax revenues. The Department of Health and Human Services contracted with Regional Economic Models, Inc. (REMI) to conduct an analysis of the numbers of new jobs that would be created by the infusion of new federal funds *if the state expands Medicaid*. REMI also did an analysis of the amount of new state revenues that would be generated from the infusion of new federal dollars. REMI is the economic forecasting tool used by the Fiscal Research Division of the NCGA. (See Appendix D)

A more detailed description of the projected enrollment and costs for the woodwork and newly eligible populations is provided below.

Woodwork Population

DMA estimated that 69,683 people who are currently eligible but not enrolled would gain coverage in 2014. (Table 3.2 and Appendix C) This will grow to 87,127 by 2021. DMA estimated that the total gross cost of services provided to the woodwork group would be approximately $105 million ($36.7 million to the state) in SFY 2014, growing to $617.4 million ($216.1 million to the state) in SFY 2021. There are no additional costs to the state of moving 58,000 children ages 6-18 with incomes between 100-138% FPL from North Carolina Health Choice to Medicaid in 2014. The gross new costs of this move to the state will be offset by the new federal funds that flow into the state as a result of the enhanced CHIP match rate (FFY 2016-2019). Beginning in SFY 2016, the federal government will increase its federal CHIP match rate by 23 percentage points (from its existing 76% federal match to 99%).[16] This will reduce the state's CHIP costs by $64.5 million in FY 2016, growing to $92.1 million in FY 2019.

In addition to the new service costs, the state will also incur additional administrative expenses. DMA estimates that the total new administrative expenses for the woodwork population will be $1.9 million in SFY 2014 ($1.0 million in state expenses), increasing to $4.6 million by SFY 2021 ($2.3 million in state expenses).

Table 3.2
Projected Costs and Enrollment for the Woodwork Population (FY 2014-2021)
(Costs in Millions)

	2014	2015	2016	2017	2018	2019	2020	2021	Total 2014-2021	Run Rate
Enrollment	69,683	72,426	75,340	78,035	80,890	83,859	85,888	87,127		
FMAP	65%	65%	65%	65%	65%	65%	65%	65%		65%
Gross Service Expenditures										
Total	$105.0	$292.7	$482.9	$513.7	$546.7	$581.2	$603.0	$617.4	$3,742.8	$617.4
Federal	$68.2	$190.3	$313.9	$333.9	$355.4	$377.8	$392.0	$401.3	$2,432.8	$401.3
State	$36.7	$102.5	$169.0	$179.8	$191.4	$203.4	$211.1	$216.1	$1,310.0	$216.1
Pharmaceutical Rebate										
Total Drug Rebate	-$1.0	-$14.6	-$23.8	-$30.6	-$33.8	-$37.3	-$41.3	-$44.7	-$226.9	-$45.8
Federal Drug Rebate	-$0.6	-$9.5	-$15.5	-$19.9	-$21.9	-$24.2	-$26.8	-$29.0	-$147.5	-$29.8
State Drug Rebate	-$0.3	-$5.1	-$8.3	-$10.7	-$11.8	-$13.1	-$14.5	-$15.6	-$79.4	-$16.0
Effect of CHIP Enhanced Match Rate										
Federal CHIP	NA	NA	$64.5	$88.0	$90.1	$92.1	NA	NA	$334.7	NA
State CHIP	NA	NA	-$64.5	-$88.0	-$90.1	-$92.1	NA	NA	-$334.7	NA
Net Service Costs (gross service costs, minus drug rebate and changes in CHIP match rate)										
Net Total Service Costs	$104.0	$278.1	$459.2	$483.2	$513.0	$543.9	$561.7	$572.8	$3,515.9	$571.6
Net Federal Service Costs	$67.6	$180.8	$362.9	$402.1	$423.5	$445.7	$365.1	$372.3	$2,620.0	$371.6
Net State Service Costs	$36.4	$97.3	$96.2	$81.1	$89.4	$98.3	$196.6	$200.5	$895.9	$200.1
Administrative Expenses										
Total Admin.	$1.9	$4.0	$4.2	$4.3	$4.4	$4.5	$4.6	$4.6	$32.6	$4.6
Federal Admin.	$1.0	$2.0	$2.1	$2.2	$2.2	$2.3	$2.3	$2.3	$16.3	$2.3
State Admin.	$1.0	$2.0	$2.1	$2.2	$2.2	$2.3	$2.3	$2.3	$16.3	$2.3
Total Costs (includes gross service and administrative costs, minus drug rebates and changes in CHIP match)										
Total	$106.0	$282.1	$463.3	$487.5	$517.4	$548.5	$566.3	$577.4	$3,548.5	$576.3
Federal	$68.6	$182.8	$365.0	$404.2	$425.7	$448.0	$367.4	$374.6	$2,636.3	$373.9
State	**$37.4**	**$99.3**	**$98.3**	**$83.2**	**$91.6**	**$100.5**	**$198.9**	**$202.8**	**$912.2**	**$202.4**

Note: See Appendix C for full cost estimates.

In total, the new cost to the state is expected to be $37.4 million in SFY 2014, increasing to $202.8 million in SFY 2021. This will bring down $68.6 million in new federal funds in SFY 2014, increasing to $448.0 million in SFY 2019 (with the enhanced federal CHIP match), and then declining to $374.6 million in SFY 2021 (with the loss of the enhanced federal CHIP match rate). Medicaid enrollment will increase for the woodwork population regardless of whether the state chooses to expand Medicaid for the newly eligibles.

Newly Eligibles

If the state decides to expand Medicaid to cover the newly eligibles with incomes up to 138% FPL, DMA estimated that 494,010 people would gain coverage in 2014, increasing to 536,481 by 2021. (Table 3.3 and Appendix C) DMA estimated that the total gross costs of services provided to the newly eligibles would be approximately $521.9 million ($0 to the state) in SFY 2014, growing to $2.4 billion in ($244.3 million to the state) in SFY 2021. The new gross costs

to the state would be reduced by the prescription drug rebate, which is estimated to be $5.4 million in SFY 2014 ($0 to the state), increasing to $193.0 million in SFY 2021 ($18.6 million to the state). In addition, the total state service costs can be offset by moving some of the existing state funds used to support other state health programs for people who will be newly eligible for Medicaid. Specifically, DMA identified three sources of potential cost offsets. These offsets are only available if the state chooses to expand Medicaid coverage to the uninsured with incomes up to 138% FPL:

1) State funds currently used to pay for mental health and substance abuse services to people who are uninsured with incomes up to 138% FPL. The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) estimated the amount of existing state appropriations that are being used to support the uninsured who could otherwise qualify for Medicaid, if expanded. Once these uninsured individuals gain Medicaid coverage, the state can redirect the state appropriations that were previously used to pay for state-funded mental health and substance abuse services to meet the state's share of the Medicaid expansion. The state cannot redirect all of the existing state mental health and substance abuse funding, as some of the existing appropriations are required in order to draw down federal mental health and substance abuse block grant funding. Other state funds will still be needed to provide wrap-around mental health and substance abuse services that are not covered through the Medicaid benchmark plan, as well as services to those who remain uninsured. DMHDDSAS estimated that the state could redirect $8.2 million of existing state appropriations in SFY 2014, growing to $16.4 million in SFY 2015 and thereafter, if the state chooses to expand Medicaid coverage to cover the uninsured with incomes up to 138% FPL. (This figure could be higher if the Medicaid package for the newly eligibles covered more extensive mental health and substance abuse services that the State Health Plan.)
2) Similarly, the state appropriates monies to pay for necessary prescriptions for uninsured individuals with HIV/AIDS through the AIDS Drug Assistance Program (ADAP). The Division of Public Health (DPH) estimated that the state could redirect $14.3 million of the existing state appropriations for ADAP in SFY 2014, growing to $28.6 million in SFY 2015 and thereafter, if the state chooses to expand Medicaid coverage to the newly eligibles.
3) Finally, the state appropriates money to pay for inpatient hospital services for individuals who are in the state's correctional institutions. Currently, most of these individuals are ineligible for Medicaid because they do not meet the categorical eligibility restrictions (i.e., most are childless adults who are not disabled or elderly). However, if the state chooses to expand Medicaid to the newly eligibles, most inmates in correctional institutions will qualify for Medicaid coverage to pay for inpatient hospital care. The state estimates that they currently spend approximately $17 million/year for inpatient hospital costs for inmates. Thus, the state could redirect $8.5 million in funding to the Department of Corrections in SFY 2014, growing to $17 million in SFY 2015 and thereafter to help pay for the Medicaid expansion.

In addition to the new service costs, the state will also incur additional administrative expenses. DMA estimates that the total new administrative expenses for the newly eligible population will be $20.8 million in SFY 2014 ($10.4 million in state expenses), increasing to $31.5 million by SFY 2021 ($15.6 million in state expenses).

As noted earlier, the North Carolina Department of Health and Human Services contracted with the REMI to conduct an analysis of the economic impact of the Medicaid expansion on the state. REMI's analysis includes both the impact of the new federal dollars to the state assuming migration of health care workforce into the state (if surrounding states do not expand Medicaid), and without migration. According to REMI, the new federal funds from the Medicaid expansion will generate approximately 25,000 jobs by 2016 (a total of 25,684 if there is migration into the state, or 24,846 without migration). REMI assumed a slight decline in new jobs after 2016, with improved labor productivity and reductions in public jobs as the state redirects internal funding. Thus, total employment declines from the high in 2016 from approximately 26,000 new jobs to a total of closer to 18,000 new jobs by 2021 (20,095 if assuming migration17,742 if no migration). Most of the new jobs will be in the private sector. Increases in annual state domestic product (SDP) is expected to range from approximately $1.7 billion higher (2016) to $1.3 billion higher (2021). While REMI was not contracted to do a complete analysis of the additional tax revenues that are likely to be generated as a result of the new federal Medicaid funds, REMI did prepare an estimate of the likely new tax revenues—based on historical data on state revenues generated from SDP. Historically, North Carolina generates approximately 4.5% of its SDP in state tax revenues. REMI applied this historical state tax revenue-to-SDP ratio to the increase in SDP generated from the new federal dollars. Based on this analysis, REMI estimated that North Carolina is likely to experience in increase of state taxes ranging from approximately $17.2 million in SFY 2014 (taking the average of the migration and non-migration estimates), to $60.7 million in SFY 2021.

In total, because of the high federal match rate, cost offsets (both pharmaceutical rebates and other state offsets), and new tax revenues generated as a result of the expansion, the state is likely to save money in early years, with a net increase in state expenditures beginning in SFY 2018. Specifically, North Carolina is likely to save $37.8 million in SFY 2014, $120.8 million in SFY 2015, $124.2 million in SFY 2016, and $40.2 million in SFY 2017. Beginning in SFY 2018, the state will need to expend new resources to cover the newly eligible. The net new costs to the state to cover approximately 500,000 newly eligible individuals will be $7.8 million in SFY 2018, $33.9 million in SFY 2019, $97.1 million in SFY 2020, and $118.7 million in SFY 2021. In total, between SFY 2014-2021, North Carolina would likely save a total of $65.4 million. The federal government is expected to spend $527.0 million in SFY 2014, increasing to $2.0 billion in SFY 2021, or $14.8 billion over the 8 year time period.

Table 3.3
Projected Costs and Enrollment for the Newly Eligible Population (FY 2014-2021)
(Costs in Millions)

	2014	2015	2016	2017	2018	2019	2020	2021	Total (2014-2021)	Run Rate
Enrollment	494,010	500,058	506,818	512,906	519,684	525,830	531,264	536,481		
FMAP	100%	100%	100%	95%	94%	93%	90%	90%		90%
Gross Service Expenditures										
Total	$521.9	$2,134.1	$2,192.2	$2,240.2	$2,300.6	$2,350.4	$2,396.7	$2,443.1	$16,579.3	$2,443.1
Federal	$521.9	$2,134.1	$2,192.2	$2,156.2	$2,168.3	$2,191.8	$2,175.0	$2,198.8	$15,738.3	$2,198.8
State	$0	$0	$0	$84.0	$132.3	$158.7	$221.7	$224.3	$840.9	$244.3
Prescription Drug Rebates										
Total Rebate	-$5.4	-$106.5	-$141.3	-$149.5	-$158.3	-$167.4	-$180.4	-$193.0	-$1,101.8	-$197.1
Federal Rebate	-$5.4	-$106.5	-$141.3	-$143.9	-$149.2	-$156.1	-$164.0	-$174.4	-$1,040.9	-$178.1
State Rebate	$0	$0	$0	-$5.6	-$9.1	-$11.3	-$16.3	-$18.6	-$60.9	-$19.0
Other State Appropriations Offsets										
DMH/DD/ SAS	-$8.2	-$16.4	-$16.4	-$16.4	-$16.4	-$16.4	-$16.4	-$16.4	-$122.8	-$16.4
ADAP	-$14.3	-$28.6	-$28.6	-$28.6	-$28.6	-$28.6	-$28.6	-$28.6	-$214.6	-$28.6
Corrections	-$8.5	-$17.0	-$17.0	-$17.0	-$17.0	-$17.0	-$17.0	-$17.0	-$127.5	-$17.0
Subtotal Offsets	-$31.0	-$62.0	-$62.0	-$62.0	-$62.0	-$62.0	-$62.0	-$62.0	-$464.9	-$62.0
Net Service Costs (gross service costs minus pharmaceutical rebates and other state offsets)										
Total Service	$516.6	$2,027.6	$2,050.9	$2,090.7	$2,142.2	$2,183.0	$2,216.3	$2,250.1	$15,477.5	$2,246.1
Total Federal	$516.6	$2,207.6	$2,050.9	$2,012.3	$2,019.0	$2,035.7	$2,102.0	$2,024.4	$14,697.4	$2,020.7
Total State with Offsets	-$31.0	-$62.0	-$62.0	$16.4	$61.2	$85.4	$143.4	$163.8	$315.1	$163.4
Administrative Expenses										
Total Admin.	$20.8	$29.5	$29.8	$30.1	$30.5	$30.8	$31.2	$31.5	$234.1	$31.5
Federal Admin.	$10.5	$14.8	$15.0	$15.1	$15.3	$15.5	$15.7	$15.8	$117.8	$15.8
State Admin.	$10.4	$14.6	$14.8	$14.9	$15.1	$15.3	$15.5	$15.6	$116.3	$15.6
REMI Analysis: New State Tax Revenues										
Migration	-$17.4	-$74.3	-$78.4	-$73.4	-$70.9	-$69.7	-$65.2	-$64.6	-$514.0	NA
No Migration	-$17.0	-$72.6	-$75.6	-$69.6	-$66.1	-$63.8	-$58.3	-$56.7	-$479.8	NA
Average Migration and No Migration	-$17.2	-$73.5	-$77.0	-$71.5	-$68.5	-$66.7	-$61.8	-$60.7	-$496.9	NA
Total Costs (Gross service costs, minus drug rebates, state appropriations offsets, and new (averaged) State revenues)										
Total	$537.4	$2,057.1	$2,080.7	$2,120.7	$2,172.7	$2,213.9	$2,247.5	$2,281.6	$15,711.6	$2,277.5
Federal	$527.0	$2,042.5	$2,065.9	$2,027.4	$2,034.4	$2,051.2	$2,117.6	$2,040.2	$14,815.2	$2,036.5
State	**-$37.8**	**-$120.8**	**-$124.2**	**-$40.2**	**$7.8**	**$33.9**	**$97.1**	**$118.7**	**-$65.4**	**NA**

Note: See Appendix C for full cost estimates.

In addition to the cost offsets identified by DMA and other state agencies, and the new state revenues identified by REMI, there are other potential cost offsets that were not included in these cost estimates. For example:

- The state may experience a decline in Medicaid medically needy expenditures. The Medicaid program covers some of the medical costs for people who are categorically

eligible for Medicaid but who have too much income to qualify under general program rules (medically needy coverage). Individuals with excess income can qualify for Medicaid if they first meet a "spend-down" (i.e., deductible) that is equal to the difference between their countable income and the Medicaid medically needy income limits. Some of the people who would otherwise be eligible for Medicaid under the medically needy coverage option will be covered through the regular Medicaid program and qualifying for the enhanced federal match rate. This could potentially reduce medically needy program costs.

- Similarly, the state provides coverage to some women who qualify with higher incomes through the state's breast and cervical cancer program coverage group. Many of these women would be eligible through the expanded Medicaid coverage. Although this is a relatively small number of women who qualify each year, the state could receive an enhanced match rate for the costs of providing Medicaid coverage to some of these women.
- As more people gain coverage, state and county governments could potentially reduce some of the expenditures to safety net providers currently used to help pay for services to the uninsured. For example, health departments provide some clinical services to the uninsured. Some of these costs may be offset if people gain insurance coverage.

In addition to these offsets to the state or local government, hospitals may experience a decrease in unnecessary use of the emergency department and reduced hospitalizations as more people gain coverage and access to preventive and primary care services. In addition, private and public sector employers may experience a decrease in the cost of health insurance premiums for workers as cost shifting becomes less necessary.

The decision about whether to expand Medicaid coverage has an impact not only on the individuals that may gain coverage, and the state budget, but also on health care providers in the state. The Medicaid expansion will provide a source of reimbursement for the care that many health care providers already provide to the uninsured. In addition, it can help offset some of the other ACA provider payment cuts that were made in anticipation of the Medicaid expansion. For example, the ACA cut Medicaid disproportionate share hospital (DSH) payments. DSH payments have historically been paid to hospitals that serve a high proportion of uninsured and Medicaid patients. In North Carolina, hospitals are scheduled to experience a loss of $384.5 million in Medicaid DSH payments (2014-2019). The federal government will cut $13.6 million in 2014, increasing to a $152.7 million cut in FY 2019.[17]

Additionally, an analysis by the American Academy of Actuaries showed that a states' failure to expand Medicaid could lead to higher costs in the individual market. This is because many of the people who remain uninsured who have incomes between 100-138% FPL can go into the Exchange and qualify for a subsidy. These individuals are expected to have higher health care costs than others who purchase coverage in the Exchange. The American Academy of Actuaries quoted an analysis by the Congressional Budget Office that health insurance premiums in the individual market would be 2 percent higher on a national level if no state expanded Medicaid.

> The Congressional Budget Office (CBO) estimates that due to the likely higher health spending among lower-income enrollees, average individual market

> premiums will be 2 percent higher than projections made under the assumption that all states expand Medicaid to 138 percent of FPL. [citations omitted] Note that this estimate reflects the increase in average premiums overall, including not only states that opt out of the Medicaid expansion but also those that do expand Medicaid. Therefore, premium increases would be even higher among those states that do not expand Medicaid.[18]

These increased costs would be borne by people who purchase nonsubsidized individual coverage in the Exchange or outside the Exchange (as premiums must be the same inside and outside the Exchange), and by the federal government for those who purchase subsidized coverage in the Exchange. The American Academy of Actuaries also noted that a state's decision whether to expand Medicaid could also have potential implications for employers. Employers with 50 or more full-time equivalent employees are required to offer coverage to their employees, or pay a penalty (discussed more fully in Chapter 2). If an employer offers coverage—but it is considered unaffordable (i.e., the employee has to pay more than 9.5% of his or her income for the premium coverage)—then the employer will have to pay a higher penalty for that individual. "In states that opt out of the Medicaid expansion, low-income workers who otherwise might have enrolled in Medicaid might access premium subsides thereby putting the employer at risk of penalties."[19]

Some members of the Overall Advisory Committee raised the question of what would happen if the federal government later reduced its FMAP rate for the newly eligibles. Historically, CMS has not changed how the FMAP rates have been calculated, except to provide temporary increases to the FMAP rates to provide greater assistance to the states during times of recessions.[20] However, CMS has provided new guidance to clarify that states that choose to expand Medicaid coverage can choose to drop this coverage to the newly eligibles at a later date.[21]

In summary, a decision to participate in Medicaid expansion as put forth in the PPACA would provide insurance coverage to approximately 500,000 North Carolinians; most of whom would remain uninsured without the expansion. Providing health insurance coverage will help people gain access to the care they need, which can help improve health outcomes. The gross service costs to the state would be $840.9 million and the new administrative costs would be $116.3 million between SFY 2014-2021. However, these new costs would be offset by pharmaceutical rebates ($60.9 million), redirecting existing state appropriations for other programs ($464.9 million), and the new tax revenues likely to be generated as a result of the increase in state domestic product from the infusion of $14.8 billion in new federal dollars ($496.9 million). Because of the high federal match rate, the offsets, and the new tax revenues, the state will actually experience a net savings of $65.4 million from the Medicaid expansion over the eight year time period (SFY 2014-2021). On a yearly basis, the state is expected to save a high of $124.2 million in SFY 2016. Beginning in SFY 2018, North Carolina will be required to contribute towards the costs of services to the newly eligibles. By, SFY 2021, the net new expenditure will be approximately $118.7 million.

The REMI analysis also projected that the Medicaid expansion would create about 25,000 new jobs by 2016 and about 18,000 sustained jobs (by 2021). The new federal funds would also help generate an additional $1.3-$1.7 billion in state domestic product per year.

RECOMMENDATION 3.1: EXPAND MEDICAID ELIGIBILITY UP TO 138% FPL

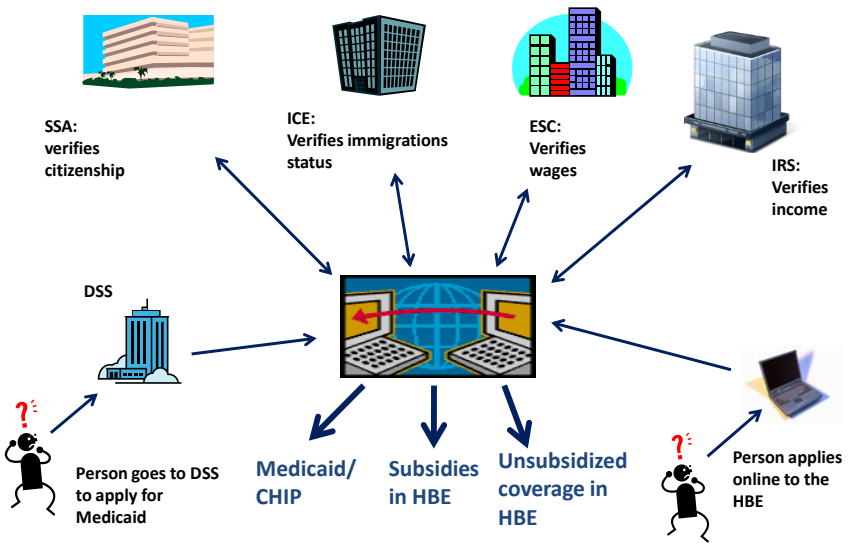
Based on North Carolina Division of Medical Assistance's projections of the number of people who may gain Medicaid coverage and the costs to the state, and the REMI analysis of jobs created, increase in the state's gross domestic product, and new tax revenues generated as a result of the expansion, the NCIOM recommends that North Carolina expand Medicaid eligibility up to 138% FPL.

STREAMLINED ELIGIBILITY AND ENROLLMENT, OUTREACH, AND COORDINATION WITH THE HEALTH BENEFITS EXCHANGE

The law requires the state to coordinate enrollment between all of the new "insurance affordability" programs, including Medicaid, NC Health Choice, the Basic Health Plan (if the state chooses to create one), and the advance payment of the premium tax credit or cost sharing subsidies available through the Exchange.[22] (At this point, there is no effort to create a Basic Health Plan in North Carolina). Essentially, there should be a "no wrong door" approach to enrollment. Therefore, if someone applies for a subsidy through the Exchange and is determined to be eligible for Medicaid, he or she must be enrolled automatically into Medicaid. Similarly, if someone applies for Medicaid whose income is too high but who is eligible for a subsidy for insurance offered through the Exchange, then he or she should be enrolled automatically into a subsidy program. Most people will be able to file their application online and will have income and citizenship (or immigration status) determined through a data match with other federal or state agencies (see Figure 3.1).

Prior to the passage of the ACA, the North Carolina Department of Health and Human Services (NCDHHS) was in the process of simplifying the Medicaid application and recertification process and streamlining eligibility requirements across all of NCDHHS's means-tested programs including, but not limited to, the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Temporary Assistance for Needy Families (TANF), and child care subsidies. In addition, NCDHHS was already creating a new electronic eligibility and enrollment system to replace its existing, antiquated system. This new eligibility and enrollment system, NC FAST (North Carolina Families Accessing Services through Technology), will capture and share information across all NCDHHS programs. Because of the new ACA requirements, the timeline for implementing the new Medicaid electronic enrollment system will be expedited so that it will be operational by the fall of 2013.[23] NC FAST will also serve as the eligibility and enrollment engine for Medicaid and NC Health Choice and will coordinate with the Exchange for people who are applying for subsidies through the Exchange. The electronic eligibility and enrollment system must be operational by October 2013, as the Secretary has established an open enrollment period for Medicaid and the Exchange beginning October 1, 2013 and running through March 31, 2014.[24]

Figure 3.1
Medicaid and Health Benefit Exchange Application and Enrollment System



The federal government issued notices of proposed rulemaking on August 17, 2011 which provided more detail for how the new eligibility and enrollment process will work across the different insurance affordability programs. The final Medicaid eligibility regulations were published on March 23, 2012,[25] and the final Exchange eligibility regulations were published on March 27, 2012.[26] These regulations are all interconnected, as under the ACA eligibility and enrollment for all the insurance affordability programs need to be coordinated. As family incomes fluctuate, families are likely to move between Medicaid and the Exchange. A study showed that 50% of individuals with incomes below 200% FPL who did not have employer-sponsored insurance would have experienced a change in income necessitating a movement between Medicaid and the Exchange within one year.[27] Twenty-four percent would have experienced at least two eligibility changes within a year, and 39% would have experienced at least two changes within two years. Thus, there is a critical need to ensure that eligibility and enrollment is streamlined and coordinated between the different insurance affordability programs.

With limited exceptions, income eligibility will be determined using IRS rules for MAGI. In addition, states must use a single, streamlined application for all insurance affordability programs, and individuals must be able to apply by Internet, telephone, mail, in person, or by fax. The Medicaid workgroup reviewed these regulations, focusing on the new Medicaid eligibility and enrollment requirements. (The HBE workgroup focused more closely on the Exchange eligibility and enrollment regulations and the IRS regulations which addressed the new requirements for premium tax credit and cost-sharing subsidies.[28])

The federal regulations prescribe most of the new eligibility and enrollment processes, but left some areas of discretion for the state. The workgroup spent most of its time focusing on these eligibility options, including Medicaid eligibility determinations for pregnant women, verification requirements, and determination of initial and ongoing eligibility if circumstances change:

- *Determining eligibility for pregnant women*. The ACA gives states the option of continuing to cover pregnant women with incomes up to 185% FPL (existing income eligibility rules) or reducing the income eligibility limits to 138% FPL in 2014. Similarly, the ACA gives states the option of counting the unborn child(ren) as part of the eligibility unit. Thus, a pregnant woman carrying one child would be a considered two people for the purpose of determining Medicaid eligibility. Counting the unborn child(ren) in the family unit helps more pregnant women qualify for Medicaid coverage. The workgroup recommended that the state maintain its existing coverage and continue to count the unborn child(ren) in the eligibility unit. North Carolina is trying to reduce infant mortality through the CCNC pregnancy home care management initiative. Through quality initiatives and other program components, the pregnancy managed care initiative should improve birth outcomes and reduce costs associated with poor birth outcomes. The fact that Medicaid covers 72,000 births a year means this initiative can have a profound influence on overall birth outcomes through improving the care that pregnant women receive. North Carolina can positively impact birth outcomes by maintaining existing eligibility coverage.

- *Verification requirements.* In order to determine eligibility for Medicaid, most individuals will only need to demonstrate proof of citizenship or lawful permanent residence, residency, household size, and income.[29] The state will obtain most of the verification from secondary data sources (i.e., through administrative data matches with the Social Security Administration, Department of Homeland Security, Internal Revenue Service, or state Employment Security Commission). In addition, applicants will be allowed to provide some information directly. For example, states must allow women to verbally attest to pregnancy status and families to attest to household composition without further written documentation (self-attestation). In addition, applicants must be given the opportunity to review and verify the information provided through the administrative data matches. The agency must use information from the applicant and the administrative data sources unless the two sources of information are not "reasonably compatible." Reasonably compatible is defined in federal regulations as information that does not vary in a way that is meaningful for eligibility.[30] Verification would not be considered reasonably compatible if the data from one source made the person eligible for coverage, but the data from another source did not. For example, if a person loses his or her job, the wage information that the state receives from an administrative data source may not comport with the individual's attestation about current earnings. In those instances, the state must seek additional information to resolve the discrepancy. This new verification process applies both to the new eligibles and the existing eligibility programs.

States have the discretion of allowing self-attestation for date of birth (age) and for residency. The state currently uses self-attestation for date of birth, but existing state law requires two forms of residency for Medicaid. This requirement causes difficulties for some of the lowest income applicants who do not have utilities or rent listed in their names. The federal regulations change the residency requirements so that now all the applicant must show is intent to reside in the state.[31] In the past, the state was concerned that people would move to North Carolina from surrounding states to gain Medicaid coverage. However, states are precluded from imposing residency requirements, as the United States Supreme Court has held that durational residency requirements are unconstitutional.[32] Thus, North Carolina could not limit eligibility to individuals who had first resided in North Carolina for a specified period of time. The workgroup recommended that North Carolina continue to allow self-attestation for date of birth, and that DMA seek changes to state laws to allow it to accept self-attestation for residency, unless there is a reason to believe that a person does not have the intent to reside in North Carolina. The workgroup was mindful that there may be certain instances when people move to North Carolina and seek to establish residency in order to obtain services from North Carolina health care institutions. While the state cannot stop people from moving, and then qualifying for Medicaid, we can try to identify people who are falsely claiming that they have moved when in fact they have not. The workgroup recommended that DMA examine its existing caseload to determine if there were certain "high risk" cases when it would be appropriate for the state to seek additional verification of residency.

The state also has the discretion to create linkages with other state secondary data sources to verify eligibility. The workgroup recommended that the NC DHHS, through NCFAST, create an electronic data link with the North Carolina Department of Revenue as another source of income verification, with Vital Records to verify age and death, and to seek other sources of electronic verification of current wages or liquid assets (for those individuals who are still required to provide proof of resources to determine Medicaid).

- *Determining initial and ongoing eligibility*. The state is required to use current income for initial eligibility determinations, but may use annualized income to determine ongoing Medicaid eligibility. Using annualized income to determine ongoing eligibility is important so that individuals are not forced to change eligibility status for small changes in earning (for example, for individuals who work fluctuating hours). This will help minimize administrative costs to the state and local departments of social services (DSS). Also, it will minimize disruptions in continuity of care and reduce administrative burdens to providers. Thus, the workgroup recommended that the state use annualized income for ongoing eligibility.

  In addition, the final regulations give states the authority to count "reasonably anticipated" future changes in the eligibility determination process.[33] For example, the state can consider the income someone would receive from a new job, and/or a layoff notice in determining eligibility. This could help reduce the number of times that a person would cycle on or off eligibility. The workgroup recommended that North Carolina include provisions to include reasonably anticipated changes, but that the state strictly define what it means by reasonably anticipated. Reasonably anticipated changes

should include a new job, loss of a job, or change in the number of hours worked on a regular schedule. If the definition is not very clear, it could lead to an increase in appeals.

Based on this information, the NCIOM recommends:

RECOMMENDATION 3.2: SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES

a) The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage. To accomplish this, DMA should exercise state flexibility to:
   - **i. Provide Medicaid coverage to pregnant woman up to 185% of the federal poverty level and count the unborn child in the eligibility determination.**
   - **ii. Use self-attestation to verify date of birth.**
   - **iii. Use annualized income to determine ongoing eligibility.**
   - **iv. Include reasonably anticipated changes in the eligibility determination process using a strict definition of what meets the threshold of a reasonably anticipated change.**

b) DMA should seek changes in state law to allow it to accept self-attestation of residency, except when it has reason to believe that a person does not have the requisite intent to reside in the state.
   - **i. DMA should examine its current case load to determine if there are certain types of cases which raise questions about the applicant's intent to reside in state. In those instances, DMA should have the flexibility to seek additional verification of residency.**

c) The North Carolina Department of Health and Human Services should continue its work to create electronic data matches with the North Carolina Department of Revenue for North Carolina wage information, Vital Records within the State Center for Health Statistics for birth and death data, and other electronic sources that have information about wages, resources, or other eligibility factors.

d) DMA should work with the Health Benefits Exchange (Exchange) to identify other strategies to ensure that individuals do not experience gaps in coverage when they have fluctuating income that requires them to change insurance coverage between Medicaid and the Exchange.

In addition to the new verification requirements, the ACA imposes requirements on state agencies and on the Exchange to conduct outreach, provide consumer education, and assist people with the eligibility and enrollment process. For example, the ACA charges state Medicaid agencies with:

> "conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX [Medicaid] or for child health assistance under title XXI [CHIP], including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial

> and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS."[34]

State Medicaid agencies are also charged with helping people with the application and enrollment process.[35] In addition, the ACA requires the Exchange to contract with patient navigators to conduct public education to raise awareness about qualified health plans in the Exchange.[36] The role of patient navigators and in-person assisters is discussed more fully in Chapter 2. Because of the need to coordinate eligibility and enrollment across all insurance affordability programs, the outreach, education, and enrollment processes must also be coordinated.

The workgroup recommended that DMA work with the North Carolina Department of Insurance (DOI) and the Exchange to develop a consolidated outreach and education campaign. As part of this campaign, DMA and the Exchange should develop educational materials that explain different available insurance options and how people can apply for and receive help paying for health insurance coverage. The educational materials should be written using clear communication strategies so that people with lower health literacy can understand them. In addition, they should meet accessibility standards under the Americans with Disabilities Act (ADA), and be linguistically and culturally appropriate for the different populations who may enroll in insurance coverage.

The workgroup also recommended that DMA, DOI, and the Exchange work with different faith-based organizations, community-based organizations, provider groups, and government agencies to educate the broader population about different coverage options. Local DSS agencies, health departments, local management entities/managed care organizations (LME/MCOs), and safety net providers will play a critical role in helping to educate and enroll uninsured individuals into new coverage options, as these organizations have often worked with this population in the past. However, there are many uninsured who do not routinely seek health care or social services. To reach these people will require different outreach strategies and different messengers. Thus, the workgroup recommended that DMA and the Exchange work through other community-based organizations that have ties to traditionally underserved populations. For example, DMA, DOI, and the Exchange should help educate the faith community, the broader health care community, community-based organizations (e.g., United Way, Goodwill, rescue missions, homeless shelters, day care programs, domestic violence agencies), and local governmental agencies (eg, employment security commission, schools, cooperative extension, law enforcement agencies, area agencies on aging, aging and disability resource centers). DMA, DOI, and the Exchange should also reach out to local Chambers of Commerce and other employer groups to educate employers—particularly small employers—about new insurance options available through the Exchange.

In addition to the outreach and educational efforts, certain groups are charged with helping people enroll. This includes local DSS agencies, patient navigators and/or in-person assisters (under contract with the Exchange), and the Consumer Assistance Program within the NC DOI (NC Smart). Agents and brokers also play an important role educating small businesses and individuals about available health insurance options and helping them enroll. Some health care

providers also have the authority to determine presumptive Medicaid eligibility for certain Medicaid eligibility groups. For example, the existing Medicaid statute gives states the authority to authorize certain qualified providers to make presumptive eligibility decisions for children, pregnant women, and breast or cervical cancer patients.[37] Presumptive eligibility is an initial Medicaid determination, based on preliminary information provided by the applicant. If a person is determined to be presumptively eligible, he or she remains eligible for a certain period of time pending verification of eligibility. In North Carolina, federally qualified health centers (FQHCs), rural health clinics, local health departments, and hospitals can make presumptive eligibility determinations for pregnant women, but the state does not allow for presumptive eligibility for children or breast and cervical cancer patients. The ACA modifies the statute to give states the option to allow these same providers to make presumptive eligibility determinations for other categories of Medicaid (including those who would be newly eligible under the ACA).[38] In addition, beginning in 2014, any hospital that participates in Medicaid can elect to make presumptive eligibility decisions for any Medicaid applicant.[39] Thus, it is particularly important that these organizations receive training to ensure they understand all the eligibility requirements as well as different insurance options.

Therefore, the NCIOM recommends:

RECOMMENDATION 3.3: DEVELOP A BROAD-BASED EDUCATION AND OUTREACH CAMPAIGN TO EDUCATE THE PUBLIC ABOUT NEW INSURANCE OPTIONS

a) The North Carolina Division of Medical Assistance (DMA), North Carolina Department of Insurance (DOI), and North Carolina Health Benefit Exchange (Exchange) should work together to develop a broad-based education and outreach campaign to educate the public about different health insurance options and insurance affordability programs. As part of this effort, DMA, DOI and the Exchange should:

- **i. Develop educational materials that explain the different insurance options and how people can apply for help paying for health insurance coverage. The educational materials should be linguistically and culturally accessible, meet ADA accessibility standards, and be written at a level that is understandable to people with low health literacy.**
- **ii. Conduct education sessions and enlist the help of community-based organizations, provider groups, and government agencies to educate the general population about the different coverage options. Special efforts should be made to identify and educate organizations that have relationships with and ties to traditionally underserved communities, including the uninsured, as well as those who have ties to small businesses. These groups should be provided with educational materials and information about the new insurance coverage and different insurance affordability options.**
- **iii. Provide enhanced training to organizations that are charged with assisting people enroll into Medicaid, North Carolina Health Choice, or private insurance coverage offered through the Exchange. This includes, but is not limited to, patient navigator and in-person assister organizations, hospitals, FQHCs, and agents and brokers.**

iv. **Create a unified toll free telephone hotline that is widely advertised to provide information about the new insurance options.**

b) **DMA, DOI, and the Exchange should seek federal, state, and/or private foundation funds to pay for media coverage to educate the public about the new insurance options.**

The workgroup discussed the important role that local DSS agencies will continue to play in helping low-income people enroll in the appropriate health insurance coverage. Many people who have received assistance in the past through DSS are likely to continue to seek help there, regardless of whether they are eligible for Medicaid, CHIP, or subsidized coverage through the Exchange. Thus, the workgroup recommended that DSS eligibility workers become certified as patient navigators and/or in-person assisters (see Chapter 2) so that they can provide impartial information and can help people enroll in any of the insurance affordability programs. This is similar to the role that DSS eligibility workers currently play in helping Medicare recipients identify appropriate Medicare Part D, Medicare Advantage, Medicare supplement, or long-term care insurance policies.[40]

The ACA allows states to claim federal administrative match funding for the work that patient navigators do in Medicaid outreach and enrollment. This would provide 50% federal administrative match for navigator work related to Medicaid, if such functions are performed under a contract or agreement that specifies a method for identifying costs and expenditures related to Medicaid and CHIP activities. The workgroup encouraged DMA and the Exchange to explore this option, in order to maximize federal funding for the Medicaid and CHIP outreach and enrollment activities.

In addition to the role that DSS will play in assisting people in applying for insurance, they also will be called upon to help people who experience enrollment problems. This is most likely to occur when information provided by the applicant conflicts with other data obtained by the administrative data sources (i.e., the data are not "reasonably compatible"). As envisioned, most individuals who apply will have their income, citizenship, and immigration status verified through an administrative data match. For most individuals, this system should work well to verify eligibility. However, some people will have more difficulty, particularly those who have experienced a recent change in their income or household composition. For example, individuals who recently gained or lost a job may have a different household income than reflected in the prior year's tax filings or ESC wage information. Similarly, someone who recently got married or divorced may have different circumstances that are not reflected in the administrative data matches. In these circumstances, it is important to have people who can verify the change in circumstances (e.g., by viewing new wage stubs or a marriage license). Local DSS agencies can help play this role, particularly as it relates to Medicaid and CHIP applicants. DSS staff will need to be trained to understand the new application and verification procedures, as well as the new roles they are likely to assume.

Therefore, the NCIOM recommends:

RECOMMENDATION 3.4: RETRAIN DEPARTMENT OF SOCIAL SERVICES ELIGIBILITY WORKERS

a) The North Carolina Division of Medical Assistance, North Carolina Division of Social Services, and the North Carolina Department of Social Services Directors should provide training to county Department of Social Services (DSS) eligibility workers to help them understand the new eligibility and enrollment processes that will go into effect in the fall of 2013, and the new roles and responsibilities of DSS workers under the Affordable Care Act.

b) Local DSS should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator or in-person assister in each DSS office, to ensure that local DSS offices know about all the available insurance affordability options.

COVERED SERVICES

The ACA mandates that states provide Medicaid coverage for tobacco cessation services for pregnant women (effective October 1, 2010),[41] services provided by free-standing birth centers (effective immediately),[42] and concurrent coverage for hospice care for children receiving treatment for their illness (effective immediately).[43] North Carolina was already in compliance with the tobacco cessation and birth center provisions prior to the passage of the ACA. However, the state did not initially offer concurrent coverage of hospice services for children. However, DMA made a policy change to provide concurrent coverage of hospice services for children effective June 1, 2011.[44]

In addition to the new Medicaid services the state was required to cover, the ACA gives the states additional flexibility in four areas: family planning services, health homes, preventive services, and home and community-based services.

Family planning services. In the past, states needed to seek a waiver to provide family planning services to individuals with higher incomes than would traditionally qualify for Medicaid. North Carolina currently operates a family planning waiver—called Be Smart—and is serving 30,000 people per year through this waiver. The waiver has been shown to be cost effective with net savings in excess of $10 million per year. Under the ACA, states can offer family planning services through a state plan amendment (SPA), rather than a waiver, to men or women of childbearing age who meet the income guidelines that would apply for pregnant women (185% FPL).[45] There is less administrative burden in offering these services through a SPA than through a waiver. DMA submitted its SPA, converting its family planning waiver to a state plan covered service on August 18, 2011, and received its approval on September 21, 2012. DMA is working towards implementation of the family planning SPA by November 2013.

Health homes. The ACA gives states the option of creating "health homes" for Medicaid recipients with chronic health problems.[46] A health home is a designated provider or team of health care professionals who provides comprehensive care management, care coordination and health promotion, transitional care, patient and family support, referrals to community and social services, and who uses health information technology. States that submit an SPA to operate a

health home are eligible for an enhanced federal match of 90% of the payments to health care providers for up to eight fiscal quarters. This provision is very similar to the way North Carolina operates the Community Care of North Carolina (CCNC) program (described more fully in Chapter 8). DMA's health home SPA was approved on May 25, 2012 with an effective date retroactive to October 1, 2011. Under this SPA, North Carolina will provide health home services to individuals receiving Medicaid who have two chronic illnesses, or one chronic illness with the risk of developing another. North Carolina chose to focus on the following chronic illnesses in the SPA: asthma, diabetes, heart disease, BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disease, chronic infectious disease, chronic mental and cognitive conditions (not including mental illness or developmental disabilities), chronic musculoskeletal conditions, and chronic neurological disorders. Health home services are being provided through CCNC.

Preventive Services. Under the ACA, the federal government will enhance the state's regular FMAP rate for preventive services by one percentage point if the state provides coverage without cost-sharing for all the clinical preventive services recommended by the United States Preventive Services Task Force with an A or B recommendation and all immunizations recommended by the Advisory Committee for Immunization Practices. This is similar to the ACA requirement for private insurers. Implementing this expanded coverage is expected to cost the state approximately $4.0 million in SFY 2014, and $8.1 million in SFY 2015. (See Chapter 6.) The Prevention workgroup recommended that the state adopt this coverage, which will help lead to improved health outcomes for the Medicaid population.

Home and community-based services. The ACA gives states a number of options to expand home and community-based services (HCBS) to older adults or people with disabilities. Two of the primary options are the Community First Choice option and the Balancing Initiative Program. In addition, the state also had opportunities to expand its Money Follows the Person program and Aging and Disability Resource Centers, described more fully below.

- *Community First Choice Option.* North Carolina currently provides home and community-based waiver services to individuals who would otherwise be eligible for Medicaid and need an institutional level of care (nursing facility, intermediate care facility for people with intellectual and developmental disabilities, state developmental centers, or hospital care).[47] Under these waivers, the state can limit the number of people it serves. The state receives its regular Medicaid match and must show budget neutrality to the federal government. Under the ACA, states can provide home and community-based attendant services and supports to people eligible for Medicaid whose income does not exceed 150% FPL or higher, at state option, if they would otherwise need institutional care (effective October 1, 2011).[48] States that implement this option are eligible for a six percentage point increase in their FMAP rate for covered HCBS.[49] If the state chooses this option, these HCBS would be an entitlement to eligible individuals (ie, the state could not limit the number of people it would cover, as it can with existing Medicaid waiver programs).

- *Balancing Initiative Program.*[50,51] The goal of the Balancing the Initiative Program is to encourage states to spend at least 50 percent of their long term services and support (LTSS) funds on home and community-based services (HCBS). Under the Balancing Initiative Program, states that spend less than 50 percent of their LTSS on HCBS programs are eligible for an enhanced FMAP on *all* HCBS program spending (including waivers, mandatory home health benefit, optional personal care services, and personal assistance services) in order to reach at least 50% spending by October 1, 2015.[52] States that choose this option must make the following changes to their long-term services and supports (LTSS) programs to enhance access to HCBS: establish a single point of entry system for all consumers to access LTSS; provide case management services where need is not assessed by the provider or by those financially responsible for the person in receiving LTSS care; and implement a standardized assessment tool for the purpose of eligibility determinations. In addition, states may not restrict eligibility for LTSS more than was in effect as of December 31, 2010. FMAP funds must be used to create new HCBS or expand existing HCBS. North Carolina would be eligible for a 2 percentage point increase in its FMAP through September 30, 2015 based on its current level of spending on HCBS. However, because North Carolina restricted access to personal care services (in response to legislative action and CMS requirements for comparability of service availability across settings of care), North Carolina is not currently eligible for the Balancing Initiative Program.

- *Money Follows the Person (MFP).* MFP is a federal and state demonstration project that began before the ACA. It was designed to assist eligible Medicaid recipients to transition out of qualified institutional facilities and into their homes and communities with appropriate supports. MFP also has the long-range objective of expanding the use of HCBS and identifying policy barriers that impact the provision of HCBS. As a result of the ACA, the federal MFP project was extended through 2020, with the final federal funding allocation to be administered in CY 2016. North Carolina has elected to continue its MFP project.

  In addition to funding the federal portion of North Carolina's MFP annual operating budget, DMA received $389,952 in federal funding through a series of ACA-funded grants to support initiatives that provide increased access to HCBS. DMA used this funding with MFP supplemental operating funds to allocate more than $2 million to the North Carolina Division of Aging and Adult Services and their local partners within the Community Resource Connections Network. This funding is being used primarily to support the federal requirement that states fund local agencies to provide outreach and options counseling to nursing facility residents interested in returning to their communities.

- *Aging and Disability Resource Centers (ADRCs).* The ACA includes funds to expand state Aging and Disability Resource Centers (ADRCs). ADRCs act as a "no-wrong door" to streamline access to information, assistance, and long-term services and supports. ADRCs generally offer options counseling and person-centered planning for long-term care, and can assist with transition support. In addition, ADRCs help families learn about and access both public and private long-term care services. In North Carolina, ADRCs

are commonly referred to as Community Resource Connections for Aging and Disabilities or CRCs. The CRC model builds on existing community infrastructure and realigns systems and processes for more efficient operations. North Carolina is in the process of implementing a statewide CRC structure with the Area Agencies on Aging serving as regional connectors to help with collaborative planning, with multiple other agencies providing basic service functions. Although fully functioning CRCs are not available statewide, critical elements of the system are in place in many communities.

The Division of Aging and Adult Services (DAAS) has received more than $600,000 in ACA funds to develop options counseling to help individuals with long term services and support needs. The funding has been used to support the development of standards, training, and core competencies for professionals who provide options counseling. The new curriculum and competency testing have been piloted and are available statewide. In November 2012, there were 67 certified options counselors, with 56 additional professionals in the process of being certified.

The Medicaid workgroup discussed the HCBS options as well as the potential cost impact to the state. Studies show that most people would prefer to remain in their homes or smaller community-based settings to receive services and supports rather than in a larger or institutional setting.[53,54] Thus, workgroup members support the goal of giving people greater options of where they receive long-term care services and supports.

The workgroup members were also mindful of the state's budgetary limitations. The Community First Choice provides an enhanced federal match rate. However, unlike the current home and community-based waivers in which the state can limit the number of people they serve, the Community First Choice option is an entitlement to the state. That means that the state would need to provide services to anyone who meets the program's eligibility rules. The workgroup was uncertain whether the enhanced match rate and the potential reduction in institutional-based, long-term care costs would offset the new costs the state might incur by offering a new HCBS program. Because of the state's fiscal crisis, the workgroup tried to identify options that would provide expanded HCBS to people with disabilities and the frail elderly without significant increases in Medicaid costs.

Some of the suggestions included:

- Expanding respite and adult day care services for the frail elderly or others with disabilities currently cared for at home. This expansion could increase the amount of time a person is cared for by family rather than seeking more costly residential services.

- Targeting new HCBS to older adults or people with disabilities who have been identified through the Adult Protective Services system (either as abused or neglected, or at risk of abuse and neglect). This targeting may help reduce state and county expenditures in providing services needed to protect these vulnerable adults from abuse, neglect, or exploitation.

The workgroup was also interested in exploring other areas where the state is already using 100% state dollars to provide similar services to a similar population. For example, the state currently provides long-term services and supports to people with mental illness, intellectual and other developmental disabilities, and substance use disorders through state (and federal) dollars. The workgroup was interested in exploring whether we could use some of the state funds as the state match to expand Medicaid HCBS to the same population. This expansion could potentially leverage new federal funds that could be used to provide services and supports to a broader population. The workgroup also discussed the need to develop an independent assessment process using standardized, validated instruments so that the state can more appropriately target services to individuals based on their level of need and other supports. In addition, the workgroup recommended that the state explore predictive modeling in order to get a better understanding of which populations are likely to need institutional care without additional home and community-based services. If the state could target its HCBS to those individuals, it may reduce Medicaid costs in the future.

In general, the workgroup was very supportive of the need to expand HCBS while at the same time minimizing new costs to the state.

Thus, the NCIOM recommends:

RECOMMENDATION 3.5: EXPLORE THE HOME AND COMMUNITY-BASED SERVICES MEDICAID EXPANSION OPTIONS

a) The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the amount of new federal funding it would receive through the enhanced FMAP rate versus the costs of expanding Medicaid through the Community First Choice option.
   - **i. DMA should explore options to use existing state dollars to leverage federal Medicaid dollars.**
   - **ii. DMA should give priority in new HCBS to respite and adult day care services for the frail elderly or people with disabilities services to help them remain at home. DMA should also give priority to older adults or people with disabilities who have been identified as at-risk through the Adult Protective Services system.**

b) DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.

REFERENCES AND NOTES

[1] The ACA requires states to expand Medicaid to cover nonelderly individuals with modified adjusted gross income of no more than 133% FPL, however the legislation also provides a 5% income disregard. Because of this disregard, individuals will be able to qualify for Medicaid if their income is not more than 138% FPL, assuming they meet other program rules.

[2] The federal poverty levels, established by the federal government, are based on family size. It is usually updated annually. In 2012, the federal poverty levels: for a family of one ($11,170); for a family of two ($15,130), family of three ($19,090), and family of four ($23,050). The federal poverty levels increase by $3,820 for each

additional family member. United States Department of Health and Human Services. http://aspe.hhs.gov/poverty/12poverty.shtml. Accessed April 16, 2012. Because the federal poverty levels are updated annually, they are likely to be higher by 2014.

[3] Patient Protection and Affordable Care Act, Pub L No. 111-148, 2001(a), amending Sec 1902(a)(10)(A)(i) of the Social Security Act, 42 USC 1396a.

[4] Kaiser Family Foundation. State Health Facts. Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL), states (2010-2011), US (2011). Available at: http://www.statehealthfacts.org/comparetable.jsp?ind=131&cat=3. Accessed November 12, 2012.

[5] Medicaid has higher income thresholds for pregnant women, so a pregnant woman earning this amount would probably qualify for Medicaid.

[6] Health Care and Education Reconciliation Act, Pub L No. 111-152, § 1201(1)(B), amending Sec.1905 of the Social Security Act, 42 USC 1396d.

[7] The FMAP rate changes every year based on a rolling three year average of the state's average per capita income.

[8] Health Care and Education Reconciliation Act, Pub L No. 111-152, § 2001(a)(2).

[9] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component. Table II.C.1. http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiic1.pdf. Accessed January 10, 2013.

[10] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component. Table II.C.1. http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiid1.pdf. Accessed January 10, 2013.

[11] Center for Medicare and Medicaid Services. Frequently Asked Questions on Exchanges, Market Reforms and Medicaid. Dated December 10, 2012. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf. Accessed January 4, 2013.

[12] Steve Owen. Chief Business Operating Officer. Division of Medical Assistance, North Carolina Department of Health and Human Services. Electronic communication. January 3, 2013.

[13] Mann C. State Medicaid Directors Letter. SMDL # 12-003. Essential Health Benefits in the Medicaid Program. November 20, 2012. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf. Accessed January 9, 2013.

[14] Center for Medicare and Medicaid Services. Medicaid Drug Rebate Program. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html. Update December 12, 2012. Accessed January 4, 2013.

[15] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10203(c)(1), amending Sec 2105(b) of the Social Security Act, 42 USC 1397ee(b).

[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10203(c)(1), amending Sec 2105(b) of the Social Security Act, 42 USC 1397ee(b).

[17] Steve Owen. Chief Business Operating Officer. Division of Medical Assistance, North Carolina Department of Health and Human Services. Electronic communication. January 3, 2013.

[18] American Academy of Actuaries. Implications of Medicaid Expansion Decisions on Private Coverage. Decision Brief. September 2012 at p. 2. http://www.actuary.org/files/Medicaid_Considerations_09_05_2012.pdf. Accessed September 23, 2012.

[19] American Academy of Actuaries. Implications of Medicaid Expansion Decisions on Private Coverage. Decision Brief. September 2012 at p. 3. http://www.actuary.org/files/Medicaid_Considerations_09_05_2012.pdf. Accessed September 23, 2012.

[20] Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing: An Overview of the Federal Medicaid Matching Rate. September 2012. http://www.kff.org/medicaid/upload/8352.pdf. Accessed January 23, 2013.

[21] Center for Medicare and Medicaid Services. Frequently Asked Questions on Exchanges, Market Reforms and Medicaid. Dated December 10, 2012. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf. Accessed January 4, 2013.

[22] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 2201, 1413-1414, enacting §1943 of the Social Security Act, 42 USC § 1397aa et. seq.

[23] North Carolina will need to be able to integrate Medicaid and CHIP eligibility with the web portal offered through the Exchange. NCDHHS already has a multi-year project to simplify and automate the eligibility verification and application processes of 13 income-related programs (NC FAST). When implemented, NC FAST should not only lead to improved customer and beneficiary service, but also to improved efficiencies. To comply with ACA's timeline of 2014 interoperable eligibility programs for public and private health coverage, NCDHHS has had to revamp its NC FAST timeline and scheduled implementation for the Medicaid eligibility module. Some of the costs of planning such changes are being recognized in the Exchange Planning Grant awarded through NCDOI. In addition, the federal portion of the development and ongoing operational cost of this Medicaid/CHIP component of NC FAST will rise from 50% to 90%.

[24] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.410.

[25] Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217.

[26] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475.

[27] Sommers BD, Rosenbaum S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Aff.* 2011;30(2):228-236.

[28] Department of the Treasury. Internal Revenue Service. Health Insurance Premium Tax Credit. Notice of proposed rulemaking and notice of public hearing. Fed Register 76(159):50931-50949.

[29] If an individual is not eligible for Medicaid under the new coverage groups (e.g., 138% FPL), then the person can apply for Medicaid under another category. In those instances, the individual may have to demonstrate proof of other eligibility requirements, such as disability status, resources, or outstanding medical bills.

[30] Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-1721742 CFR § 435.952(c).

[31] Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR § 435.403.

[32] The United States Supreme Court held, in Shapiro v. Thompson, 394 US 618 (1969), that a durational residency requirement which denied welfare benefits to low-income people unless they resided in the state for at least one year was unconstitutional. The court held that such residency requirements denied individuals' equal protection of the law, and violated their right of interstate travel.

[33] Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.603(h)(3).

[34] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2201, amending § 1943(b)(1)(F) of Title XIX of the Social Security Act, 42 USC 1397aa et seq.

[35] Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR § 435.908.

[36] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(i).

[37] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2202(a), amending Sec. 1902(a)(47) of the Social Security Act, 42 USC 1396a(a)(47).

[38] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2001(a)(4)(B) amending Section 1920 of the Social Security Act, 42 USC 1396r-1(e).

[39] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2202.

[40] There are currently DSS workers in 99 of the county DSS offices who are certified as Senior Health Insurance Information Program (SHIIP) counselors. These counselors receive training and certification through the North Carolina Department of Insurance (See Chapter 2 [Health Benefits Exchange Chapter] for more information about the SHIIP program).

[41] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4107.

[42] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2301.

[43] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2302, amending Sec. 340B of the Public Health Service Act, 42 USC 256b.

[44] Larson, T. Chief Clinical Operations Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication. January 10, 2011.

[45] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2303.

[46] Patient Protection and Affordable Care Act, Pub L No. 111-148, §2703, as enacting § 1945 of Title XIX of the Social Security Act, 42 USC 1396a et. seq.

[47] DMA currently operates three HCBS waiver programs: CAP-DA (Community Alternatives Program for Disabled Adults), CAP-MR/DD (Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities), and CAP-C (Community Alternatives Program for Children with complex medical needs).

[48] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2401, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, 1205.

[49] The Federal Medical Assistance Percentage, or FMAP, is the percentage of the Medicaid costs that are paid by the federal government for allowable health care services and supplies. In FFY 2013, the underlying North Carolina FMAP rate was 65.51%. Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2012 through September 30, 2013. *Fed Regist.* 2011;76(230):74061-74063.

[50] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10202.

[51] United States Government Accountability Office (GAO). Report to Congressional Requesters. Medicaid: States' Plans to Pursue New and Revised Options for Home- Community-Based Services. http://gao.gov/assets/600/591560.pdf. Published 2012. Accessed January 2, 2013.

[52] Kaiser Family Foundation. Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law. http://www.kff.org/healthreform/upload/8079.pdf. Published 2010. Accessed January 2, 2013.

[53] National Institute of Mental Health. United States Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health; 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Published 1999. Accessed September 22, 2010.

[54] Bayer A.H., Harper L. American Association of Retired Persons. Fixing to Stay: A National Survey of Housing and Home Modification Issues. Washington, DC: AARP Independent Living Program; 1995, 2000. http://assets.aarp.org/rgcenter/il/home_mod.pdf. Accessed February 8, 2011.

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 4: SAFETY NET

OVERVIEW

One of the major goals of the Affordable Care Act (ACA) is to increase access to care. As discussed in previous chapters, the ACA, as written, expanded access to public insurance through an expansion in Medicaid and private insurance through changes in requirements for businesses and individuals, as well as subsidies and tax credits to make private health insurance more affordable. Currently approximately 1.5 million North Carolinians are uninsured in 2013. [1] Many of these people are already receiving some type of medical care from safety net organizations and private providers. While most of the uninsured are expected to enroll in health care coverage in 2014, some will remain uninsured.[2] This percentage will be even higher in states that do not choose to expand Medicaid. (See Chapter 3 for a full discussion of Medicaid.) Uninsured individuals will continue to receive care through safety net organizations.

The safety net is composed of organizations that have a mission or legal obligation to provide health care and other related services to uninsured and underserved populations. They include federally qualified health centers (FQHCs), school-based or school-linked health services, public health departments, rural health clinics, hospitals, free clinics, and other community-based organizations.[3] (See Appendix E.) Safety net organizations have a track record of providing care to low-income, uninsured, and diverse populations that may not receive care from private community providers.[4]

Different safety net organizations provide access to primary and preventive services, specialty services, pharmaceutical services, dental services, behavioral health services, and hospital services. Some safety net organizations work together to create integrated care delivery systems for the uninsured. In many safety net organizations, services are provided for free or at reduced cost.[5] In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers (FQHCs), school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations. Through the North Carolina HealthNet initiative, the Office of Rural Health and Community Care provides technical assistance and flexible mini-grants to local communities to support efforts to increase access and quality of care for the uninsured through a coordinated system of care, and to share and conserve limited resources through collaborative partnerships so that resources can be directed to needs that have no alternative funding source (i.e., care/disease management, enrollment). HealthNet links Community Care of North Carolina's administrative infrastructure and networks of physicians and care managers with local and regional safety net organizations and indigent care programs that are providing free and discounted health care for the uninsured. However, communities are highly dependent on providers' donations for access to care and significant gaps remain. In addition, communities are often unable to leverage other resources or align resources for efficiencies across agencies.

North Carolina may not have sufficient numbers of new health care professionals to meet the increased demand for services that is likely to arise as people gain coverage. (See Chapter 5.) Further, many of the people who are currently uninsured have transportation and other barriers which will make it difficult to access private providers. Safety net organizations have traditionally served these populations, and will be needed to meet the health care needs of the newly insured. The ACA recognizes the important role of safety net providers and requires all Qualified Health Plans (QHPs) offered through the Health Benefit Exchange (Exchange) to contract with safety net providers that serve predominantly low-income, medically-underserved individuals.[6] In addition to the role that safety net organizations will play in meeting the health care needs of the newly insured, safety net organizations will be needed to meet the health care needs of the people who remain uninsured. Recent CBO estimates, developed after the Supreme Court decision in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), suggest that the ACA will extend coverage to 89% of all Americans by 2022 (30 million of the 60 million who would otherwise be uninsured).[7] However, 11% of Americans will remain uninsured. Safety net providers will need to continue to provide care for many uninsured individuals who cannot afford private insurance or are ineligible for public programs.

The ACA recognizes these challenges and included provisions to increase and strengthen the health care safety net. There is a particular focus on FHQCs as critical providers of primary care for the newly insured and uninsured. There is also an emphasis on expanding safety net capacity through school health centers and the National Health Service Corps. The Safety Net Workgroup examined these and other sections of the ACA along with the unmet needs of the safety net. Although there are many other types of safety net organizations in North Carolina, this chapter focuses only on those related to safety net provisions in the ACA. Some other safety net organizations are referred to in other chapters of this report. The Safety Net Workgroup strongly supported the inclusion of safety net organizations in all aspects of health care and reform including but not limited to Health Benefits Exchanges, new models of care, prevention, quality, and workforce as discussed in other chapters of this report.

SAFETY NET ORGANIZATIONS AS PROVIDERS OF CARE FOR THE NEWLY INSURED

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the United States Bureau of Primary Health Care under section 330 of the Public Health Services Act.[8] FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers. FQHCs must provide comprehensive primary and preventive health care services, and are required to provide enabling services including transportation, case management, outreach, and interpretation and translation. In addition, FQHCs are required by law to provide services to the uninsured on a sliding scale basis. In 2011, there were 28 FQHCs in North Carolina delivering care at 150 different sites. There were also three FQHC look-alikes providing services at twelve clinical sites[9] and a Migrant Voucher program that provides grants and reimbursement for clinical and outreach services.[10,11] More than 50% of the FQHC patients served in North Carolina in 2010 were uninsured, and 95% had incomes below 200% FPL.

Congress created special payment rules for FQHCs because they are less able to cost-shift the costs of caring for the uninsured to other private payers. Thus, FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted

medications through the 340B federal prescription drug discount program (see 340B program expansion section).

Expanding and Strengthening FQHCs

The ACA includes new appropriations to expand the number of FQHCs and to increase the number of people they can serve. As noted earlier, FQHCs have historically been a major provider of primary care and other health services to the uninsured. They are also likely to play a prominent role in providing services to the people who gain coverage in 2014. In Massachusetts, the numbers of patients that FQHCs served increased by almost 10% after the state passed its health reform legislation in 2006.[12] FQHCs in Massachusetts also continued to serve many of the state's uninsured patients. In fact, while the total number of uninsured patients that FQHCs served declined after Massachusetts' coverage expansion, the proportion of all remaining uninsured seen by FQHCs increased by 14%.[13]

Congress recognized the continued importance of FQHCs after the coverage expansion in 2014. The ACA initially appropriated a total of $9.5 billion over five years to expand the number of community and migrant health centers nationally, expand the array of services provided, and increase the number of people they serve. The Bureau of Primary Health Care (BPHC) within the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. The North Carolina Community Health Center Association, with financial support from Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. North Carolina submitted 30 applications; however, after the applications were submitted Congress cut the level of ACA funding available to support new FQHCs. The federal budget compromise reduced operational funding for existing FQHCs by $600 million. Rather than cut services at existing centers, some of the $9.5 billion ACA FQHC funds were diverted to keep existing FQHCs operating at the same level of funding.[14] Because of this reduced funding, North Carolina only received funding to create two new FQHCs through Greene County Health Care (Snow Hill) and Albemarle Regional Hospital Authority (Elizabeth City). The combined total of these two grants was $1.5 million. Additionally, two other organizations were awarded $80,000 planning grants to prepare plans to transition to FQHC: Triad Adult and Pediatric Medicine (Greensboro) and Community Health Interventions and Sickle Cell Agency (Fayetteville).[15]

In June 2012, additional Health Center New Access Points grants totaling $128.6 million were awarded to 219 health centers across the country. North Carolina received more than $5 million for 9 FQHCs. The grants were awarded to Bakersville Community Medical Clinic, Inc. (Bakersville), High Country Community Health (Boone), Cabarrus Community Health Centers, Inc. (Concord), Gaston Family Health Services, Inc. (Gastonia), Blue Ridge Community Health Services (Hendersonville), Robeson Health Care Corporation (Pembroke), Rural Health Group, Inc. (Pembroke), Opportunities Industrialization Center, Inc. (Rocky Mount), and Southside United Health Center (Winston-Salem).

In addition, the ACA includes $1.5 billion for construction and renovation of FHQCs. Congress appropriated $1 billion in new funding in FFY 2011, which increases to $3.6 billion by FFY 2015.[16] North Carolina FQHCs received ACA grant funds totaling $19.2 million to support capital improvements and renovations, and to expand access to care through existing FQHCs in

the first award cycle.[17] This funding was provided to support four FQHCs: Roanoke Chowan Community Health Center (Ahoskie), Blue Ridge Community Health Services (Hendersonville), First Choice Community Health Centers (Mamers), and Metropolitan Community Health Services (Washington). These funds are in addition to the $33.3 million provided to 26 FQHCs through the federal ARRA funds.[18] In May 2012, North Carolina FQHCs received more than $9 million in capacity building grants. The four NC FQHCs awarded capacity building grants were Goshen Medical Center, Inc. (Faison), Rural Health Group, Inc. (Roanoke Rapids), Carolina Family Health Centers, Inc. (Wilson), and West Caldwell Health Council, Inc. (Collettsville). An additional $2.2 million was awarded to five FQHCs in North Carolina for immediate facility improvements. These grants were awarded to Piedmont Health Services, Inc. (Carrboro), the C.W. Williams Community Health Center, Inc. (Charlotte), Goshen Medical Center, Inc. (Faison), Rural Health Group, Inc. (Roanoke Rapids), and Stedman-Wade Health Services, Inc. (Wade).

The ACA also includes special payment rules for FQHCs. QHPs that contract with federally qualified health centers must pay the center the same amount it would receive under Medicaid prospective cost-based reimbursement.[19] The ACA also requires the Secretary of the United States Department of Health and Human Services (USDHHS) to develop a prospective cost-based reimbursement methodology in Medicare similar to that used for FQHCs in Medicaid.[20] The new methodology will be effective on or after October 1, 2014.

Enhancing the Quality of Care Provided by FQHCs

In addition to the grants to create new health centers, USDHHS also provided grant opportunities to increase the capacity of existing community health centers to provide patient-centered medical homes. The federal government offered two new funding opportunities:

- *Bureau of Primary Health Care's Patient-Centered Medical Home (PCMH) Supplemental Funding Opportunity*. The Bureau of Primary Health Care announced supplemental awards to approximately 900 FQHCs nationwide to support the practice changes needed to transition to patient-centered medical homes. Eighteen FQHCs in North Carolina received this $35,000 grant award. (FQHC look-alikes were not eligible for participation.) Grantees must "agree to seek recognition, increase their recognition level, or maintain the highest level as a PCMH through a national or State-based recognition or accreditation program."[21] The following North Carolina Health Centers received this additional funding: Roanoke Chowan Community Health Center (Ahoskie); Medical Resource Center for Randolph County (Asheboro); Western North Carolina Community Health Services (Asheville); Piedmont Health Services (Carrboro); C.W. Williams Community Health Center (Charlotte); Lincoln Community Health Center (Durham); Stedman-Wade Health Services (Fayetteville); Gaston Family Health Services, (Gastonia); Blue Ridge Community Health Services (Hendersonville); First Choice Community Health Centers (Mamers); CommWell Health (Newton Grove); Robeson Health Care Corporation (Pembroke); Wake Health Services (Raleigh); Rural Health Group (Roanoke Rapids); Greene County Health Care (Snow Hill); Metropolitan Community Health Services (Washington); New Hanover Community Health Center (Wilmington); and Carolina Family Health Centers, Inc (Wilson). (See Chapter 8 for more discussion of patient-centered medical homes.)

- *FQHC Advanced Primary Care Practice Demonstration*. This is a three-year demonstration project for FQHCs and FQHC look-alikes offered to approximately 500 health centers nationally. Funding is provided from the Center for Medicare and Medicaid Innovation, within the Centers for Medicare and Medicaid Services (CMS) and HRSA. The demonstration project is "designed to evaluate the effectiveness of the advanced primary care practice model, commonly referred to as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care" by moving sites toward NCQA Level 3 recognition by the end of the three years.[22] CMS received more than 800 applications, and 18 sites representing ten FQHC organizations were selected for participation in North Carolina, including: First Choice Community Health Center (Spring Lake, Angier, Cameron); Gaston Family Health Services (Bessemer City); Greene County Health Care (Snow Hill, Greenville); Metropolitan Community Health Services (Washington); Opportunities Industrialization (Roanoke Rapids); Piedmont Health Services (Burlington, Prospect Hill); Roanoke Chowan Community Health (Colerain); Robeson Health Care Corporation (Pembroke, Maxton); Wake Health Services (Raleigh, Apex); and Rural Health Group (Norlina, Hollister, Whitakers). To help participating FQHCs undergo practice transformation and progress toward PCMH recognition, they will receive an $18 quarterly care management fee per eligible Medicare beneficiary receiving primary care services. These quarterly payments are in addition to Medicare's per visit payments. CMS and HRSA will provide technical assistance, and FQHCs are required to submit NCQA Readiness Assessment scores every six months.

School-based or School-linked Health Centers

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.[23] A school-based health center (SBHC) is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health services, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration.[2] Nationally, a majority (64%) of school health centers provide services to children and families in the community as well as students at the affiliated schools.[24] There are 52 school health centers serving 22 counties in North Carolina. Most of these are school-based health centers, several are school-linked health centers, and a few health centers operate from traveling vans or buses to serve several schools.[25]

The ACA appropriated $50 million toward capital expenses for SBHCs in each FFY 2010-2013, although it did not appropriate funding for operating expenses.[26] HRSA awarded $95 million to 278 school-based health center programs across the country in July 2011. In North Carolina, nine sites were awarded more than $2 million including Alamance-Burlington School System (Burlington); Bakersville Community Medical Clinic, Inc. (Bakersville); Blue Ridge Community Health Services (Hendersonville); FirstHealth of the Carolinas (Pinehurst); Lincoln Community Health Center, Inc. (Durham); Mitchell County Board of Education (Bakersville); Morehead Memorial Hospital (Eden); West Caldwell Health Council, Inc. (Collettsville); and Yancey County Schools (Burnsville).[27] The second round of awards was made in December 2011. HRSA awarded more than $14 million to 45 school-based health center programs across the

country including more than $600,000 to two North Carolina SBHCs—Cherokee County Schools (Murphy) and Wilmington Health Access for Teens, Inc. (Wilmington).[28]

Rural Health Clinics

State-funded rural health clinics are nonprofit 501(c)(3) organizations that provide primary care, routine diagnostic and therapeutic care, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental, behavioral health, or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.[29] There are 86 certified rural health clinics in North Carolina.

There are 28 rural health service delivery sites that receive state funding from the Office of Rural Health and Community Care (ORHCC) to help pay for indigent care. One of the requirements for ORHCC funding is that rural health clinics be located in either a health professional shortage area (HPSA) or medically underserved area (MUA).[30] In North Carolina, the ORHCC is responsible for designating communities as HPSAs. The HPSA designation allows communities to qualify for many sources of federal funding including the National Health Service Corps. The National Health Service Corps provides scholarships and loan repayment to health professionals who practice in HPSAs. The ACA appropriated $1.5 billion to expand the National Health Service Corps over five years.[31]

Recruiting new health professionals to underserved areas expands access to care for those communities. The Office of Rural Health and Community Care plays a critical role both in designating underserved areas as primary care, mental health, and dental HPSAs and recruiting primary care providers, psychiatrists, and dentists to serve in them. The Safety Net Workgroup strongly supports the Health Professional Workforce Workgroup recommendation to strengthen and expand the North Carolina Office of Rural Health and Community Care in order to recruit more health professionals to underserved areas. (See Chapter 5 for more information.)

Hospital Emergency Departments and Other Services

Hospital emergency departments and outpatient and inpatient clinics are a major part of the health care safety net. Despite increasing capacity in primary care safety net providers, many people go to the emergency room for care. According to a recent CDC report, in 2009, more than 21% of adults over the age of 18 had at least one emergency department visit in the past year, and 8% had two or more visits.[32] Other studies report that 60% of patients in the emergency department could be treated elsewhere.[33] Emergency department utilization was 93% higher among people with a family income below the poverty level compared with those with a family income at least four times the poverty level.[34] Emergency departments are not the optimal place for people to get routine primary care.

The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for Medicaid patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The Committee identified categories of patients who might present to an emergency department for treatment who could be more

appropriately treated in another health care setting.[35] The patient categories include dental complaints, chronic pain complaints, and behavioral health complaints.[36] Preliminary planning for the project between the Committee and the Community Care of North Carolina has already begun.

The ACA authorized $24 million per year for five years beginning in FY 2010 for competitive grants for regionalized systems for emergency response.[37] It also authorized $100 million in FY 2010 and such funds as are necessary thereafter for grants for trauma care centers and additional funding for emergency services for children.[38,39] Although the ACA authorized funding for these programs, Congress did not appropriate new funding for most of these programs—with the exception of the Children's emergency medical services demonstration grants. Both the University of North Carolina at Chapel Hill, and the North Carolina Department of Health and Human Services have received grants for emergency medical services for children under this grant program.[40]

While new funding has not been made available through the ACA for emergency room diversion pilot projects, there is still a need to focus on reducing unnecessary use of the emergency department. Based on the work of the Access to Care Committee, the NCIOM recommends:

RECOMMENDATION 4.1: DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT

a) The North Carolina College of Emergency Physicians (NCCEP) and Community Care of North Carolina should work with the North Carolina Hospital Association, North Carolina Department of Health and Human Services, Care Share Health Alliance, the North Carolina Community Health Center Association, North Carolina Dental Society, North Carolina Foundation for Advanced Health Programs, North Carolina Free Clinic Association, Governor's Institute of Substance Abuse, and others to develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on:
   - **i) Dental complaints**
   - **ii) Chronic conditions**
   - **iii) Behavioral health issues**

b) NCCEP and partners should seek funding for the emergency transition of care project through the United States Assistant Secretary for Preparedness and Response for regionalized systems for emergency care and from other federal sources.

Enhancing Hospital Community Benefits

Hospitals also help meet the health care needs of the broader community. For example, North Carolina hospitals provide charity care to many low-income uninsured patients, make cash and in-kind contributions to community groups, and get involved in other community health activities.[41]

The ACA establishes new requirements for charitable hospitals. These hospitals must have a publicly available financial assistance policy including information on how charges are

calculated, billed, and collected. The charges for emergency or other medically necessary care for the uninsured were limited to what a person with insurance would be charged.[42]

The North Carolina Hospital Association works with hospitals to help meet these requirements. The Hospital Community Benefits Report webpage voluntarily lists the financial assistance policies for all North Carolina hospitals that have made them public since 2007.[43] Guidance is available to help hospitals calculate their community benefits so that data may be reported uniformly across hospitals. In FY 2010, North Carolina hospitals provided $853 million in free care.[44]

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health".[45] The required health assessment is similar to the community health assessment that each health department in North Carolina is required to conduct. The North Carolina Hospital Association and North Carolina Division of Public Health are working together to encourage community hospitals and local health departments to collaborate in conducting their community health needs assessments.[46] In response to the collaboration between hospitals and health departments, the NCIOM recommends:

RECOMMENDATION 4.2: INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS

- **a) As part of the hospital and local health department community health assessments, these organizations should:**
  - **i. Solicit input from patients and a broad range of stakeholders and community leaders.**
  - **ii. Include data from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area.**
  - **iii. Examine access to quality care issues along with population health and other community health needs through broad, open solicitation input from multiple partners.**
  - **iv. Use stakeholder and patient input to develop common criteria for determining priorities for implementation.**
- **b) In implementing community health needs priorities, hospitals and public health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.**
- **c) Local communities should use the community health assessment action plan to pursue funding resources and strategically allocate existing resources.**

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers including FQHCs and hospitals that receive Medicare disproportionate share hospital (DSH)[47] payments. The program was expanded to include children's hospitals, free-standing cancer hospitals, critical access hospitals, and sole community hospitals.[48] In North Carolina, 29 of the currently eligible FHQCs[49] and 70 of the currently eligible hospitals are participating in the program. The ORHCC assists critical assess hospitals in the state process. The savings the 340B

program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the NCIOM recommends:

RECOMMENDATION 4.3: EXPAND 340B DISCOUNT DRUG PROGRAM ENROLLMENT AMONG ELIGIBLE ORGANIZATIONS

The North Carolina Division of Medical Assistance and Office of Rural Health and Community Care of the Department of Health and Human Services , North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage DSH hospitals, critical access hospitals, sole community hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.

HELPING LINK UNINSURED TO APPROPRIATE INSURANCE COVERAGE

Safety net providers have a direct connection to many underinsured and uninsured people. Many safety net providers offer health education, transportation, and connection to other community resources. In that role, patients look to safety net providers for information about health care.

The ACA requires that each state's Exchange to establish a program to award grants to entities that serve as navigators/in-person assisters. It described the role of a navigator/in-person assister and the entities that may serve as navigators/in-person assisters. The duties of a navigator include public education; distribution of fair and impartial information; facilitation of enrollment in QHPs; provision of referrals for grievance, complaint, or question about their health plan; and provision of information in a manner that is culturally and linguistically appropriate to the needs of the population being served.[50] In order to receive a grant, an organization must demonstrate that it has, or could readily establish, relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP.[51] (More information about the Health Benefit Exchange and navigators is provided in Chapter 2.)

In North Carolina, safety net providers have established relationships with the diverse uninsured population that is traditionally hard to reach. These established relationships provide a unique opportunity for safety net providers to serve as navigators for their patients, thus the NCIOM recommends:

RECOMMENDATION 4.4: ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS OR IN-PERSON ASSISTERS

- **a) The Health Benefits Exchange should train and certify staff at safety net organizations to serve as patient navigators/in-person assisters. In accordance with the ACA, these groups would be required to:**
  - **i. Provide public education to raise awareness of qualified health plans (QHPs).**
  - **ii. Distribute fair and impartial information.**
  - **iii. Facilitate enrollment in QHPs.**

iv. **Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or other appropriate state agency for an enrollee with a grievance, complaint, or question about their health plan.**
v. **Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.**
vi. **Meet standards to avoid conflict of interest.**

b) **As staff of safety net organizations, patient navigators/in-person assisters should also educate consumers and patients about appropriate use and location of care.**

CARE FOR THOSE THAT REMAIN UNINSURED

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. Most free clinics offer primary care and preventive services and treat both acute and chronic conditions. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.[52] Each free clinic sets its own eligibility guidelines for people who can be served. Services are provided for free to the uninsured with incomes below a certain income threshold and others may be charged on a sliding-fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.[53] There are 79 free clinics across North Carolina. Free clinics provided more than 200,000 patient visits and delivered $167.6 million in free care in 2010.[54]

Volunteers are the cornerstone of the free clinic movement. Health care providers and staff volunteer their time to provide services and support to patients. In order to provide services, these volunteers need medical malpractice insurance. The Health Insurance Portability and Accountability Act (HIPPA) granted medical malpractice coverage through the Federal Tort Claims Act (FTCA) to volunteer free clinic health professionals. The ACA extends medical malpractice coverage to free clinic board members, officers, employees, and individual contractors.[55] The extension of malpractice insurance to more free clinic staff and board members allows these organizations to direct their already limited funding toward patient care or other needed services. Nationally, there are 170 free clinics participating in the FTCA program, and 15 of those are in North Carolina.[56]

Continued Need for Safety Net Organizations

Safety net organizations are designed to fill gaps in the overall health care system and will still be needed after the full implementation of health reform. Many of the newly insured population will experience barriers to care including provider shortages, transportation, language, and other barriers.[57] The variety of insurance programs and eligibility requirements may cause people to transition between public and private insurance programs as their income changes, which may cause coverage gaps. In addition, we still expect to have significant numbers of people who are uninsured, even after full implementation of the ACA.

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. Workgroup members recognized the need for safety net organizations to continue to meet, on a periodic basis, to facilitate ongoing collaborations and communication. In the past, a group of safety net organizations met on a periodic basis (called the Safety Net Advisory Council or SNAC) in order to foster communication between the various organizations.[58] The SNAC also serves as the advisory group to help the ORHCC distribute state Community Health Center grant monies.[59] However, this workgroup has not been as active in recent years as it was when it was first created in 2005. Thus, the workgroup recommended that the Safety Net Advisory Council reconvene to identify communities with greatest unmet needs, increase collaboration among safety net organizations, and work together to help monitor and collaborate on future funding opportunities. In addition, the NCIOM recommended that safety net organizations provide data to the NC Health Care Help website[60] to maintain up-to-date information on available safety net resources.

RECOMMENDATION 4.5: RECONVENE THE SAFETY NET ADVISORY COUNCIL

a) The Safety Net Advisory Council should reconvene with facilitation assistance provided by Care Share Health Alliance in order to:
   - **i. Determine the future role of the Council in the state.**
   - **ii. Identify communities with the greatest unmet needs using hospital and public health collaborative community health assessments and other safety net data tools.**
   - **iii. Increase collaboration among agencies in a region to leverage resources as part of a larger service network.**
   - **iv. Monitor safety net funding opportunities and disseminate them to appropriate organizations.**
   - **v. Make a recommendation and plan for integrating safety net tools, including the NC Health Care Help website and county level resources.**
   - **vi. Serve as a unified voice for the safety net.**

b) North Carolina foundations and other agencies that provide funding to safety net organizations should encourage their recipients to submit or update data to the NC Health Care Help website on a regular basis.

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[5] North Carolina Institute of Medicine. Health Care Services for the Uninsured and Other Uninsured Populations: A Technical Assistance Manual. Morrisville, NC: 2008. http://www.nciom.org/wp-content/uploads/NCIOM/pubs/safetynet_tam.pdf. Published April 2008. Accessed May 2, 2012.

[6] The law required QHPs to contract with "essential community providers" which is a subset of the broader category of safety net providers, and includes those providers—such as FQHCs, hospitals, family planning projects, Ryan White Care Act grant recipients, state-operated AIDS Drug Assistance Programs, black lung clinics, comprehensive hemophilia diagnostic treatment centers, Native Hawaiian Health Center, urban Indian organizations, and STD or tuberculosis treatment grantees who are eligible entities for 340B discount drug pricing. Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(c)(1)(C).

[7] Congressional Budget Office. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf. Accessed November 14, 2012.

[8] Health Centers Consolidation Act of 1996, Pub L No. 104-299.

[9] FQHC look-alikes are organizations granted status by the Bureau of Primary Health Care (BPHC) for conforming to the structure and services of an FQHC. They receive no Section 330 grant funding but do receive FQHC Medicaid reimbursement rates and other benefits. Look-alikes do not report their service statistics to the BPHC and their data is not reflected in federal funds brought into the state.

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EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 5: HEALTH PROFESSIONAL WORKFORCE

OVERVIEW

In 2014, almost 800,000 uninsured North Carolinians may gain insurance coverage.[1] The increase in the number of North Carolinians with health insurance will increase demand for health care services, particularly primary care.[2] This acceleration of demand will include physical and behavioral health care as well as oral health care. There is evidence that North Carolina does not have enough health practitioners to meet current and future population health needs for all of its population. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. If the ACA is to deliver on its goals of improving population health and quality of care while reducing costs in our state, North Carolina must take steps to ensure there is an adequate workforce.

The Health Professional Workforce Workgroup was charged with identifying the decisions the state must make in implementing the workforce provisions of the ACA as it affects the state. While the ACA includes provisions to increase the number of physical,[3] behavioral,[4] and oral health practitioners[5] to address current and future workforce needs, and authorized new programs to expand the number of health care professionals, it did not include appropriations to fund all of these provisions. Given limited federal funding for workforce initiatives, the Workgroup focused on critical steps that the state could take to ensure an adequate workforce to meet the health care needs of North Carolinians. The Workgroup discussed many workforce-related challenges facing the state with a focus on short-term workforce issues including:

- Can the current workforce meet the changes in demand?
- What are the drivers that affect the quantity and quality of North Carolina's workforce?
- Do we educate enough health care practitioners to meet our population health needs?
- Are there other sources of health care practitioners?
- What policy solutions can help North Carolina meet changing demands?
- How is the practice of health care changing, and what types of changes to the workforce are needed to meet new practice demands?

Given the difficulties in rapidly expanding the health care practitioner workforce in the short-run, this Workgroup focused on what the state can do to be better prepared to meet the increase in demand for services in 2014 and beyond.

HEALTH WORKFORCE

Increasing access to and the quality of primary care is critical to ensure that North Carolina's health care needs are met. The primary care workforce includes physicians, nurse practitioners, physician assistants, certified nurse midwives, and registered nurses as well as support staff including licensed practical nurses, medical assistants, and others. These practitioners are responsible for providing a wide range of services from preventive care, chronic disease management, and urgent care, to basic psychosocial needs. They are the front door to the health care world and provide continuity of care to patients through ongoing relationships.[6] The

primary care workforce is facing large increases in demand due to aging baby boomers becoming eligible for Medicare, expanded insurance coverage through the ACA, and overall growth in the population.[7] While the primary care workforce is expected to experience the greatest increases in demand, increasing insurance coverage will likely result in significant increases in all types of health care utilization.[8] Over the past decade, North Carolina has expanded its primary care workforce. In 2010, North Carolina had a total of 9,017 primary care physicians, 3,679 nurse practitioners, and 3,625 physician assistants. North Carolina's primary care physician supply was above the national average with 9.2 practitioners per 10,000 population compared to 8.4 nationally. From 1997-2010, North Carolina saw a slight increase in the number of practicing physicians reporting a primary care specialty, from 41% to 43%. At the same time, the percentage of nurse practitioners and physician assistants reporting primary care specialties declined (from 50% to 45% and 45% to 34%, respectively).[9]

While primary care supply is currently strong overall in North Carolina, uneven distribution in rural areas means that many areas of North Carolina qualify as primary care health professional shortage areas (HPSAs). Additionally, it is unlikely that the current primary care workforce and workforce in training in North Carolina will be adequate to handle the large increase in demand for services.

The ACA includes provisions not only to expand access to physical health care, but also behavioral health care, which includes mental health and substance abuse services.[10] The Mental Health Parity and Addiction Equity Act of 2008 was the first federal bill requiring parity for mental and physical health benefits offered by large employers. The ACA further expands access to behavioral health services by requiring behavioral health coverage as part of the essential benefits package.[11] (See Chapter 3 for more discussion of the essential benefits package.) In addition, individual and small group plans offered through the Health Benefit Exchange will be required to cover mental health and substance abuse services in parity with treatment provided for physical health problems.[12] The ACA also includes provisions to encourage integration between physical and behavioral health services and to grow the behavioral health workforce.[13] The behavioral health workforce includes professionally trained (graduate-level) psychiatrists, psychologists, licensed clinical social workers, licensed clinical addiction specialists, and psychiatric-mental health nurses as well as bachelor's prepared nurses, technicians, aides, and others with training at or below the bachelor's level.[14] North Carolina's behavioral health workforce is not adequate to address population needs for prevention of and treatment for mental health and addiction disorders.[15] Seventeen counties have no psychiatrists and 24 counties have no psychologists; 82 counties have fewer than one psychiatrist per 10,000 residents and 73 have one or fewer psychologists per 10,000.[16] North Carolina's behavioral health workforce is inadequate to meet existing needs in many parts of the state and will be further strained as large numbers of individuals gain coverage for behavioral health services.

Oral health is an integral component of general health and can significantly affect overall health and well-being.[17] As part of the ACA, all insurance plans that are not grandfathered or self-funded ERISA plans must provide coverage of the essential health benefits. The essential health benefits must provide coverage of pediatric services, including oral and vision care.[18] The ACA does not include provisions to increase adults' access to oral health care. While the ACA does not include provisions requiring dental benefits for adults, it did include provisions aimed at

increasing the dental workforce (which have not been funded).[19] North Carolina has fewer dentists per capita than the United States (4.4 per 10,000 vs. 6.0 per 10,000, respectively).[20] This disparity is expected to increase due to a rapidly increasing population and declining retention rates for North Carolina educated dentists.[21] Limitations due to the size of the workforce and the new dental coverage for children is likely to exacerbate existing dental access barriers.

Allied health practitioners make up the largest proportion of the North Carolina health workforce (35%) and account for 44% of job growth in health care over the past decade.[22] Allied health workers are found in primary care, behavioral health, oral health, and other health care fields. Allied health practitioners include, but are not limited to, audiologists, certified medical coders, counselors, dental hygienists, dietitians, medical assistants, medical interpreters, medical office administrators, nurse aides, optometrists, pharmacists, physical therapists, rehabilitation counselors, and speech-language pathologists.[23] Many allied health practitioners work in primary care, with fewer working in behavioral and oral health care. As with other health care professionals, additional allied health professionals will be needed to meet the health care needs of the newly insured.

GROWING THE HEALTH WORKFORCE

The increase in demand for health care services due to the increasing size of North Carolina's population, the aging of the population, and increases in the insured population, combined with the shortages North Carolina is already experiencing in primary care, behavioral health, and oral health, mean that North Carolina must find ways to expand the health workforce. The Workgroup discussed many methods that could be used to expand the health workforce and ensure the workforce is prepared to meet North Carolina's primary health care needs including:

- Training more North Carolinians in North Carolina schools and institutions by increasing capacity.
- Training new and existing health professionals to practice in new models of care.
- Increasing the diversity of the workforce.
- Retaining more practitioners trained in North Carolina institutions when they graduate.
- Retaining practitioners currently practicing.
- Recruiting more practitioners from out of state.
- Changing practice models to maximize the efficiency of the existing workforce.

Training More Health Practitioners

Educating and training more health care practitioners is a necessary step to ensure that North Carolina has an adequate workforce to meet the growing health needs of the population. However, increasing the workforce without attention to the types of health practitioners and the geographic distribution of health practitioners needed to meet the needs of the population will not solve the problem. As discussed in Recommendation 5.5, all North Carolina agencies and educational institutions that play a role in the education, training, recruitment, and retention of health practitioners should be involved in health workforce planning.

There are efforts underway to increase the health care workforce, many of which focus on meeting the primary health and oral health workforce needs in rural and underserved areas. Many schools in North Carolina have recently expanded or plan to expand their health practitioner training programs including:

- East Carolina University (ECU) opened a School of Dental Medicine in 2011 with a class size of 50. ECU recruits students from North Carolina with an emphasis on students from disadvantaged backgrounds and underserved areas. Students will do their clinical training in community service learning centers in underserved areas around the state.
- The ECU School of Medicine has delayed plans to increase its class size from 80 to 120 students until funding is available. Plans call for students to do their clinical rotations in new satellite clinics located in eastern North Carolina.
- The UNC-CH School of Dentistry has delayed plans to increase its class size from 80 to 100 students until funding is available.
- The UNC-CH School of Medicine increased the medical class size from 160 to 170 in 2011 and added another 10 students in 2012. The additional students will receive their clinical education at regional campuses in Charlotte and Asheville. Clinical education for the students enrolled in the Charlotte and Asheville programs will focus on providing primary care to underserved populations. Planned expansion to 230 students is on hold until further funding is available.
- Campbell University plans to open a School of Osteopathic Medicine in the fall of 2013. The program aims to have an average class size of 150. Students will spend their third and fourth years of school training in community hospitals. The program will emphasize primary care, behavioral health, and general surgery with an emphasis on underserved populations.
- New physician assistant programs at Campbell (2011), Elon (planned for 2013), the University of North Carolina at Chapel Hill (UNC-CH) (planned for 2014); expansion of physician assistant programs at Duke University, Methodist University.
- The UNC School of Medicine is developing a new physician assistant program targeted to veterans with the medical training and experience of a Special Forces Medical Sergeant. The Master of Physician Assistant Studies degree program will include clinical rotations throughout the state, as well as a rigorous classroom experience. Blue Cross Blue Shield of North Carolina has pledged $1.2 million over the next four years to help UNC establish the master's curriculum, hire full-time program staff, and provide scholarship funds.
- St. Augustine's University has plans to begin a Master's level physician assistant program in the fall of 2014.
- Duke University has a new program to increase the number of Adult Nurse Practitioners (ANPs) and Family Nurse Practitioners (FNPs) who enroll full-time and graduate within two years and will accelerate the graduation rate of part-time students in these tracks.
- There have been many other efforts in nursing and allied health over the past five years. The workgroup noted that there were too many efforts to catalogue them all. However, examples of include:
    - The nursing programs at UNC Wilmington, Western Carolina University, ECPI University, East Carolina University, and some of the North Carolina Community College System schools have significantly expanded enrollment.[24, 25]
    - Pitt Community College is leading a regional consortium to develop health information technology training programs.
    - Carolinas College of Health Sciences has created an anesthesia technician certification program at Carolinas College of Health Sciences.

- Additionally there have been some smaller program expansions and various efforts to increase the number of medical, physician assistant, and nursing students interested in entering primary care.

In addition to these efforts, North Carolina has received some ACA grant funds aimed at expanding the health professional workforce. As part of the ACA, $253 million in Prevention and Public Health Fund grants were allocated to the Health Resources and Services Administration (HRSA) within the United States Department of Health and Human Services to support workforce grants in FFY 2010.[26] State agencies, academic institutions, and medical centers applied for grants from HRSA, and these entities were successful in competing for some of the new workforce funding. The following is a summary of ACA grants to increase the health professional workforce awarded to entities in North Carolina as of November 1, 2012.

- *Primary care residency expansion:* The UNC Chapel Hill Department of Pediatrics/UNC Hospitals received a five-year grant of $3.7 million to fund an increase of four residents per year with a focus on training general pediatricians for communities in North Carolina. The program will be done in collaboration with Moses Cone Health System and the UNC pediatrics faculty who are based there. The first four residents were admitted in 2011. In addition, New Hanover Regional Medical Center/South East AHEC received a five-year grant of $1.8 million to fund an expansion of the family medicine residency in Wilmington from four residents per year to six. The expanded residency program will develop a partnership with the New Hanover Community Health Center, a federally qualified health center (FQHC), to serve as a second site for training residents.
- *Expansion of Physician Assistant training.* Duke University School of Medicine's Physician Assistant (PA) Program was awarded a $1.3 million HRSA grant that will provide 34 students $44,000 in tuition support in an innovative longitudinal primary care curriculum. Selected students will do the majority of their clinical training in medically underserved areas of North Carolina, with the goal of practicing in these communities after graduation. In addition, the Methodist University Physician Assistant Program received a five-year grant of $1.9 million to both increase class size and to provide support to students to strengthen the likelihood they will enter primary care practice. The program will increase the size of the entering class from 34 to 40, with a possibility of going to 46 in later years. The funds will also be used for financial support to students and allow the program to develop some additional rural clinical training sites.
- *Personal and home care aide training.* North Carolina was one of only six states to receive one of these grants, with the North Carolina Department of Health and Human Services (NCDHHS) Office of Long-term Services and Supports being the grant recipient and the North Carolina Foundation for Advanced Health Programs as a subcontractor. With this three-year $2.1 million personal and home care aide training grant, two pilot projects will be developed to enhance the training of between 190-230 personal and home care aides with 60-80 trained via allied health programs in community colleges or high schools and another 120-150 participating in training through home care agencies and adult care homes.

- *Expansion of Advanced Nursing education and training.*
    - Western Carolina University and the Duke University School of Nursing received $601,000 and $213,000 respectively to support nurses pursuing advanced nursing education.
    - The Duke University School of Nursing received $1.3 million to increase full-time enrollment in their primary care nurse practitioner programs. The grants will provide many nursing students $44,000 in tuition support.
    - Many schools of nursing in North Carolina, including the University of North Carolina at Chapel Hill, Charlotte, Greensboro, and Wilmington, as well as Duke University, East Carolina University, and Winston-Salem State University, received funding from the Advanced Education Nursing Traineeships Program to fund traineeships for nurses receiving advanced nursing education.
    - The Duke University School of Nursing, Western Carolina University, Eastern Carolina University, and University of North Carolina at Charlotte and Greensboro received funds to support licensed regular nurses enrolled in nurse anesthetist programs.
    - The University of North Carolina at Chapel Hill and Duke University School of Nursing received $195,000 and $105,000 respectively to provide loan for*g*iveness for registered nurses completing graduate education to become nursing faculty.
    - The University of North Carolina at Chapel Hill received $210,000 to support efforts to increase nursing workforce diversity. Grant assistance includes financial assistance, academic support, and mentoring.
    - Duke University Hospital is part of the Centers for Medicaid and Medicare Services graduate nurse education demonstration project which will provide reimbursement (of up to approximately $50 million over five years) for clinical training costs for advanced practice registered nursing students.
- *Public Health Training Centers*. The University of North Carolina at Chapel Hill received $639,000 to establish the Southeast Public Health Training Center (SPHTC), which is part of the North Carolina Institute for Public Health at the Gillings School of Global Public Health. The SPHTC's focus is on training development, dissemination, maternal and child health, rural public health, leadership, and management.
- *Interdisciplinary and interprofessional education*. The University of North Carolina at Chapel Hill received $253,000 to support the integration of public health content into clinical curricula.
- *Geriatric education*. The Duke University School of Nursing received $262,000 to train and educate those providing care for the elderly.
- *State Health Care Workforce Development Grants*. The North Carolina Department of Commerce received $144,595 to support workforce development planning which was lead by the North Carolina Health Professions Data System at the Cecil B. Sheps Center for Health Services Research.

With the exception of the federal workforce development grant, all of these funds have been limited to incrementally increasing the workforce. While the Workgroup believes such increases are necessary, they are not sufficient to meet the healthcare demands of North Carolina's population. The Workgroup believes that broader changes and investments are necessary to meet the needs of the state and the changing healthcare practice environment. As outlined in this

chapter, the Workgroup strongly recommends making additional investments in increasing diversity in the health practitioner workforce, undertaking comprehensive workforce planning, revising existing medical education programs to better meet state needs and the changing healthcare practice environment, and strengthening the state's ability to take advantage of federal workforce recruitment funds.

The Workforce workgroup recognizes that there may be other funding opportunities that could become available sometime in the future to support North Carolina's workforce needs. For example, the ACA includes provisions that authorize, but do not appropriate, funding for other workforce programs, including provisions to increase the number of physical, behavioral, and oral health practitioners through loan and scholarship programs; create medical school rural training programs; develop and implement interdisciplinary medical education; and develop other programs to address current and future workforce needs.[27] Thus, the Workgroup supports the work of organizations that are monitoring federal funding opportunities. These groups should also examine existing funds to determine if the state can take advantage of any opportunity to expand the health care professional workforce and change the way health practitioners are educated. The Workgroup encourages the members and others to continue to work together to develop a coordinated, competitive response when funding opportunities are identified.

Educating a Health Workforce Prepared to Meet North Carolina's Needs

To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, behavioral, and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. While the current expansions in educational programs will certainly help, they are not likely to meet the full need alone. North Carolina is a net importer of primary care, behavioral health, and oral health practitioners, meaning the state trains fewer health practitioners in these areas than we need for a population of our size and must rely on recruitment of practitioners from other states and countries.[28] Growth in demand in all of these areas, as well as in emerging roles such as health information technology and care coordinators, fuels the increase in demand for a wide range of allied health workers in primary care as well as behavioral and oral health. School's admissions policies, course offerings, training locations, and scholarship opportunities all affect the types of practitioners produced. North Carolina's schools have the means to steer more students into primary care, behavioral and oral health and to increase students' interest and willingness to serve in rural and underserved communities.

While North Carolina must increase the number of health practitioners being educated in areas of need, we cannot continue to educate and train health practitioners using current models. As discussed in Chapter 8 and later in this chapter, the provision of health care in the field is changing, therefore, education and training models must also change. The health care workforce must understand how to work in and with patient centered medical homes. These function using interdisciplinary teams working together to meet population health needs using electronic medical records while implementing quality improvement practices. Therefore, health professional education curricula and training for both students and the existing workforce must evolve to teach the skills and competencies that the workforce will need such as patient safety, interdisciplinary team based care, quality initiatives, health information technology, and cultural competency. Additionally, curricula and training must incorporate and mirror the patient

centered medical homes and other new models of care in which practitioners will work. These new technologies, models, and standards for the provision of health care must become part of our educational programs so that newly trained health practitioners and the existing workforce can function in emerging models of care.

In order to ensure that North Carolina's health workforce is able to meet the needs of the population and practice effectively in patient-centered medical homes and other new models of care, the NCIOM recommends:

RECOMMENDATION 5.1: EDUCATE HEALTH WORKFORCE USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE

a) The North Carolina Community College System (NCCCS), the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties, should:
   - **i) Create targeted programs and modify admission policies to increase the number of students and residents with expressed interest in primary care, behavioral health and dentistry, and in serving underserved populations, particularly in rural areas of North Carolina.**
   - **ii) Incorporate successful new models of interdisciplinary, team-based care into training curricula and ensure that students and residents have the opportunity to practice working together in interdisciplinary teams.**
   - **iii) Identify new core competencies needed by the health care workforce including patient safety, quality initiatives, cultural competency, health information technology, and others. Develop educational and training curricula to teach these competencies to students and residents.**
   - **iv) Establish or expand training programs for emerging health workforce roles including community health workers, case managers, client coordinators, patient navigators, and health information technologists.**
   - **v) Establish or expand training programs in community-based ambulatory patient care centers.**

b) AHEC should develop learning collaboratives and other strategies to educate the existing workforce on new core competencies needed by the health care workforce including patient safety, quality initiatives, cultural competency, health information technology, and others.

c) The North Carolina General Assembly should require AHEC to prepare an annual report that includes information detailing progress that has been made, if any, to achieve the goals identified in Recommendations 5.1a, and 5.1b.

d) The North Carolina Employment Security Commission, the Commission on Workforce Development in North Carolina, local workforce development boards, and NCCCS should continue to work together to match laid-off and unemployed workers to new health care job and training opportunities.

The Need for a More Diverse Workforce

Patients benefit from receiving care from a diverse workforce that mirrors the population being served. Increasing under-represented minorities' access to careers in the health professions is one of the goals of the ACA.[29] North Carolina's workforce should mirror the population being served—a population that is increasingly diverse. Minority populations make up 32% of North Carolina's population.[30] While some health professions are quite diverse, including primary care physicians and licensed practical nurses (27% and 31% nonwhite and non-Hispanic, respectively), most lack diversity. Even among the health professions with more diversity, the racial and ethnic makeup of practitioners does not mirror the makeup of North Carolina's population.[31] Research shows that when patients receive care from a provider of the same race/ethnicity they report higher levels of satisfaction, communication and trust, and are more likely to adhere to care instructions. Given these improvements, research suggests patients would also have better health outcomes when they receive care from a provider of similar demographics.[32] North Carolina's military families and veterans have unique needs and having practitioners with military backgrounds or training in working with military families is essential to being able to care for this population.[33] Language and cultural barriers also pose a significant challenge to ensuring all North Carolinians receive high quality care. Increasing the cultural competency of the health care workforce is one of the goals of the ACA.[34] Multilingual practitioners and practitioners from different cultural backgrounds can help increase the quality of care for North Carolina's diverse population.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[35] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health, and may reduce costs. Although many of North Carolina's health care education programs are working hard to increase the diversity of the practitioner workforce, data show the state has a long way to go.[36] Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the NCIOM recommends:

RECOMMENDATION 5.2: SUPPORT AND EXPAND HEALTH PROFESSIONS PROGRAMS TO MORE CLOSELY REFLECT THE COMPOSITION OF THE POPULATION SERVED

The North Carolina Area Health Education Centers Program, North Carolina Community College System, the University of North Carolina University System, private colleges and universities with health professions degree programs, and other interested parties, including the Alliance for Health Professions Diversity, should collaborate to create more intensive programs and coordinate efforts to expand and strengthen existing evidence-based health professions pipeline programs. These educational systems and related programs should strengthen their collective efforts so that underrepresented minority, rural, and other disadvantaged students who are interested in entering health careers can receive continued opportunities for enrichment and support in middle school, high school, college, and health professions schools. These entities should work collaboratively to seek foundation

and federal funding to strengthen existing programs, develop new models of educational enrichment, and evaluate the effect of the various programs on the diversity of the health professions in the state. If shown to be effective, the North Carolina General Assembly should provide ongoing program support.

Recruiting and Retaining a Strong Health Care Workforce

North Carolina will not prosper as a whole unless the differences in population health and access to care across the state are addressed. It will take specific incentives and strategies to accomplish this goal. North Carolina should invest more heavily in the health practitioner workforce, particularly in rural and underserved areas of the state.

The federal government provides scholarships or loans to certain types of health care practitioners in return for practicing in a health professional shortage area (HPSA) through the National Health Service Corps (NHSC). In fact, the ACA expands this program—increasing the program by $1.5 billion over five years.[37] NHSC funding can be used to recruit primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, dentists, dental hygienists, psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors into rural and underserved communities that are designated as HPSAs. North Carolina has 71 counties or parts of counties that are designated as primary care shortage areas, 54 counties (or parts thereof) that are designated as behavioral health shortage areas, and 78 counties (or parts thereof) that are designated as dental shortage areas.[38] Potential practitioners cannot qualify for NHSC funds to locate in North Carolina communities unless they have first been designated as a HPSA with a high enough designation score. The North Carolina Office of Rural Health and Community Care (ORHCC) plays a critical role in this designation process by working with counties to gather and verify information and submit the application to the federal government. The ORHCC also helps recruit eligible health professionals to practice in HPSAs. In addition to federal funding, there is some state and medical society foundation funding for loan repayment for individuals who commit to practice in a HPSA.

The ORHCC helps eligible health professionals apply for the federal and state loan repayment programs. The federal program only funds health professionals in HPSAs that have been rated to have the greatest need. Currently only 34 of the 71 counties or parts of counties that are designated as primary care shortage areas score high enough for health professionals serving in them to be eligible for NHSC loan repayment. Health professionals serving in HPSAs with lower scores, or who are otherwise not eligible for federal funding, can apply for loan repayment through the ORHCC (which uses state funding). The state provides $1.5 million in recurring funding to the ORHCC to support loan repayment for health professionals.

North Carolina, like many other states, is a net importer of primary care, behavioral and oral health practitioners.[39] Thus, we rely heavily on our ability to recruit primary care and behavioral and oral health practitioners to practice in North Carolina. Not surprisingly, many states are competing to attract health professionals using NHSC funding. North Carolina has benefitted from the recent increases in NHSC funding,[40] which allowed the state to increase the number of NHSC practitioners from 70 to 145. However, North Carolina has fewer NHSC practitioners than it should based on its size.[41] Successful recruitment is affected by the amount of staff time

spent understanding the needs of the health professionals and their families as well as the number of eligible HPSA sites in the state. The capacity to recruit and retain health professionals in rural and underserved areas across the state is critical to meet the health needs of North Carolinians. Additionally, increasing the number of practitioners in rural and underserved areas can help improve the local economies and increase an area's attractiveness to businesses. Health care is a knowledge driven industry and the creation of health care jobs brings a high added value to communities. In 64 North Carolina counties, largely rural or economically depressed, the health care industry is one of the top five employers. Data show that in 2008:

- For every $1 produced by the health care industry an additional $0.89 was generated in the state's economy;
- Every $1 in wages/benefits paid to health care industry employees produced an additional $0.55 in other wages/benefits; and
- For every 1 worker employed in the health care industry, an additional 0.72 workers are employed in the state's work force.[42]

The North Carolina Department of Commerce has recruitment funds that it can use to recruit or support industries "deemed vital to a healthy North Carolina." Yet historically, these funds have not been used to support North Carolina's health care industry, despite its critical role to the success of local economies.[43] Because of the way these programs are designed, it is difficult for individual health care practitioners or small group practices, like the ones typically found in our rural areas, to qualify. Therefore, the NCIOM recommends:

RECOMMENDATION 5.3: STRENGTHEN AND EXPAND RECRUITMENT OF HEALTH PROFESSIONALS TO UNDERSERVED AREAS OF THE STATE

In order to support and strengthen the ability of the Office of Rural Health and Community Care (ORHCC) to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina Department of Commerce should use $1 million annually of existing discretionary programs funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into North Carolina. The funding should be used to:

a) **Provide financial incentives to encourage professionals to remain in practice in health professional shortage areas past their loan repayment obligations.**
b) **Recruit veterans with medical training to practice in North Carolina.**
c) **Provide enhanced technical assistance to areas to increase the number of communities designated as health professional shortage areas (HPSAs) and to improve the counties' HPSA scores.**
d) **Create state-based area and population health professional shortage areas, if this will assist in recruiting practitioners into HPSAs.**
e) **Create and maintain a database of private and public loan repayment opportunities for health professionals working in North Carolina.**

THE IMPACT OF NEW PAYMENT AND DELIVERY MODELS ON THE HEALTH PROFESSIONAL WORKFORCE

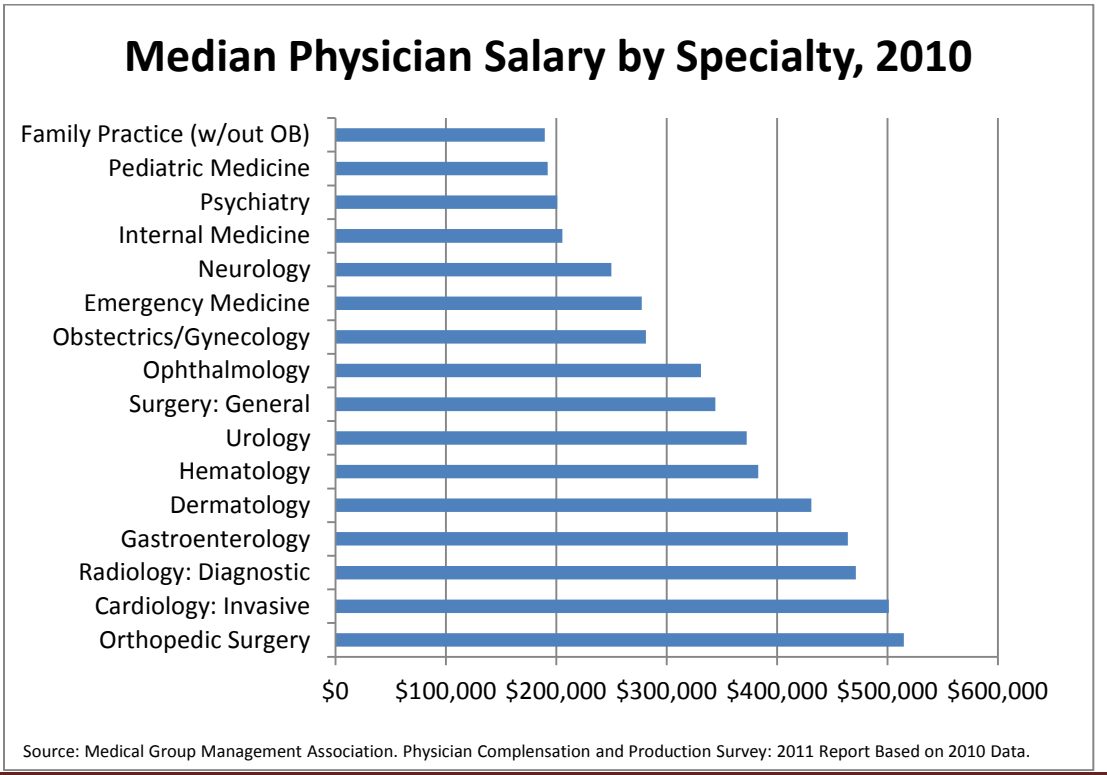
One of the chief goals of the ACA is to redesign the health care delivery system to simultaneously meet three objectives: improve population health, enhance patient care, and

reduce or control the cost of care. Our current health care delivery and payment system does not achieve these goals.

Improving patient outcomes and population health while reducing unnecessary health care expenses will require changes in how we deliver care. As discussed more fully in Chapter 8, some of the common elements in the new models are greater reliance on interdisciplinary primary care teams to manage the care of the patient, shifting the emphasis of care from acute care to preventive care and disease management, engaging consumers in their own care, greater coordination of care across care settings, and use of electronic health records or other information technology to proactively manage patients and to monitor and improve quality. This shift will not be easy. It will involve changing patients' behavior, how practitioners work and interact with patients, and delivery and payment models. Further, we need a strong, robust primary care system to achieve this goal.

The Workgroup discussed many ways to strengthen the existing primary care, behavioral and oral health workforces. One of the core elements is to make sure that health care practitioners are adequately reimbursed. For example, reimbursement rates for primary care are substantially lower than for specialty care, which affects provider incomes and the willingness of students and trainees to go into primary care.[44,45] This difference in reimbursement rates translates into a large differential between the average salaries for primary care practitioners versus specialists. (See Table 1.) Further, a provider's willingness to accept certain insured populations is affected by the payer's reimbursement rates.[46] This can have a profound effect on access to care.

Table 1.
Median Physician Salary by Specialty, 2010



Source: Medical Group Management Association. Physician Complensation and Production Survey: 2011 Report Based on 2010 Data.

To recruit more physicians, nurse practitioners, and physician assistants into primary care and psychiatrists to address the state's mental health needs, and to retain the workforce we currently have will require a rebalancing of how practitioners are paid—rewarding those health care professionals who practice in primary care and psychiatry. In order to encourage health care professionals to enter into primary care or psychiatric practices and to retain current practitioners, the NCIOM recommends:

RECOMMENDATION 5.4: INCREASE REIMBURSEMENT FOR PRIMARY CARE AND PSYCHIATRY SERVICES

Public and private payers should enhance their reimbursement to primary care practitioners and psychiatrists to more closely reflect the reimbursement provided to other specialty practitioners. For purposes of this recommendation, primary care practitioners include, but are not limited to: family physicians, general pediatricians, general internists, as well as nurse practitioners, physician assistants, and certified nurse midwives practicing in primary care.

Medicaid reimbursement rates are of particular concern because traditionally Medicaid reimbursement rates are lower than commercial rates. Low reimbursement rates limit the number of practitioners willing to see patients with Medicaid, particularly dental and behavioral health practitioners.[47,48,49] New proposed federal regulations have been promulgated to create a process for states to use to assure that Medicaid payments "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough practitioners so that care and service are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[50] States will be required to monitor access to care and, if needed, take action to ensure adequate access. The Workforce workgroup supports efforts to monitor Medicaid recipient access to care and the requirement that states' take action to ensure access.

The Need for an Integrative Approach to Health Care

The Workgroup believes that our greatest opportunity to improve population health is by providing patient-centered holistic health care including physical, behavioral, and oral health. Patient-centered care requires a shift away from paternalistic care towards a partnership where practitioners work with patients to reach a shared understanding of the problem and course of treatment. In this type of model, patients share in decision-making and responsibility.[51] Research has shown that patient-centered care can reduce primary care charges, the number of diagnostic tests, and referrals—all of which reduce costs and increase the overall efficiency of the system.[52] By taking this approach, the emphasis shifts from treating acute events to providing comprehensive preventive care and treating health problems within a framework focusing on optimizing health over the lifespan. For this shift to occur, the current system must place more emphasis on prevention and primary care.

In integrative health models, all members of the health care team are valued for their contribution to overall health, from primary care practitioners, to oral and behavioral health practitioners, to allied health practitioners such as physical and occupational therapists, nutritionists, health information technologists, and others. In an integrative model, different

types of health practitioners work seamlessly together to ensure that the patient gets the right kinds of care, at the right time, from the right person.

New Workforce Models are Needed

While demand for primary care is expected to increase due to the ACA, the primary care physician workforce is shrinking due to declining interest and retiring practitioners. Only 32% of physicians in the United States practice primary care. Fewer than 18% of medical students are expected to practice primary care, and large numbers of primary care physicians are expected to retire in the next decade.[53] Nurse practitioners and physician assistants face similar challenges with increasing specialization away from primary care.[54]

Additionally, as part of the ACA, the types of care covered by health insurance plans are expanding. There are new requirements for covering preventive services,[55] mental health and substance abuse services,[56] women's health services,[57] and others. This expansion in what is covered by most health insurance plans could further increase time demands on primary care practitioners. A study looking at the time demands on primary care physicians showed that 4.6 hours per working day is spent on acute health problems. Comprehensive high-quality management of the 10 most common chronic diseases would require an additional 10.6 hours per day. An additional 7.4 hours a day would be needed if these physicians were to also try to meet the preventive services recommendations for all of their patients. For individual physicians to meet the comprehensive health requirements of their patients, they would need to spend almost 23 hours of every work day providing patient care.[58] Clearly this is not a sustainable model.

In the existing system, patients are not getting all the recommended care, primary care practitioners are often overwhelmed, and new health care practitioners are less interested in going into primary care.[59,60] While more practitioners may be one element of the solution in the long run, a more immediate solution is to explore innovations in the way the current workforce is deployed. The Workgroup believes the best way to solve these problems is to explore alternatives to the traditional care delivery model with its strong emphasis on physician provided care. Models of care that use a variety of health practitioners—physicians, nurse practitioners, physician assistants, and the allied health disciplines—working together as a team to care for patients are needed. In such models, each team member should practice to the full extent of their education and competence. For example, physicians could focus on patients requiring a high level of expertise, nurse practitioners and physician assistants could provide acute and chronic care within the scope of their training, registered nurses could educate patients with chronic conditions to improve self-management, and medical assistants could provide care coordination.[61]

Approaches that encourage delegating tasks from physicians and nurses to other capable, trained practitioners provide opportunities for savings and increased productivity.[62] Expanding the education of current practitioners could allow the current system to expand its capacity without adding additional practitioners. Utilizing all health practitioners at the highest level they are able to contribute within their education will increase the effectiveness and efficiency of the existing workforce. Currently complex federal and state rules about reimbursement and requirements for scope of practice, licensure, and staffing ratios limit the ability of practitioners to implement such models.[63] Therefore, the Workgroup supports the examination of state regulations and

licensure board requirements to improve the regulatory environment for all licensed health practitioners. (See Recommendation 8.4 in Chapter 8.)

Current restrictions by payers limit the types of health practitioners that can provide services and the types of services that can be billed. Typically only face-to-face care provided by physicians, nurse practitioners, and physician assistants can be billed.[64] The current fee-for-service model limits the use of team-based care. Innovative payment models such as capitation or bundled payments would give interprofessional teams more discretion to delegate delivery of needed services. (For more discussion of new models of care, see Chapter 8.) The use of new payment models is essential if other types of health practitioners, both professional and lay health workers, are to be fully utilized as members of the health care team. Therefore, the Workgroup strongly supports testing of new Medicaid, Medicare, North Carolina Health Choice, and private insurance payment models that would allow for workforce innovations in the provision of care.

Changes in the model of primary care provision could make the existing workforce more productive and care more cost effective, while improving patient experiences and outcomes.[65] The Workgroup strongly supports the rethinking of current practice models to create more effective, productive, and efficient models of health care provision. Research shows that successful models rely on strong teamwork and incorporate meaningful use of technology.[66] Exactly what these models look like and what the appropriate mix of health care practitioners is cannot be understood without testing out innovative new payment and delivery models. Therefore, the Workgroup supports the work of the New Models of Care Workgroup to foster innovations in the way health care is provided and paid for with the goal of more productively using the existing workforce. (See Chapter 8.)

THE STATE HAS A VESTED INTEREST IN HEALTH PRACTITIONER WORKFORCE PLANNING

The increase in the number of individuals with health insurance happens at a time when the health workforce, particularly primary care practitioners, is under the increased stress of trying to provide for the aging baby boomer population. The addition of approximately 800,000 newly insured patients in North Carolina will further increase the burden on the existing health care systems. Comprehensive workforce planning is needed if North Carolina hopes to meet the workforce challenges raised by the ACA.

Health Industry Vital to North Carolina's Economy and Well-Being

Health care plays a major role in North Carolina's economy. One out of every eight North Carolinians works in the health care field (12.6% or 487,933 individuals).[67,68] This makes the health care industry one of the largest employment sectors in North Carolina. Only the trade, transportation, and utilities sector employs a larger percentage of the workforce. In most North Carolina communities, health care is one of the largest employers.[69] In 2008, North Carolina's health care industry produced over $46.3 billion in revenue and wages and contributed an additional $41.4 billion in health care goods and services.[70]

As North Carolina looks at areas of growth in the economy, the health care industry, and particularly the health care workforce, offers one area for consistent and continuous job growth.[71] Even before the ACA, the United States Bureau of Labor Statistics and the North Carolina Employment Security Commission estimated that employment in the health care

industry would grow faster than almost any other industry.[72,73] Although the health care industry is one of the bright spots in North Carolina's lagging economy, the state does very little to plan for how to meet the workforce needs of the health care industry.

Although the state does not proactively work to identify health workforce needs, North Carolina does play a major role in the production of the health care workforce by underwriting the cost of education. In 2010-2011, the state spent $508 million to support medical education programs and students in the University of North Carolina system.[74] In addition, the state provided $112 million to the North Carolina Community College System in 2011-2012 to support medical education.[75] In addition to underwriting the education of the health care workforce, the state is also a major consumer of health care as a payer of medical claims for the 2.5 million North Carolinians who have health insurance coverage through Medicaid, North Carolina Health Choice, and the State Health Plan.[76,77] This number is expected to increase to approximately 3 million if the state chooses to expand Medicaid eligibility.[78,79] For these programs to function well, there must be adequate numbers of health practitioners to meet needs.

Limited Workforce Planning is Occurring

The Cecil G. Sheps Center for Health Services Research's Health Professions Data System (HPDS), housed at the University of North Carolina at Chapel Hill, has descriptive data about most of the licensed health professions in the state. The HPDS collects data on the supply and distribution of 20 types of licensed health professionals including physicians, nurses, dentists, pharmacists, and psychologists.[80] Data from the HPDS allow local communities and the state to assess the current workforce.[81] Data from the HPDS do an excellent job highlighting the geographic variations in the health practitioner workforce. For example, data show that in 2010 there were 9.4 primary care physicians per 10,000 people in North Carolina. Orange and Durham counties had the highest concentrations (33.5 and 24.8 per 10,000 residents respectively) while Tyrell and Gates had the lowest concentrations with less than 1 physician per 10,000 residents. North Carolina has more data on the health care practitioner workforce than most states; however, even this data is limited. For example, the HPDS does not currently collect data on certain licensed behavioral health professionals, including licensed clinical social workers, licensed professional counselors, or licensed clinical addiction specialists, which makes it difficult to examine the adequacy of the existing behavioral health workforce. Further, data are not available to forecast the workforce supply or to assess whether the existing and future workforce can meet the expected sharp increase in demand for services in 2014 and future years.

The HPDS team, in partnership with the North Carolina Commission on Workforce Development and funding from a federal Workforce Planning Grant, worked with stakeholders to create a long-term plan for developing newly emerging roles in the state's health practitioner workforce. The group worked to identify new health workforce roles, certifications and trainings, career pathways, and strategies to increase the supply of new types of health care practitioners. However, this funding ended in 2012 and there is no ongoing support for this type of in-depth analysis thereafter. This is the type of work that needs to be done for all types of health practitioners as part of a comprehensive effort to identify North Carolina's health practitioner workforce needs and strategies for meeting those needs.

Many Roadblocks to Increasing Health Practitioner Workforce

The ACA authorizes funding to create or expand programs that provide loans, scholarships, and grants to health practitioners. While the ACA authorizes many programs, little funding was appropriated for new workforce training programs. If funded, these programs would be targeted to increase the size of the primary care workforce at all practitioner levels, increase racial and ethnic diversity of the health professional workforce, and provide incentives to work in rural and underserved areas. Even if these funds were available, North Carolina faces ongoing health professions faculty shortages at many of our community colleges, colleges, and universities. Faculty shortages are the result of both a lack of properly trained individuals and, in some cases, salaries that are inadequate to compete with the private market. In addition to faculty shortages, North Carolina does not have enough primary care clinical training sites. Research shows that individuals who receive training in primary care locations are more likely to go into primary care.[82] Training sites that incorporate new models of care, such as team-based care, are also lacking.

Given the role of the health care industry in North Carolina's economy, the amount of money the state invests in educating health care practitioners, and the state's role in financing insurance coverage for certain populations (including current and retired state employees and teachers, Medicaid, and North Carolina Health Choice), there is a pressing need for North Carolina to identify workforce priorities and to create policies that ensure there are enough practitioners with the proper training to meet the health care needs of the population. Therefore, the NCIOM recommends:

RECOMMENDATION 5.5: SUPPORT COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS

- **a) The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. As part of their work the Center should:**
  - **i) Identify, collect, and develop data streams to model future health practitioner workforce needs. Potential data need to include:**
    - **A) Population health measures including health status and socio-demographic factors that may influence future health care needs.**
    - **B) Practice level data such as geographic location, types of practitioners employed, types of health insurance accepted, number of patients, services provided, and other capacity information.**
    - **C) Health practitioner workforce data including demographic, practice, and educational characteristics.**
    - **D) Higher education data on the number of students in health education programs as well as tracking information to see where and what students end up practicing.**
  - **ii) Use aforementioned data streams to:**
    - **A) Analyze the link between workforce supply, costs, and outcomes.**
    - **B) Identify practitioner shortages by specialty and geographic location.**
    - **C) Identify barriers to expanding the health practitioner workforce in areas of need.**

D) Plan for the state's future workforce needs by identifying priorities for training and education funding.

E) Report on the diversity of the health professions workforce in the state on an annual basis.

F) Address barriers that affect entry into the health care workforce or continued practice. As part of this work, the Center should examine:

(1) State regulations and licensure board requirements to improve the regulatory environment for all licensed health practitioners. This examination should allow all health practitioners to be able to practice to the full extent of their education and competence.

(2) Public and private insurance payment policies that create barriers to entry and continued practice.

(3) Barriers to effective team care.

iii) Report its findings and proposed recommendations on an annual basis to the North Carolina General Assembly, the Governor, the Department of Health and Human Services, and the Department of Commerce.

b) The Center should have an advisory board that includes representatives from the North Carolina Department of Health and Human Services, North Carolina Department of Commerce, North Carolina Office of Rural Health and Community Care, North Carolina Area Health Education Centers program, the North Carolina Community College System, The University of North Carolina General Administration, the five North Carolina academic health centers, private health professional education institutions, relevant professional associations and licensing boards, the Council for Allied Health in North Carolina, the North Carolina Hospital Association, North Carolina Medical Society Foundation, insurers, and nonmedical public members.

c) The North Carolina General Assembly should provide $550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.

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EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 6: PREVENTION

Ultimately, the goal of any broad scale health system reform should be to improve population health. The Affordable Care Act (ACA) includes new funding to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina. North Carolina typically ranks in the bottom third of most health rankings. North Carolina was ranked 32 of the 50 states in the 2011 edition of the America's Health Rankings, a composite of 23 different measures affecting health, including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[1]

The ACA appropriated $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 to a new Prevention and Public Health fund to support states and communities in their efforts to prevent illness and promote health.[2] The funds have been used to support:

- Community prevention activities such as implementation of the Community Transformation Grant, use of evidence-based interventions to reduce tobacco use and health disparities, and obesity prevention.
- Clinical prevention, including increasing awareness of new preventive care benefits, expanding immunization services, and strengthening employer participation in wellness programs.
- Public health infrastructure to strengthen state and local health department capacity for health promotion, disease prevention, and response to infectious disease outbreaks.
- Research and tracking including surveillance and evaluation of preventive services.

These national priorities closely align with the Healthy North Carolina 2020 (HNC2020) objectives that North Carolina set with the goal of making North Carolina a healthier state by the year 2020.[3] The focus areas for these objectives are tobacco use, physical activity and nutrition, injury, sexually transmitted diseases, unintended pregnancies, maternal and infant health, substance abuse, mental health, infectious disease and food-borne illness, oral health, environmental health, chronic disease, and social determinants of health. The North Carolina Division of Public Health (DPH) is the lead agency for implementation of HNC 2020 objectives over the next decade.

The Prevention Workgroup focused on provisions of the ACA with immediate implementation requirements or funding opportunities. These areas of focus included tobacco use, physical activity and nutrition, maternal and child health, prevention of sexually transmitted disease (STD) and unplanned pregnancies, improved access to preventive services, worksite wellness, and community infrastructure needed to respond to future funding opportunities.

TOBACCO

Tobacco use is the leading cause of preventable death and disease in North Carolina. Smoking harms nearly every organ of the body and causes many diseases, including coronary heart disease, several types of cancer, acute and chronic respiratory illnesses, and adverse pregnancy outcomes[4] North Carolina ranks 36th in prevalence of smoking—with 19.8% of the population reporting smoking in 2011—31st in cardiovascular deaths, and 35th in cancer deaths.[5]

Two provisions of the ACA support efforts to reduce tobacco use. First, the ACA prevents states from excluding coverage for tobacco-cessation drugs from their Medicaid programs.[6] Some FDA-approved tobacco-cessation pharmaceuticals are covered by North Carolina's Medicaid Program (Medicaid). However, there are several barriers to access, including:

- A physician visit, that requires out-of-pocket expense, is required to get a prescription for over-the-counter nicotine replacement therapy.
- Co-pays are required for all tobacco pharmaceuticals.
- Medicaid does not cover nicotine nasal spray and nicotine inhaler.

Under the ACA, the state has an option to provide all United States Preventive Services Task Force (USPSTF) recommended services rated A or B with no cost sharing to Medicaid recipients in return for an increase in reimbursement from the federal government for services to Medicaid clients.[7] If the state takes this option, then cessation therapies, including pharmaceuticals, would be covered. (Medicaid coverage of preventive services is discussed more fully later in the chapter).

Second, the ACA requires states to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, and prohibits cost-sharing for these services.[8] The North Carolina Division of Medical Assistance (DMA) has determined that the state is in compliance with this provision, as North Carolina currently screens pregnant women receiving Medicaid for tobacco use as part of the pregnancy medical home, and provides coverage for smoking and tobacco cessation counseling visits. The workgroup identified that providers need education on billing options for these services, particularly for providers not enrolled in the pregnancy medical home model.

Funding was made available through the ACA to support tobacco cessation efforts. DPH was awarded two ACA grants, of $98,266 and $139,210, to support tobacco cessation through expanded use of the Quitline, as well as policy and media interventions. North Carolina also received funding through a community transformation grant that will provide funding to communities to, in part, reduce tobacco use.

Community transformation grants (CTG) are competitive grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.[9] In September 2011, the CDC announced the funding for the CTG to support states or large cities (population of 500,000 or more) with multifaceted interventions to improve population health. North Carolina was one of 35 states and communities that received an implementation grant. The

state received $7.466 million, the fourth largest award announced. DPH is the state agency responsible for administering the CTG grant in North Carolina. DPH is working with 10 multi-county collaboratives across the state to implement strategies in three core areas: tobacco free living, active living and healthy eating, and use of high impact evidence-based clinical and other preventive services. This funding is being disseminated through one lead health department in each collaborative. The strategies for the tobacco free living core area are listed below. The strategies for physical activity and nutrition, and other strategies to promote healthy lifestyles are discussed later in this chapter.

1. Increase smoke-free regulations in local government buildings and indoor public places.
2. Increase tobacco-free regulations for government grounds, including parks and recreational areas.
3. Increase smoke-free housing policies in affordable multi-unit housing and other private sector market-based housing.
4. Increase the number of 100% tobacco free policies on community college campuses and state and private university/college campuses.
5. Increase the number of health care organizations that support tobacco use screening and referral to cessation services.

North Carolina has taken many steps to reduce tobacco use; however, more could be done to increase tobacco cessation. Therefore, the NCIOM recommended:

RECOMMENDATION 6.1: INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS

- **a) The North Carolina Division of Medical Assistance (DMA) and the North Carolina State Center for Health Statistics should monitor the utilization of tobacco-cessation drugs and the impact on tobacco-related health outcomes.**
- **b) DMA should provide all FDA-approved over-the-counter nicotine replacement therapy (nicotine patch, gum, lozenge) if accessed through the Quitline or through a physician prescription as part of comprehensive tobacco cessation services.**
- **c) To encourage the provision of counseling and pharmacotherapy to pregnant women for cessation of tobacco use:**
  - **i. The North Carolina Area Health Education Centers Program (AHEC), the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Obstetrical and Gynecological Society, and other appropriate groups should partner to provide education to providers on billing options for Medicaid preventive services, particularly for those providers who are not enrolled in the medical home model.**
  - **ii. Community Care of North Carolina care managers should educate patients on the availability of these preventive services without copayment.**
- **d) If the state does not take the option to provide all United States Preventive Services Task Force recommended services rated A or B with no cost sharing to Medicaid recipients in return for an increase in reimbursement from the federal government, then the following additional recommendations would provide tobacco cessation support for Medicaid recipients:**

i. **DMA should reduce out-of-pocket costs for clients for effective cessation therapies.**
ii. **DMA should provide access to all FDA-approved tobacco pharmaceuticals without a co-pay for at least two cessation attempts per year.**

PHYSICAL ACTIVITY AND NUTRITION

The percentage of North Carolinians who are obese more than doubled between 1990 (12.9%) and 2011 (28.6%).[10] In 2011, North Carolina ranked 30th in percentage of the population that was obese.[11] As part of the ACA prevention funding, DPH received $3.8 million in Communities Putting Prevention to Work (CPPW) funding. These funds have been used to implement sustainable evidence- and practice-based approaches to changing policies, systems, and environments contributing to the obesity epidemic in the Appalachian District (including Allegany, Ashe, and Watauga counties) and Pitt County. An additional $272,000 was awarded to support BRFSS data collection in these two communities.

As discussed, DPH also has been awarded CTG funding which is being used to promote active living and healthy eating, as well as other strategies to improve clinical care and promote healthy lifestyles. These strategies include:

1. Increase the number of convenience stores that increase the availability of fresh produce and decrease the availability of sugar-sweetened beverages.
2. Increase the number of communities that support farmers' markets, mobile markets, and farm stands.
3. Increase the number of communities that implement comprehensive plans for land use and transportation.
4. Increase the number of community organizations that promote joint use/community use of facilities.
5. Increase the number of health care providers who utilize quality improvement systems for clinical practice management of high blood pressure and high cholesterol.
6. Increase the number of community supports for individuals identified with high blood pressure, high cholesterol and tobacco use (e.g., chronic disease self-management programs, weight management programs, tobacco cessation programs).

MATERNAL AND CHILD HEALTH

Comprehensive, coordinated pre-conception, maternity, and post-partum care is important for improving birth outcomes in North Carolina. The incidence of premature and low-weight births may be reduced through addressing the health of the mother before and during pregnancy. Risk factors associated with poor birth outcomes include diabetes, hypertension, tobacco or other substance use, and unsafe living environments. North Carolina ranks 36th in diabetes incidence, 40th in hypertension, and 36th in smoking.[12] These rankings are not specific to the pregnant population, but are indicators of the overall population's health.

Home Visiting

Support is provided through the ACA for pregnant and parenting teens and home visiting programs, as well as requiring reasonable break times for nursing mothers who are working. The

support to pregnant and parenting teens is provided in the form of grants to states, institutions of higher education, schools, and communities.[13] Funds can be used for programs such as those that help pregnant or parenting teens stay in or complete high school, and for assistance to states in providing intervention services and outreach so that pregnant and parenting teens and women are aware of services available to them. The North Carolina Department of Health and Human Services (NCDHHS) received $1,768,000 to help pregnant and parenting women in high needs communities through *Project Connect*. *Project Connect* supports pregnant and parenting women ages 13- 24 years with health maintenance, parenting skills, and parental self-sufficiency. The goals of *Project Connect* are to: support community strategies to create effective systems of care; incorporate evidence-based practices, strategies, and models; and improve the health of pregnant and parenting women by providing comprehensive support services that are easy to access and meet their needs.

The ACA also provides funding to states to implement evidence-based maternal, infant, and early childhood evidence-based visitation models targeted at reducing infant and maternal mortality and its related causes. Model goals include improving prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.[14] In 2010, the North Carolina infant mortality rate was the lowest in the State's history at 7.0 deaths per 1,000 live births.[15] North Carolina received $5.46 million to implement the North Carolina Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The MIECHV program offers information, risk assessment, and home-based parenting support using evidence-based models in at-risk communities, including sections of Buncombe, Durham, Gaston, Edgecombe, Halifax, Hertford, Northampton, Mitchell, and Yancey counties.[16] Three evidence-based home visiting models are supported: Nurse Family Partnership, Healthy Families America, and an integrated Healthy Families America and Parents As Teachers program. The Nurse Family Partnership provides nurses to educate and support low-income, first-time mothers through the first two years of motherhood. Healthy Families America is a evidence-based home visiting program for families at risk of child abuse or neglect. The program's goals include development of nurturing relationships, promotion of healthy child development and growth, and building the foundation for a strong family. Parents As Teachers provides family education and support to families with young children. This support includes home visits by parent educators, parent group meetings, developmental and health screenings, and linkages to community resources.

Supporting Nursing Mothers at Work

The ACA requires employers with 50 or more employees to provide reasonable break time and a private place (other than a bathroom) for an employee to express breast milk for nursing children for one year after the birth of a child.[17] Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions. This provision became effective when the ACA was signed in to law in March 2010, and affects employees covered by the Fair Labor Standards Act. Employers are not required to compensate the employee for this break time.

The primary gap identified for North Carolina was the need for education of employers and employees on this provision, including on the definition of reasonable break time and appropriate facilities. The workgroup also identified that the ACA provision for workplace

lactation support provides break time and space for hourly employees, which leaves gaps in the law for salaried employees. The break time for hourly employees is unpaid, unless that employer routinely pays for break time. The North Carolina Office of State Personnel policy provides more comprehensive protection for state employees covered by the State Personnel Act, but further action is still required to fill remaining gaps for those state employees not covered by the State Personnel Act, and to provide similar support for non-state employees. Therefore, the NCIOM recommends:

RECOMMENDATION 6.2: SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

a) **The North Carolina Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy.**
b) **Small businesses should be encouraged to provide similar support to working mothers. The North Carolina Division of Public Health should partner with the North Carolina Small Business Administration to provide information to small businesses on supporting breastfeeding mothers, as well as information on the requirement to apply for and prove undue hardship for an exemption to this requirement. The North Carolina Department of Labor should partner with the North Carolina Breastfeeding Coalition, which already has trained business outreach workers, to provide guidance on the Business Case for Breastfeeding, a national training model for best-practices.**

PREVENTING SEXUALLY TRANSMITTED DISEASES AND UNINTENDED PREGNANCIES

Personal Responsibility and Abstinence Education

Preventing sexually transmitted diseases (STDs) and unintended pregnancies will help improve quality of life, decrease death and disability, and reduce health care costs. North Carolina has been working to reduce cases of STDs and has seen improvements in recent years. In 2010, the reported number of new HIV diagnoses, early syphilis cases, chlamydia cases, and gonorrhea cases declined from the previous year (8.6%, 23.0%, 3.6%, and 4.4% declines respectively).[18] For the past ten years, the percentage of pregnancies reported to be unintended has remained steady at between 40-45%.[19,20] However, North Carolina's teen pregnancy rate has declined significantly since 2000 from 44.4 to 26.4 per 1,000 teens ages 15-17 in 2010.[21]

The ACA provides $75 million per year through FY2014 for Personal Responsibility Education (PREP) grants to states for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.[22] Funding is also available for innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, allotments to Indian tribes and tribal organizations, and research and evaluation, training and technical assistance. NCDHHS applied for and received $1.5 million in PREP funds to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections.

In October 2010, the North Carolina Division of Public Instruction (DPI) received $1.5 million in Title V funds for abstinence education as part of implementation of comprehensive sex

education pursuant to the "Healthy Youth Act of 2009." The workgroup recognized that the overlap of the goals and audience for these two programs provided an opportunity for collaboration between DPH and DPI. The Workgroup supported collaboration between DPH and DPI on providing this education.

IMPROVING ACCESS TO PREVENTIVE SERVICES

Private Health Insurance

The ACA requires most employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care and screening for infants, children, and adolescents, and additional preventive services for women that are recommended by Health Resources and Services Administration of the United States Department of Health and Human Services.[23] The only health plans that are not subject to this requirement are "grandfathered plans". Grandfathered plans are those health plans that have been in existence continuously since March 2011 without significant changes in covered benefits or cost sharing.[24] [25]The primary gaps identified by the workgroup were monitoring of health plans to ensure that coverage is provided, education of providers and patients on the covered services, and providing mechanisms in electronic medical record systems to promote the provision of these services.

Medicare

Preventive service coverage is also provided to those covered by Medicare. The ACA eliminates copayments and application of deductible for Medicare preventive services that are rated A or B by the USPSTF, as well as deductibles for colorectal cancer screening tests.[26] The ACA also eliminates copayments for Medicare enrollees who receive an annual wellness exam that includes a health risk assessment and a personalized prevention plan.[27] The annual wellness exam consists of an update of medical and family history and a list of current providers and suppliers of medical care; measurement of height, weight, blood pressure, and other routine measurements; detection of cognitive impairment; establishment of or update to screening schedules and lists of risk factors; and furnishing of personalized health advice and referral. The annual wellness exam is not the same as an annual physical exam, which is not reimbursable by Medicare. The primary gap identified was education of providers and Medicare enrollees on what the annual wellness visit covers, and the elimination of copayments for USPSTF-recommended preventive services. Therefore, the Workgroup recommended educating providers and Medicare recipients on new benefits. (See Recommendation 6.4.)

Medicaid

The ACA provides the option for states to provide similar coverage of preventive services for Medicaid-eligible adults.[28] Beginning in January of 2013, states may provide Medicaid coverage for all preventive clinical services recommended by the USPSTF and all immunizations recommended by ACIP. States that elect to cover these preventive services and vaccines and provide these services without cost sharing, will receive an increase of one percentage point in their Federal Medical Assistance Percentage (FMAP) rate for these services. The FMAP is used to determine the amount of federal matching funds provided to the state for Medicaid medical expenditures.

DMA already covers most of the recommended services and immunizations. However, it does not currently cover BRCA testing (which tests for a gene mutation associated with a high risk of breast cancer), the herpes zoster (shingles) vaccine, aspirin for cardiovascular disease prevention, folic acid supplementation for women of child-bearing years, iron supplementation for at-risk children, or human papilloma virus (HPV) immunizations for people ages 21-26. As discussed above, many of the tobacco cessation drugs are covered by DMA, but copays and prescriptions are required. DMA conducted a cost analysis to determine the costs involved in offering all of the recommended clinical preventive services and immunizations without cost-sharing versus the additional reimbursement it would receive from the enhanced FMAP rate (Table 6.1). The number of Medicaid enrollees was projected based on SFY2010 counts with trending based on historical increases in enrollment. The number of enrollees does not include costs associated with the potential Medicaid expansion. In the table below, the "Total cost impact" is the total cost of adding each benefit. The "State cost impact" is the total cost minus the federal cost. The federal cost is the total cost times the new FMAP. The existing FMAP rate is 64.71%, so the state is responsible for 35.29% of the costs. Assuming a similar match rate, if North Carolina includes coverage for all USPSTF A and B recommended services and ACIP recommended immunizations, the federal government would pay 65.71% and the state would pay 34.29% of the costs.

The analysis indicates that there will be an immediate cost to the state to implement the USPSTF and ACIP recommendations without cost-sharing. However, substantial savings through disease prevention may occur that are not considered in this analysis. The workgroup members recommended that North Carolina provide the same coverage of preventive services through Medicaid as is provided by private coverage plans. Thus, the Workgroup recommends that the state provide coverage of all of the preventive services or immunizations recommended by the USPSTF (rated A or B) and ACIP without cost-sharing. The workgroup recognizes that there is a significant financial impact to the state from this recommendation; however, the financial cost may be offset by potential long-term cost savings through health status changes.

Table 6.1
Analysis of Cost to State for Addition of USPSTF and ACIP Recommended Services

	SFY2013*	SFY2014	SFY2015¥
Total cost of all prevention services currently provided to Medicaid recipients	$44,447,991	$48,359,000	$49,287,500
FMAP rate (current)	0.6471	0.6471	0.6471
State match rate (current)	0.3529	0.3529	0.3529
Total cost to state of all prevention services currently provided to Medicaid recipients. total cost x state match rate)	$15,685,696	$17,065,891	$17,393,559
Additional costs for new preventive services	$12,797,921	$24,785,508	$24,673,474
Cost of removing copays	$115,495	$118,152	$120,869
Total additional costs for USPSTF and ACIP services	$12,913,416	$24,903,660	$24,794,343
Total costs of all services (current plus USPSTF/ACIP)	$57,361,407	$73,262,660	$74,081,843
New FMAP rate (current rate plus one percentage point)	0.6571	0.6571	0.6571
New state match (if state receives additional federal match)	0.3429	0.3429	0.3429
Cost to state for all services (current and USPSTF/ACIP).	$19,669,226	$25,121,766	$25,402.664
Cost to state to add preventive services (includes additional costs of services and removal of cost sharing, as well as benefit from additional FMAP applied to all preventive services)	$3,983,530	$8,055,875	$8,009,105

*Costs for SFY 2013 cover only half the fiscal year (January-June) because states could not get the enhanced FMAP for adding preventive services until January 2013.

Many Medicaid enrollees, as well as people enrolled in other insurance programs, do not always receive appropriate clinical preventive services, even when they are covered. Thus, merely extending Medicaid coverage to include new preventive services will not ensure their use. Therefore, the Workgroup recommends that DMA, along with health care professional associations, should engage in provider education to ensure that health professionals are aware of—and actively advise—their patients to obtain appropriate clinical preventive services.

Increasing Child and Adult Immunizations

The ACA authorizes states to purchase adult vaccines under the Centers for Disease Control and Prevention (CDC) contracts and reauthorizes the federal Immunization Program.[29] These contracts for adult vaccines provide savings that range from 23%-69% compared to the private sector cost. This provision also authorizes a demonstration program to improve immunization coverage. Under this program, the CDC will provide grants to states to improve immunization coverage of children, adolescents, and adults through implementation of interventions recommended by the Task Force on Community Preventive Services or other evidence-based interventions, such as reminders or recalls for patients or providers, or home visits.

NCDHHS applied for and received $1,023,484 from the Prevention and Public Health Fund to support immunizations. These funds will support information technology contracts to enhance interoperability between electronic health records (EHR) and the North Carolina Immunization Registry, and develop a vaccine ordering module that interfaces with CDC's Vtrcks Vaccine Ordering and Management System.

Preventive care services can improve the health and well-being of North Carolinians as well as reduce the incidence of death and disease from preventable factors. Therefore, the NCIOM recommends:

RECOMMENDATION 6.3: PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

a) North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. Thus, North Carolina should provide coverage of all preventive services and immunizations recommended by United States Preventive Services Task Force (USPSTF) (with a rating of A or B) and Advisory Committee on Immunization Practices (ACIP) without cost-sharing.

b) The North Carolina Department of Insurance (NCDOI) should continue to monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF; immunizations recommended by ACIP; preventive care and screening for infants, children, and adolescents; and additional preventive services for women that are recommended by the Health Resources and Services Administration (HRSA). Tracking of compliance should include tracking the insurance plan year in which the coverage is required.

c) The North Carolina Office of Health Information Technology (NC-HIT) should encourage companies that provide electronic medical record (EMR) systems in North Carolina to provide clinical decision support tools to identify and promote USPSTF and ACIP recommended services targeted to the patient needs.

d) NC-HIT, Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC), and the North Carolina Healthcare Quality Alliance should ensure that quality improvement initiatives at the state level include monitoring of utilization of patient-targeted prevention services.

e) **North Carolina Area Health Education Centers (AHEC), DMA, the North Carolina Medical Society (NCMS), Old North State Medical Society, other health care professional associations, and the North Carolina Division of Social Services should partner to educate providers to ensure that health professionals and caseworkers are aware of, and actively advise their patients and clients to obtain, appropriate clinical preventive services. They also should provide education to providers on billing options to obtain reimbursement from public and private payers for clinical preventive services, particularly for those providers who are not enrolled in the medical home model.**
f) **Providers should be encouraged to educate patients on the value of these preventive services, as well as availability, without copayment or application of deductible, and to appropriately encourage utilization of preventive services.**
g) **AHEC, NCMS, the North Carolina Division of Aging and Adult Services (DAAS), CCNC, the North Carolina Academy of Family Physicians, and the AARP should provide education to primary care physicians on the annual wellness visit benefit for Medicare enrollees.**
h) **Senior's Health Insurance Information Program (SHIIP), AARP, and DAAS should provide education to enrollees on the annual wellness visit benefit.**
i) **AARP, DMA, SHIIP, and the DAAS should engage community leaders to do community outreach for education of the public on the availability and importance of preventive services.**

WORKSITE WELLNESS

Worksite wellness programs can improve the health of North Carolinians by increasing healthy eating and physical activity, decreasing tobacco use, and decreasing stress. By improving the health status of employees, health care costs can be reduced.[30]

The worksite wellness provisions of the ACA allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or prevent disease.[31] Discrimination based on health status is prohibited. However, employers can include requirements that enrollees satisfy health status factors (i.e., tobacco cessation or healthy weight) if the financial consequences (reward or penalty) do not exceed 30% of the cost of employee-only coverage (or 30% of family coverage if dependents participate).[32] Nationally, small businesses with fewer than 25 employees are far less likely to offer wellness benefits—such as gym membership discounts or on-site exercise facilities, smoking cessation programs, or lifestyle or behavioral coaching—than are other employers.[33]

The ACA also includes provisions that direct the Centers for Disease Control and Prevention to provide technical assistance to employers to implement and evaluate evidence-based worksite wellness programs.[34] Funding for this provision has not yet been made available. However, there are several ongoing efforts in North Carolina to provide technical assistance to employers interested in implementing worksite wellness efforts. For example, the Physical Activity and Nutrition Branch within DPH maintains the Work*Well* NC page on the Eat Smart, Move More NC website.[35] The Work*Well* NC page includes toolkits to help businesses develop wellness programs, turnkey programs to encourage healthy behaviors, worksite wellness success story videos from diverse businesses across the state, sample worksite wellness policies, links to

worksite wellness services, and guides to implementing wellness program components at the worksites. North Carolina Prevention Partners offers a prevention academy and an evaluation tool for worksites to evaluate their wellness policies, benefits, and environment focused on tobacco, nutrition, and physical activity.[36]

Despite these statewide efforts to work with employers that are interested in implementing worksite wellness initiatives, the workgroup also noted gaps. For example, many employers do not know about the resources that are available, or the potential impact of implementing these programs on improved worker productivity, reduced absenteeism, and reduced health care costs. The workgroup recommended further employer education about worksite wellness opportunities and requirements, to encourage businesses to adopt a healthy lifestyle culture, and to provide the assistance required for implementation of evidence-based wellness programs with fidelity. Therefore, the NCIOM recommends:

RECOMMENDATION 6.4: PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES

a) The Center for Healthy North Carolina and the North Carolina Division of Public Health should continue to provide information to businesses on evidence-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.

b) Eat Smart, Move More NC should continue to provide information on evidence-based worksite wellness tools and programs through its website,[37] including CDC's worksite wellness technical assistance program.

INFRASTRUCTURE

State Infrastructure

A portion of the Prevention and Public Health Fund was used to strengthen local and state public health infrastructure. DPH received a grant of $371,894 to improve epidemiology and laboratory capacity for surveillance for and responses to infectious diseases and other conditions of public health importance.[38] Public Health Infrastructure Grants were offered to advance health promotion and disease prevention through improved information technology, workforce training, regulation, and policy development. North Carolina was one of only 14 states to receive both component I (non-competitive) and component II (competitive) awards. In component I, North Carolina received $400,000 to support the Public Health Quality Improvement Center. As part of component II, North Carolina received $1,503,858 for the State Center for Health Statistics to strengthen collection, reporting, and analysis of health statistics, including enhancement of the its web-based data query system, the re-design of death registration in preparation for automation, and increased use of electronic health records for disease surveillance. North Carolina received additional funds ($1,037,779) for the second year of this grant cycle. These National Public Health Improvement Initiative grant funds continue to support work on quality improvement activities and preparation for accreditation, as well as electronic death registration and the web-based data dissemination tool (HealthStats).

Develop Local Infrastructure to Respond to Grant Opportunities

The Prevention Workgroup examined funding opportunities available through the ACA and explored strategies to target funding to communities of greatest need. Often the communities with the greatest health needs are those that lack the personnel or infrastructure to apply for grants or to implement new initiatives. State data suggest that some of the smaller, poorer counties have higher *rates* of certain preventable conditions, but urban counties have greater *numbers* of people with the same health problems. Thus, the workgroup discussed the need to target both large and small communities for new prevention activities. The workgroup created an infrastructure subcommittee to identify mechanisms to assist communities with limited public health and grant proposal writing infrastructure to respond effectively to prevention funding opportunities that may become available through the ACA or other sources. An additional objective was to provide communities assistance needed to develop the infrastructure to address the HNC2020 objectives.

DPH's mission is to improve the health of North Carolinians. Two of the DPH organizations—the Center for Healthy North Carolina and the Office of Minority Health and Health Disparities (OMHDD)—support this effort by working with communities build capacity. For example, the Center for Healthy North Carolina has been tasked with working with communities to help them develop the infrastructure to reach the HNC2020 objectives. OMHHD works with non-profits in communities on infrastructure development (including capacity building and leadership development) with the goals of improving minority health and reducing health disparities. The subcommittee recognized the importance of community engagement to the success of interventions to improve community health.

To effectively work with communities to build capacity, these two state organizations need to form partnerships with other organizations already working in these communities or those able to assist communities. Such partnerships should help develop infrastructure in these communities that could support participation in funding opportunities. These partnerships also are crucial to maximize results given limited resources, by improving coordination and reducing duplication of effort. Thus, the NCIOM recommended:

RECOMMENDATION 6.5: BUILD CAPACITY OF COMMUNITIES TO RESPOND TO FUNDING OPPORTUNITIES

The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should:

a) Encourage partnerships between local health departments and community organizations in responses to funding opportunities.
b) Provide information to these organizations on available resources to assist with identifying funding opportunities, grant writing, evaluation design and implementation, development of leadership capacity, and evidence-based interventions.
c) Cultivate partnerships between communities, community organizations, and academic institutions to provide mutual opportunities for research and service.
d) Provide training to local providers to improve cultural competence, and work to increase cultural diversity in community partnerships and funding opportunity participants.

e) Work with communities to develop communication mechanisms to help communities identify potential collaborators, develop the capacity to produce competitive grant applications, and avoid competition within the same community. Use multiple mechanisms of communicating with community members, recognizing that the availability, ability to utilize, and interest in technology varies widely.

Monitoring Additional Funding Opportunities

The ACA includes many other provisions aimed at promoting healthy lifestyles and preventing chronic diseases. For example, the ACA includes provisions to promote healthy aging, promote oral health, and conduct a broad-based education and outreach campaign to support healthy lifestyles and use of clinical preventive services. The ACA includes funding for some of these provisions; others could be funded in the future through the Prevention and Public Health Trust Fund. Therefore, the NCIOM recommended that the state continue to monitor new funding opportunities made available through the Prevention and Public Health Trust Fund or other funding sources.

RECOMMENDATION 6.6: MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS

The state should monitor the federal appropriations process, as well as funding made available as part of the Prevention and Public Health Trust Fund, to identify additional funding of prevention provisions.

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EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 7: QUALITY

The Affordable Care Act (ACA) has many provisions aimed at improving quality and patient safety. This is an important goal for the health of the country and for the health of North Carolinians. In 1999, the Institute of Medicine of the National Academies released its seminal report, *To Err is Human*, which estimated that preventable medical errors led to between 44,000-98,000 deaths per year.[1] A more recent study suggests that adverse events occur in one-third of all hospital admissions.[2] In addition to medical errors which can affect patient safety in and outside of hospitals, there are also studies which show that people, on average, only receive about half of all recommended ambulatory care treatments.[3,4]

North Carolina has been a leader in trying to improve patient safety and quality within a hospital setting. The North Carolina Center for Hospital Quality and Patient Safety (NCCHQPS) is run through the North Carolina Hospital Association.[5] NCCHQPS captures quality measures from North Carolina hospitals and makes these data available to the public. In addition, NCCHQPS has several different initiatives designed to improve hospital quality and patient safety.

Community Care of North Carolina (CCNC)[6] has led to significant improvements in quality of care provided to Medicaid recipients with chronic health problems. Using the Healthcare Effectiveness Data and Information Set (HEDIS)[a] performance measures, CCNC out-performs most Medicaid managed care plans in cardiovascular disease care, and ranks in the top ten percent nationally for diabetes and asthma.

The North Carolina Healthcare Quality Alliance (NCHQA)[7] provides leadership for the improvement of health care delivery in North Carolina; promotes and facilitates transparency and public accountability; and fosters innovative and sustainable activities that improve the quality and value of health care. NCHQA is currently pursuing projects related to coordinated care for patients regardless of payer; improving transitions and quality of care across providers; and increasing transparency and accessibility of quality of care information.

High quality care, especially for the chronically ill, cannot occur in a vacuum. Technology tools, and practice systems that maximally use them, are required to achieve the goals of the ACA. To this end, the North Carolina Area Health Education Centers (AHEC),[8] in partnership with CCNC and NCHQA, has provided AHEC practice-based services throughout the state. Using this practice-based consultation to intertwine data systems with quality improvement, practices responsible for the care of 113,000 diabetic patients have experienced absolute improvements of 11%-23% in blood pressure control, cholesterol reduction, and blood sugar control for these patients. Future plans call for expansion of these services to another 300,000 patients with

[a] HEDIS is a tool consisting of 75 measures across eight domains of care. It is used by more than 90% of America's health plans to measure and compare performance and to identify areas where improvement is needed.

diabetes, to patients affected by cardiovascular disease and chronic lung disease, and to those with complex care situations such as transitions between multiple types of care.

However, there is still room for improvement. The Commonwealth Fund does a ranking of health system performance, which includes 63 measures across five domains including access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives. Overall, North Carolina ranked 41 out of 50 states and the District of Columbia.[9] The analysis suggested that 131,627 more adults with diabetes in North Carolina would have received recommended clinical services to prevent disease complications if North Carolina performed as well as the best state. Similarly, North Carolina would have experienced 23,384 fewer preventable Medicare hospitalizations, saving close to $146 million.

Some experts suggest that our current payment structure incentivizes the volume of care provided, not the quality of care. Most providers are paid on a fee-for-service basis. They are paid on the number of procedures provided, regardless of the quality of care or health outcomes. The ACA attempts to address these issues, focusing on measuring and reporting on quality, and paying based on the value of services provided.

OVERVIEW

The ACA includes many provisions aimed at improving the quality of care provided by different types of health care professionals and providers. The legislation also directs the Secretary of the United States Department of Health and Human Services (USDHHS) to develop a national strategy to improve health care quality.[10] The national strategy for quality improvement in health care initially focused on six priority areas: reducing harm and making care safer, engaging people and families as partners in care, promoting effective communication and coordination of care, promoting effective prevention and treatment practices (starting with cardiovascular disease), working with communities to promote healthy living, and making quality care more affordable by implementing new care delivery models.[11] The USDHHS is working with the National Quality Forum, which solicited feedback from stakeholder groups, to help recommend key measures in each of the six priority areas. In selecting performance measures, USDHHS is trying to align measure across different initiatives (eg, physician quality reporting system and the electronic health record (EHR) meaningful use requirements); select as few measures as possible to achieve the national quality goals, focus more heavily on patient outcomes and patient experience of care, and remove measures that are no longer needed. In its 2012 Report to Congress, the National Quality Strategy included a total of 16 different measures for the six priority areas.[12] The Secretary was also directed to create a plan to collect these data and make the data available to the public.

In addition, the ACA modifies reimbursement methodologies to provide payments to health care professionals and different providers based, in part, on the value of the services provided. The ACA created a new Patient-Centered Outcomes Research Institute to develop research priorities and help fund comparative effectiveness research.[13] Comparative effectiveness research is designed to test different health care interventions (such as drugs, devices, treatment protocols, services, care management, or integrative health practices) against one or more other interventions.[14] The goal is to understand what treatment modalities work best for different populations with different health conditions. Funding for comparative effectiveness research

began through the American Recovery and Reinvestment Act (ARRA) funds. The ACA includes additional sources to support ongoing funding.

The Quality workgroup recognized that most of the requirements of the quality provisions impact providers and the public, resulting primarily in the need for education. No legislative changes were needed for implementation of the quality provisions. The workgroup also focused on transitions of patient care between providers, since these transitions are critical to ensuring continuity of care and preventing unnecessary hospital and emergency department admissions.

ACA PROVISIONS

Quality Measure Reporting

In order to participate in Medicare, certain types of health care providers have been required to report data to the Center Medicare and Medicaid Services (CMS) on quality of care measures. For example, hospitals already report on patient hospital experiences, surgical process of care, 30-day mortality, use of medical imaging, and complications and deaths for certain conditions. Nursing facilities are inspected at least annually. These data are available to the public.[15] Physicians, while not currently required to report quality data, are provided a financial incentive to do so. The Physician Quality Reporting System collects data on quality measures for covered professional services furnished to Medicare beneficiaries. For 2012, these measures evaluate specific aspects of care for many illnesses, including diabetes mellitus, heart disease, depression, stroke, glaucoma, macular degeneration, perioperative care, osteoporosis, medication reconciliation, preventive care, and respiratory illness. More information on these measures is available on the CMS website.[16] However, data comparing physicians on quality measures is not currently available.

The ACA includes new provisions that require the development of quality measure reporting systems for hospice and long-term care, and for a prospective payment system (PPS)-exempt cancer and inpatient rehabilitation hospitals.[17] Quality measures for these new reporting systems, as well as existing systems for acute care hospitals, skilled nursing facilities, and physicians, will be developed and updated by the Secretary, in consultation with the Agency for Healthcare Research and Quality (AHRQ) and CMS.[18]

The Secretary also is charged with developing a set of quality measures for Medicaid-eligible adults that is similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. States will report these quality measures on a regular basis.[19] The initial set of measures was published in the *Federal Register* in January 2012.[20] Fifty-one measures were identified in the areas of maternal/reproductive health, overall adult health, complex healthcare needs, and mental health/substance abuse. Funding for the development, testing, and validation of additional measures was provided through the Medicaid Quality Measurement Program in January 2012. A standardized reporting system has been developed and voluntary reporting by states is encouraged. By September 2014, states will be required to submit these measures, and the results of the analysis will be made available to the public.

Medicare's physician feedback program will be expanded to include the development of confidential individualized reports. These reports will compare the per capita utilization of

resources and services for an episode of care for physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.[21] The Physician Compare website began providing data to the public on quality and patient experience measures for physicians enrolled in the Medicare program in January 2013. Under a final rule released in December 2011, Medicare data will also be available to qualified entities to combine with data from other payers and to create public reports on the performance of providers[22]. The workgroup discussion centered on concerns as to how efficiency would be assessed, the need for legal protections for providers who follow evidence-based care, and the need for education of providers and the public on how to use these data. In response to this discussion the NCIOM recommended:

RECOMMENDATION 7.1: EDUCATE PRIMARY AND SPECIALTY CARE PROVIDERS ON QUALITY MEASURE REPORTING REQUIREMENTS
The North Carolina Division of Medical Assistance should partner with the Area Health Education Centers program, Community Care of North Carolina, North Carolina Chapter of American College of Physicians, and the North Carolina Academy of Family Physicians to assume responsibility for educating primary care physicians, and with the North Carolina Medical Society to assume responsibility for educating specialty physicians, on the requirement to report adult health quality measures on all Medicaid eligible adults.[23]

A concern addressed by the workgroup was the impact on providers of multiple requests or demands for quality indicator data, since the state and federal governments and private insurers are all requesting data. The observation also was made that, if providers submit data directly and only to specific requestors, then the state loses access to the wealth of information provided in these data that could be utilized for state-level research and quality improvement initiatives. To reduce this reporting burden on providers, while providing data to the state for state level quality improvement initiatives, the NCIOM recommended:

RECOMMENDATION 7. 2: EXPLORE CENTRALIZED REPORTING
The North Carolina Health Information Exchange (NC HIE) Board should facilitate mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of North Carolina quality measures with Federal requirements.[24]

RECOMMENDATION 7.3: INVESTIGATE OPTIONS FOR DATA STORAGE
The North Carolina Department of Health and Human Services, working with the North Carolina Health Information Exchange and other stakeholder groups, should examine options to capture federally reported quality data at the state level, including options for capturing the required quality data automatically from electronic health records, and then coordinate submission of data to the appropriate entities. Data should be made available at the state level for research and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.

Further reduction in the reporting burden could be achieved through alignment of the state quality measure requirements (e.g., CCNC, DMA) with the federal measures.

Value-Based Purchasing

Another new initiative of the ACA is value-based purchasing, which ties a percentage of Medicare payments to performance based on quality measures. The resulting pay-for-performance mode, a shift from the current pay-for-care-volume mode, is intended to improve health outcomes and lead to savings over time. Value-based purchasing will affect physicians, hospitals, home health, hospice, and skilled nursing facilities.[25] For example, in FFY 2013, Medicare will reduce hospital payments across the board by 1%.[26] [27] This is expected to generate $850 million, which will be used to provide incentive payments to hospitals that score well on certain performance measures. Hospitals may qualify for incentive payments based on their performance compared to other similar hospitals, or based on their improvement over time.

For physicians, Medicare payments under value-based purchasing will be based on risk-adjusted performance data. The performance data will include measures of quality of care that reflect health outcomes, as well as resource use or costs of care. Feedback reports will contain primarily comparisons of performance among similar physicians. The goal is to provide Medicare patients with high quality, efficient care. Medicare will begin adjusting payments to some physicians based on their performance in 2015.[28] The performance based payment will apply to all physicians participating in Medicare beginning in 2017.

In response to the volume of quality reporting required, the implementation of new payment systems, and other new requirements for physicians, the NCIOM recommended:

RECOMMENDATION 7.4: EDUCATE PROVIDERS ON ACA ISSUES

The North Carolina Area Health Education Centers program, North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Chapter of American College of Physicians, North Carolina Pediatric Society, Community Care of North Carolina, the Carolinas Center for Medical Excellence, and the North Carolina Healthcare Quality Alliance should partner to educate physicians on the following issues related to ACA:

- **a) Impact of the use of quality, efficiency, and resource use data by the public and Medicare.**[29]
- **b) Opportunities to provide input into the development of quality measures.**[30]
- **c) Penalties for not reporting quality data, and the advantages of integrating reporting and EHR.**[31]
- **d) Value-based purchasing.**[32]
- **e) Requirement for providers to have a system to improve healthcare quality to allow Health Benefits Exchange providers to contract with them.**[33]
- **f) Medical diagnostic equipment requirements.**[34]
- **g) Care coordination and other important follow-up factors to reduce hospital readmissions.**

For hospitals, the quality measures used for value-based purchasing are related to common and high-cost conditions, and include efficiency and consumer satisfaction measures. CMS plans to

align these measures with the meaningful use standards, so that collection of performance data is a natural part of care delivery. For FY 2011, 45 measures were adopted that evaluate process of care, mortality and readmission rates, patient safety measures, patient experience of care, and participation in cardiac surgery, stroke care, and nursing sensitive care databases.[35] The new payment policy is applicable for discharges occurring on or after 1 Oct 2011 for acute care and long-term care hospitals. In response to the volume of quality reporting and other information for hospitals provided by the ACA, the NCIOM recommended:

RECOMMENDATION 7.5 : EDUCATE HOSPITALS ON ACA ISSUES
The North Carolina Hospital Association should provide education to hospitals on the following issues related to ACA:

a) **Importance of using the "present on admission indicator" and the meaning and implications of the quartiles.[36]**
b) **Quality reporting requirements.[37]**
c) **Value-based purchasing.[38]**
d) **Importance of having a safety evaluation system to allow Health Benefits Exchange providers to contract with hospitals with more than 50 beds.[39]**
e) **Medical diagnostic equipment requirements.[40]**

Quality standards and reporting requirements also are defined for inpatient rehabilitation hospitals, certain cancer hospitals, ambulatory surgery centers,[41] and hospice. Value-based purchasing will be tested for these institutions, and, if implemented, providers who do not successfully participate in the quality reporting program would be subject to a reduction in their annual inflationary payment increase (called the annual market basket payment update).[42] The NCIOM also recommended education for other providers of care on the quality issues in the ACA that affect them.

RECOMMENDATION 7.6: EDUCATE HOME AND HOSPICE CARE PROVIDERS ON ACA ISSUES
The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the ACA value-based purchasing provisions.[43]

RECOMMENDATION 7.7: EDUCATE FACILITY PERSONNEL ON ACA ISSUES
The North Carolina Division of Health Service Regulation, Association for Home and Hospice Care of North Carolina, and North Carolina Health Care Facilities Association should provide education to their respective constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value based purchasing.[44]

Public Availability of Quality Data
Data acquired through the quality reporting systems will be made available to the public. Information on quality of care provided by some hospitals and nursing homes is already available to the public. The Hospital Compare[45] and Nursing Home Compare[46] websites allow the public to compare the quality of care provided based on data provided by the institutions on

specific measures. The Hospital Compare website categories include surgical process of care, mortality rates, use of medical imaging, hospital experience, and patient safety. The Nursing Home Compare website provides information on staffing, quality measures, and fire safety and health inspections.

The ACA expands the types of facilities and providers for which quality data will be publically available, to include long-term care, inpatient rehabilitation, and PPS-exempt hospitals, and hospices.[47] The Secretary is required to establish a process by which hospitals can review their data prior to posting on the Hospital Compare website.

The Secretary was also required to develop a similar Physician Compare website that allows Medicare enrollees to compare scientifically sound measures of physician quality and patient experience measures.[48] This quality reporting system covers physicians enrolled in the Medicare programs, as well as other professionals who participate in the Physician Quality Reporting System, such as therapists (physical, occupational, or speech language), audiologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dieticians, and nutrition professionals.

The workgroup felt that physicians and other practitioners would benefit from education to ensure that they were aware of the reporting requirements and the public availability of their data. (See previous recommendations 7.4 and 7.5.) Connecting the quality measures to long-term outcomes will help providers realize the importance of participating in reporting of these measures and using the information meaningfully.

The workgroup also recognized that education for consumer decision-making will be a key element in quality improvement and cost savings through implementation of the ACA. There is currently no group with the breadth to reach all necessary constituents that also has the resources to execute this large undertaking. Therefore, the NCIOM recommended:

> **RECOMMENDATION 7.8: EDUCATE CONSUMERS ON AVAILABILITY AND INTERPRETATION OF PROVIDER QUALITY MEASURES**
> **The North Carolina Healthcare Quality Alliance, North Carolina Area Health Education Centers program, Community Care of North Carolina and the North Carolina Health Information Exchange should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.**

Health Care Acquired Conditions

As a result of the ACA, Medicaid now is prohibited from paying for services related to a health care-acquired condition. A similar policy already exists for Medicare.[49] The Secretary maintains a list of health care-acquired conditions for Medicaid (effective July 2011).[50] These conditions must be high cost and/or high volume, and must be reasonably preventable using evidence-based guidelines. For FY2011, the list of hospital-acquired conditions includes retention of a foreign object following surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, manifestations of poor glycemic control, falls, trauma, urinary tract or venous catheter associated

infections, and deep vein thrombosis after specific surgeries. Hospitals will not lose reimbursement if the condition was already present when the person was first admitted to the hospital, so education of hospitals on the use of the "present on admission" indicator is important.

Hospitals also will be subject to a Medicare payment penalty starting in FFY2015 if they are in the top 25th percentile of rates of hospital-acquired conditions. The financial penalty would apply to hospital-acquired conditions for certain high-cost and common conditions. This policy also may be applied to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.[51] The workgroup identified provider education as the primary gap regarding these policies.

In December 2011, the Center for Medicare and Medicaid Innovation announced it had contracted with 26 hospital engagement networks to offer technical assistance and create learning collaborative involving other hospitals to help reduce hospital acquired conditions and to improve transition care.[52] The North Carolina Hospital Association and Carolinas Healthcare System have both been given grants to serve as hospital engagement networks.

Readmission Reduction and Transitions in Care

The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. Specifically, beginning in October 2012, hospitals could be subject to Medicare rate reductions if they had excess readmissions for three conditions: heart attacks, heart failure, and pneumonia.[53] To be considered eligible for the penalty, the hospital must have had at least 25 admissions per condition. CMS also applied a risk adjustment mechanism, endorsed by the National Quality Forum, which adjusted for patient characteristics, comorbidities, and patient frailty.[54] In North Carolina, 59 hospitals were subject to the penalty with an average penalty of .28% per eligible hospital.[55] Three hospitals received the maximum penalty of 1.00%.[56] The Secretary has the authority to expand the policy to additional conditions in future years. The Secretary also was directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available.

The goal of this focus on preventable readmissions is to improve quality and efficiency of care by improving transitions in care. Transitions in care refer to movement of patients between health care providers and health care settings, for example, transfer between a nursing home and an emergency department; return to the care of a primary care physician following discharge from a hospital; or multiple providers providing care within a hospital. Problems with transition can occur when information about a patient's care or situation is not communicated adequately to other providers or to the patient. For example, a patient may receive conflicting medication lists on discharge from a hospital due to multiple medication lists stored in the hospital's medical record system, or a follow-up with a primary care physician following discharge from a hospital may not occur due to lack of communication by the patient and hospital regarding the patient's hospitalization. These coordination failures can result in hospital readmissions and/or poor outcomes. North Carolina ranked 18th in the percentage of Medicare 30-day hospital readmissions as a percent of all readmissions in 2006/2007, and 21st in the percent of short-stay

nursing home residents with a hospital readmission within 30 days in 2006.[57] The Commonwealth Fund analysis suggests that 5,042 fewer hospital readmissions would have occurred among Medicare beneficiaries if North Carolina performed as well as the best state, saving approximately $60,262,008.

The Quality Workgroup identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, a shared savings model, information technology support, the forging of relationships between providers of care, and the need to reduce the number of patients transferred from skilled nursing facilities (SNFs) to emergency departments (EDs). The workgroup identified quality initiatives already in place in North Carolina and the provider type and/or transitions between provider types affected by the initiative. This analysis provided the basic information required for the gap analysis, which provided a clear indication of where quality initiatives are needed to improve transitions in care. A subcommittee of the Quality Workgroup, in partnership with a subcommittee of the New Models of Care Workgroup, reviewed models and existing programs that address transitions in care at different points in the health care system, and made recommendations about which models and programs could be used or expanded in North Carolina to reduce preventable readmissions and improve transitions in care. (See Appendix C.) Subsequent to the completion of the work of the Quality workgroup, one Northwest Triad Care Transitions Community Program received a grant from the Center for Medicare and Medicaid Innovations to partner with community based organizations and seven local and regional hospitals to improve care transitions.[58]

In order to improve transitions of care, the NCIOM recommended:

RECOMMENDATION 7.9: IMPROVE TRANSITIONS OF CARE

a) The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina (CCNC) to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms for evaluating outcomes. Partner organizations should also work to:

- **i) Improve patient (or responsible family member) discharge education at hospitals, with a focus on the health literacy checklist and teach-back methodology.**
- **ii) Improve discussions of goals of care and education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**
- **iii) Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.**
- **iv) Align existing initiatives that address care transitions at state and local levels.**

v) **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.**
vi) **Encourage collaboration and contracts between hospitals, local management entities/managed care organizations, critical access behavioral health agencies, and other community providers (e.g., pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.**
vii) **Encourage formal development of medical home models that include the use of non-physician extenders to work with some patients (e.g., stable diabetics), with physicians focusing on higher-need patients.**

b) **In each community, stakeholder alliances including provider groups, CCNC, home health representatives and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.**
c) **Individuals should be provided their own personal health records after hospital discharge, pending the availability of a more robust Health Information Exchange.**
d) **Solutions utilizing transition principles should be applied to all patients regardless of payer.**

Hospitalizations and re-hospitalizations of patients in long-term care settings can result in discomfort, secondary injury or illness, and excessive costs. A CMS-funded study in Georgia evaluated the proportion of hospitalizations that were avoidable and the reasons for these hospitalizations. Of the 200 hospitalizations evaluated in this study, 67% were flagged as potentially avoidable. Reasons for these hospitalizations included lack of on-site availability of clinicians, inability to access needed testing or treatment, and difficulty in assessment of acute changes.[59] A quality improvement study using clinical practice tools and support by advanced-practice nurses resulted in a reduction in the potentially avoidable hospitalizations of 36%.[60] One of the difficulties in implementing the use of advanced practice nurses in long-term care and skilled nursing facilities is reimbursement for their services. These nurses can provide support for transitions from hospital to nursing facilities, provide consistent routine and follow-up care, improve communication with physicians, and, thus, improve the quality and reduce the cost of care of nursing home patients. In order to use advance practice nurses to improve care in skilled nursing facilities, the NCIOM recommended;

RECOMMENDATION 7.10: REIMBURSE NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES

The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.

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EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 8: NEW MODELS OF CARE

One of the goals of the Affordable Care Act is to reign in escalating health care costs. Over the last ten years, health insurance premiums have increased at more than three times the rate of general inflation. The average employer-sponsored premium for single coverage in North Carolina increased 80% between 2000-2001 and 2009-2010 and 85% for family coverage.[1] Nationally, the comparable premiums increased 109% and 115% respectively during the same time period. In contrast, general inflation increased 24%.[2] Absent major interventions, health care spending is expected to continue to rise faster than other spending in our society.[3]

OVERVIEW

There is more than a three-fold variation in per capita health care spending across the country.[4] Most of the variation in health care spending across the country is due to differences in the types and quantity of services. This variation has not been found to be as related to differences in price of services, severity of health problems, or patient preferences.[5] Further, communities that spend more on health care services do not achieve better health outcomes. In fact, some experts suggest that the amount spent on health care is associated with lower health care quality.[6]

In general, our current fee-for-service (FFS) health care payment system rewards health care providers based on the volume of the services provided, not outcomes or quality.[7] Health care professionals receive payment each time they provide health care services. Payments are not tied to quality or outcomes. In addition, the existing reimbursement structure creates incentives for health care professionals to provide care based on whether a service can be reimbursed. This can create a financial disincentives and discourage health care professionals from providing certain health care services that could have a greater positive impact on an individual's health, but which are not currently reimbursed. The current FFS system also contributes to more fragmented care, as health care professionals get paid regardless of whether care is coordinated among different health care professionals.

The NCIOM New Models of Care workgroup recognized that we—as a state and a nation—need to rethink how we pay for and deliver health care services. We cannot continue to pay increasing amounts of our state or nation's wealth on health care services without receiving a commensurate improvement in health care quality and outcomes. The development and implementation of new models of care is essential to face the challenge of improving the value delivered by our health care system. We need to develop new models of care that expand access to and utilization of needed services; incentivize providers to improve quality as well as individual and community health outcomes; involve patients more directly in their own care; reduce redundant, ineffective, and inefficient utilization (i.e., unnecessary utilization); and moderate rising health care costs. In addition, we need to focus more on prevention and improving the health status of the population (i.e., improving overall population health) to reduce the need for more costly health care services. This will require a more holistic view of health care, one which recognizes that the health of a population is profoundly influenced by more than the health care services that the population receives. Population health is also influenced by the

individuals'environment, socioeconomics (including income, education, and housing), lifestyle choices, and racial/ethnic disparities.[8]

The workgroup developed a set of principles that should guide the state, as well as other private organizations, as they implement new delivery and finance models. An abbreviated version of the principles is included below. The complete version is included in Appendix G:

1. Individual patients' and their families' needs and preferences should be the central focus of any health system.
2. North Carolina will be best served by developing models that will improve access, quality, and population health, and reduce unnecessary utilization and the rate of increase in health care expenditures. The availability of funding should not drive the development of new models; rather models should be pursued to address North Carolina specific needs.
3. North Carolina should aggressively test new models, building on existing initiatives but continuing to explore other options with the goals of improving health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.
4. North Carolina should continue testing different models of patient-centered interdisciplinary teams that address the health needs of the whole person.
5. Consumers should be given the information, training, and support to be active participants in managing their own health and informed consumers in a redesigned health system.
6. In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals and paraprofessionals to the fullest extent of their education and competency.
7. Models of care should be designed to improve quality, health care outcomes, and health care access for populations that have been traditionally underserved including, but not limited to, low-income populations, the chronically ill, racial and ethnic minorities, and people with disabilities.
8. Data should be collected and analyzed in a manner that allows for the ongoing redesign and improvement of our care delivery systems, and pertinent health care information and performance data should be made available to consumers.
9. Models of care should be thoroughly evaluated in a timely manner to determine if these innovations are leading to the stated goals, and to understand what models work best for different populations in different communities and with different configurations of providers. Any new model tested in the state should be transparent in terms of design, outcomes, and costs.
10. Successful initiatives should be disseminated throughout the state.
11. To the extent possible, the new models of care should involve other payers in addition to Medicaid and Medicare.
12. If savings are realized from the changes in the health care delivery and financing systems, these savings should be reinvested to support additional improvements in access, quality, health care outcomes, and population health and/or be shared with consumers, taxpayers, payers, and providers.

North Carolina is a leader in testing new delivery and payment models, particularly within its Medicaid program. Community Care of North Carolina (CCNC) is a nationally recognized PCMH model that has helped improve the quality of care and reduce health care costs provided to Medicaid recipients.[9] This PCMH model is now being expanded to include some commercially insured populations (i.e., Blue Cross Blue Shield of North Carolina enrollees), and Medicare recipients (described more fully below). In addition, some of our large insurers and health care systems are also testing new models of care. The ACA provides some opportunities to partner with the federal government to test new models or expand existing models to the Medicare or Medicaid population. However, North Carolina's efforts have not focused solely on opportunities offered through the ACA. This chapter describes some of the new funding opportunities made available under the ACA to test new models of care, as well as some of North Carolina's existing demonstrations, including value-based plan designs and broader population health interventions.

ACA PROVISIONS AND NORTH CAROLINA MODELS

The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and health care expenditures, while improving individual health outcomes and overall population health. To encourage innovations in health care delivery design and payment models, the ACA created the Center for Medicare and Medicaid Innovation (CMI) within the Center for Medicare and Medicaid Services (CMS). The stated intent of CMI is "to test innovative payment and service delivery models to reduce program expenditures under … [Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals under such titles."[10] Three of the signature models include PCMHs, episode of care/patient bundling, and accountable care organizations. However, the ACA also gives CMI, and CMS more broadly, the authority to test other delivery models in the Medicare, Medicaid, and Child Health Insurance Program (CHIP) programs, including, but not limited to, community-based care transitions, state demonstrations to fully integrate care for Medicare and Medicaid dual eligibles, independence at home, medication therapy management, telehealth or telemonitoring for chronically ill individuals at high risk of hospitalizations, and co-location of primary care and behavioral health.

Private insurers are also exploring similar models to improve quality of care and population health, and to reduce health care costs. Many of the private efforts predate the enactment of the ACA, but the ACA provides additional incentives that will encourage insurers to implement similar initiatives in their commercial products. For example, insurers that offer qualified health plans within the Health Benefit Exchange (Exchange) are required to include quality improvement activities.[11] The ACA defines allowable quality improvement strategies to include increased reimbursement or other incentives to improve health outcomes (e.g., through quality reporting, case management, care coordination, chronic disease management, medication management, or a medical home model), prevention of hospital readmissions, improvement in patient safety and reduction of medical errors, implementation of wellness and health promotion activities, or reduction in health care disparities.

These different models, along with some of the similar delivery and payment models being tested in North Carolina are described briefly below. A more complete listing of new models being tested in North Carolina is included in Appendix H.

Patient-Centered Medical Homes (PCMH)[12]

PCMH are teams of health care professionals and other ancillary staff who provide comprehensive primary care to patients including preventive, acute, and chronic care management.[13] The care should be patient-centered, actively engage the patient in their own care and tailored to meet the patient's needs and preferences. In addition, PCMHs often include electronic health records and other technology to improve quality of care and patient outcomes. PCMH models sometimes include payment reform, including pay-for-performance or separate payments for care coordination and care management.

CMS and/or CMI have developed several initiatives to promote PCMHs in Medicare and Medicaid. For example, CMI is testing a multi-payer PCMH initiative in seven markets (called the Comprehensive Primary Care Initiative).[14] CMS has a demonstration to support federally qualified health centers (FQHC) in pursuing Level 3 PCMH recognition from the National Committee for Quality Assurance (FQHC Advanced Primary Care Practice demonstration).[15] The ACA includes funding to encourage every state to develop "health homes" in their Medicaid program.[16] Essentially, "health home" is another name for a type of PCMH that focuses on care management, care coordination and health promotion, and patient and family support for Medicaid beneficiaries with chronic illnesses. States that agree to the terms of the federal health home requirements are eligible for a 90% federal medical assistance percentage (FMAP) match for certain covered services for eight fiscal quarters after their state plan amendment (SPA) is approved.

Community Care of North Carolina (CCNC) is a nationally recognized, award winning, non-profit, practitioner-led, PCMH model that links more than one million Medicaid recipients (80% of all North Carolina Medicaid recipients) and others in the state, to primary care practices.[17,18,19] CCNC originated over a decade ago as a collaborative effort between the North Carolina Division of Medical Assistance (DMA), the local CCNC networks, and the North Carolina Office of Rural Health and Community Care (ORHCC). There are 14 autonomous non-profit regional CCNC network entities across North Carolina covering all 100 counties. North Carolina Community Care Network, Inc. (NCCCN) serves as the umbrella coordinating organization for the 14 networks. In developing the CCNC model, there was an understanding that many factors affect health, and that networks needed to include more than health care providers to have an impact on the health of the Medicaid population. Thus, each network incorporates primary care providers, FQHCs and other safety net organizations, hospitals, social services agencies, local health departments, and other community resources that work together to provide high quality care and care coordination for the enrolled population. A significant portion of the care coordination provided by CCNC is in person, rather than remotely through the telephone.

Each of the CCNC networks has a clinical director, network director, nurse and social worker care managers, pharmacist, psychiatrist, quality improvement coordinator, and informatics system manager. Primary care providers under contract with CCNC receive a per-member-per-month (pmpm) payment from the state to help manage the care provided to their enrolled patients. In addition, the network receives an additional pmpm payment to help pay for care management, disease management, and quality improvement activities; an informatics system that undergirds the quality improvement initiatives; and other resources needed to improve the care provided to the enrollees.

CCNC networks are all involved in clinical improvement initiatives, including specific disease management programs (including diabetes, asthma, congestive heart failure), medication management, chronic care and transitional care programs, and emergency room initiatives. CCNC, working with primary care providers, helps build comprehensive teams that coordinate services for Medicaid and other enrolled patients. Some of the ancillary team members are available at the network level (e.g., pharmacists and psychiatrists), and others (e.g., nurse and social work care managers) are embedded within the practices—particularly larger practices — and 38 hospitals. The team focuses on care for people with chronic, or complex health conditions, working to improve the quality of care provided as well as patient self-management skills.

In addition, CCNC has a pregnancy home initiative which is intended to improve the quality of maternity care provided to Medicaid recipients. Medicaid currently covers approximately half of all births in the state, including many women who are at risk of poor birth outcomes such as preterm birth or low birth weight. Improving care for this higher risk population can help improve the state's birth outcomes. This is a collaborative effort between CCNC networks, DMA, the Division of Public Health, and local health departments. Participating Medicaid providers will be measured on four performance measures: no elective deliveries before 39 weeks; providing progesterone shots to women at risk of preterm births (17P); reducing the primary c-section rate; and performing standardized initial risk screening of all obstetrical patients. In addition, the Pregnancy Medical Home provider must coordinate with local public health pregnancy case management to ensure that high-risk patients receive case management. The initial goals of the pregnancy home model are to reduce the rate of low birth weight by 5% in each of the first two years and to achieve a primary c-section rate at or below 20%.

DMA has also submitted a SPA to the CMS to implement the health home option. Health home services are limited to Medicaid recipients who have two or more chronic conditions, one chronic condition with a risk of a second chronic condition, or one serious and persistent mental illness. Once the SPA is approved by CMS, the state will use the enhanced funding to support comprehensive care management, care coordination transitional care, individual and family support services, and referrals to community and social supports to qualified Medicaid participants. The care coordination function will be split between CCNC (for patients with more significant medical needs and less acute behavioral health problems), and Local Management Entities/Managed Care Organizations (LME/MCOs) (for patients with more significant behavioral health problems and less acute medical needs).

Although CCNC began as a Medicaid-only initiative, the enrolled population has gradually expanded over time to include additional populations. In 2011, the North Carolina General Assembly expanded CCNC to include North Carolina Health Choice recipients.[a] As of October 2012, CCNC managed the care of 143,736 North Carolina Health Choice recipients, or 94% of all North Carolina Health Choice enrollees. In addition, as part of the Medicare 646 waiver, CCNC is now managing the care of 102,690 dual eligibles (described more fully below). More recently, CCNC has begun to work with the State Health Plan, Medicare, Blue Cross and Blue

[a] North Carolina Health Choice, North Carolina's CHIP program, is open to children whose family income is below 200% of the federal poverty guidelines but exceeds Medicaid income requirements.

Shield of North Carolina (BCBSNC), and some large employers to provide PCMHs to commercially insured populations. For example, North Carolina was one of the first eight states awarded a demonstration grant through CMI. The demonstration was awarded to test a multi-payer partnership between DMA, CCNC, Blue Cross Blue Shield of North Carolina, and the State Health Plan in seven rural counties: Ashe, Avery, Bladen, Columbus, Granville, Transylvania, and Watauga. CCNC medical homes currently serve more than 40,000 Medicaid recipients in these seven counties. The new partnership is expected to expand the patients served by CCNC practices to more than 20,500 Medicare beneficiaries and more than 20,800 privately insured or State Health Plan enrollees. Medicare will pay a pmpm payment to participating primary care practices, and BCBSNC and the State Health Plan are also providing financial support for participating primary care practices.

In addition to the multipayer initiative, CCNC is also partnering with several large employers to offer PCMHs to self-funded populations.[20] This effort, called "First in Health," is a collaboration between CCNC, GlaxoSmithKline (GSK), the State Health Plan, Kerr Drug, SAS, and BCBSNC. Beginning with GSK and the State Health Plan, these self-funded employers are offering their employees the option of joining a CCNC PCMH, with the goal of improving quality of care and reducing costs for their employees, dependents, and retirees.

There are also other initiatives across the state to try to support and expand the availability of PCMHs. BCBSNC has an initiative—Blue Quality Physicians Program (BQPP)—which provides enhanced funding to primary care practices based on four areas of provider performance: quality of care, patient experience, administrative efficiency, and cost and efficiency of care.[21] The amount of the enhanced payment is based on the physician's performance in these four areas, with more of the assessment weighted towards quality of care measures. Certain performance criteria are mandatory, others are optional. BQPP is an optional program available to physicians in family medicine, internal medicine, pediatrics, obstetrics/gynecology, or general practice.

More recently, BCBSNC and UNC Health Care have partnered to create a new delivery model—Carolina Advanced Health in Chapel Hill. Carolina Advanced Health is a health care center that includes a comprehensive team of health care professionals who will work with patients to improve health care outcomes, increase patient satisfaction, and reduce health care costs. The center will focus on caring for patients with chronic illnesses or more complex health problems. This is a unique arrangement between two independent entities, a health system and a private payer, in which both organizations are helping to share in both the costs and savings of the center.

Other private insurers are also supporting innovative payment and care delivery models. For example, WellPath[b] has entered into new agreements with health systems and medical group practices designed to improve the quality and value of services provided and enhance patient outcomes. WellPath believes that health care professionals are in the best position to redesign the health care delivery system to enhance quality, outcomes, and efficiency. As a result, WellPath has focused on designing and implementing collaborative approaches to support redesign efforts

[b] WellPath is a Coventry health care plan operating in North and South Carolina since 1996.

to remove barriers and financial disincentives that make it difficult for provider groups to achieve these goals. Some of the key elements include:

- Support for PCMHs. WellPath has worked with the provider organizations to change provider compensation to support necessary but previously non-revenue producing activities and more closely align with evidence-based quality measures.
- Support for provider-led system redesign by aligning benefit plan design and compensation systems for the purpose of meeting the comprehensive needs of the patient/members and providing increased affordability.
- Comprehensive information sharing between WellPath and the provider organizations to support quality, improved health outcomes, and greater efficiency.

Episode of Care/Patient Bundling[22]

Under this model, a group of health care professionals and providers are incentivized to work together to manage all of the services needed by the patient during that episode of care.[23] An episode of care may be based around a discrete medical event (such as treatment for a heart attack), treatment for a chronic health problem over a certain period of time (such as care provided to someone with diabetes over a year), or may be focused on a specific procedure (such as knee or hip replacement). The episode of care payment can be designed to include hospitals, physicians, home health, or other health care providers necessary for the care of a patient for a specific episode of care, or it can be limited to only a subset of this group of health professionals. Episode of care models are intended to encourage greater coordination of care across providers and health care professionals, and to reduce unnecessary utilization. If the provider group saves money under this episode of care payment, the group of providers/professionals could keep the savings. Conversely, if there are complications that require additional expenditures—the group would need to absorb the additional costs. Insurers could develop tiered payment levels, based, in part, on health care outcomes.

CMI is testing four limited episode of care/bundled payment models in the Medicare program.[24] In three of the models--acute care hospital stay only, acute care with post-acute care associated with the stay, and post-acute care after discharge—the providers are paid a negotiated discount off their traditional Medicare payment (e.g., fee-for-service or inpatient prospective payment system), with the potential for sharing savings with the federal government. This is a retrospective bundled payment, because the potential for shared savings occurs after comparing total costs to a "target" price at the end of the year. CMI is also testing a prospective acute care hospital payment. Under this model, Medicare will pay hospitals a single, prospective bundled payment that would pay for all the services rendered during inpatient stay by the hospital, physician, and other practitioners.[25] All of the participating providers and health professionals would be paid out of the bundled payment to the hospital. The participating health professionals and providers can keep any savings that are achieved through greater coordination amongst the different individuals and entities. Several North Carolina health care organizations are in discussions with CMS about testing an episode of care payment model in Medicare.

This model is also being tested in the commercial population. BCBSNC, the State Health Plan, and CaroMont are testing a comprehensive episode of care payment for knee replacement

surgery. The episode of care payment will cover preoperative, inpatient stay, and post-acute care for up to 180 days after surgery. Payments will be based, in part, on health care outcomes. This initiative began April 2011 and will be evaluated.

Accountable Care Organizations (ACO)[26]

An ACO is a group of providers and health care professionals who agree to be accountable for the quality, cost, and overall care of their assigned beneficiaries. The performance of the ACO is based on the cost and quality of care provided to the beneficiaries that are attributed to their ACO. This attribution is "virtual" in that it is based on where the beneficiary chooses to go to receive most of their primary care services. Beneficiaries continue to have complete freedom of choice in health care providers (in or outside the ACO). CMI has released regulations with different options for ACOs

One of the CMS ACO options is a Medicare Shared Savings program.[27] Under this program, the ACO will share in Medicare savings if it meets program requirements and quality standards, and has achieved savings against a targeted spending threshold. Because of the potential for shared savings, providers have an incentive to better coordinate services, reduce unnecessary health care utilization, and improve quality of care. Under the Medicaid Shared Savings regulations, there are two options for shared risk and shared savings: a one-sided model (the ACO can share in up to 50% of the savings, but assumes none of the risks if costs exceed the spending target) or a two-sided model (the ACO can share in up to 60% of the savings, but will also share in between 5%-10% of the excess costs if spending exceeds the target). ACOs in the Medicaid Shared Savings program will be measured against 33 performance measures that capture the patient/care giver experience, care coordination, preventive health services, and services for at-risk populations or the frail elderly.

CMI has also created a number of other ACO models to test other variations of ACOs. For example, CMI has created an Advance Payment ACO model to make it easier for smaller organizations or groups of health professionals to participate in an ACO. The intent is to provide some up-front capital to smaller ACOs to help them build the infrastructure needed to actively manage their assigned Medicare FFS beneficiaries.[28] CMI also has a shared savings model, the Pioneer ACO Model, which is targeted to health care organizations and providers that have more experience coordinating care across different health care settings and who are willing to share risk.[29] To date, five organizations in North Carolina have applied for and been named as shared savings ACOs: Accountable Care Coalition of Caldwell County (Lenoir), Accountable Care Coalition of Eastern North Carolina (New Bern), Cornerstone Health Care (High Point), Meridian Holdings (which includes organizations in North Carolina as well as seven other states and the District of Columbia), and the Triad Healthcare Network. In addition, one organization has qualified as an Advance Payment ACO: Coastal Carolina Quality Care (New Bern).

Prior to the enactment of the ACA, Section 646 of the Medicare Modernization Act created a five-year demonstration program to test models to improve patient safety, effectiveness, efficiency, patient centeredness, and timeliness of care for Medicare recipients. CCNC was one of two organizations authorized to participate in this demonstration. The CCNC demonstration program operates in 26 counties across the state: Bertie, Buncombe, Cabarrus, Chatham, Chowan, Edgecombe, Gates, Greene, Hertford, Hoke, Lincoln, Madison, Mecklenburg, Mitchell,

Montgomery, Moore, New Hanover, Orange, Pasquotank, Pender, Perquimans, Pitt, Sampson, Stanly, Union, and Yancey. The program assigns dual eligibles and Medicare-only beneficiaries, on a volunteer basis, to a primary care professional, offers care coordination services, enhances the data available to help manage patient care, and includes quality of care performance measures. Under the 646 waiver, CCNC can share in the savings with CMS if it meets certain quality standards and shows cost savings.

Community-Based Care Transitions[30]

Medicare began reducing payments to hospitals that have "excess readmissions" for discharges occurring on or after October 1, 2012. Under this system, hospitals are held accountable for a readmission that occurs within 30 days of discharge for heart attack, heart failure, and pneumonia (this list of conditions will expand in FY 2015).[31] CMS has funding to test models to reduce hospital-acquired conditions, improve transitions in care, and reduce preventable hospital readmissions.[32] Improving care transitions and reducing preventable readmissions can help reduce health care costs, as one study showed that approximately one-fifth of Medicare beneficiaries are readmitted within 30 days of discharge, and one-third are readmitted within 90 days.[33]

One of these programs focuses on improving care transitions (in order to reduce preventable hospital readmissions). Hospitals that have high 30-day readmission rates that fall within the top quartile for the state in at least two of the three following conditions: acute myocardial infarction, heart failure, or pneumonia can serve as lead organizations for this funding. To qualify, the hospital must partner with community-based organizations (CBOs) that provide transition services. CMS identified 16 North Carolina hospitals that can serve as a lead organization under this program, including: North Carolina Baptist Hospital, University of North Carolina Hospital, Rutherford Hospital, Lenoir Memorial Hospital, Franklin Regional Hospital, Southeastern Regional Medical Center, Watauga Medical Center, Presbyterian Hospital, Morehead Memorial Hospital, WakeMed, Raleigh Campus, Thomasville Medical Center, Sandhills Regional Medical Center, Lake Norman Regional Medical Center, Martin General Hospital, Nash General Hospital, and Person Memorial Hospital.[34] If a CBO is the applicant, the CBO can partner with other hospitals (even if they are not currently listed as a high readmission hospital). CMS, working in conjunction with the United States Agency on Aging, has also funded other care transitions programs, including: The Care Transitions Intervention,[35] The Transitional Care Model,[36] Project BOOST,[37] Re-engineered Discharge,[38] and Transforming Care at the Bedside.[39] CMS will have a rolling application period for the Community Based Care Transition program.

A subcommittee of the New Models of Care workgroup met with a subcommittee of the Quality of Care workgroup to make recommendations on how to improve care transitions. (See Recommendation 7.8 in Chapter 7 and Appendix F.) Subsequent to this work, the North Carolina Hospital Association has taken the lead in pulling together different stakeholder groups, including representatives of hospitals, CCNC, North Carolina Department of Health and Human Services (NCDHHS), nursing facilities, North Carolina Healthcare Quality Alliance, Carolinas Center for Medical Excellence, home health and hospice, AHEC, aging and disability resource centers, area agencies on aging, foundations, and other community-based organizations to examine strategies to improve care transitions, including the possibility of applying for federal

funds to support this effort. One North Carolina program, the Northwest Triad Care Transitions Community Program, received funding through the CMI Community-based Care Transitions program.[40] Northwest Community Care Network is the lead organization and will be working with other community partners and seven acute care hospitals including Forsyth Medical Center, Hugh Chatham Memorial Hospital, Lexington Medical Center, Medical Park Hospital, Northern Hospital of Surry County, Thomasville, Medical Center, and Wake Forest Baptist Health.

State Demonstrations to Integrate Care for Dual Eligible Individuals[41]

CMI also has funding to test models to improve the care provided to dual eligibles (i.e., those individuals who are eligible for both Medicaid and Medicare). The goal of this initiative is to coordinate preventive, primary care, acute, behavioral, and long-term care services for dual eligibles, thereby improving quality and reducing costs. Because of their health needs, dual eligibles are generally among the most expensive of Medicaid and Medicare beneficiaries. Nationally, dual eligibles comprise 15% of the Medicaid population but account for 39% of Medicaid costs and 16% of Medicare beneficiaries using 27% of Medicare costs.[42]

North Carolina is one of 15 states that received planning grant funds to better integrate care for dual eligibles.[43,44] CCNC, DMA, and other NCDHHS agencies, including the Division of Aging and Adult Services, Division of Vocational Rehabilitation, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services worked with other state and community partners to develop a model of care and an implementation plan to better integrate are for dual eligibles. More than 180 stakeholders participated in the planning and development of the *Dual Eligible Beneficiary - Integrated Delivery Model*.

North Carolina's *Dual Eligible Beneficiary - Integrated Delivery Model* has the triple aims of improving responsiveness to beneficiary goals, improving care outcomes and achieving shared savings. Under this three-year demonstration initiative with CMS, North Carolina will support PCMH for community-residing dual eligible beneficiaries and extend medical home offerings to dual eligible beneficiaries in nursing homes and non-medical residential care (adult care home) settings; develop an integrated independent needs assessment and functional need-based resource allocation processes for medical need/level of care determination and authorization; and develop cross-stakeholder opportunities for communication through greater access to electronic information. The plan also includes strategies to develop provider and beneficiary capacity, skills and use of actionable data, and to maximize the flexible use of public funds available for supports to dual eligible beneficiaries. The proposal was submitted to CMI on May 1, 2012. At this time, the state is awaiting further discussions with CMS on the Memorandum of Understanding (MOU) which will guide the implementation of the demonstration. CCNC expects that implementation will not begin until April 1, 2013 or sometime thereafter. Once implemented, it will subsume the existing 646 waiver.

Independence at Home[45]

CMS has the authority to test models that provide primary care services to certain frail Medicare beneficiaries in their homes.[46] To be eligible for services, the Medicare beneficiary must have two or more chronic illnesses, two or more functional dependencies, or have had a non-elective hospital admission within the past 12 months. Primary care services will be provided by a team of practitioners lead by a physician or nurse practitioner. CMI funded Doctors Making

Housecalls (Durham) as one of the first 18 Independence at Home demonstration organizations.[47]

Duke University Health System and Lincoln Community Health Center developed a similar initiative, called Just for Us. Care is provided to older adults or people with disabilities age 30 or older who have access to care problems. The care team is comprised of a physician, physician assistant, nurse practitioner, occupational therapist, social worker, community health worker, and phlebotomist. Just for Us is currently serving approximately 350 residents in 14 housing complexes. Duke's evaluation showed that this program reduced emergency room use and inpatient hospital costs and improved quality of care.[48]

Medication Therapy Management[49]

The ACA includes several provisions which authorize CMI or CMS to create demonstration projects to test medication therapy management for patients who take four or more medications, high-risk medication, or have multiple chronic diseases.

North Carolina has several medication therapy management models. The Health and Wellness Trust Fund (HWTF) launched ChecKMeds in North Carolina in 2007, which reimburses pharmacists to provide medication reviews to Medicare beneficiaries age 65 and older across the state who have a Part D drug plan. When the HWTF was defunded, ChecKmeds NC was moved to the North Carolina Office of Rural Health and Community Care. The program is funded through June 2013. The North Carolina General Assembly approved the Medication Therapy management pilot which charges CCNC with establishing a pilot that will explore options, including funding options, to continue the ChecKmeds program.

In addition, CCNC also has a medication therapy management component. CCNC has pharmacists embedded in each of the 14 networks. The network pharmacists help provide consultation to primary care professionals when they have questions about medication management. In addition, CCNC has a medication management system that collects medication data from Surescripts, administrative claims, medical records, case managers, patients, and physicians. The data can be accessed by CCNC case managers, pharmacists, and primary care providers. The system helps identify potential adverse events due to drug interactions, as well as addressing poor medication adherence. This enables CCNC care managers and other health care professionals to intervene before adverse events occur.

The State Health Plan also has a medication adherence pilot project.[50] Under this initiative, started in December 2009, all State Health Plan retirees using diabetes or cardiovascular medications were eligible for a reduction in their copayment. Retirees were targeted due to the high prevalence of these diseases among the retiree population and the potential to improve adherence through reduced cost sharing. By October 2011, approximately 26,000 retirees had participated in the program. Medco, the Plan's Pharmacy Benefit Manager, determined that the program saved members more than $1 million in co-payments, and reduced pharmacy costs to the State Health Plan by more than $2.3 million. In addition, the medication adherence rate improved by more than 14% for oral diabetes and cholesterol medications, and by more than 19% for blood pressure medications.

At the local level, Senior PharmAssist has provided medication management to seniors in Durham since 1994. Program evaluation demonstrated a 51% reduction in the rate of any hospitalizations and a 27% reduction in the rate of any emergency department use after two years in medication management.[51]

Telehealth or Telemonitoring for Chronically Ill Individuals at High Risk of Hospitalization[52]
CMI is also authorized to test a number of models that involve the use of telehealth or telemonitoring for individuals with chronic illness, behavioral health problems, or other health conditions. The goal is to help monitor and treat individuals more effectively in the community, in order to reduce unnecessary hospitalizations and improve health outcomes. In addition, telehealth—which links patient data to practitioners located in other parts of the state—offers opportunities to expand access to services and increase the quality of care provided to individuals who live in medically underserved communities.

North Carolina has implemented several successful telehealth and telemonitoring initiatives. Roanoke Chowan Community Health Center received funding from the North Carolina Health and Wellness program in 2006 to establish a telemonitoring program for low-income, chronically ill patients with health disparities in northeastern North Carolina. Patients with diabetes, cardiovascular disease, and hypertension are given monitoring equipment, including a scale, blood pressure/pulse monitor, blood glucose monitor, and pulse oximeter to monitor their health on a daily basis. A registered nurse (RN) monitors the daily data, and contacts the patients and/or the patient's primary care provider if the readings are abnormal. Over the last six years, this initiative has also received funding through the Kate B. Reynolds Charitable Trust, US Department of Health and Human Services, Office for the Advancement of Telehealth, ORHCC, and other state and local foundations. Wake Forest University conducted an independent, objective evaluation of the program and found a reduction in hospitalization costs of more than $1.2 million for the 64 patients studied. Roanoke Chowan Community Health Center currently provides remote monitoring for people with cardiovascular disease, diabetes, hypertension, and pulmonary disease in 14 counties across the state.[53]

The Brody School of Medicine at East Carolina University has one of the longest running telemedicine operations in the country. One of ECU's core telemedicine programs is its telepsychiatry program. ECU employs three full-time equivalent psychiatrists to provide services to patients in 13 eastern counties (Beaufort, Bertie, Craven, Edgecombe, Gates, Greene, Hertford, Jones, Nash, Northampton, Pamlico, Pitt, Wilson). The ECU psychiatrists provide services to patients through videoconferencing and face-to-face visits, consultation with other clinicians for complicated care, and coordination with the mobile crisis teams covering the 13 counties.

In addition, North Carolina Foundation for Advanced Health Programs (NFAHP) recently completed a congestive heart failure telehealth program funded by The Duke Endowment. This program operated in selected CCNC networks. A CCNC nurse care manager established a relationship with patients before they were discharged from the hospital. The care manager then met with the patients in their homes, and provided telemonitoring equipment as well as ongoing support and education. Evaluation results from the CCNC Informatics Center showed an improvement in the medication adherence rate and a decrease in the inpatient hospital rate. In

addition, the total cost per member per month decreased from $2,374 to $1,400—excluding drugs. DMA is pursuing a policy change to cover telemonitoring for patients with congestive heart failure.

Co-location of Primary Care and Behavioral Health[54]

The ACA also includes potential grant funding to support co-location of primary care and behavioral health services. These funds could be used to support the provision of behavioral health services in primary care practices, or primary care services within community-based mental health settings. This demonstration grant opportunity was not specific to Medicare or Medicaid.

North Carolina has been working to expand efforts to integrate behavioral health and primary care services in both primary care practices and in behavioral health settings for many years. In 2006, a coalition of medical and behavioral health organizations, state agencies, and patient advocacy groups created the ICARE partnership to prepare for and pilot integrated practices with primary care, mental health, and substance abuse professionals.[55] This work was supported by Kate B. Reynolds Charitable Trust, The Duke Endowment, and AstraZeneca. In 2007, the North Carolina General Assembly provided support to the ORHCC to help integrate behavioral health and primary care services in both primary care and specialty mental health offices. ORHCC continues to support practices in the adoption of best practices for integrated care. In April 2010, DMA began providing funding to CCNC networks to embed a psychiatrist into each network. These psychiatrists support the care coordinators and providers within the CCNC practices.

NCFAHP has provided additional support to help CCNC practices integrate behavioral health and medical services bi-directionally. NCFAHP is helping behavioral health providers integrate medical screening and chronic disease monitoring and helping integrate behavioral health into primary care. NCFAHP is home to the North Carolina Center of Excellence for Integrated Care which provides technical assistance, training collaborative, and capacity building for health providers to integrate behavioral and medical care. NCFAHP has a contract with the ORHCC for the Center of Excellence to promote integrative care focused on children with special health care needs in selected CCNC-enrolled pediatric practices, family practices, and health departments.[56] The Center of Excellence is also supporting initiatives targeting autism spectrum disorder, maternal depression, oral health, and childhood obesity. The Center of Excellence is under contract to the Governor's Institute on Alcohol and Substance Abuse to provide technical assistance and training to FQHCs to improve early identification and treatment of patients with substance abuse conditions. In addition, Kate B. Reynolds Charitable Trust provided additional grant support to enable NCFAHP to work with safety net providers and mental health/substance abuse providers in more than 30 counties. All models, including integration, reverse co-location, reverse integration, and co-location, are being tested and implemented.

State Innovation Model (SIM)[57]

CMI recently announced a competitive funding opportunity for states to design and/or test multi-payer payment and delivery models designed that will improve health care quality, while helping lower health care costs in Medicare, Medicaid, and/or the Children's Health Insurance Program. North Carolina submitted its application for SIM funding on September 24, 2012. No decisions have yet been made. If funded, the SIM Initiative will help strengthen North Carolina's PCMH

model through workforce development, academic education and residencies, allied health worker training, consumer education and engagement to better health status, health information technology support for providers, and assistance to providers to improve quality and achieve NCQA PCMH recognition.

Value Based Insurance Product Design

Another "new model" that is being tested among private insurers is value based insurance design (VBID). With VBID, insurers encourage enrollees to use services or medications with greater efficacy by reducing or eliminating the out-of-pocket cost sharing (for example, eliminating cost sharing for highly effective medications), or by increasing the cost sharing on services, procedures, or medications that are less useful.[58] VBID products can also be designed to provide financial incentives to enrollees to encourage them to obtain care from high quality, lower-cost health care providers. Unlike a traditional Preferred Provider Organization (PPO) insurance product—which have differential cost-sharing arrangements for in-network and out-of-network providers—value-based insurance products may have multiple tiers of cost sharing. The amount of the cost-sharing may differ depending on the procedure/service and the provider. Thus, a large health care system may be considered a best value provider for open heart surgery, but not for knee or hip replacement. BCBSNC is testing a value-based insurance product design for one large employer group.

Improving Population Health

In addition to the new models that focus on changes in the health care delivery system and payment methodologies, some communities are testing new models focused on improving overall population health. Population health programs include some of the changes in delivery and payment models discussed previously, but also include community-based efforts to address socioeconomic, transportation, literacy, and other broader societal issues that affect population health. The Durham Health Innovation (DHI) is an example of this broader community-focused health intervention. This is a collaboration between Duke Medicine, the Durham County Department of Public Health, and the Durham community that seeks to improve the health status of Durham County residents, focusing on areas in the county that are low-income, more heavily comprised of racial and ethnic minorities, and which have greater health disparities. In 2009, DHI funded 10 planning teams to find ways to reduce death or disabilities from diseases or other health problems prevalent in the community. These teams identified seven strategies that could improve the health and health care delivery in Durham, including: increasing health care coordination and eliminating barriers to services and resources; integrating social, medical, and mental health services; expanding health-related services provided in group settings; leveraging information technology; using social hubs (such as places of worship, community centers, salons and barber shops) as sites for clinical and social services and information; increasing local access to nurse practitioners, physician assistants, and certified nurse midwives; and using traditional marketing methods to influence health behaviors.

EVALUATION AND DISSEMINATION OF SUCCESSFUL MODELS

North Carolina has many different pilots or demonstrations under development, both in the public and private sector. The New Models of Care workgroup attempted to catalogue the different initiatives under development across the state, including basic information about program design, goals, evaluation data (if any), and contact information. (See Appendix H.) To

the knowledge of workgroup members, this was the first time that such pilots and demonstrations were catalogued and maintained in one location. The New Models of Care workgroup recommended that funding be provided to NCFAHP to maintain a similar centralized tracking system and update it on an ongoing basis. Rather than "reinvent the wheel," North Carolina public and private payers, health systems, and health care professionals should learn from existing initiatives about what works and what does not. Once NCFAHP identifies successful strategies, it should help disseminate the information across the state and provide technical assistance to health care organizations seeking to replicate similar models.

In addition, NCFAHP could play a role in bringing together different public and private payers, health care systems, and health care providers to identify patient safety, quality of care, and cost drivers affecting the state or particular regions in the state. Public and private payers and health systems have some capacity to analyze their own internal data to identify cost drivers or potential quality concerns for their specific enrollees. However, no group is currently charged with examining these issues for a state as a whole. The workgroup recommended that NCFAHP assume this analytical and facilitative role, and help link potential partners to potential health care delivery or payment models that could address statewide quality and cost concerns. To accomplish these goals, the NCIOM recommended:

RECOMMENDATION 8.1: DEVELOP A CENTRALIZED NEW MODELS OF CARE TRACKING SYSTEM

North Carolina state government and North Carolina foundations should provide funding to the North Carolina Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state. The role of NCFAHP would be to:

- **a) Monitor federal funding opportunities and new regulations identifying new models of care.**
- **b) Identify and/or convene stakeholder groups to examine existing data on costs and utilization, geographic areas of the state that are outliers in terms of costs, quality, or population health measures, and help identify appropriate new payment or delivery models of care to test.**
- **c) Maintain a data base of existing North Carolina demonstrations that test new payment and delivery models of care, whether funded through private or public funds.**
- **d) Collate evaluation data on these demonstrations and, to the extent possible, identify what models work best to address specific problems. The NCFAHP should help identify whether the new payment and delivery models are evidence-based, promising practices, or unsuccessful models.**
- **e) Disseminate information across the state to other health care providers, health systems, insurers, consumer groups, and state policy makers about the success of these initiatives.**
- **f) Provide technical assistance to communities, health care providers, insurers, or others who are interested in replicating a new model of payment or health care delivery, and encourage groups to involve consumers in the development of new initiatives.**

As noted earlier, the workgroup members felt strongly that North Carolina needs to continually examine the way we provide and pay for health care services, to ensure that we are achieving optimal individual and population health outcomes, while providing care in the most efficient manner possible. While we should encourage the development of new models, we must also obtain unbiased data about the effectiveness of these models, whether the models work equally well for different populations, and how well the models work in different health care environments. For example, the CCNC medical home model has been shown to work well among the Medicaid populations, but there is less evidence of the outcomes for the commercially insured population. Similarly, the PCMH model holds great promise to improve care coordination, quality of care, and patient engagement. However, some populations may not choose to seek care through a comprehensive primary care home, preferring episodic care when they are sick from urgent care or retail clinics.

We can learn both from our successes and our failures. But to do this requires strong, independent evaluations. The evaluations should examine common quality, outcome, and cost metrics, so that different models of care can be compared to one another. We should identify what works, for whom, and in what environment. Further, the evaluation data should be shared publicly among insurers, other health systems, and the public. Thus the NCIOM recommended:

RECOMMENDATION 8.2: EVALUATE NEW PAYMENT AND DELIVERY MODELS

a) Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. The evaluation should, to the extent possible, be based on existing nationally recognized metric and should include:
   - **i. Quality of care metric that includes process, appropriateness, and outcome measures**
   - **ii. Patient satisfaction data**
   - **iii. Access to care measures**
   - **iv. Cost information, including changes in per member per month costs over time**
   - **v. The potential to improve population health**
   - **vi. The effect on health disparities**

b) Evaluation data should be made public and shared with other health systems, groups of health care providers, payers, insurers, consumer groups, or communities so that others can learn from these new demonstrations.

c) North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery modvels should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

Several of the NCIOM health reform workgroups noted the need for enhanced data to improve the functioning of the current health care system. State government, public and private payers, health systems, health care professionals, employers, and consumers need information about diagnosis, utilization, costs, and outcomes in order to evaluate new delivery or payment models.

The Health Benefits Exchange workgroup identified the potential need for diagnosis and utilization data to develop a risk adjustment system that can help stabilize the individual and small group insurance market inside and outside the Exchange (See Chapter 2.) The ACA also requires health care providers (e.g., hospitals, nursing facilities) and health care professionals (e.g., doctors, physician assistants, nurse practitioners) to report quality measures to the federal government. However, the Quality workgroup recognized the importance of also collecting and analyzing these data at the state level and making data available to individual health care systems or providers so that we can more rapidly to develop appropriate interventions to improve patient safety and quality. (See Chapter 7.) This is especially important as Medicare moves towards value-based purchasing. As noted previously, Medicare started reducing payments to hospitals that have "excess readmissions" for discharges beginning October 1, 2012. Hospitals are held accountable for a readmission that occurs within 30 days of discharge, however, hospitals do not always know whether their patients were readmitted if the patients were admitted to another hospital. Hospitals need the data to assess readmission rates and examine cause of readmissions across hospitals. Similarly, the New Models of Care workgroup recognized the importance of creating a data system that could evaluate quality, costs, and patient experience as we move to test new payment and delivery models.

Several states have created all payer claims data (APCD) systems to help provide the necessary state-level data that can support quality improvement activities, compare disease prevalence or utilization patterns across the state, identify successful cost containment measures, and evaluate health care reform efforts on costs, quality, and access. As of 2012, 10 states had fully functional APCD systems, six states were in implementation, 17 states expressed strong interest, and two states had existing voluntary activities.[59] The NCDHHS has created a workgroup to examine the possibility of creating a similar APCD or a confederated data system that can capture data from multiple existing data systems that could be used in North Carolina to examine similar population health, cost, and quality issues across the state. North Carolina's efforts are currently on hold, while the state is implementing other major health information technology.

The NCIOM recommended that NCDHHS, in collaboration with the North Carolina Department of Insurance, continue this effort to examine the state's existing data systems, gaps in the existing systems, and different options to address data gaps.

RECOMMENDATION 8.3: CAPTURE DATA TO SUPPORT NEW MODELS OF CARE

a) The North Carolina Department of Health and Human Services (NCDHHS) should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to develop a plan that examines options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.

b) NCDHHS should examine what other states are doing to meet similar data needs and assess the scope, costs, technical requirements, feasibility, impact, and sustainability for different approaches. As part of this study:

i. **NCDHHS should examine existing sources of data to determine whether existing systems can provide the necessary data, and, if not, identify the gaps in existing systems.**
ii. **NCDHHS should examine the feasibility, costs, technical requirements, and sustainability of collecting and/or aggregating different types of data to serve different purposes, including, but not limited to, clinical, operational, population, policy, and evaluation.**

c) **The plan should ensure that:**
   i. **The new data system uses data already collected in the system for other purposes. Such data sources include, but are not limited to: the Health Information Exchange, Community Care of North Carolina Quality Center, Thompson Reuters, and the State Center for Health Statistics.**
   ii. **All providers, payers, and administrators are required to contribute necessary data.**
   iii. **All providers, payers, and administrators have access to their own data, as well as aggregated data for allowable purposes.**
   iv. **The new data system meets strict patient confidentiality and privacy protections in accordance with North Carolina laws.**

d) **NCDHHS should prepare a plan with recommendations, including a timeline and potential financing mechanisms, and report it to North Carolina General Assembly.**

REMOVING BARRIERS TO THE TESTING AND IMPLEMENTATION OF NEW PAYMENT AND DELIVERY MODELS

While several public and private health care organizations in our state have taken advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. Some of the workgroup's efforts focused on identifying the barriers that prevent North Carolina from more aggressively testing new models that can help reduce health care cost escalation while at the same time improving outcomes. The workgroup recognized that North Carolina will need to more fully utilize all types of health care professionals with the increased demand for health care that is likely to occur as more of the uninsured gain coverage. However, current health professional licensure laws prevent some members of the health care team from practicing to the full extent of their education and competence. The workgroup recommended that we explore options to more effectively utilize all members of the health care team, substituting less highly paid health professionals for more highly paid professionals when this substitution is appropriate and can lead to improved care for lower costs. The workgroup also discussed the challenges in coordinating care across different types of health care providers and systems.

In addition, the workgroup heard concerns about current reimbursement policies that make it difficult for clinicians to offer certain services, even if these services could lead to improved outcomes and lower costs. For example, insurers generally do not reimburse providers for the time they spend answering patient emails or on telephone calls. As a result, some individuals who could have their concerns appropriately addressed through a quick email or phone call are forced to come into the office for a visit—adding both time and costs to the health care

encounter. Some insurers also talked how current state insurance laws make it difficult to create new provider payment models that shift some of the financial risk for a defined population to a health care system or group of health care providers. Additionally, the workgroup heard about barriers some insurers face in developing value-based tiered insurance products, in which insurers can offer lower cost health services to enrollees if they agree to obtain care from higher quality, lower-cost health care providers.

We also heard from provider groups about how multiplicity of different insurer administrative requirements, including provider credentialing, utilization review, and quality initiatives has led to higher administrative costs and reduced clinical time for health care professionals. Further, the workgroup heard examples of how state health professional licensure laws have not kept pace with changes in electronic health records in terms of who is allowed to enter what type of health information into health records. These state regulatory policies can create barriers to effective use of health information systems or the implementation of other innovative system reforms.

A broader group of stakeholders need to be involved in discussions to address potential barriers as well as solutions to overcome those barriers, including licensure boards, the North Carolina Department of Insurance, health professional associations, and health care systems. Thus, the NCIOM recommended:

RECOMMENDATION 8.4: EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS

a) The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models that can improve health outcomes, improve population health, and reduce health care cost escalation. Some of the barriers should include, but not be limited to:

- **i. Health professional licensure restrictions that prevent health professionals from practicing, being held accountable, and receiving payment for care delivered within the full scope of their education, training, and competency.**
- **ii. Insurance laws which impair the development of value-based insurance design or products which shift some of the financial risk to health care professionals or provider groups.**
- **iii. Anticompetitive contractual arrangements which prevent insurers from implementing insurance designs that incentivize use of high-quality, lower cost health care providers or professionals.**
- **iv. Health professional reimbursement issues which reduce the ability of health care professionals from providing evidence-based clinical services that could lead to improved patient outcomes at lower costs.**
- **v. Lack of coordination between public and private payers that create differing and uncoordinated quality and outcome measures for health care professionals.**
- **vi. Uncoordinated and costly administrative requirements stemming from multiple payers with differing administrative requirements.**
- **vii. Resistance to the adoption of new models of care among insurers, health care providers, professionals, and consumers.**

b) The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or otherwise prevent effective use of electronic health records.

c) The NCIOM Task Force should identify barriers and potential solutions. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.

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CHAPTER 9: FRAUD, ABUSE, AND OVERUTILIZATION

OVERVIEW OF THE PROBLEM

The ACA includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and North Carolina Health Choice, the state's Child Health Insurance Program. These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs). Many of these requirements will require the state to implement new enforcement procedures.

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went into effect in 2010 or 2011. The ACA increases funding to the Healthcare Fraud and Abuse Control Program by $350 million over the next decade. These funds can be used for fraud and abuse control and for the Medicare Integrity Program.[1]

The ACA also includes new or enhanced program requirements for Medicare, Medicaid, and CHIP, including new provider requirements to participate in these programs. States are required to apply these new rules and requirements to Medicaid and CHIP:

- *Provider screening*. States must screen all providers and suppliers of services through Medicaid and CHIP as part of enrollment and re-enrollment in these programs.[2] A period of enhanced oversight is also required for newly enrolled providers and suppliers. Providers and suppliers must disclose any past affiliation with a provider who has had their Medicare, Medicaid, or CHIP payments suspended or has been excluded from participation.[3]

- *Terminating or excluding providers who have been terminated from other public programs*. States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare or CHIP.[4] Similarly, states must exclude providers from participating if they are owned by individuals or entities who have not repaid overpayments, are suspended or excluded from participation in Medicaid, or are affiliated with an individual or entity that has been suspended, excluded, or terminated from participation (effective January 2011).[5,6]

- *Creation of risk categories*. The ACA requires the state Medicaid agency to create limited, moderate, and high risk categories for provider specialty types, and to impose different screening and monitoring standards and requirements upon the different categories. Home health and durable medical equipment providers are identified in the ACA as high risk. The proposed federal regulations have created corresponding risk categories for Medicare.

- *Payment suspension.* The state Medicaid agency must suspend all Medicaid payments to a health care professional or entity when there is a pending investigation of a credible Medicaid fraud allegation.

- *Provider registration and identification numbers.* Groups submitting claims on behalf of providers must register with the state and CMS.[7] Providers and suppliers of services are also required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid, and CHIP (effective January 1, 2011).[8, 9]

- *Expanded data reporting and matching activities to identify fraud and abuse*. States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (effective for data submitted on or after January 1, 2010).[10] For example, states are required to report all final actions including revocation or suspension of licenses, reprimands, probation, dismissal, loss of license, or the right to apply for or renew a license, or other negative action. To ensure that these data elements can be shared with the federal government, state Medicaid information systems must be compatible with the National Correct Coding Initiative (effective March 2011).[11] The federal government will establish a National Health Care Fraud and Abuse Data Collection Program to report all final actions against health care providers, suppliers, and practitioners (effective one year after enactment or when regulations are published, whichever is later).[12]

- *Penalties and federal powers to investigate fraud and abuse are enhanced.* Penalties include those for persons who make false statements when making claims, involuntarily enroll or transfer enrollees, or do not provide timely access to information for audits, investigations, evaluations, or other statutory functions.[13]

- *Overpayments.* The state has an expanded period to recover overpayments (effective March 2010).[14] Individuals who receive overpayments through Medicare, Medicaid, and CHIP are required to report and return the overpayment within 60 days.[15] In addition, states must establish a Recovery Audit Contractor (RAC) program to identify underpayments and overpayments and recoup overpayments under Medicaid. The RAC program is expanded to include Medicare Advantage plans and Medicare Part D (effective December 31, 2010).[16,17]

- *Medicaid payments outside the US.* States are prohibited from providing Medicaid payment for services to entities outside the US (effective January 2011).[18]

- *Home health and suppliers of durable medical equipment (DME)*. The ACA includes several new provisions to prevent fraud and abuse in home health and DME. For example, a face-to-face encounter with the recipient is required before home health services can be certified or authorized under Medicare and Medicaid and before payment can be made for DME under Medicare (effective January 1, 2010).[19] Providers and suppliers in Medicare are required to supply documentation about referrals, orders for DME, and certification for home health services to entities at a high risk for fraud and abuse (effective for orders, certification, or referrals on or after Jan. 1, 2010).[20] The ACA

also requires the surety bonds for DME and home health agencies be adjusted by billing volume.[21] Payments to DME suppliers can be withheld for 90 days if there is a significant risk for fraud (effective January 2011).[22] In addition, physicians or eligible professionals who are not enrolled in Medicare are prohibited from ordering home health services or DME for Medicare enrollees (effective July 2010).[23]

- *Provider anti-fraud and abuse compliance programs.* The ACA mandates that providers and suppliers establish anti-fraud and abuse compliance programs.[24] Core program elements and the required implementation date are to be determined by the Secretary.

NORTH CAROLINA RESPONSE

Many requirements of the ACA provisions were already being addressed in North Carolina including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. Specific examples include:

- *Provider enrollment and oversight.* CSC is the agent contracted by NC-DHHS to perform Medicaid provider enrollment, verification, and credentialing (EVC) activities as well as provider file maintenance. HP Enterprise Services is the fiscal agent contracted by DMA to process claims for Medicaid-enrolled providers.

- *Provider education.* Information on changes to provider requirements and processes is provided through the DMA website through Medicaid Bulletins. Topics include enrollment, audits and post-payment reviews, claim submission, and identification of fraud. Providers also may sign up for email alerts for information that is not covered by the Bulletins.

- *Pre-payment review*. DMA contracts with The Carolinas Center for Medical Excellence (CCME) for pre-payment review of Medicaid claims. The recent audit by CMS indicates that North Carolina is in full compliance for its pre-payment review process.

- *National Provider Identifier*. Providers and suppliers of services in North Carolina are already required to include their National Provider Identifier on all enrollment applications and claims submissions for Medicaid and CHIP.

- *Performance statistics.* The DMA Program Integrity Unit tracks performance statistics on fraud and abuse investigations.

TASK FORCE WORK

The Fraud and Abuse Workgroup conducted a gap analysis, breaking down the requirements of each provision, identifying ongoing efforts to address these requirements; gaps between what is currently underway in North Carolina and the new requirements; and required changes and/or legislation to fully implement the ACA provisions. A copy of the Gap Analysis is available on the NCIOM website.[25] The workgroup used the gap analysis to develop a 19-item legislation concept list representing the guiding principles for legislation. The workgroup also helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the concept list, to draft its recommended fraud and abuse legislation.

DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399. The legislation included provisions addressing the following topics:

- Medicaid and Health Choice provider screening
- Criminal history record checks for certain providers
- Payment suspension and audits utilizing extrapolation
- Registration of agents, clearinghouses, and alternative payees
- Prepayment claims review
- Threshold recovery amount
- Provider enrollment criteria
- Change of ownership and successor liability
- Cooperation with investigations and audits
- Appeals by Medicaid providers and applicants
- Procedures for changing medical policy

Although this legislation covers the requirements of most of the ACA Fraud and Abuse provisions, DMA continues to work on rules to address some of the remaining requirements, such as provider compliance programs, fingerprinting as part of provider screening, registration of groups submitting claims on behalf of providers, a face-to-face requirement for certification for home health services, surety bond size adjustment for DME and home health agencies, and withholding of payment for DME suppliers with significant fraud risk. In addition, final federal rules for the RAC program were released in September 2011, so the state will issue a request-for-proposal (RFP) for a RAC contractor. The state plan amendment has been approved, and an interim contractor is in place, which puts the state in compliance with the RAC program requirement. Two additional provisions regarding submission of Medicaid encounter data require further information from the Federal government before the State can respond.[26]

REFERENCES AND NOTES

1 Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 1303, 6402.
2 Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6401, 10603.
3 DMA already requires providers and suppliers to disclose if they, or any affiliated provider, have had their Medicare, Medicaid or CHIP payments suspended or if they have been excluded from participation. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.
4 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6501, amending § 1902(a)(39) of the Social Security Act, 42 USC 1396a(a).
5 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6502, amending §1902(a) of the Social Security Act, 42 USC 1396a(a).
6 DMA already excludes providers from participating for these reasons. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.
7 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6503.
8 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6402, amending Sec. 1902(a) of the Social Security Act, 42 USC 1396a(a).
9 DMA already implemented this registration requirement. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.
10 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6504.

[11] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6507, amending Sec. 1903(r) of the Social Security Act, 42 USC 1396b(r).
[12] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6403.
[13] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6402, 6408, 10606.
[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6506.
[15] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6402.
[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6411.
[17] DMA submitted a State Plan Amendment as required, and has a RAC in place. The state is waiting for further guidance on underpayments, but is currently in compliance with the federal requirements to collect overpayments. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.
[18] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6505, amending Sec. 1902(a) of the Social Security Act, 42 USC 1396b(a).
[19] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6407, 10605.
[20] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6406.
[21] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6402.
[22] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1304.
[23] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6405.
[24] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6401, 10603.
[25] Fraud, Abuse, and Overutilization Workgroup. Gap Analysis. http://www.nciom.org/wp-content/uploads/2010/10/GapAnalysis.pdf. Published December 13, 2010. Accessed April 17, 2012.
[26] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6402, 6504.

EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 10
CONCLUSION

North Carolina, like the rest of the nation, faces significant health challenges. Every year, health care spending consumes a higher percentage of employee and employer earnings as well as government revenues. This trend of ever increasing health care costs is unsustainable. Rising health care costs make it difficult for people to afford insurance coverage, businesses to offer coverage, and state and federal governments to meet their obligations. Many of the 1.6 million uninsured in North Carolina are unable to afford to the primary and preventive services they need. Without this care, they end up in the hospital for conditions that could have been prevented. We need to do more to improve overall population health to ensure that North Carolina families are healthy. Further, we need to ensure that we are getting good value and outcomes for the health care people receive.

The Affordable Care Act (ACA) was enacted by Congress in March 2010 to address some of these problems. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, places an increased emphasis on quality measurement and reporting, and tests new models of delivering and paying for health care to reduce unnecessary expenditures. The federal legislation also includes provisions aimed at increasing the supply of health professionals, strengthening the health care safety net, and preventing fraud, abuse, and overutilization. North Carolina has successfully competed for federal grant funding to help support public and private initiatives aimed at increasing access to care, improving the health of North Carolinians, increasing quality, and reducing unnecessary expenditures. A complete listing of the grant funds North Carolina has received is in Appendix I.

While the ACA goals may be laudable, the legislation creates many implementation challenges. This is a complex piece of legislation that will affect everyone in the state. The Health Reform Workgroups were convened to develop recommendations for the state on how to take advantage of opportunities and handle the challenges of implementing the ACA. This report is a culmination of the work of more than 260 people across the state. The public policy leaders, public servants, health care professionals, insurers and agents, business and industry leaders, consumers, academicians, and members of the faith community who participated in these workgroups devoted their time and energy to ensure that the decisions the state makes are in the best interest of the state as a whole.

The following chart includes a summary of the workgroup recommendations, along with the organization or organizations that would have primary responsibility implementing the recommendations.

	NCGA	NCDOI	Exchange Board	DMA	Other
HEALTH BENEFITS EXCHANGE					
Recommendation 2.1: State and Federal Health Benefits Exchange Operational Responsibilities The North Carolina General Assembly should create a state-based Health Benefits Exchange (Exchange). The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management.	**X**		**X**		
Recommendation 2.2. Health Benefits Exchange Board Authority for Exchange Certification The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority, beginning in 2014, to standardize terminology, benefit designs, or limit the number of plan offerings if needed to facilitate meaningful choice and promote competition among insurers, but only if the Exchange Board determines there is a reasonable level of choice in the Exchange market. The Exchange Board should also have the authority, beginning in 2016, to require or incentivize insurers to meet state standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services.	**X**		**X**		
Recommendation 2.3. Develop Objective Network Adequacy Standards If necessary to meet federal requirements, the North Carolina Department of Insurance (NCDOI) should develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the Exchange. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.		**X**			
Recommendation 2.4. Monitor Essential Community Provider Provisions The Health Benefits Exchange (Exchange) Board, in collaboration with the North Carolina Department of Insurance, should monitor insurers' contracts with essential community providers to ensure that low-income and other vulnerable populations have reasonable and timely access to a broad range of providers. If necessary, the Exchange Board should provide additional guidance to insurers about what constitutes a sufficient number or reasonable geographic distribution necessary to meet this requirement for qualified health plans offered in the Exchange.		**X**	**X**		

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 2.5. Ensure Health Benefits Exchange Financial Sustainability The North Carolina General Assembly should establish a Health Benefits Exchange (Exchange) Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the Exchange Trust Fund to pay for reasonable Exchange operations. The North Carolina General Assembly (NCGA) should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the Exchange Trust Fund. The NCGA should give the Exchange Board the authority to raise other revenues, within parameters established by the NCGA, if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for reasonable Exchange operations.	**X**		**X**		
Recommendation 2.6. Health Benefits Exchange Outreach and Education The Health Benefits Exchange (Exchange), in conjunction with the North Carolina Department of Insurance, and North Carolina Division of Medical Assistance should develop a standardized community outreach and education toolkit and provide workshops so that interested organizations and individuals can disseminate information about public and private insurance options, the Exchange website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.		**X**	**X**	**X**	
Recommendation 2.7. Role, Training, Certification, Oversight, and Compensation of Navigators and In-person Assisters The Health Benefit Exchange (Exchange) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator/in-person assister program. The NCDOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators and in-person assisters, and should create strong conflict of interest rules.		**X**	**X**		

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 2.8. Requirements for Agents and Brokers Selling Coverage in the Health Benefits Exchange The Health Benefits Exchange (Exchange) Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the Exchange. The Exchange should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The NCDOI, in conjunction with the Exchange, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the Exchange, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage.		**X**	**X**		
Recommendation 2.9. "No Wrong Door" Eligibility and Enrollment Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice eligibility workers are cross-trained and certified as navigators or in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or NC Health Choice to enroll into a qualified health plan offered through the Health Benefits Exchange.			**X**	**X**	**X** DSS, NCACDSS
MEDICAID					
Recommendation 3.1. Expand Medicaid Eligibility up to 138% FPL Based on North Carolina Division of Medical Assistance's projections of the number of people who may gain Medicaid coverage and the costs to the state, and the REMI analysis of jobs created, increase in the state's gross domestic product, and new tax revenues generated as a result of the expansion, the North Carolina Institute of Medicine recommends that North Carolina expand Medicaid up to 138% FPL.	**X**				
Recommendation 3.2. Simplify Medicaid Eligibility and Enrollment Processes The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage.			**X**	**X**	**X** DHHS

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 3.3. Develop a Broad-Based Education and Outreach Campaign to Educate the Public about New Insurance Options The North Carolina Division of Medical Assistance, North Carolina Department of Insurance, and North Carolina Health Benefit Exchange should work together to develop a broad-based education and outreach campaign to educate the public about different health insurance options and insurance affordability programs.		**X**	**X**	**X**	
Recommendation 3.4. Retrain Department of Social Services Eligibility Workers The North Carolina Division of Medical Assistance, North Carolina Division of Social Services, and the North Carolina Association of County Directors of Social Services should provide training to county Department of Social Services (DSS) eligibility workers to help them understand the new eligibility and enrollment processes that will go into effect in the fall of 2013, and the new roles and responsibilities of DSS workers under the Affordable Care Act. Local DSS should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator or in-person assister in each DSS office.				**X**	**X** DSS, NCACDSS
Recommendation 3.5. Explore the Home and Community-Based Services Medicaid Expansion Options The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the costs and benefits of options to expand home and community-based services (HCBS), and should explore options to use existing state dollars to leverage federal Medicaid funding to expand HCBS. DMA should give priority to support caregivers or otherwise provide services to help the frail elderly or people with disabilities to remain in their homes, and should give priority to those who have been identified as at-risk through the Adult Protective Services system. DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.				**X**	

	NCGA	NCDOI	Exchange Board	DMA	Other
SAFETY NET					
Recommendation 4.1. Develop an Emergency Transition of Care Pilot Project The North Carolina College of Emergency Physicians (NCCEP) and partners should develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on dental complaints, chronic conditions, and behavioral health issues. NCCEP and partners should seek funding for the emergency care diversion project through federal sources. If adequate funding is not received from the federal sources, the North Carolina General Assembly should fund the emergency care diversion pilot project.					**X** NCCEP, CCNC, NCHA, NCDHHS, CSHA, NCCHCA, NCDS, NCFAHP, NCFCA, GISA
Recommendation 4.2. Involve Safety Net Organizations in Community Health Assessments As part of the hospital and local health department community health assessments, these organizations should include input from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area. In implementing community health needs priorities, hospitals and local health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.					**X** Hospitals, LHDs
Recommendation 4.3. Expand 340B Discount Drug Program Enrollment among Eligible Organizations The North Carolina Division of Medical Assistance, Office of Rural Health and Community Care, North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage eligible hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.				**X**	**X** ORHCC, NCHA, NCCHCA

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 4.4. Allow Safety Net Organizations to Function as Patient Navigators or In-person assisters The Health Benefits Exchange (Exchange) should train and certify staff at safety net organizations to serve as patient navigators or in-person assisters as long as these organizations meet the federal requirements for patient navigators or in-person assisters. As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.			**X**		
Recommendation 4.5. Reconvene the Safety Net Advisory Council The Care Share Health Alliance should reconvene the Safety Net Advisory Council to identify communities with the greatest unmet needs; increase collaboration among safety net agencies; monitor safety net funding opportunities; make a recommendation and plan for integrating safety net tools including the North Carolina Health Care Help website and the county level resources; and serve as a unified voice for the safety net.					**X** SNAC, CSHA
HEALTH PROFESSIONAL WORKFORCE					
Recommendation 5.1. Educate Health Workforce Using New Technologies and Strategies in New Models of Care The North Carolina Community College System, the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties should work together to create targeted programs and admissions policies to increase the number of students with expressed interested in primary care, behavioral health, and dentistry. AHEC should educate the existing workforce on new core competencies needed by the health care workforce including interdisciplinary team-based care, patient safety, quality initiatives, cultural competency, health information technology, and others.	**X**				**X** NCCCS, UNC, AHEC, NCESC, CWD

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 5.2. Support and Expand Health Practitioner Programs to More Closely Reflect the Composition of the Population Served The North Carolina Area Health Education Centers Program, the North Carolina Community College System, the University of North Carolina University System, private colleges and universities with health professions degree programs, and other interested parties, including the Alliance for Health Professions Diversity, should collaborate to create more intensive programs and coordinate efforts to expand and strengthen existing evidence-based health professions pipeline programs.	X				X AHEC, NCCCS, UNC, AHPD
Recommendation 5.3. Strengthen and Expand Recruitment of Health Professionals to Underserved Areas of the State In order to support and strengthen the ability of the North Carolina Office of Rural Health and Community Care (ORHCC) to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina Department of Commerce should use $1 million annually of existing industry recruitment funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into North Carolina.					X ORHCC, NCDOC
Recommendation 5.4. Increase Reimbursement for Primary Care Services Public and private payers should enhance their reimbursement to primary care practitioners to more closely reflect the reimbursement provided to other specialty practitioners. For purposes of this recommendation, primary care practitioners include, but are not limited to: family physicians, general pediatricians, general internists, psychiatrists as well as nurse practitioners, physician assistants, and certified nurse midwives practicing in primary care.					X Public and private payers
Recommendation 5.5. Support Comprehensive Workforce Planning and Analysis The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. The North Carolina General Assembly should provide $550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.					X NCHPDS

	NCGA	NCDOI	Exchange Board	DMA	Other
PREVENTION					
Recommendation 6.1. Increase Tobacco Cessation Among Medicaid Recipients The North Carolina Division of Medical Assistance should provide all Federal Drug Administration (FDA) approved over-the-counter nicotine replacement therapy without a physician prescription as part of comprehensive tobacco cessation services and work to reduce out-of-pocket costs for such therapies. Primary care providers and Medicaid recipients should be educated about covered tobacco cessation therapies.				**X**	**X** NCSCHS, AHEC, NCMS, NCAFP, NCOGS, CCNC
Recommendation 6.2. Support Nursing Mothers in the Work Environment The North Carolina Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy. Small businesses should be encouraged to provide similar support to working mothers.					**X** NCDOL, OSP, DPH, NCSBA, NCBC
Recommendation 6.3. Promote and Monitor Utilization of Preventive Care Services North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. The North Carolina Department of Insurance should monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services. Electronic medical record systems offered in North Carolina should provide clinical decision support tools to identify and promote prevention services. Outreach should be done to educate providers and individuals about covered preventive services.		**X**		**X**	**X** NC-HIT, CCNC, NCHQA, AHEC, NCMS, ONSMS, DSS, DAAS, NCAFP, AARP, SHIIP
Recommendation 6.4. Promote Worksite Wellness Programs in North Carolina Businesses The Center for Healthy North Carolina and the North Carolina Division of Public Health should provide information to businesses on evidenced-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.					**X** CHNC, DPH, ESMM

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 6.5. Build Capacity of Communities to Respond to Funding Opportunities The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should develop the infrastructure needed to allow communities of greatest need to respond to prevention-related funding opportunities.					**X** CHNC, OMHHD
Recommendation 6.6. Monitor Funding Opportunities for Prevention Provisions The state should monitor the federal appropriations process, as well as funding made available as part of the Public Health and Prevention Trust Fund, to identify additional funding of prevention provisions.					**X** DPH
QUALITY					
Recommendation 7.1. Educate Primary and Specialty Care Providers on Quality Measure Reporting Requirements The Division of Medical Assistance and partners should educate primary care and specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults.				**X**	**X** AHEC, CCNC, ACP, NCAFP, NCMS
Recommendation 7.2. Explore Centralized Reporting The North Carolina Health Information Exchange (NC HIE) Board should facilitate mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of North Carolina quality measures with federal requirements.					**X** NC HIE
Recommendation 7.3. Investigate Options for Data Storage The North Carolina Department of Health and Human Services, working with the NC HIE and other stakeholder groups, should examine options to capture data automatically from electronic health records and then coordinate submission of data to the appropriate entities. Data should be made available at the state level for research and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.					**X** NCDHHS, NC HIE

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 7.4. Educate Providers on ACA Issues The North Carolina Area Health Education Centers and partners should educate physicians on new ACA requirements and provisions aimed at improving quality.					**X** AHEC, NCMS, NCAFP, ACP, NCPS, CCNC, CCME, NCHQA
Recommendation 7.5. Educate Hospitals on ACA Issues The North Carolina Hospital Association should provide education to hospitals on new ACA requirements and provisions aimed at improving quality of care in hospitals.					**X** NCHA
Recommendation 7.6. Educate Home and Hospice Care Providers on ACA Issues The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the ACA value-based purchasing provisions.					**X** AHHCNC, CCHELC
Recommendation 7.7. Educate Facility Personnel on ACA Issues The North Carolina Division of Health Service Regulation and partners should educate their constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value-based purchasing.					**X** NCDHSR, AHHCNC, NCHCFA
Recommendation 7.8. Educate Consumers on Availability and Interpretation of Provider Quality Measures The North Carolina Healthcare Quality Alliance and partners should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.					**X** NCHQA, AHEC, CCNC, NC HIE

	NCGA	NCDOI	Exchange Board	DMA	Other
Recommendation 7.9. Improve Transitions of Care The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying, and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms to evaluate outcomes. Solutions utilizing transition principles should be applied to all patients regardless of payer.					**X** NCHQA, NCHA, CCNC, NC HIE
Recommendation 7.10. Reimburse Nurse Practitioners in Skilled Nursing Facilities The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.				**X**	**X** NCHCFA, CCNC
NEW MODELS OF CARE					
RECOMMENDATION 8.1. DEVELOP A CENTRALIZED NEW MODELS OF CARE TRACKING SYSTEM North Carolina state government and North Carolina foundations should provide funding to the North Carolina Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state.					**X** NCFAHP
RECOMMENDATION 8.2. EVALUATE NEW PAYMENT AND DELIVERY MODELS Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that others can learn from these new demonstrations. North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.		**X**		**X**	**X** Health systems, providers, insurers

	NCGA	NCDOI	Exchange Board	DMA	Other
RECOMMENDATION 8.3. CAPTURE DATA TO SUPPORT NEW MODELS OF CARE The North Carolina Department of Health and Human Services should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to identify options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.		**X**			**X** NCDHHS
RECOMMENDATION 8.4. EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models. The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or the otherwise effectively use of electronic health records. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.					**X** NCIOM

Acronym	Full Name
AARP	
ACP	North Carolina Chapter of American College of Physicians
AHEC	North Carolina Area Health Education Centers Program
AHHCNC	Association for Home and Hospice Care of North Carolina
AHPD	Alliance for Health Professions Diversity
CCHELC	Carolinas Center for Hospice and End of Life Care
CCME	Carolinas Center for Medical Excellence
CCNC	Community Care of North Carolina
CHNC	Center for Healthy North Carolina
CSHA	Care Share Health Alliance
CWD	Commission on Workforce Development in North Carolina
DAAS	North Carolina Division of Aging and Adult Services
DMA	Division of Medical Assistance, North Carolina Department of Health and Human Services
DPH	Division of Public Health, North Carolina Department of Health and Human Services
DSS	Division of Social Services, North Carolina Department of Health and Human Services
ESMM	Eat Smart, Move More NC
GISA	Governor's Institute of Substance Abuse
LHD	Local Health Department
NCACDSS	North Carolina Association of County Directors of Social Services
NCAFP	North Carolina Academy of Family Physicians
NCBC	North Carolina Breastfeeding Coalition
NCCCS	North Carolina Community College System
NCCEP	North Carolina College of Emergency Physicians
NCCHCA	North Carolina Community Health Center Association
NCDHHS	North Carolina Department of Health and Human Services
NCDHSR	North Carolina Division for Health Service Regulation
NCDOC	North Carolina Department of Commerce
NCDOI	North Carolina Department of Insurance
NCDOL	North Carolina Department of Labor
NCDS	North Carolina Dental Society
NCESC	North Carolina Employment Security Commission
NCFAHP	North Carolina Foundation for Advanced Health Programs
NCFCA	North Carolina Free Clinic Association
NCGA	North Carolina General Assembly
NCHA	North Carolina Hospital Association
NCHCFA	North Carolina Health Care Facilities Association
NC HIE	North Carolina Health Information Exchange
NC-HIT	North Carolina Office of Health Information Technology
NCHPDS	North Carolina Health Professions Data System
NCHQA	North Carolina Healthcare Quality Alliance
NCMS	North Carolina Medical Society
NCOGS	North Carolina Obstetrical and Gynecological Society
NCPS	North Carolina Pediatric Society
NCSBA	North Carolina Small Business Administration

NCSCHS	North Carolina State Center for Health Statistics
OMHHD	Office of Minority Health and Health Disparities
ONSMS	Old North State Medical Society
ORHCC	Office of Rural Health and Community Care, North Carolina Department of Health and Human Services
OSP	Office of State Personnel
SHIIP	Senior's Health Insurance Information Program
UNC	University of North Carolina University System

APPENDIX A
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Characteristics of Uninsured North Carolinians

2010-2011 Data Snapshot

Almost one out of every five non-elderly people in North Carolina were uninsured in 2010-2011. This is approximately the same rate as in the prior year report (2009-2010), but represents a slight decrease of 0.6% over five years ago. Most of the decline is due to more children being covered by health insurance.

More than 70% of the uninsured live in families where there is at least one full-time worker. However, there has been a large decline in the percentage of uninsured who live in families with two or more people who are working full time (decline of 12.0 percentage points over the last five years), with a commensurate increase in the percentage of uninsured who live in a household with no workers, part-time workers, and only one full-time worker. This is likely a reflection of the poor economy over the last three years, in which many people lost jobs altogether or moved to part-time positions.

The Patient Protection and Affordable Care Act (PPACA) will extend coverage to many of the uninsured. However, the US Supreme Court ruled that state expansion of Medicaid was optional. If North Carolina choses to participate in Medicaid expansion, approximately 648,000 uninsured individuals would be eligible for Medicaid coverage, based on their having incomes equal to or less than 138% Federal Poverty Level (FPL). In addition, many of the 710,000 uninsured with incomes above 138% and below 400% of the FPL will be eligible for tax credits to purchase health insurance coverage through a newly created Health Benefits Exchange.

This data snapshot provides information about uninsured individuals in North Carolina, including family income, race/ethnicity, workforce status, firm size, age, citizenship, rural/urban residence, health status, and industry. Uninsured estimates are presented for 2010-11, using data from the US Census Bureau. Data are also provided to show the change in uninsured estimates over a five-year span from 2005-2006 to 2010-2011. County-level estimates of the uninsured are available at www.nciom.org.

Interpreting the Data

Consider the second row of data for the uninsured non-elderly persons with family incomes less than 138% of the federal FPL. In North Carolina:

	2010-2011 Rates			Change: 2005-2006 to 2010-1011		
Category	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
Total Population Ages 0-64	1,555	100	18.9	37	0[a]	-0.6
Income						
<138% FPL	648	41.6	31.8	117	6.7	-0.8

In 2010-2011

- There were 648,000 non-elderly uninsured with family incomes less than 138% of the FPL.
- 41.6% of the non-elderly uninsured have family incomes less than 138% FPL.
- 31.8% of the non-elderly with family incomes less than 138% FPL were uninsured.

From 2005-2006 to 2010-2011

- The number of non-elderly uninsured with family incomes less than 138% FPL increased by 117,000.
- The percentage of non-elderly uninsured with family incomes less than 138% FPL increased by 6.7% (i.e. 34.9% of the non-elderly uninsured had family incomes below 138% in 2004-2005 compared to 41.6% in 2010-2011).
- The percentage of the non-elderly with family incomes less than 138% FPL who were uninsured decreased by 0.8% percentage points (i.e. 32.6% of non-elderly with family incomes below 138% FPL were uninsured in 2005-2006, compared to 31.8% in 2010-2011).

[a] 100% of non-elderly uninsured individuals (total population ages 0-64) were used in the calculations for both years. Therefore there is no change in the percent of all uninsured between 2005-2006 and 2010-2011.

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Table 1: Ages 0-64

Category	2010-2011 Rates			Change: 2005-2006 to 2010-1011		
	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
Total Population Ages 0-64	1,555	100	18.9%	37	0	-0.6
Income						
<100% FPL	437	28.1	31.6	77	4.4	-1.2
100-138% FPL	211	13.5	32.1	40	2.3	0
138-200% FPL	241	15.5	25.5	-103	-7.2	-7.9
200-25-% FPL	169	10.9	22.5	-21	-1.6	-3
250-400% FPL	299	19.2	16.9	12	0.3	0.9
400%+ FPL	198	12.7	7.3	32	1.8	0.9
Gender						
Male	784	50.4	19.5	-25	-2.9	-1.4
Female	771	49.6	18.4	62	2.9	0.2
Race/Ethnicity						
White, Not Hispanic	740	47.6	14.5	11	-0.4	0
Black, Not Hispanic	431	27.7	22.5	62	3.4	1.8
Not White or Black or Hispanic	86	5.6	18.5	-7	-0.6	-8.6
Hispanic	298	19.2	40.7	-28	-2.3	-12.3
Age						
0-18	233	15	9.4	-85	-6	-4.2
19-29	422	27.2	31.3	26	1.1	1
30-44	479	30.8	25.1	41	2	2.2
45-54	246	15.8	19.1	31	1.6	0.6
55-64	175	11.3	14.5	24	1.3	0.4
Citizenship						
Citizen	1,306	84	16.7	62	2	-0.3
Not a citizen	249	16	59.5	-25	-2	3.2
Rural/Urban						
Urban	1,088	70	19	164	9.1	1.3
Rural	467	30	18.7	-127	-9.1	-4.5
Self-perceived Health Status						
Excellent	353	22.7	12.9	-69	-5.1	-1.9
Very Good	483	31.1	17.4	22	0.7	-1
Good	519	33.4	27.5	32	1.3	0
Fair	155	9.9	27.3	39	2.3	1.5
Poor	45	2.9	16.8	13	0.8	2.5
Family Workforce Status						
No Workers	253	16.3	20.9	49	2.9	-2.6
Only PT Workers	196	12.6	30.8	44	2.6	1.8
1 FT Worker	704	45.3	19	116	6.5	0.9
2+ FT Workers	402	25.8	15	-172	-12	-3.2

[a] 100% of non-elderly uninsured individuals (total population ages 0-64) were used in the calculations for both years. Therefore there is no change in the percent of all uninsured between 2005-2006 and 2010-2011.

Table 2: Children Ages 0-18

Category	2010-2011 Rates			Change: 2005-2006 to 2010-1011		
	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
Children Ages 0-18	233	100	9.4	-85	0[a]	-4.2
Income						
<100% FPL	82	35.2	13.3	1	9.6	-4
100-138% FPL	27	11.7	11.8	-9	0.3	-7.1
138-200% FPL	41	17.4	12.5	-35	-6.4	-8.2
200-250% FPL	28	12	12.1	-17	-2.1	-7
250-400% FPL	39	16.9	8.3	-15	-0.3	-3.5
400%+ FPL	16	6.8	2.7	-9	-1.2	-1.5
Gender						
Male	101	43.2	7.9	-75	-12.2	-6.7
Female	132	56.8	11	-10	12.2	-1.6
Race/Ethnicity						
White, Not Hispanic	90	38.5	6.6	-48	-4.7	-3.5
Black, Not Hispanic	69	29.7	11.2	-16	2.8	-2.3
Not White or Black or Hispanic	19	8.1	11.2	2	2.9	-2.6
Hispanic	55	23.6	17.2	-23	-1.1	-19.6
Citizenship						
Citizen	219	94	9	-72	2.3	-3.9
Not a citizen	14	6	35.4	-13	-2.3	-1.8
Urban/rural						
Urban	169	72.5	10.1	-12	15.6	-1.6
Rural	64	27.5	8	-73	-15.6	-9.5
Self-perceived Health Status						
Excellent	93	39.8	7.8	-38	-1.2	-3.3
Very Good	77	33.1	9.4	-33	-1.6	-6.2
Good	59	25.3	14.7	-13	2.8	-2.9
Fair	4	1.9	8.2	-1	0.3	-6.2
Poor	0	0	0	-1	-0.2	-14.7
Living with Parents?						
Both parents	114	54.4	7.4	-60	-4.7	-4.7
Mother only	51	24.4	8.9	-31	-3.5	-5.5
Father only	30	14.2	33.1	17	10	17.7
Neither parent	15	7	14.7	-11	-1.8	-14.1
Family Workforce Status						
No Workers	38	16.3	10.1	14	8.7	-0.7
Only PT Workers	19	8	9.4	-10	-1	-6.3
1 FT Worker	120	51.6	10.2	-21	7	-2.9
2+ FT Workers	56	24.1	7.8	-67	-14.7	-6.9

[a] 100% of children ages 0-18 were used in the calculations for both years. Therefore there is no change in the percent of all uninsured between 2005 -2006 and 2010-2011.

Table 3: Adults Ages 19-64

Category	2010-2011 Rates			Change: 2005-2006 to 2010-1011		
	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
Adults Ages 19-64	1,322	100	23	122	0[a]	1.0
Income						
<100% FPL	355	26.9	46.2	76	3.6	1.9
100-138% FPL	183	13.9	43.1	49	2.7	3.5
138-200% FPL	200	15.2	32.4	-68	-7.2	-8.1
200-250% FPL	142	10.7	27.1	-4	-1.4	-1.4
250-400% FPL	260	19.7	20.2	28	0.3	2.6
400%+ FPL	182	13.8	8.5	41	2	1.5
Gender						
Male	684	51.7	24.8	51	-1.0	1.1
Female	639	48.3	21.3	72	1.0	0.9
Race/Ethnicity						
White, Not Hispanic	650	49.2	17.4	59	-0.1	1.3
Black, Not Hispanic	361	27.3	27.9	78	3.7	3.2
Not White or Black or Hispanic	67	5.1	22.6	-9	-1.3	-11.5
Hispanic	243	18.4	58.8	-5	-2.3	-2.7
Age						
Age 19-29	422	31.9	31.3	26	-1.0	1.0
Age 30-44	479	36.2	25.1	41	-0.2	2.2
Age 45-54	246	18.6	19.1	31	0.7	0.6
Age 55-64	175	13.2	14.5	24	0.6	0.4
Citizenship						
Citizen	1,087	82.2	20.2	135	2.8	1.3
Not a citizen	235	17.8	62	-12	-2.8	2.4
Urban/rural						
Urban	919	69.5	22.7	176	7.6	2.5
Rural	403	30.5	23.7	-54	-7.6	-1.9
Self-perceived Health Status						
Excellent	261	19.7	16.9	-31	-4.6	-0.6
Very Good	406	30.7	20.8	55	1.5	1.2
Good	460	34.8	30.9	44	0.2	0.5
Fair	150	11.4	29.2	39	2.1	2.5
Poor	45	3.4	17.7	14	0.8	3.5
Family Workforce Status						
No Workers	215	16.3	25.8	36	1.3	-2.2
Only PT Workers	178	13.4	40.5	54	3.2	4.3
1 FT Worker	584	44.1	23.2	137	6.9	2.5
2+ FT Workers	345	26.1	17.6	-105	-11.4	-1.8

[a] 100% of adults ages 19-64 were used in the calculations for both years. Therefore there is no change in the percent of all uninsured between 2005-2006 and 2010-2011.

Table 3: Adults Ages 19-64 continued

Category	2010-2011 Rates			Change: 2005-2006 to 2010-1011		
	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
Adults Ages 19-64	1,322	100	23	122	0.0	1.0
Individual's Labor Force Status						
Not in Labor Force	337	25.5	23.8	19	-1.0	-3.3
Unemployed	191	14.4	48.3	107	7.5	5.3
Part Time	233	17.6	34.8	61	3.3	5.9
Full Time	561	42.5	17.5	-65	-9.7	-0.6
Firm size (among full time and part time)						
Not employed	528	39.9	28.2	126	6.5	-0.5
1-99	462	34.9	31	-61	-8.7	0.6
100-999	84	6.4	14.6	2	-0.5	1.1
1000 or more	212	16	12.3	71	4.3	3.5
Unknown	36	2.7	43.3	-16	-1.6	-5.1
Industry (among full time and part time)						
Agriculture	20	2.5	48.1	5	0.6	20.8
Construction	126	15.8	41.5	-71	-8.8	-7.6
Manufacture	71	8.9	17.1	1	0.2	5.1
Transport	30	3.8	18.6	6	0.8	4.1
Trade	150	18.8	26.6	51	6.5	8.2
Health & Education	121	15.2	12.4	8	1.1	-0.3
Finance	21	2.6	8.3	-19	-2.4	-4.7
Government	11	1.4	5.9	5	0.6	2.3
Hospitality	99	12.5	36.1	-15	-1.8	3.0
Other	146	18.3	20.7	24	3.1	0.5

Estimates prepared for the North Carolina Institute of Medicine by Mark Holmes, PhD, Health Policy and Management, UNC Gillings School of Global Public Health.

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North Carolina County-Level Estimates of Non-Elderly Uninsured

North Carolina Institute of Medicine

2010-2011 **Data Snapshot**

This data snapshot provides information about uninsured individuals in North Carolina by age and county of residence. Uninsured estimates are presented for 2010-2011. This information will be helpful to state and local policymakers, health care professionals, insurers, and community groups and others interested in the provision of health care at the local level.

State-level estimates about the characteristics of uninsured individuals in North Carolina, including family income, race/ethnicity, workforce status, firm size, age, citizenship, rural/urban residence, health status, and industry are available on the North Carolina Institute of Medicine website at www.nciom.org.

Methodology

County-level estimates were developed using data from the U.S. Census Bureau and the North Carolina Employment Security Commission. To generate county-level uninsured estimates, the state-level estimates for uninsured in North Carolina, obtained from the U.S. Census Bureau's Current Population Survey, Annual Social and Economic Supplement, were adjusted using county-level estimates of age, race/ethnicity, gender, poverty, and unemployment, as well as data on the types of industries and firm sizes in each North Carolina county. Estimates are not directly comparable to previously published NCIOM/Sheps Center estimates due to slight changes in the methodology.

The table below outlines the estimated rates for North Carolina's 100 counties for children (ages 0-18), adults (ages 19-64), and total non-elderly (ages 0-64). (Following convention, we do not include the elderly since only about one percent of older adults are uninsured.) Because these are estimates, numbers of uninsured have been rounded to the nearest thousands. We also present the quartile of the county – "Low" denotes those 25 counties with the lowest rate, "Mid-Low" the next 25 lowest rates, etc.

	Children (0-18)			**Adult (19-64)**			**Total (0-64)**		
County	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*
Alamance County	4,000	8.8%	High	21,000	21.3%	Mid-High	25,000	17.6%	Mid-High
Alexander County	1,000	7.6%	Low	5,000	19.5%	Low	5,000	16.2%	Low
Alleghany County	<500	8.7%	High	1,000	21.6%	Mid-High	2,000	18.2%	Mid-High
Anson County	1,000	8.5%	Mid-High	4,000	23.1%	High	5,000	19.2%	High
Ashe County	<500	7.6%	Low	3,000	19.7%	Low	4,000	16.7%	Mid-Low
Avery County	<500	8.2%	Mid-Low	3,000	21.1%	Mid-High	3,000	18.2%	Mid-High
Beaufort County	1,000	8.5%	Mid-High	6,000	20.3%	Mid-Low	7,000	17.0%	Mid-Low
Bertie County	<500	8.7%	High	3,000	24.8%	High	4,000	20.6%	High
Bladen County	1,000	8.6%	Mid-High	5,000	21.2%	Mid-High	6,000	17.7%	Mid-High
Brunswick County	2,000	7.8%	Low	14,000	20.0%	Mid-Low	16,000	17.0%	Mid-Low
Buncombe County	4,000	7.7%	Low	30,000	18.5%	Low	34,000	15.8%	Low
Burke County	2,000	8.0%	Mid-Low	11,000	18.7%	Low	13,000	15.6%	Low
Cabarrus County	4,000	8.1%	Mid-Low	25,000	20.9%	Mid-High	29,000	16.8%	Mid-Low
Caldwell County	2,000	7.7%	Low	10,000	18.6%	Low	12,000	15.6%	Low
Camden County	<500	6.8%	Low	1,000	19.5%	Low	1,000	15.6%	Low

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	Children (0-18)			Adult (19-64)			Total (0-64)		
County	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*
Carteret County	1,000	7.4%	Low	8,000	18.8%	Low	9,000	16.1%	Low
Caswell County	<500	8.1%	Mid-Low	4,000	23.2%	High	4,000	19.4%	High
Catawba County	3,000	7.9%	Mid-Low	18,000	17.5%	Low	21,000	14.7%	Low
Chatham County	1,000	8.9%	High	9,000	22.5%	High	11,000	18.8%	High
Cherokee County	<500	7.9%	Mid-Low	3,000	17.2%	Low	3,000	14.8%	Low
Chowan County	<500	8.2%	Mid-Low	2,000	20.6%	Mid-Low	2,000	17.0%	Mid-Low
Clay County	<500	7.6%	Low	1,000	18.7%	Low	1,000	16.0%	Low
Cleveland County	2,000	7.9%	Mid-Low	12,000	19.3%	Low	14,000	16.0%	Low
Columbus County	1,000	8.5%	Mid-High	8,000	22.2%	Mid-High	10,000	18.3%	Mid-High
Craven County	2,000	8.0%	Mid-Low	14,000	20.2%	Mid-Low	16,000	16.6%	Mid-Low
Cumberland County	9,000	8.6%	Mid-High	50,000	22.8%	High	58,000	18.4%	Mid-High
Currituck County	<500	7.0%	Low	3,000	19.8%	Mid-Low	4,000	16.2%	Low
Dare County	1,000	7.8%	Low	4,000	18.2%	Low	5,000	15.7%	Low
Davidson County	3,000	7.8%	Low	22,000	20.5%	Mid-Low	25,000	16.9%	Mid-Low
Davie County	1,000	7.6%	Low	5,000	19.8%	Mid-Low	6,000	16.3%	Low
Duplin County	2,000	10.0%	High	10,000	26.7%	High	12,000	21.6%	High
Durham County	7,000	9.1%	High	41,000	21.5%	Mid-High	48,000	18.1%	Mid-High
Edgecombe County	1,000	8.8%	High	8,000	22.2%	Mid-High	9,000	18.2%	Mid-High
Forsyth County	9,000	8.9%	High	47,000	20.3%	Mid-Low	56,000	16.9%	Mid-Low
Franklin County	1,000	8.4%	Mid-High	9,000	23.0%	High	11,000	18.7%	High
Gaston County	4,000	8.0%	Mid-Low	28,000	20.3%	Mid-Low	32,000	16.8%	Mid-Low
Gates County	<500	7.7%	Low	2,000	22.8%	High	2,000	18.5%	High
Graham County	<500	7.9%	Mid-Low	1,000	20.4%	Mid-Low	1,000	16.9%	Mid-Low
Granville County	1,000	8.4%	Mid-High	9,000	20.5%	Mid-Low	10,000	17.3%	Mid-High
Greene County	1,000	9.7%	High	4,000	27.0%	High	5,000	22.3%	High
Guilford County	11,000	8.5%	Mid-High	68,000	20.3%	Mid-Low	79,000	16.9%	Mid-Low
Halifax County	1,000	8.6%	High	8,000	23.0%	High	9,000	18.9%	High
Harnett County	3,000	8.5%	Mid-High	19,000	24.3%	High	22,000	19.1%	High
Haywood County	1,000	7.4%	Low	7,000	18.0%	Low	8,000	15.3%	Low
Henderson County	2,000	8.2%	Mid-Low	13,000	20.0%	Mid-Low	15,000	16.8%	Mid-Low
Hertford County	1,000	8.9%	High	4,000	22.7%	High	4,000	18.8%	High
Hoke County	1,000	8.8%	High	9,000	27.1%	High	10,000	21.0%	High
Hyde County	<500	8.5%	Mid-High	1,000	24.6%	High	1,000	20.9%	High
Iredell County	3,000	7.7%	Low	20,000	19.1%	Low	24,000	15.7%	Low
Jackson County	1,000	8.3%	Mid-High	6,000	20.6%	Mid-Low	6,000	17.4%	Mid-High
Johnston County	5,000	8.5%	Mid-High	26,000	23.3%	High	31,000	18.5%	High
Jones County	<500	8.3%	Mid-High	1,000	22.7%	High	2,000	18.9%	High
Lee County	2,000	9.4%	High	8,000	22.2%	Mid-High	10,000	18.2%	Mid-High
Lenoir County	1,000	8.7%	High	8,000	20.9%	Mid-High	9,000	17.3%	Mid-High
Lincoln County	2,000	7.6%	Low	11,000	20.3%	Mid-Low	12,000	16.8%	Mid-Low
Macon County	1,000	8.1%	Mid-Low	4,000	19.5%	Low	5,000	16.4%	Mid-Low

	Children (0-18)			Adult (19-64)			Total (0-64)		
County	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*
Madison County	<500	7.5%	Low	3,000	19.2%	Low	3,000	16.1%	Low
Martin County	1,000	8.5%	Mid-High	3,000	21.1%	Mid-High	4,000	17.6%	Mid-High
McDowell County	1,000	7.8%	Low	6,000	18.9%	Low	6,000	15.9%	Low
Mecklenburg County	24,000	8.7%	High	139,000	21.2%	Mid-High	163,000	17.5%	Mid-High
Mitchell County	<500	7.6%	Low	2,000	18.7%	Low	2,000	15.9%	Low
Montgomery County	1,000	9.5%	High	4,000	22.5%	Mid-High	5,000	18.7%	High
Moore County	2,000	8.0%	Mid-Low	10,000	19.5%	Low	12,000	16.2%	Low
Nash County	2,000	8.6%	Mid-High	13,000	20.7%	Mid-Low	15,000	17.2%	Mid-Low
New Hanover County	4,000	7.9%	Mid-Low	28,000	20.0%	Mid-Low	32,000	16.9%	Mid-Low
Northampton County	<500	8.6%	Mid-High	3,000	23.1%	High	4,000	19.2%	High
Onslow County	4,000	8.0%	Mid-Low	30,000	24.0%	High	34,000	19.2%	High
Orange County	3,000	8.2%	Mid-High	19,000	19.5%	Low	22,000	16.4%	Low
Pamlico County	<500	7.9%	Mid-Low	2,000	20.2%	Mid-Low	2,000	17.2%	Mid-High
Pasquotank County	1,000	8.2%	Mid-High	6,000	21.1%	Mid-High	7,000	17.4%	Mid-High
Pender County	1,000	8.0%	Mid-Low	8,000	22.2%	Mid-High	9,000	18.2%	Mid-High
Perquimans County	<500	7.7%	Low	2,000	21.5%	Mid-High	2,000	17.8%	Mid-High
Person County	1,000	7.9%	Mid-Low	5,000	20.7%	Mid-Low	6,000	17.1%	Mid-Low
Pitt County	4,000	8.5%	Mid-High	26,000	22.0%	Mid-High	30,000	18.1%	Mid-High
Polk County	<500	8.0%	Mid-Low	2,000	18.6%	Low	3,000	15.9%	Low
Randolph County	3,000	8.3%	Mid-High	19,000	20.5%	Mid-Low	22,000	16.9%	Mid-Low
Richmond County	1,000	8.6%	Mid-High	7,000	22.8%	High	8,000	18.6%	High
Robeson County	4,000	9.8%	High	22,000	25.4%	High	26,000	20.3%	High
Rockingham County	2,000	8.0%	Mid-Low	12,000	20.3%	Mid-Low	14,000	17.0%	Mid-Low
Rowan County	3,000	8.2%	Mid-High	19,000	20.8%	Mid-High	22,000	17.2%	Mid-Low
Rutherford County	1,000	7.9%	Mid-Low	9,000	20.2%	Mid-Low	10,000	16.8%	Mid-Low
Sampson County	2,000	9.6%	High	11,000	26.0%	High	12,000	21.0%	High
Scotland County	1,000	8.5%	Mid-High	5,000	21.7%	Mid-High	6,000	17.7%	Mid-High
Stanly County	1,000	7.5%	Low	7,000	18.9%	Low	9,000	15.6%	Low
Stokes County	1,000	7.1%	Low	6,000	20.0%	Mid-Low	7,000	16.5%	Mid-Low
Surry County	2,000	8.4%	Mid-High	9,000	19.7%	Mid-Low	11,000	16.5%	Mid-Low
Swain County	<500	9.4%	High	2,000	21.8%	Mid-High	2,000	18.1%	Mid-High
Transylvania County	1,000	7.7%	Low	4,000	18.5%	Low	4,000	15.7%	Low
Tyrrell County	<500	9.0%	High	1,000	26.6%	High	1,000	22.5%	High
Union County	5,000	7.7%	Low	28,000	21.3%	Mid-High	33,000	16.6%	Mid-Low
Vance County	1,000	9.1%	High	7,000	23.2%	High	8,000	18.8%	High
Wake County	22,000	8.1%	Mid-Low	126,000	19.7%	Low	149,000	16.2%	Low
Warren County	<500	8.9%	High	3,000	25.2%	High	4,000	20.9%	High
Washington County	<500	8.8%	High	2,000	22.1%	Mid-High	2,000	18.3%	Mid-High
Watauga County	1,000	8.1%	Mid-Low	8,000	21.8%	Mid-High	9,000	18.6%	High
Wayne County	3,000	8.8%	High	18,000	22.6%	High	21,000	18.5%	Mid-High

	Children (0-18)			Adult (19-64)			Total (0-64)		
County	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*	*Number*	*Percent*	*Rank*
Wilkes County	1,000	7.7%	Low	9,000	19.2%	Low	10,000	16.0%	Low
Wilson County	2,000	9.0%	High	12,000	22.1%	Mid-High	14,000	18.1%	Mid-High
Yadkin County	1,000	8.3%	Mid-High	5,000	20.9%	Mid-High	6,000	17.3%	Mid-High
Yancey County	<500	7.9%	Mid-Low	2,000	19.9%	Mid-Low	3,000	16.8%	Mid-Low
North Carolina	214,000			1,341,000			1,562,000		

The North Carolina Institute of Medicine (NCIOM) serves as a non-political source of health policy analysis and advice in North Carolina. The NCIOM is an independent, quasi-state agency that was chartered by the North Carolina General Assembly in 1983 to provide balanced, nonpartisan information on issues relevant to the health of North Carolina's population. To meet its mission, the NCIOM convenes task forces of knowledgeable and interested individuals to study these issues and develop workable solutions. For more information, visit http://www.nciom.org.

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Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina
Appendix C (Revised 2/12/2013)

Table 1. Projected Costs and Enrollment for the Woodwork Population (FY 2014-2021) (Costs in Millions)
Estimates by the Division of Medical Assistance, North Carolina Department of Health and Human Services and Regional Economic Model, Inc. (REMI), under contract with the North Carolina Department of Health and Human Services

	2014	2015	2016	2017	2018	2019	2020	2021	Total (2014-2021)	*Run Rate*
Enrolled population	69,683	72,426	75,340	78,035	80,890	83,859	85,888	87,127		
Federal Match Rate	65%	65%	65%	65%	65%	65%	65%	65%		
Service Expenditures										
Total Expenditures	$ 104,983,851	$ 292,714,525	$ 482,947,067	$ 513,716,486	$ 546,744,703	$ 581,226,081	$ 603,049,092	$ 617,434,186	$ 3,742,815,992	*$ 617,434,186*
Total Federal	$68,239,503	$190,264,441	$313,915,594	$333,915,716	$355,384,057	$377,796,953	$ 391,981,910	$ 401,332,221	$ 2,432,830,395	*$ 401,332,221*
State Appropriations	$ 36,744,348	$ 102,450,084	$ 169,031,474	$ 179,800,770	$ 191,360,646	$ 203,429,128	$ 211,067,182	$ 216,101,965	$ 1,309,985,597	*$ 216,101,965*
Pharmaceutical Rebate										
Total Drug Rebate	$ (965,059)	$ (14,616,536)	$ (23,783,604)	$ (30,548,681)	$ (33,766,296)	$ (37,292,021)	$ (41,301,323)	$ (44,659,389)	$ (226,932,908)	*$ (45,788,131)*
Federal Drug Rebate	$ (627,288)	$ (9,500,748)	$ (15,459,343)	$ (19,856,643)	$ (21,948,092)	$ (24,239,814)	$ (26,845,860)	$ (29,028,603)	$ (147,506,390)	*$ (29,762,285)*
State Drug Rebate	$ (337,771)	$ (5,115,788)	$ (8,324,261)	$ (10,692,038)	$ (11,818,204)	$ (13,052,207)	$ (14,455,463)	$ (15,630,786)	$ (79,426,518)	*$ (16,025,846)*
Effect of CHIP Enhanced Match Rate										
CHIP changes to federal government	0	0	$ 64,472,190	$ 88,021,269	$ 90,089,411	$ 92,126,196	$0	$ -	$ 334,709,067	$ -
CHIP Changes to State (Increases FMAP by 23 percentage points 2016-2019, reduces state, increases federal)	0	0	$ (64,472,190)	$ (88,021,269)	$ (90,089,411)	$ (92,126,196)	$0	$ -	$ (334,709,067)	$ -
Net Service Costs (Gross service costs, minus pharmaceutical rebate, plus changes in SCHIP match rate)										
Net Total Service Costs	$ 104,018,792	$ 278,097,989	$ 459,163,463	$ 483,167,805	$ 512,978,407	$ 543,934,060	$ 561,747,769	$ 572,774,797	$ 3,515,883,084	*$ 571,646,055*
Net federal appropriations (minus drug rebate plus CHIP enhancement)	$67,612,215	$180,763,693	$362,928,441	$402,080,342	$423,525,376	$445,683,335	$365,136,050	$ 372,303,618	$ 2,620,033,072	*$ 371,569,936*
Net state appropriations (minus drug rebate, minus CHIP enhancement)	$ 36,406,577	$ 97,334,296	$ 96,235,023	$ 81,087,463	$ 89,453,031	$ 98,250,725	$ 196,611,719	$ 200,471,179	$ 895,850,012	*$ 200,076,119*
Administrative Expenses										
Total administrative	$ 1,938,239	$ 4,024,246	$ 4,175,928	$ 4,322,500	$ 4,384,961	$ 4,537,221	$ 4,592,755	$ 4,640,808	$ 32,616,658	*$ 4,640,808*
Ongoing federal administrative expenses	$ 969,120	$ 2,012,123	$ 2,087,964	$ 2,161,250	$ 2,192,481	$ 2,268,610	$2,296,377	$ 2,320,404	$ 16,308,329	*$ 2,320,404*
Ongoing state adminstrative expenses	$ 969,119	$ 2,012,123	$ 2,087,964	$ 2,161,250	$ 2,192,480	$ 2,268,611	$ 2,296,378	$ 2,320,404	$ 16,308,329	*$ 2,320,404*
Total appropriations (including drug rebates, CHIP enhancement, service and administrative costs)										
Total	$ 105,957,031	$ 282,122,235	$ 463,339,391	$ 487,490,305	$ 517,363,368	$ 548,471,281	$ 566,340,524	$ 577,415,605	$ 3,548,499,742	*$ 576,286,863*
Total Federal	$68,581,335	$182,775,816	$365,016,405	$404,241,592	$425,717,857	$447,951,945	$367,432,427	$374,624,022	$2,636,341,401	*$373,890,340*
Total State	**$ 37,375,696**	**$ 99,346,419**	**$ 98,322,987**	**$ 83,248,713**	**$ 91,645,511**	**$ 100,519,336**	**$ 198,908,097**	**$ 202,791,583**	**$ 912,158,341**	***$ 202,396,523***

Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina
Appendix C (Revised 2/12/2013)

Table 2. Projected Costs and Enrollment for the Newly Eligible Population (FY 2014-2021) (Costs in Millions)
Estimates by the Division of Medical Assistance, North Carolina Department of Health and Human Services and Regional Economic Model, Inc. (REMI), under contract with the North Carolina Department of Health and Human Services

	2014	2015	2016	2017	2018	2019	2020	2021	Total (2014-2021)	Run Rate
Enrolled population	494,010	500,058	506,818	512,906	519,684	525,830	531,264	536,481		
Federal Match Rate	100%	100%	100%	95%	94%	93%	90%	90%	90%	90%
Gross Service Expenditures										
Total Expenditures	$ 521,929,213	$ 2,134,105,487	$ 2,192,230,960	$ 2,240,197,739	$ 2,300,550,883	$ 2,350,432,584	$ 2,396,695,904	$ 2,443,113,565	$ 16,579,256,334	$ 2,443,113,565
Total Federal	$ 521,929,213	$ 2,134,105,487	$ 2,192,230,960	$ 2,156,190,324	$ 2,168,269,207	$ 2,191,778,384	$ 2,175,001,533	$ 2,198,802,208	$ 15,738,307,316	$ 2,198,802,208
State Expenditures	$ -	$ -	$ -	$ 84,007,415	$ 132,281,676	$ 158,654,200	$ 221,694,371	$ 244,311,356	$ 840,949,018	$ 244,311,356
Drug Rebates										
Total Rebate	$ (5,377,623)	$ (106,459,255)	$ (141,319,880)	$ (149,545,586)	$ (158,328,489)	$ (167,388,260)	$ (180,361,655)	$ (192,970,911)	$ (1,101,751,659	$ (197,053,717)
Federal Rebate	$ (5,377,623)	$ (106,459,255)	$ (141,319,880)	$ (143,937,627)	$ (149,224,601)	$ (156,089,552)	$ (164,049,062)	$ (174,410,557)	$ (1,040,868,157	$ (178,100,670)
State Rebate				$ (5,607,959)	$ (9,103,888)	$ (11,298,708)	$ (16,312,593)	$ (18,560,354)	$ (60,883,502)	$ (18,953,047)
Potential Other Offsets										
DMHDDSAS	$ (8,185,997)	$ (16,371,993)	$ (16,371,993)	$ (16,371,993)	$ (16,371,993)	$ (16,371,993)	$ (16,371,993)	$ (16,371,993)	$ (122,789,948)	$ (16,371,993)
ADAP	$ (14,308,623)	$ (28,617,246)	$ (28,617,246)	$ (28,617,246)	$ (28,617,246)	$ (28,617,246)	$ (28,617,246)	$ (28,617,246)	$ (214,629,345)	$ (28,617,246)
Corrections	$ (8,500,000)	$ (17,000,000)	$ (17,000,000)	$ (17,000,000)	$ (17,000,000)	$ (17,000,000)	$ (17,000,000)	$ (17,000,000)	$ (127,500,000)	$ (17,000,000)
Subtotal offsets	*$ (30,994,620)*	*$ (61,989,239)*	*$ (61,989,239)*	*$ (61,989,239)*	*$ (61,989,239)*	*$ (61,989,239)*	*$ (61,989,239)*	*$ (61,989,239)*	$ (464,919,293)	$ (61,989,239)
Net Service Costs (Gross Service Costs Minus Pharmaceutical Rebates and Other Offsets)										
Net Total Service Costs	$ 516,551,590	$ 2,027,646,232	$ 2,050,911,080	$ 2,090,652,153	$ 2,142,222,394	$ 2,183,044,324	$ 2,216,334,249	$ 2,250,142,654	$ 15,477,504,675	$ 2,246,059,848
Net Federal Service Costs	$ 516,551,590	$ 2,027,646,232	$ 2,050,911,080	$ 2,012,252,697	$ 2,019,044,606	$ 2,035,688,832	$ 2,010,952,471	$ 2,024,391,651	$ 14,697,439,159	$ 2,020,701,538
State Service Costs with Offsets (new state dollars)	$ (30,994,620)	$ (61,989,239)	$ (61,989,239)	$ 16,410,217	$ 61,188,549	$ 85,366,253	$ 143,392,539	$ 163,761,763	$ 315,146,223	$ 163,369,070
Administrative Expenditures										
Total	$ 20,826,262	$ 29,455,852	$ 29,762,436	$ 30,081,429	$ 30,491,968	$ 30,820,280	$ 31,179,400	$ 31,490,115	$ 234,107,742	$ 31,490,115
Federal	$ 10,463,086	$ 14,827,835	$ 14,981,127	$ 15,140,624	$ 15,345,893	$ 15,510,049	$ 15,690,773	$ 15,847,138	$ 117,806,525	$ 15,847,138
State	$ 10,363,176	$ 14,628,017	$ 14,781,309	$ 14,940,805	$ 15,146,075	$ 15,310,231	$ 15,488,627	$ 15,642,977	$ 116,301,217	$ 15,642,977
REMI New State Tax Revenues										
Migration	($17,377,000)	($74,312,000)	($78,407,000)	($73,443,000)	($70,948,000)	($69,666,000)	($65,208,000)	($64,623,000)	$ (513,984,000)	NA
No Migration	($17,041,000)	($72,616,000)	($75,559,000)	($69,621,000)	($66,119,000)	($63,788,000)	($58,312,000)	($56,711,000)	$ (479,767,000)	NA
Avg Migration/No migration	($17,209,000)	($73,464,000)	($76,983,000)	($71,532,000)	($68,533,500)	($66,727,000)	($61,760,000)	($60,667,000)	($496,875,500)	NA
Total Expenditures (Includes Service and Administrative Costs, Minus Pharmaceutical Rebates and Other Offsets, and New Revenues)										
Total	$ 537,377,852	$ 2,057,102,084	$ 2,080,673,516	$ 2,120,733,582	$ 2,172,714,362	$ 2,213,864,604	$ 2,247,513,649	$ 2,281,632,769	$ 15,711,612,417	$ 2,277,549,963
Total federal costs	$ 527,014,676	$ 2,042,474,067	$ 2,065,892,207	$ 2,027,393,321	$ 2,034,390,499	$ 2,051,198,881	$ 2,026,643,244	$ 2,040,238,789	$ 14,815,245,684	$ 2,036,548,676
Net State Costs	$ (37,840,444)	$ (120,825,222)	$ (124,190,930)	$ (40,180,978)	$ 7,801,124	$ 33,949,484	$ 97,121,166	$ 118,737,740	$ (65,428,060)	NA

A Contrast: Modeling the Macroeconomic Impact of "Medicaid Expansion" in North Carolina

Prepared by Regional Economic Models, Inc. (REMI)

For the North Carolina Department of Health and Human Services (NC DHHS)

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EXECUTIVE SUMMARY

Using a 1-region, 70-sector PI^{+} model of the North Carolina economy, the North Carolina Department of Health and Human Services contracted Regional Economic Models, Inc. to perform an impact study of the potential economic implications of expanding Medicaid under the provisions of the Patient Protection and Affordable Care Act. This study used data from the state on the net increase in healthcare consumption from the expansion and the needed redirection of state funds from other priorities to pay for the state's share against federal matching funds. With this data and assumptions, the Medicaid expansion had potential to be a positive for North Carolina and its economy from 2014 to 2021. Total employment increased by around 23,000 jobs, private employment increased by a similar number, annual GDP was about $1.4 billion higher, and annual real disposable personal income was around $1.0 billion higher. Spending by the state does fall, but the anticipated influx of federal dollars was enough to generate a positive impact. These benefits were concentrated in the industries related to healthcare, professional services like research or operations, and for workers able to work in the occupations demanded by health services firms, either as a provider or in administration. We did not seek to advocate a certain course of action for North Carolina but only to provide better information on this issue.

POLICY HISTORY AND BACKGROUND

The economic implications of policy decisions are always at the front of the mind with policymakers and the public, and this is most definitely true in the case of Medicaid expansion. This "expansion" followed from a series of events beginning with the passage of the Patient Protection and Affordable Care Act in 2010 (typically abbreviated at the "ACA" or "Obamacare" in the political lexicon). This law represented the most significant reform and overhaul of the United States' public healthcare system since the beginning of Medicare and Medicaid in the 1960s,[1] and it sought to expand health insurance coverage in the United States through a series of mandates, premium subsidies, and taxes. One of the chief mechanisms of the ACA was an expansion of the federal/state Medicaid program, which encountered complications at the legal bench when the ACA went before the Supreme Court through the summer and to a final ruling on June 28, 2012.

While surviving the overall legal challenge, the case of *National Federation of Independent Business (NFIB) v. Sebelius* made the situation for states regarding the expansion complicated. The court ruled the general provisions of the law constitutional under Congress' power to tax, though it held that forcing states to expand Medicaid coverage (and thereby their costs in matching federal funds) an unconstitutional appropriation of their sovereign powers.[2] Hence, the original "deal" of the 1965 law remained in force—states would have the choice to expand Medicaid under the provisions of the ACA or not, just as they did under the original Social Security amendment during the Great Society. The Arizona program, Arizona Health Care Cost Containment System (AHCCCS or "Access"), for example, did not start until 1982.[3] While all fifty states did eventually join Medicaid, the reaction to potential expansion under the ACA has been mixed.

Some states eagerly embraced the potential expansion, while others have taken a "wait and see" approach to the details and financing of the state/federal program. Governor Terry Branstad of Iowa, for instance, said Iowa will not participate. Citing worries of changing federal matching rates down the line, he said, "We don't believe the federal government when they say they're going to pay the whole cost of this for the next three years."[4] At the close of 2012, eight states have firmly declared their nonparticipation, and six leaned that way (including Iowa). Reasons changed, but most outlined concerns about paying for the expansion or defects in the ACA.[5] The policy opinion within states between the legislatures and governors and their relationships vary, as well. Thirteen states have announced their intentions to opt-in to the program, either to supplement or complement current state-level programs, to replace states money with federal funding, or to further the original goals of the ACA to expand coverage to lower income households.

Federal funding for states to expand may be substantial. To quote from *The Heritage Foundation*, "States may chose to expand their Medicaid populations to include individuals below 138% of the federal poverty level, with the federal government picking up 100% of payment for the first three years and then rolling back federal payments." They continued, "This structure is designed to be attractive to states, since it appears to increase

[1] James Vicini and Jonathon Stempel, "US top court upholds healthcare law," *Reuters*, June 2012, <www.reuters.com/article/2012/06/28/usa-healthcare-court-idUSL2E8HS4WG20120628>
[2] "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion," *The Henry K. Kaiser Family Foundation*, August 2012, <www.kff.org/healthreform/upload/8347.pdf>
[3] "Managed Medicaid: Arizona's AHCCCS Experience," *National Health Policy Forum*, January 2000, <www.nhpf.org/library/site-visits/SV_AZ00.pdf>
[4] Jon Ward, "Terry Branstad, Iowa Governor, Won't Expand Medicaid in Light of Supreme Court Ruling," *Huffington Post*, July 2012, <www.huffingtonpost.com/2012/07/02/terry-branstad-iowa-medicaid_n_1643428.html>
[5] "Where each state stands on ACA's Medicaid expansion," *The Advisory Board Company*, December 2012, <www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/>

health coverage at little or no state-level costs."[6] While Branstad and others have expressed this initial "no cost" situation to states is temporary and may change with future federal legislation, there is a lot of money on the table from federal coffers to aid states with the expansion. The Congressional Budget Office (CBO) estimated Washington will spend $930 billion on the expansion from 2014 to 2022, paying for the entire share the first three years and gradually declining to 90% federal and 10% state portions by 2020.[7] At current, $930 billion is about 6.2% of the United States' annual gross domestic product (GDP). One could not ignore the potential effect of this money on a single state's economy, which was where this analysis began.

Study Introduction and Perspective

This paper seeks to illustrate the economic impact of the federal dollars on the state of North Carolina from the Medicaid expansion provisions of the ACA. **It does not advocate for expansion or non-expansion in either direction**. There are factors about Medicaid and healthcare policy in the United States that are difficult or impossible to know—most notably, the nature of future legislative action by Congress and the various states. This study looked at the current law, and it did not attempt to prognosticate what policymakers in 2017, 2021, or any other year might do with healthcare. Regional Economic Models, Inc. (REMI) used data provided by the North Carolina Department of Health and Human Services (NC DHHS or just DHHS) to model the impact of the expansion in our model, PI^+. The results here came from the data inputs and assumptions.

REMI is strictly nonpartisan, nonpolitical, and involved only in the economic modeling and reporting from the data provided by NC DHHS. We sought to provide robust information for policymakers and the public on the economic implications of certain decisions—in this case, Medicaid expansion in North Carolina. The rest of the study included an introduction to REMI as a firm, the PI^+ model used for this study, the data and assumptions from DHHS, and the economic impact results. Some of these assumptions included considerations of how other states respond to the ACA, how migration patterns and household decision-making may change, dealing with the offset of federal money and taxes, and how state-level spending in North Carolina changed to make this into a "net" analysis. The exact numbers in the input data were confidential—one should turn to the NC DHHS to inquire as to exact figures.[8] The $930 billion potential outflow from Medicaid expansion over the next ten years is a stupendous amount of money, and this study inquired into its impact in this one region.

Regional Economic Models, Inc. (REMI)

Regional Economic Models, Inc. is a Massachusetts- and Washington, DC-based firm specializing in services related to economic modeling. It began as a project by a professor, Dr. George Treyz, at the University of Massachusetts-Amherst in the 1970s looking into the long-term impact of investments in the I-90 corridor (from Boston to Albany to Buffalo). From there, Dr. Treyz founded a company around his research, which has grown over the past thirty years into the present firm. REMI currently provides software, support services, and issue expertise in forty-seven of the fifty states, the District of Columbia, and several nations abroad. Our model users include state government agencies, local authorities, regional planners, federal departments, consulting firms, private corporations, and academia. In North Carolina, for example, REMI currently works with the General Assembly's Fiscal Research

[6] Drew Gonshorowski, "Medicaid Expansion Will Become More Costly," *The Heritage Foundation*, August 2012, <www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states>
[7] Robert Pear, "Uncertainty Over States and Medicaid Expansion," *New York Times*, June 2012, <www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html?_r=0>
[8] "North Carolina Medicaid," *North Carolina Department of Health and Human Services*, December 2012, <www.ncdhhs.gov/dma/medicaid/>

Division and Winston-Salem State University (WSSU). Other relevant users include the Georgia Department of Transportation (GDOT), Atlanta Regional Commission (ARC), the state legislatures in Kentucky and Florida, the comptroller's office in Texas, and the Departments of Revenue in Louisiana, Mississippi, Kansas, and Iowa. REMI's relationship with these organizations consists of providing them a model of their region (in the form of a software package) as well as working with them on the interface, vetting data, selecting variables, interpreting the results, and—in cases like these—running the simulation and reporting the findings.

THE PI$^+$ REGIONAL MODEL

For this study, REMI used a 1-region, 70-sector build of the counties of North Carolina agglomerated to create a state-level model. The PI$^+$ model is the "core" of REMI capabilities. The research behind it included four different quantitative methodologies from regional science and economics, which compensated for their individual weaknesses and highlighted their strengths. They included input-output (IO) tabulation, which captured the effects of inter-industry transactions, technological relationships, and multipliers. PI$^+$ also included a computable general equilibrium (CGE) component, which accounted for the "long-term" impact of policies once all related markets in products, housing, labor, and others have had a chance to return to an equilibrium or "clear." These two types of models only allowed for a "before" and an "after" simulation, however, which was why PI$^+$ included an econometric component. The econometrics gave a time component, including speed of adjustment, behavioral responses, elasticities, and statistical parameters. The last methodology was New Economic Geography (NEG), which took account of labor pooling, the clustering of industry supply chains, and the spatial elements of a regional economy and its tendency to organize into localized production units.

The research behind the REMI PI$^+$ model appeared in peer-reviewed journals, and REMI used the federal statistical agencies as data sources when building the software. Data came from the Bureau of Economic Analysis (BEA), Bureau of Labor Statistics (BLS), the U.S. Census Bureau, and the Energy Information Administration (EIA).[9] A macroeconomic forecast came from the Research Seminar in Quantitative Economics (RSQE) at the University of Michigan,[10] which drove many of the county-level or state-level trends in the short-term of the model through the forthcoming business cycle. After that, the REMI model used the BLS' long-term forecast of national growth by industry and in the labor force. The county-level data from these sources allowed for PI$^+$ to have a customized geography at the sub-national or sub-state basis, but the model here included the discreet state of North Carolina in the inputs and results. The journals included the *Journal of Regional Science*, the *American Economic Review*, and the *Review of Economics and Statistics*.[11]

The model existed in a block structure (see *Figure 1*, next page). Block 1, at the top, represented the economy of the region with final demand and production. These included the various components of GDP, including the spending by governments, investment, net exports, and consumption. Block 2 represented the firm perspective on the economy, where demand turned into sales orders and firms made decisions about the most efficient way to produce. The model optimized their choices with a Cobb-Douglas production function amid labor, capital, and fuel as factors of production. Block 3 represented households in the economy. This included their demographics, their participation in the labor market, their location decisions, non-pecuniary amenity, and their consumption of food,

[9] For a full listing of data sources and types, see "Data Sources and Estimation Procedures," *REMI*, November 2012, <www.remi.com/download/documentation/pi+/pi+_version_1.4/Data_Sources_and_Estimation_Procedures.pdf>

[10] George Fulton, "RSQE specializes in economic forecasting of the U.S. and Michigan economies," *University of Michigan*, <http://rsqe.econ.lsa.umich.edu/>

[11] For journal citations, please see p. 46 of the PDF online, "PI$^+$ v. 1.4 Model Equations," *REMI*, November 2012, <www.remi.com/download/documentation/pi+/pi+_version_1.4/PI+_v1.4_Model_Equations(2).pdf>

housing, healthcare, and everything else to fulfill their wants and needs. Block 4 was where households and businesses came together in the marketplace, and it included labor market concepts like employment opportunity and compensation rates, cost of living factors such as real estate and housing prices, and the cost of doing business for an industry in any given region. These then flowed into Block 5, which measured competitiveness against other regions (domestic and international), the ability to export, and the aptitude to keep imports from competitors away from a geographic arena.

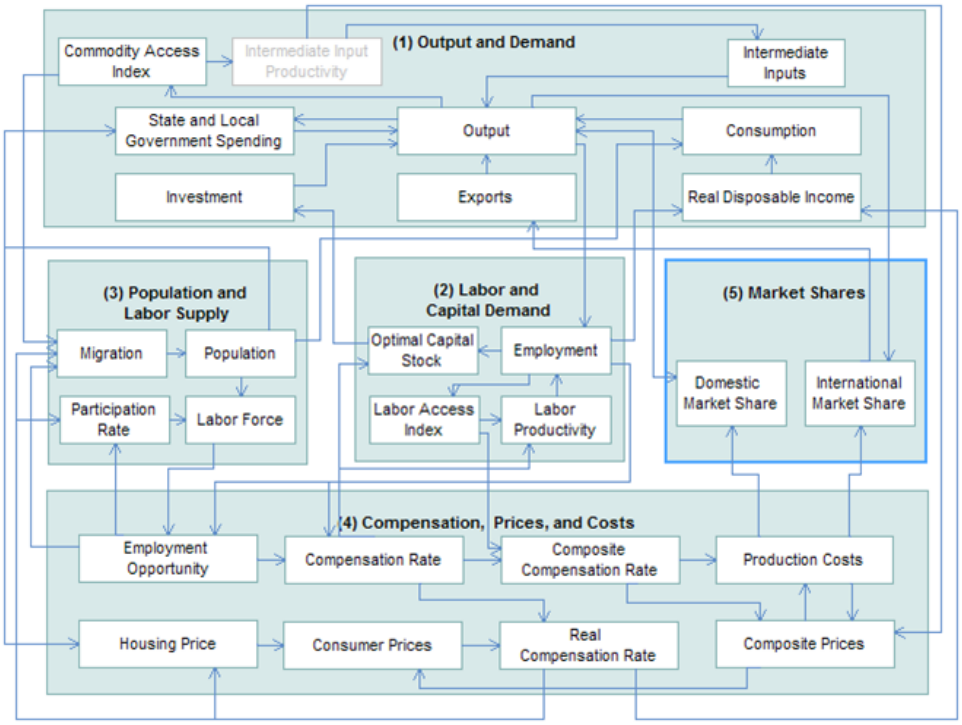


FIGURE 1 – THIS WAS THE BLOCK STRUCTURE OF THE REMI PI^{+} MODEL, INCLUDING OUTPUT LEADING INTO LABOR AND CAPITAL, HOUSEHOLDS IN BLOCK 3, MARKETS IN BLOCK 4, AND MARKET SHARES. THE "RECTANGLES" REPRESENTED SOME METRIC, WHILE THE ARROWS SHOW THEIR INTERRELATIONSHIPS IN THE FORM OF EQUATIONS TO ILLUSTRATE THE INTERACTIONS BETWEEN AREAS.[12] THE MODEL WAS A CONSISTENT SYSTEM TO SHOW HOW ALL OF THESE WORK TOGETHER TO GENERATE IMPACTS AND FORECASTS ON A REGIONAL BASIS.

The PI^{+} model had two purposes: forecasting and analysis via simulations. The forecasting works by building the government's data into the structure and allowing it to run until the sunset in 2060. REMI builds this "base case" so users can have a forecast of their regional economy, the chance to analyze the internal trends of the model, and to have something to compare against when performing their simulations. The simulations allow the user to make exogenous—"coming from outside"—changes through the above structure in what PI^{+} calls "policy variables."[13] These changes represented the effect of their policy and can include production, price changes, and other factors. For example, a Boeing 737 line moving to an area will produce a large amount of output. The model represents it above, and then it hires the workers, pays them their wages, has them spend it, and redirects the capital portion of production into investment and intermediate demand to other industries (such as aluminum providers, design and engineering firms, or accounting services). From there, the model generates a new simulation and compares it

[12] Please see n. 9 on p. 5
[13] "Exogenous," *EconModel*, December 2012, <www.econmodel.com/classic/terms/exogenous.htm>

against the old case to give an "impact" to the forecast for the regional economy. This impact, or difference, is the estimated implication of the policy in question.

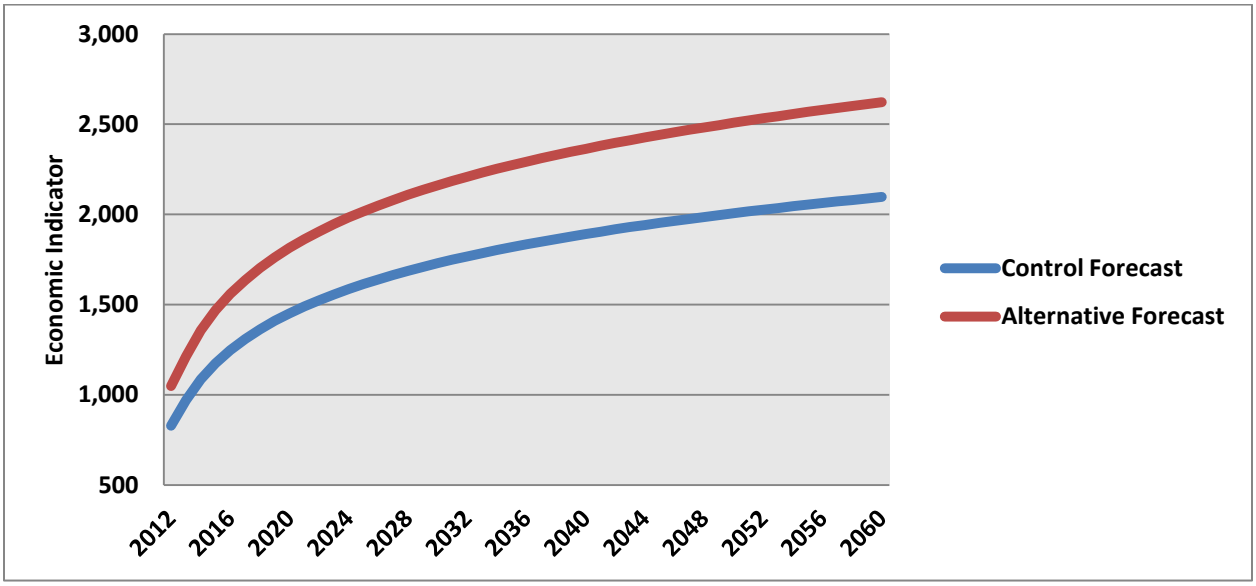


FIGURE 2 – THIS GRAPH REPRESENTS THE BASIC PRINCIPLES OF ANALYSIS WITH PI+. THE BLUE LINE WAS THE BASELINE, BASE CASE, OR "NULL" WITH NO EXTERNAL SHOCKS TO THE ECONOMY. THE RED LINE WAS THE SIMULATION DUE TO CHANGES IN THE POLICY VARIABLES. ONE CAN EITHER LOOK AT THE FORECAST OUT OF THE MODEL FOR THE FUTURE OR THE VERTICAL DIFFERENCE BETWEEN RED AND BLUE TO DETERMINE THE "IMPACT" OF A CERTAIN POLICY. HERE, FOR INSTANCE, THE RED LINE WAS A REGION'S DEVELOPMENT WITH A TRANSPORTATION INVESTMENT, WHILE THE BLUE LINE IS ABSENT THE BUILD. THE Y-AXIS WILL BE SOME ECONOMIC MEASUREMENT OR DATA, INCLUDING MAIN INDICATORS LIKE EMPLOYMENT, GDP, BUSINESS SALES/OUTPUT, OR INCOME.

SIMULATING MEDICAID EXPANSION IN NORTH CAROLINA

In this case, illustrating the impact of the expansion of Medicaid under the ACA's provisions required two major sets of assumptions. One involved the direct application of the federal spending for the expansion, and the other was accounting for the cost to the state for paying for its portion. Modeling this required a "micro-simulation" of the nature of the demand and supply for healthcare in the region when new policies and incentives come into play. This micro-simulation data from DHHS went into the PI+ model to sort healthcare spending by industry and year. On the other hand, even with the generous federal match, the ACA expansion is not entirely free of cost to the government in Raleigh. The state will still shoulder some burden of paying for the expansion, which one can model as a mixture of spending reductions or tax increases, which represents the state's fiscal constraints in the face of expanding Medicaid and more people participating in the market.

NC DHHS provided REMI with an estimation of how the expansion would impact healthcare spending in North Carolina as well as data on how to sort that into individual NAICS industries. NAICS stands for North American Industrial Classification System, and it is the official way the government keeps data and defines a series of firms

into individual "industries" that provide similar services and compete against each other.[14] The direct industries impacted by the expansion include hospitals, offices of physicians, prescription drug manufacturers and retailers, diagnostic and treatment equipment manufacturers and practitioners, dentists' offices, and other providers of healthcare specialties. A number of factors lead to a net increase in healthcare spending: the "woodwork effect" from the individual mandate,[15] moving SCHIP beneficiaries over to Medicaid, and the availability of Medicaid for households between 100% and 138% of the federal poverty threshold.[16] REMI could not answer to the veracity of these micro-simulations, though other groups throughout the literature have made their own estimations of what Medicaid expansion might cost the federal and state governments.[17]

Even without expanding, the ACA will change the nature of the North Carolina economy. There are two reasons for this: the woodwork effect and the decisions other states make about Medicaid. An article in the *New England Journal of Medicine* stated, "the participation rates [for Medicaid have] a national average of 61.7% eligible individuals."[18] However, now facing a financial penalty for not enrolling from the individual mandate, people are more likely to enroll in plans. This will happen without regard to what the state does with Medicaid expansion. Decisions by other states will also impact North Carolina's economy; healthcare is a labor-intensive, localized industry, and North Carolina is one of the United States' leaders in providing care and in R&D. The decision of a large state, even far away ones like Texas and California, will impact the flow of dollars coming into North Carolina. The same is true of the smaller state economies in the neighboring South. We needed to make a few assumptions and clarifications about these factors before proceeding with a Medicaid simulation.

REMI produced multiple simulations to take account of these issues. First, REMI updated the base case simulation of the North Carolina economy to include the woodwork effect regardless of what the state decided to do with expansion. This increased demand for healthcare in the state while reducing government spending (as the federal match for the preexisting Medicaid program was much less than 90% or 100%). The alternative simulation then became a case where only eligibility expansion is included as an exogenous factor. Secondly, PI^+ automatically moves money and people between states in any simulations. However, given this study is about North Carolina, **we did not model the impact of federal dollars in other states and their potential to make their way to North Carolina**. That interstate trade of capital, sales orders, and employment will happen no matter what Raleigh does about its Medicaid program; hence, we did not include it in the simulations.

Another factor to consider is migration. The PI^+ model moves households from place-to-place due to changes in relative job availability, wages, and cost of living. The ACA will have a profound effect on each of these in every state, and modeling as if North Carolina was the only state to expand—and therefore the only state to undergo these changes—is not complete. However, one should expect there to be some change in how people locate themselves due to the ACA and expansion. The North Carolina economy has a high concentration of healthcare firms, which attracts the young or footloose looking for employment and high wages. North Carolina would be on something of an "island" in the South if it were to participate in the Medicaid expansion because many nearby states (Virginia, South Carolina, Georgia, Alabama, Mississippi, and Texas) intend to opt-out of the expansion

[14] "North American Industrial Classification System," *Department of Commerce – U.S. Census*, December 2012, <www.census.gov/eos/www/naics/index.html>

[15] Joseph Ahern, "Medicaid and the 'Woodwork Effect,'" *The Center for Community Solutions*, December 2012, <tinyurl.com/cjlut2z>

[16] "Medicaid Expansion: A Short Explanation," *American Public Health Association*, December 2012, <www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm>

[17] Please see n. 6 on p. 4

[18] Benjamin Sommers and Arnold Epstein, "Medicaid Expansion – The Soft Underbelly of Health Care Reform," *New England Journal of Medicine*, 2010, <www.nejm.org/doi/full/10.1056/NEJMp1010866>

altogether.[19] This would give North Carolina an advantage in attracting households in light of the other states turning down the federal dollars and associated spending in the healthcare sector. Hence, one would want a migratory effect, but not one as strong as a "regular" simulation. More migration means more people, more spending, and therefore more impact. We ran cases with the migration effect turned on and off, and we reported both of them to give sensitivity towards other states' decisions.

The federal match of 90% by 2020 in the current ACA law still left 10% (or so, depending on the year) of the fiscal cost for the expansion to the state. To model this, PI^+ had variables to either decrease state government spending or raise taxes in various areas, such as on income or consumption. Raising taxes generally requires some legislative act; therefore, this study intentionally cut spending in order to make Medicaid expansion consistent with North Carolina's need to balance its budget. State agencies can, on the whole, reprioritize spending on the margin in the face of fiscal constraints more easily than a legislature can enact wholesale changes to taxes. If in 2019 (to pick a random year) for example, Medicaid expansion were costing the state $112, then $112 would come out of state spending elsewhere. We chose to cut the spending "across-the-board," as well, given that it is the most likely assumption to make without information on the future priorities of elected leaders.

The last big assumption involved federal taxes, because the ACA included a number of new revenue provisions. These involved capital gains, payroll taxes, a tax on medical devices, excise taxes on high-value insurance plans for individuals and families, and a number of other measures.[20] For this study, these taxes and their impact were beyond the purview of any decision Raleigh might make in the future about Medicaid. The federal government enacted these changes, and only it can unmake them in its legislation. The taxes are still going to take place in a state whether it chose to expand Medicaid or not. Hence, the federal money coming into the state was exogenous in the simulation, or "without opportunity cost," and the lack of an offset will make these results look positive. It was important to remember, however, this money came from somewhere, and it would contribute negatively to the impact of the ACA in North Carolina and the rest of the United States if included. Nevertheless, the decision about Medicaid expansion in North Carolina would not change this.

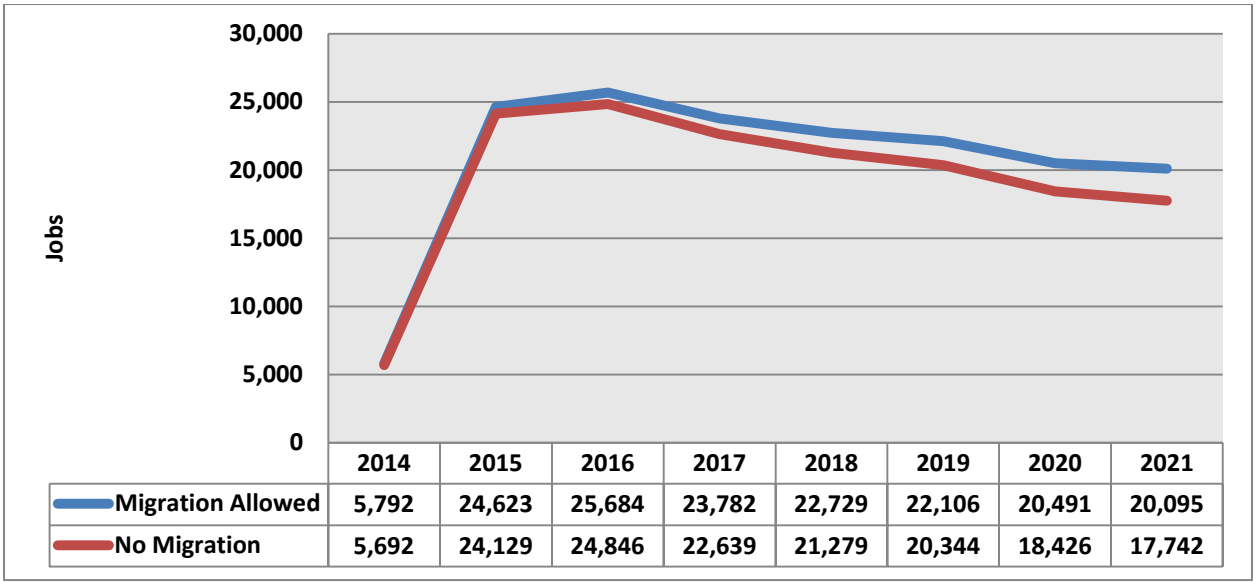
ECONOMIC IMPACT RESULTS

This section describes the results of the simulation. It included major economic indicators for the state of North Carolina in cases between non-expansion (which included the woodwork effect) and expansion under the ACA. To return to *Figure 2*, the blue line was the former situation while the red line was the latter. From the PI^+ model, this was the expected impact or difference from adding the Medicaid expansion to North Carolina. We subtracted state government spending to cover any anticipated need for state funds to make up for the ~10% not covered by federal money in later years. Each result had three lines: a baseline "zero" (which was the model's forecast of the state after the woodwork effect alone), one including economic migration, and one that did not include economic migration. The total scale and effect of migratory effects would depend on the decisions of other states throughout the South and the whole United States. If more states opted-in to the program, then the impact would trend closer to the non-migration situation. If fewer states chose to participate in the ACA, then North Carolina (and other states undergoing expansion) would have a larger migratory effect. These results were predictions, and they were not intended to be absolutely accurate. **They were meant to give a sense of scale towards the impact of the federal dollars for Medicaid expansion in the state**.

[19] Please see n. 5 on p. 3

[20] "Affordable Care Act Tax Provisions," *Internal Revenue Service*, December 2012, <www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>

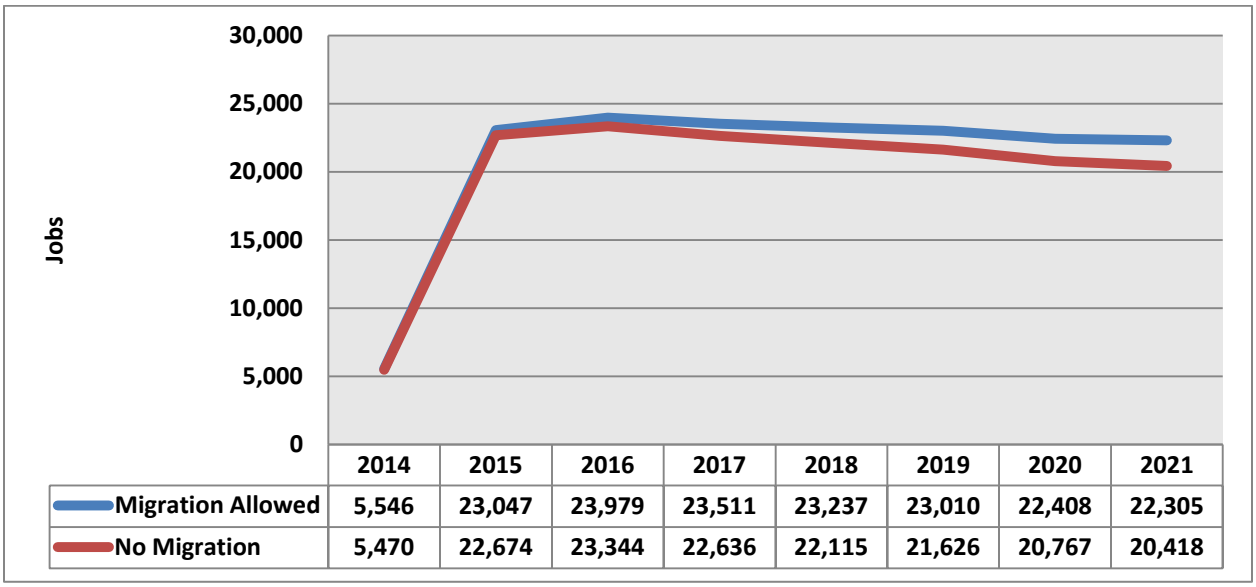
Total Employment



	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	5,792	24,623	25,684	23,782	22,729	22,106	20,491	20,095
No Migration	5,692	24,129	24,846	22,639	21,279	20,344	18,426	17,742

Figure 3 – This shows the total employment impact to North Carolina between expansion and non-expansion with the migration equation either on or off. The zero line here is a base case of the state economy, including the woodwork effect but without expansion. The flow of federal dollars into the healthcare sector generated a positive impact in the state, though gradually-improving labor productivity and the need for the state to redirect its internal funds to its portion caused the slightly-downward trend starting in 2016 and towards 2021.

Private Non-Farm Employment



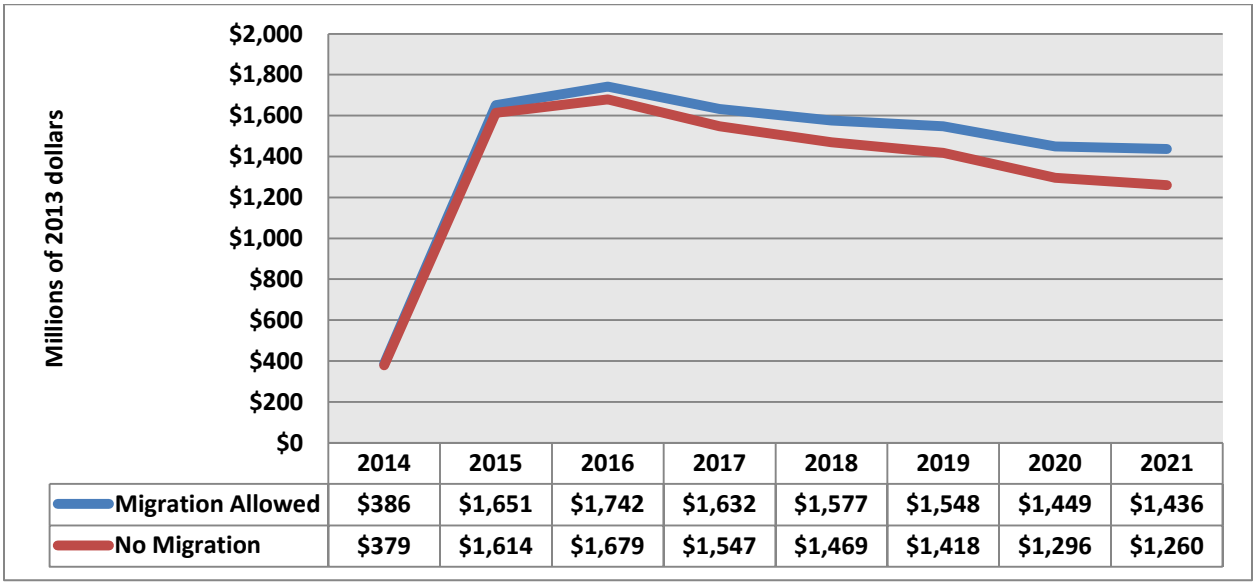
	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	5,546	23,047	23,979	23,511	23,237	23,010	22,408	22,305
No Migration	5,470	22,674	23,344	22,636	22,115	21,626	20,767	20,418

Figure 4 – This shows the same graph including only private non-farm employment in the NAICS industries. Therefore, the graph was flatter in the later years of the impact.

The difference between total employment and private non-farm employment was naturally public employment. This includes employment at the state-, local-, and federal-levels. Since state spending decreased in other areas relative to the baseline to pay for the ACA expansion, public employment was actually slightly lower in the alternative cases. For instance, in 2019, total employment rose 22,106 (when allowing migration) and private non-farm employment rose 23,010, which means public employment must have fell by 904 in the simulation. This subtractive exercise would lead the same results between different years and settings.

One should note that these numbers represented "job-years," rather than a rolling total of job creation.[21] The PI$^+$ model used the BEA's definition of employment, which is a "labor demanded" concept rather than an idea of "how many people have a job" at a moment. That headcount methodology came from the BLS, and they feature it in the monthly job and unemployment figures. The numbers above represented the number of "roster slots" available from business or government at the prevailing wage conditions during a time period. To read it, for example, one could say that total employment in 2019 is 22,106 jobs greater, which means that there are 22,106 more jobs available and occupied than in the baseline. It did not mean that 22,106 new jobs began that year or 22,106 more people have a job (when accounting for people who work multiple jobs or commute in or out of North Carolina for work), but it did mean there was more work in the state to such degree.

Gross Domestic Product (GDP)



	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	$386	$1,651	$1,742	$1,632	$1,577	$1,548	$1,449	$1,436
No Migration	$379	$1,614	$1,679	$1,547	$1,469	$1,418	$1,296	$1,260

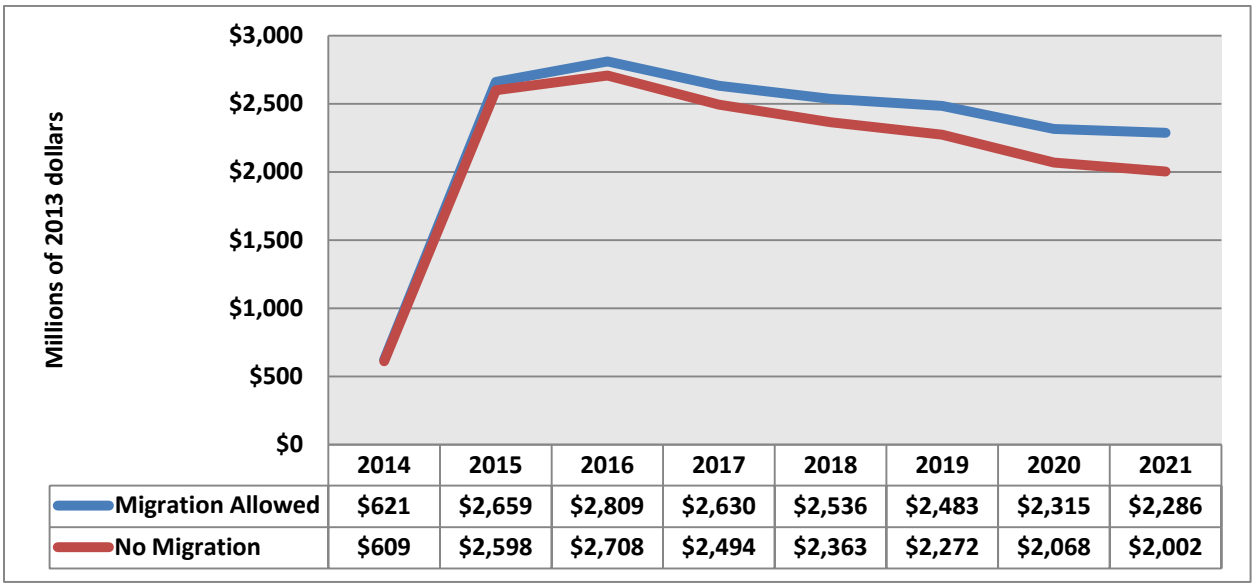
Figure 5 – This shows the GDP impact in North Carolina from the expansion. Much of the pattern is the same as employment concepts, because the expansion brings more direct medical spending and spinoffs to the state before a reduction in government spending drives the lines down slightly after 2016. Do note that this is in an inflation-adjusted dollar; therefore, these numbers are comparable across the timeframe from 2014 to 2021 in their values.

GDP reproduces annually, and hence it is sensible to sum it across years. From 2014 to 2021, from the above results, the state gained $11.042 billion in GDP when averaging the impact amid the migration and non-migration

[21] Tim Fernholz, "What the Heck is a Job-Year," *The American Prospect*, May 2009, <http://prospect.org/article/what-heck-job-year>

scenarios. This gave an average impact on an annual basis of $1.380 billion for the six years of the expansion above. One could do the same exercise with job-years on *Figure 3* and *Figure 4*.

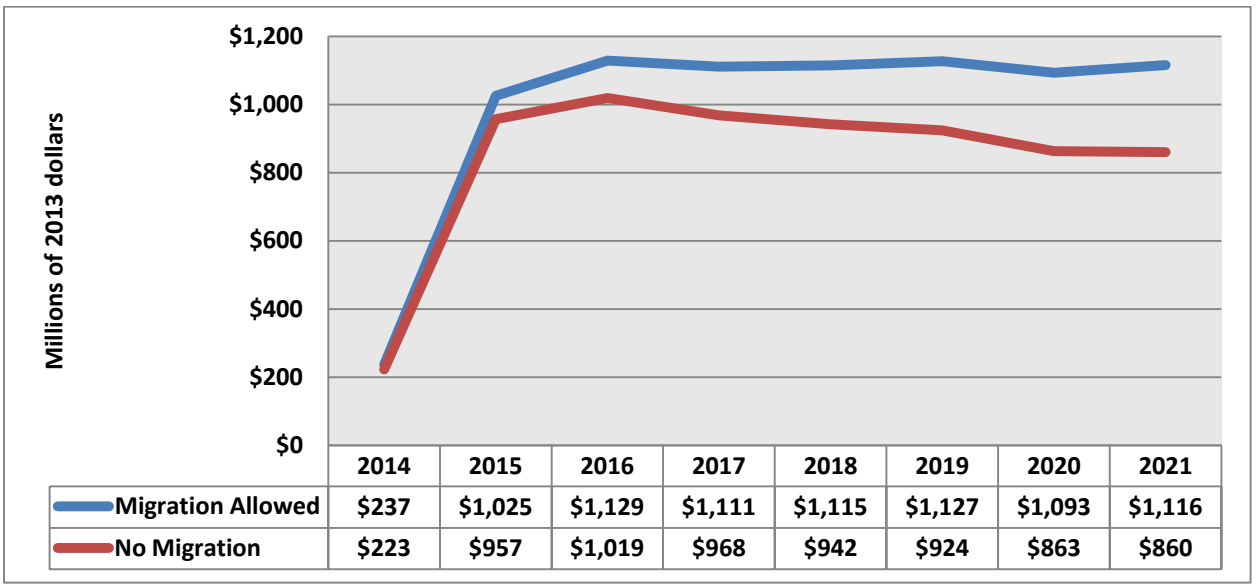
Business Sales/Output



	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	$621	$2,659	$2,809	$2,630	$2,536	$2,483	$2,315	$2,286
No Migration	$609	$2,598	$2,708	$2,494	$2,363	$2,272	$2,068	$2,002

Figure 6 – The above reports what the PI+ model calls "output," which is an equivalent concept to total production or sales orders. In the long-run, businesses only produce if they are able to sell wares, so these numbers represent either conception. Much of the pattern in the lines was the same. One should read it as, for example in 2016, the model for Medicaid expansion (in the non-migration scenario) predicted business sales in North Carolina would increase by $2.809 billion over a baseline simulation without the expansion but including the woodwork effect.

Real Disposable Personal Income

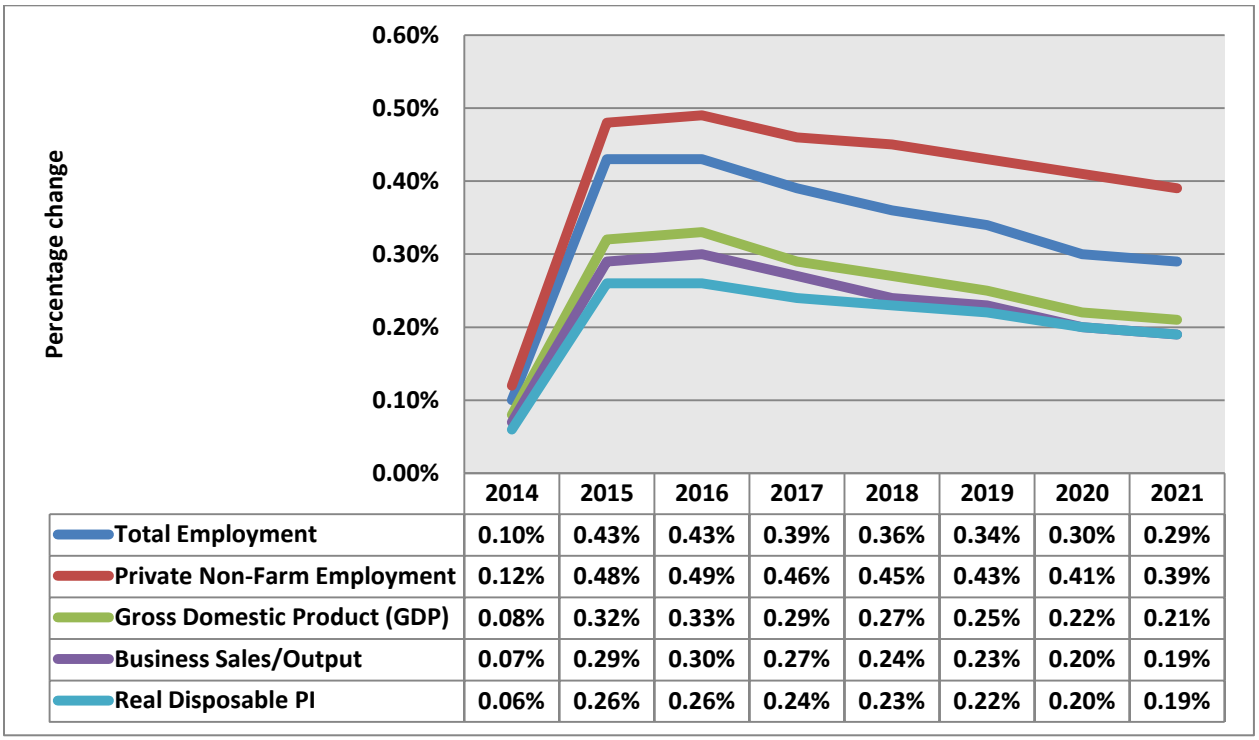


	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	$237	$1,025	$1,129	$1,111	$1,115	$1,127	$1,093	$1,116
No Migration	$223	$957	$1,019	$968	$942	$924	$863	$860

FIGURE 7 – THIS SHOWS THE TOTAL AMOUNT OF AFTER-TAX PERSONAL INCOME ASSOCIATED WITH THE MEDICAID EXPANSION IN NORTH CAROLINA. THE REMI MODEL ADJUSTS FOR PRICES AND THE COST OF LIVING, AND THEREFORE THE ABOVE TOOK ACCOUNT OF ANY CHANGES TO THE COST OF HOUSING OR CONSUMER GOODS. THE TREND IS MUCH THE SAME AS OTHER GRAPHS, THOUGH THE BLUE LINE DOES SOMETHING NOVEL. ADDITIONAL ECONOMIC MIGRATION MEANS MORE PEOPLE IN NORTH CAROLINA THAN OTHERWISE, AND THOSE ADDITIONAL PEOPLE BRING MORE CONSUMPTION, DEMAND FOR HOUSING STOCK, AND NEED FOR GOVERNMENT SERVICES (SUCH AS EDUCATION OR POLICE AND FIRE PROTECTION). THIS DRIVES THE TOTAL AMOUNT OF JOBS, GDP, AND PERSONAL INCOME UPWARDS, WHILE THE RED LINE DOES NOT DISPLAY A SIMILAR PATTERN UPWARDS.

PERCENTAGE CHANGES

The next section detailed the impact to these major indicators in proportional terms. In 2012, the North Carolina economy produced approximately $380 billion in GDP and had a total "job stock" of around 5.4 million with around 4.5 million of those in the private sector. The above were sizeable impacts in absolute terms, but they were still important to conceptualize the Medicaid expansion against the rest of the economy. Medicaid and healthcare was an important driver to the state economy, as one can see from *Figure 9* below.



	2014	2015	2016	2017	2018	2019	2020	2021
Total Employment	0.10%	0.43%	0.43%	0.39%	0.36%	0.34%	0.30%	0.29%
Private Non-Farm Employment	0.12%	0.48%	0.49%	0.46%	0.45%	0.43%	0.41%	0.39%
Gross Domestic Product (GDP)	0.08%	0.32%	0.33%	0.29%	0.27%	0.25%	0.22%	0.21%
Business Sales/Output	0.07%	0.29%	0.30%	0.27%	0.24%	0.23%	0.20%	0.19%
Real Disposable PI	0.06%	0.26%	0.26%	0.24%	0.23%	0.22%	0.20%	0.19%

FIGURE 8 – THIS SHOWS THE PERCENTAGE IMPACT ON INDICATORS FROM THE PROGRAM. FOR THIS CHART, WE AVERAGED THE IMPACT BETWEEN THE CASES OF NON-MIGRATION AND MIGRATION. EMPLOYMENT CONCEPTS ROSE FASTER THAN MACROECONOMIC MEASURES. THIS WAS BECAUSE HEALTHCARE AND ITS SUPPLY CHAIN WERE RELATIVELY LABOR-INTENSIVE INDUSTRIES WHEN COMPARED TO THINGS LIKE THE NATURAL RESOURCES, SHIPPING, AGRICULTURE, OR MANUFACTURING. THIS LEADS TO A HIGH RATIO OF "JOBS TO GDP." PRIVATE NON-FARM EMPLOYMENT NUMBERS ROSE MORE THAN TOTAL EMPLOYMENT, WHICH REFLECTED THE CUTBACKS FROM THE EXPANSION IN STATE SPENDING IN OTHER ARENAS. OVERALL, THE EXPANSION REPRESENTED ABOUT 0.33% OF THE STATE'S ECONOMY, WHICH MEANS IT WAS A FACTOR OF SOME SIGNIFICANCE.

Fiscal Impact

Directly modeling the fiscal impact of Medicaid expansion to North Carolina was not an object of this study. To do this, we would require another model, REMI Tax-PI,[22] and additional data and assumptions about the state's budget and planning in the future. Tax-PI includes a customized budget module on top of a 1-region PI$^+$ model of the state. This involves revenue categories (income taxes, sales taxes, corporate taxes, fees, federal transfers, and more), expenditures (education, healthcare, transportation, corrections, and others), and how they change in response to forecasts and simulations of the state's economy and demography. It also includes assumptions about how the state balances its budget in the future, as well as how taxes and spending respond to policy changes at the state- or federal-level. This additional work would have required additional cost for NC DHHS and data from the revenue agencies—**given time and financial constraints, we did not use Tax-PI, but rather concentrated on PI$^+$ and the economic impacts of Medicaid expansion.**

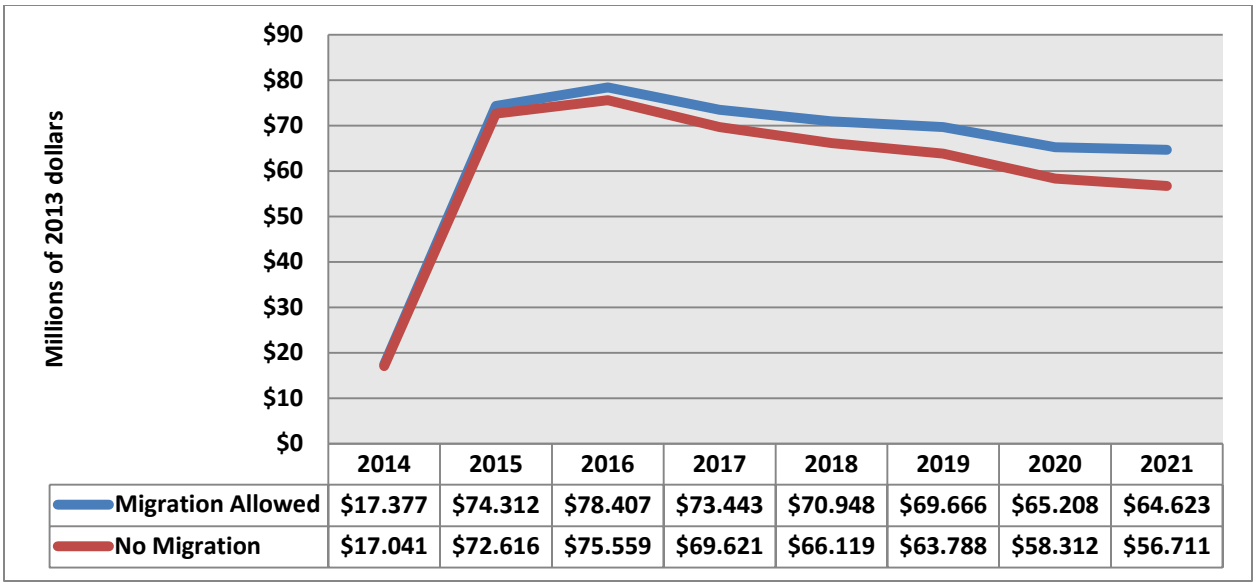
One can still estimate fiscal impacts based on the previous results. This was not as exact or detailed as Tax-PI and its breakdown of the state budget categories, but high-level indicators like GDP correlated closely with the total revenue collections of the state in the past. Researchers tracked revenue-to-GDP ratios at the federal-level,[23] and the same idea applied with the states. Using historical data from the North Carolina Office of State Budget and Management, we looked at revenues and how they compared to GDP over time:

Fiscal Year	North Carolina state tax revenues (Millions of nominal dollars)[24]	North Carolina GDP (Millions of nominal dollars)	Revenue-to-GDP Ratio
FY2010	$17,745.0	$377,811.2	4.70%
FY2011	$18,092.2	$396,735.5	4.56%
FY2012	$18,871.4	$414,531.4	4.55%

Figure 9 – This showed that, historically since the last recession in 2008, North Carolina tended to bring in just above 4.5% of its GDP in tax revenues. GDP is meant as a measurement of the total amount of economic activity occurring in an area. Therefore, it was easy to imagine the additional jobs, production, and personal income behind that GDP leading to state tax revenues in the form of income taxes, sales taxes, and various fees in the state's jurisdiction.

Applying the 4.5% ratio of revenue-to-GDP generated an estimate of additional revenue for the state. There were several cautions behind this methodology. Households and firm's decision-making is a complicated process, and state budgets are complex things with many idiosyncrasies. REMI designed Tax-PI to capture much of this, but that model was not available. Conversely, revenue was never the whole story. Modifying Medicaid on a state-level changed household cost of living, the condition of the labor market, and the incentives for people to move in or out of the state. These changes in demography might change expenditure requirements for North Carolina—additional people requiring more roads, schools, police officers, and other services. It may change Medicaid spending, too, but more states undergoing this expansion would weaken this effect. While leaving these on the table was an assumption, $1.4 billion in additional annual GDP would generate substantial state tax revenues, and it would have the potential to overcome any needs for "carrying cost" expenditures.

[22] "Tax-PI," *REMI*, December 2012, <www.remi.com/products/tax-pi>
[23] "Historical Source of Revenue as Share of GDP," *Tax Policy Center*, April 2012, <www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=205>
[24] "Governor's Recommended Budget, 2011-2013," *North Carolina Office of State Budget and Management*, December 2012, <www.osbm.state.nc.us/new_content/historical_budget_data.pdf>



	2014	2015	2016	2017	2018	2019	2020	2021
Migration Allowed	$17.377	$74.312	$78.407	$73.443	$70.948	$69.666	$65.208	$64.623
No Migration	$17.041	$72.616	$75.559	$69.621	$66.119	$63.788	$58.312	$56.711

FIGURE 10 – THIS SHOWED THE ANTICIPATED REVENUE IMPACT OF MEDICAID EXPANSION IN NORTH CAROLINA, BASED ON THE ASSUMPTIONS AND METHODOLOGY ON P. 14 AND IN *FIGURE 9*. DO NOTE THAT THESE ARE CALENDAR AND NOT FISCAL YEARS. THIS REVEALED THE STATE COULD EXPECT AROUND $70 MILLION MORE IN ANNUAL REVENUE FROM THE MEDICAID EXPANSION WHEN COMPARED TO NON-EXPANSION. FROM THERE, THE STATE COULD "RECYCLE" THIS MONEY BACK THROUGH THE BUDGET AND ECONOMY VIA ADDITIONAL SPENDING, INCENTIVES, OR GENERAL TAX RELIEF. THESE WOULD HAVE ECONOMIC IMPACTS, TOO. REMI CALLED THIS "FEEDBACK" IN THE TAX-PI MODEL, BUT THE PI$^+$ BUILD HERE DID NOT INCLUDE ANY RECYCLING. THIS ADDITIONAL MONEY WOULD HAVE TO BALANCE WITH ANY CHANGE IN EXPENDITURES FROM LABOR MARKET CONDITIONS OR MIGRATION.

DATA TABLES

This section detailed the results in industry-level and occupational-level impacts. The industries followed the NAICS while the occupations follow the BLS' Standard Occupational Classification (SOC) codes.[25] We averaged the impact between the migration and non-migration scenarios (the same as the percentage changes in *Figure 9*). A 70-sector REMI model does not exactly follow the NAICS codes at any particular level; those 70-sectors approximated 3-digit NAICS.[26] Different industries should expect different impacts from the ACA, and those industries either in the healthcare sector or within their supply chain have the strongest impacts. Some other industries (such as retail or construction, which related closely to housing) collected much of the additional wages paid to households in the simulation, which accounted for their positive impacts. Some industries had slightly negative numbers owing to their closeness to state government spending or their high productivity. High productivity industries do not require much labor, so there is not much of an impact to jobs. The occupational distribution gives an impression of the socioeconomics of Medicaid expansion. Industries and governments hire all sorts of workers, which we had in *Table 3*. **Do note, this was not meant as an absolute representation of the expansion's impact, but rather a potential scenario—from given data and assumptions—for an impression of the distribution of the impact across industries and occupations**. The results were in keeping with this caveat.

[25] "Standard Occupational Classification," *Bureau of Labor Statistics*, December 2013, <www.bls.gov/SOC/>
[26] "NAICS Industries for PI$^+$ - Hierarchical v. 1.4," *REMI*, November 2012, <www.remi.com/download/documentation/pi+/pi+_version_1.4/NAICS_Industries_for_PI+-Hierarchical_v1.4.pdf>

TABLE 1 - BUSINESS SALES/OUTPUT BY INDUSTRY (MILLIONS OF 2013 DOLLARS)

NAICS Industries	2014	2015	2016	2017	2018	2019	2020	2021
Forestry and logging; Fishing, hunting, and trapping	$0.017	$0.043	-$0.082	-$0.241	-$0.389	-$0.521	-$0.639	-$0.723
Agriculture and forestry support activities	$0.013	$0.063	$0.061	$0.030	$0.009	-$0.005	-$0.029	-$0.038
Oil and gas extraction	$0.022	$0.098	$0.097	$0.070	$0.048	$0.030	$0.006	-$0.008
Mining (except oil and gas)	$0.013	$0.056	$0.047	$0.011	-$0.022	-$0.052	-$0.087	-$0.108
Support activities for mining	$0.010	$0.044	$0.057	$0.058	$0.054	$0.047	$0.038	$0.031
Utilities	$3.469	$15.073	$16.050	$14.725	$13.919	$13.393	$12.084	$11.777
Construction	$29.125	$141.295	$193.440	$195.985	$187.629	$175.036	$149.020	$131.975
Wood product manufacturing	$0.495	$2.260	$2.653	$2.342	$1.966	$1.592	$1.053	$0.717
Nonmetallic mineral product manufacturing	$0.757	$3.360	$3.839	$3.560	$3.240	$2.921	$2.406	$2.103
Primary metal manufacturing	$0.029	$0.072	-$0.140	-$0.413	-$0.667	-$0.887	-$1.077	-$1.190
Fabricated metal product manufacturing	$1.088	$4.819	$5.449	$5.021	$4.593	$4.189	$3.505	$3.165
Machinery manufacturing	$0.220	$0.987	$1.155	$1.100	$1.047	$0.996	$0.885	$0.871
Computer and electronic product manufacturing	$1.002	$4.229	$3.747	$2.421	$1.287	$0.340	-$0.689	-$1.203
Electrical equipment and appliance manufacturing	$0.256	$1.052	$0.814	$0.207	-$0.352	-$0.841	-$1.345	-$1.643
Motor vehicles, bodies and trailers, and parts manufacturing	$1.433	$6.090	$6.527	$6.155	$5.909	$5.713	$5.260	$5.179
Other transportation equipment manufacturing	$0.031	$0.107	$0.025	-$0.088	-$0.191	-$0.281	-$0.361	-$0.410
Furniture and related product manufacturing	$0.354	$1.412	$1.098	$0.514	$0.013	-$0.406	-$0.819	-$1.046
Miscellaneous manufacturing	$0.448	$1.867	$1.882	$1.735	$1.629	$1.548	$1.428	$1.354
Food manufacturing	$0.521	$2.062	$1.518	$0.631	-$0.120	-$0.743	-$1.350	-$1.705
Beverage and tobacco product manufacturing	$0.705	$2.985	$2.949	$2.338	$1.906	$1.590	$1.117	$0.927
Textile mills; Textile product mills	$0.040	$0.120	-$0.062	-$0.274	-$0.457	-$0.605	-$0.727	-$0.792
Apparel manufacturing; Leather and allied product manufacturing	$0.117	$0.494	$0.498	$0.433	$0.383	$0.345	$0.293	$0.272
Paper manufacturing	$0.670	$2.858	$2.918	$2.511	$2.253	$2.073	$1.746	$1.621
Printing and related support activities	$0.851	$3.657	$3.785	$3.339	$3.095	$2.957	$2.619	$2.533
Petroleum and coal products manufacturing	$0.337	$1.523	$1.665	$1.444	$1.287	$1.172	$0.934	$0.845
Chemical manufacturing	$13.653	$55.930	$55.141	$51.918	$49.649	$47.752	$45.496	$44.358
Plastics and rubber product manufacturing	$1.282	$5.412	$5.476	$4.802	$4.254	$3.784	$3.144	$2.806
Wholesale trade	$23.940	$101.707	$106.809	$101.157	$98.244	$96.477	$90.897	$90.213
Retail trade	$40.112	$169.879	$180.287	$176.989	$176.119	$175.840	$170.953	$171.729
Air transportation	$0.189	$0.793	$0.589	$0.191	-$0.158	-$0.452	-$0.755	-$0.988
Rail transportation	$0.013	$0.051	$0.030	-$0.010	-$0.046	-$0.078	-$0.109	-$0.129
Water transportation	$0.005	$0.019	$0.015	$0.007	-$0.001	-$0.007	-$0.014	-$0.017
Truck transportation	$1.013	$4.294	$4.407	$3.927	$3.543	$3.213	$2.720	$2.495
Couriers and messengers	$0.422	$1.749	$1.737	$1.593	$1.488	$1.398	$1.274	$1.225
Transit and ground passenger transportation	$22.551	$92.221	$94.749	$96.700	$99.248	$101.409	$103.353	$105.478
Pipeline transportation	$0.001	$0.004	-$0.002	-$0.009	-$0.016	-$0.021	-$0.026	-$0.029
Scenic transportation; Support activities for transportation	$0.024	$0.056	-$0.126	-$0.359	-$0.581	-$0.788	-$0.983	-$1.129
Warehousing and storage	$0.036	$0.095	-$0.159	-$0.477	-$0.770	-$1.029	-$1.263	-$1.432
Publishing industries, except Internet	$1.348	$5.923	$6.520	$6.219	$6.131	$6.173	$5.933	$6.120
Motion picture and sound recording industries	$0.032	$0.127	$0.119	$0.096	$0.077	$0.062	$0.044	$0.039
Internet publishing and broadcasting; ISPs, search portals, and data	$1.422	$6.314	$6.889	$6.338	$6.096	$6.038	$5.595	$5.672
Broadcasting, except Internet	$0.604	$2.515	$2.427	$2.046	$1.755	$1.521	$1.223	$1.077
Telecommunications	$3.477	$14.929	$15.235	$13.184	$11.711	$10.587	$8.767	$8.102
Credit intermediation; Funds, trusts, & other financial	$12.207	$51.576	$52.399	$46.750	$42.465	$38.893	$33.483	$31.338
Securities, commodity contracts, investments	$1.545	$6.422	$5.533	$3.551	$1.786	$0.202	-$1.556	-$2.581
Insurance carriers and related activities	$5.855	$24.089	$24.741	$24.648	$24.767	$24.879	$24.780	$24.970
Real estate	$37.902	$161.168	$171.032	$162.774	$154.707	$146.750	$134.082	$128.270
Rental and leasing services; Leasers of nonfinancial assets	$3.437	$14.702	$15.541	$14.500	$13.726	$13.074	$11.842	$11.470
Professional, scientific, and technical services	$12.856	$55.250	$56.143	$47.334	$40.770	$35.779	$28.287	$25.504
Management of companies and enterprises	$1.910	$7.324	$5.177	$2.381	-$0.260	-$2.700	-$4.909	-$6.429
Administrative and support services	$15.626	$65.946	$67.359	$62.101	$58.935	$56.746	$52.347	$51.238
Waste management and remediation services	$0.847	$3.941	$4.157	$3.019	$2.344	$1.945	$1.019	$0.710
Educational services	$1.166	$5.093	$5.684	$5.429	$5.292	$5.225	$4.888	$4.893
Ambulatory health care services	$213.856	$877.362	$898.826	$906.454	$921.982	$935.499	$944.233	$959.967
Hospitals	$140.619	$574.920	$589.131	$598.211	$611.004	$621.596	$630.787	$641.891
Nursing and residential care facilities	$2.025	$8.747	$9.073	$8.088	$7.494	$7.123	$6.320	$6.162
Social assistance	$0.314	$1.422	$1.643	$1.596	$1.612	$1.659	$1.602	$1.633
Performing arts and spectator sports	$1.165	$5.003	$5.348	$5.042	$4.858	$4.733	$4.393	$4.320
Museums, historical sites, zoos, and parks	$0.135	$0.582	$0.637	$0.627	$0.626	$0.632	$0.617	$0.631
Amusement, gambling, and recreation	$0.775	$3.291	$3.371	$3.031	$2.789	$2.604	$2.296	$2.198
Accommodation	$1.170	$4.839	$4.424	$3.279	$2.329	$1.537	$0.641	$0.165
Food services and drinking places	$7.667	$32.933	$35.583	$34.092	$33.499	$33.313	$31.673	$31.803
Repair and maintenance	$3.323	$14.399	$15.154	$13.593	$12.635	$12.011	$10.587	$10.221
Personal and laundry services	$3.868	$16.306	$16.464	$14.771	$13.690	$12.909	$11.496	$11.080
Membership associations and organizations	$1.689	$7.145	$7.419	$6.786	$6.269	$5.848	$5.246	$5.085
Private households	$0.310	$1.302	$1.312	$1.172	$1.079	$1.009	$0.893	$0.876

TABLE 2 - INDUSTRY-LEVEL EMPLOYMENT (JOB-YEARS)

NAICS Industries	2014	2015	2016	2017	2018	2019	2020	2021
Forestry and logging; Fishing, hunting, and trapping	0	0	-1	-2	-3	-4	-5	-5
Agriculture and forestry support activities	0	2	2	0	0	-1	-2	-2
Oil and gas extraction	0	0	0	0	0	0	0	0
Mining (except oil and gas)	0	0	0	0	-1	-1	-1	-1
Support activities for mining	0	0	0	0	0	0	0	0
Utilities	4	19	19	17	15	14	12	11
Construction	288	1,379	1,852	1,836	1,717	1,564	1,294	1,115
Wood product manufacturing	2	9	10	8	7	5	2	1
Nonmetallic mineral product manufacturing	3	11	12	11	9	8	6	4
Primary metal manufacturing	0	0	-1	-1	-2	-2	-2	-2
Fabricated metal product manufacturing	4	18	19	17	14	12	9	8
Machinery manufacturing	1	3	3	2	2	1	1	0
Computer and electronic product manufacturing	2	8	6	2	0	-2	-4	-5
Electrical equipment and appliance manufacturing	1	3	2	0	-2	-3	-4	-5
Motor vehicles, bodies and trailers, and parts manufacturing	3	10	10	9	8	7	6	6
Other transportation equipment manufacturing	0	0	0	-1	-1	-1	-2	-2
Furniture and related product manufacturing	2	7	5	1	-2	-4	-7	-8
Miscellaneous manufacturing	2	8	7	6	5	4	4	3
Food manufacturing	1	4	2	-1	-4	-6	-8	-10
Beverage and tobacco product manufacturing	1	2	2	1	1	0	-1	-1
Textile mills; Textile product mills	0	0	-1	-3	-4	-5	-5	-6
Apparel manufacturing; Leather and allied product manufacturing	1	4	4	3	3	2	2	1
Paper manufacturing	1	6	6	4	3	3	2	1
Printing and related support activities	5	19	19	16	14	13	11	10
Petroleum and coal products manufacturing	0	1	1	1	1	1	0	0
Chemical manufacturing	16	61	58	52	47	43	39	36
Plastics and rubber product manufacturing	4	16	15	12	10	8	5	4
Wholesale trade	110	457	465	425	398	378	342	328
Retail trade	536	2,213	2,273	2,158	2,077	2,010	1,892	1,842
Air transportation	1	2	1	0	-2	-3	-4	-5
Rail transportation	0	0	0	0	0	0	0	0
Water transportation	0	0	0	0	0	0	0	0
Truck transportation	6	24	21	14	9	3	-2	-6
Couriers and messengers	4	14	13	11	9	8	6	5
Transit and ground passenger transportation	371	1,510	1,537	1,556	1,582	1,604	1,621	1,638
Pipeline transportation	0	0	0	0	0	0	0	0
Scenic transportation; Support activities for transportation	0	0	-2	-4	-6	-8	-10	-11
Warehousing and storage	0	0	-3	-7	-11	-14	-16	-18
Publishing industries, except Internet	4	15	15	12	11	10	8	8
Motion picture and sound recording industries	0	1	0	0	-1	-1	-1	-1
Internet publishing and broadcasting; ISPs, search portals, and data	3	14	14	12	11	10	8	8
Broadcasting, except Internet	2	8	7	6	4	4	3	2
Telecommunications	6	26	25	20	17	14	11	9
Credit intermediation; Funds, trusts, & other financial	28	113	106	85	68	54	38	29
Securities, commodity contracts, investments	12	49	38	20	4	-9	-23	-31
Insurance carriers and related activities	25	101	101	97	95	93	90	89
Real estate	115	482	499	462	426	392	346	320
Rental and leasing services; Leasers of nonfinancial intangible assets	8	34	34	30	27	24	20	18
Professional, scientific, and technical services	90	382	376	302	246	203	145	120
Management of companies and enterprises	9	33	19	5	-8	-19	-28	-34
Administrative and support services	254	1,054	1,049	940	867	812	727	693
Waste management and remediation services	4	19	20	14	11	8	4	2
Educational services	16	70	76	71	68	66	61	60
Ambulatory health care services	2,199	9,051	9,253	9,332	9,483	9,618	9,708	9,855
Hospitals	1,004	4,085	4,137	4,159	4,209	4,249	4,280	4,322
Nursing and residential care facilities	27	117	113	91	76	65	49	42
Social assistance	5	23	23	19	16	14	11	9
Performing arts and spectator sports	16	67	69	63	59	56	50	48
Museums, historical sites, zoos, and parks	1	4	5	4	4	4	4	4
Amusement, gambling, and recreation	15	63	64	55	50	45	38	35
Accommodation	10	42	37	25	16	9	1	-4
Food services and drinking places	125	528	557	519	498	484	448	441
Repair and maintenance	33	142	146	128	116	107	92	86
Personal and laundry services	60	248	245	214	193	178	154	144
Membership associations and organizations	23	95	96	84	75	67	58	54
Private households	44	184	180	157	141	129	111	107

TABLE 3 - OCCUPATIONAL-LEVEL EMPLOYMENT (JOBS-YEARS)

SOC Occupations	2014	2015	2016	2017	2018	2019	2020	2021
Top executives	62	270	281	236	208	188	151	137
Advertising, marketing, promotions, public relations, and sales managers	11	47	47	42	38	35	31	29
Operations specialties managers	35	151	153	127	111	101	81	74
Other management occupations	87	374	393	361	340	325	293	281
Business operations specialists	85	379	397	321	274	243	180	157
Financial specialists	47	205	206	153	119	95	54	38
Computer occupations	60	259	261	214	184	165	129	117
Mathematical science occupations	2	9	9	7	6	5	3	3
Architects, surveyors, and cartographers	2	11	12	8	6	4	1	0
Engineers	15	71	74	50	35	25	6	-1
Drafters, engineering technicians, and mapping technicians	8	39	41	26	16	10	-2	-7
Life scientists	8	36	37	31	27	25	21	19
Physical scientists	4	21	21	12	6	3	-3	-5
Social scientists and related workers	12	54	55	46	41	39	33	31
Life, physical, and social science technicians	6	27	28	19	14	11	4	2
Counselors and Social workers	83	359	368	321	298	288	256	249
Miscellaneous community and social service specialists	30	139	143	100	77	65	34	25
Religious workers	6	25	26	24	23	22	21	21
Lawyers, judges, and related workers	10	49	50	20	2	-7	-29	-36
Legal support workers	5	26	26	15	8	3	-6	-8
Postsecondary teachers	5	22	23	21	21	20	19	19
Preschool, primary, secondary, and special education school teachers	8	37	39	34	31	29	25	24
Other teachers and instructors	5	22	22	17	14	12	8	7
Librarians, curators, and archivists	4	24	25	5	-6	-11	-25	-29
Other education, training, and library occupations	5	23	25	17	13	10	5	3
Art and design workers	8	34	35	30	27	25	21	20
Entertainers and performers, sports and related workers	6	27	28	22	18	16	12	10
Media and communication workers	10	45	46	38	34	31	26	24
Media and communication equipment workers	2	10	10	8	7	6	4	4
Health diagnosing and treating practitioners	874	3,591	3,661	3,662	3,702	3,741	3,755	3,799
Health technologists and technicians	491	2,021	2,056	2,033	2,037	2,046	2,033	2,049
Other healthcare practitioners and technical occupations	14	57	58	54	53	52	50	50
Nursing, psychiatric, and home health aides	278	1,167	1,207	1,206	1,226	1,250	1,260	1,280
Occupational therapy and physical therapist assistants and aides	38	160	165	167	172	176	179	182
Other healthcare support occupations	338	1,380	1,398	1,392	1,399	1,404	1,400	1,413
Supervisors of protective service workers	7	40	42	7	-13	-23	-48	-56
Fire fighting and prevention workers	9	58	61	6	-25	-41	-80	-92
Law enforcement workers	35	223	236	25	-91	-152	-301	-346
Other protective service workers	45	199	202	157	130	115	81	70
Supervisors of food preparation and serving workers	14	58	60	54	50	48	43	41
Cooks and food preparation workers	50	210	216	195	183	175	157	152
Food and beverage serving workers	94	396	412	381	362	350	322	315
Other food preparation and serving related workers	18	75	78	70	65	62	55	53
Supervisors of building and grounds cleaning and maintenance workers	8	34	34	27	23	21	16	14
Building cleaning and pest control workers	105	437	439	393	364	343	308	295
Grounds maintenance workers	29	128	132	103	86	75	53	45
Supervisors of personal care and service workers	4	19	20	13	9	7	2	1
Animal care and service workers	5	20	21	18	16	15	13	12
Entertainment attendants and related workers	10	47	49	29	18	11	-4	-9
Funeral service workers	3	13	13	11	10	9	8	8
Personal appearance workers	23	97	97	87	81	76	67	64
Baggage porters, bellhops, and concierges; Tour and travel guides	2	8	8	7	6	5	4	4
Other personal care and service workers	129	553	577	556	555	562	552	558
Supervisors of sales workers	46	192	197	185	177	170	158	154
Retail sales workers	283	1,175	1,207	1,134	1,084	1,043	971	942
Sales representatives, services	27	111	112	100	91	83	72	67
Sales representatives, wholesale and manufacturing	33	141	147	135	126	118	106	100
Other sales and related workers	31	130	135	124	114	106	94	88
Supervisors of office and administrative support workers	81	340	347	321	305	296	275	269
Communications equipment operators	11	43	42	38	36	33	30	29

Financial clerks	172	719	736	686	654	631	588	574
Information and record clerks	288	1,210	1,229	1,123	1,064	1,029	950	930
Material recording, scheduling, dispatching, and distributing workers	108	454	461	411	379	357	316	301
Secretaries and administrative assistants	280	1,177	1,208	1,139	1,103	1,082	1,028	1,018
Other office and administrative support workers	174	745	767	672	615	580	503	479
Supervisors of farming, fishing, and forestry workers	0	1	1	0	0	0	-1	-1
Agricultural workers	2	11	11	8	6	5	3	2
Fishing and hunting workers	0	0	0	0	0	-1	-1	-1
Forest, conservation, and logging workers	0	2	1	0	-1	-2	-3	-3
Supervisors of construction and extraction workers	20	99	129	120	108	95	72	59
Construction trades workers	168	803	1,050	1,002	918	826	658	556
Helpers, construction trades	13	61	82	81	76	69	57	49
Other construction and related workers	11	63	71	31	8	-6	-37	-48
Extraction workers	1	5	6	6	6	5	4	3
Supervisors of installation, maintenance, and repair workers	12	55	60	50	44	39	30	27
Electrical and electronic equipment mechanics, installers, and repairers	11	50	55	49	43	39	32	28
Vehicle and mobile equipment mechanics, installers, and repairers	49	211	219	195	181	171	151	144
Other installation, maintenance, and repair occupations	81	361	398	345	306	275	216	190
Supervisors of production workers	6	24	25	19	15	12	7	6
Assemblers and fabricators	15	63	63	55	49	44	37	33
Food processing workers	9	37	38	34	32	30	28	26
Metal workers and plastic workers	11	48	51	45	40	35	28	24
Printing workers	3	13	12	10	9	8	6	6
Textile, apparel, and furnishings workers	13	53	52	44	39	35	30	28
Woodworkers	2	8	8	7	5	4	2	1
Plant and system operators	6	32	33	13	2	-4	-18	-22
Other production occupations	31	130	130	115	104	95	83	77
Supervisors of transportation and material moving workers	13	53	55	49	46	43	39	37
Air transportation workers	2	10	9	8	8	7	6	6
Motor vehicle operators	328	1,353	1,386	1,347	1,334	1,328	1,296	1,292
Rail transportation workers	1	4	4	2	1	1	-1	-1
Water transportation workers	0	1	1	0	0	0	-1	-1
Other transportation workers	17	70	71	63	59	56	50	49
Material moving workers	81	345	354	304	270	245	202	184

APPENDIX E
DESCRIPTION OF SAFETY NET ORGANIZATIONS

This appendix describes many but not all types of safety net organizations in the North Carolina. Those included here participated in the Safety Net Workgroup or were referred to in safety net provisions of the ACA.

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the US Bureau of Primary Health Care under section 330 of the Public Health Services Act.[1] In order to be designated as an FQHC and receive federal funding, FQHCs must meet certain basic criteria. They must be located in a medically underserved area (MUA) or serve a medically underserved population (MUP) based on poverty and population health indicators. FQHCs must provide comprehensive primary and preventive health care services either directly or by contract regardless of a person's ability to pay. They must provide enabling and support services to improve access to health and social services (eg, case management, outreach, transportation, and interpretation and translation). FQHCs must have a community-based board of directors with a majority of board members who are active users of center services. They must have a schedule of fees similar to local health rates and apply a sliding fee scale based on patient income and family size. FQHCs must provide 24-hour/7-day coverage and offer clinic hours outside the typical 9 to 5 work schedule. Finally, they must have a quality assurance program and meet other program performance criteria.[2,3] FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted medications through the 340B federal prescription drug discount program (see 340B program expansion section). FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers.

In 2012, there were 34 FQHCs in North Carolina delivering care at 165 different sites. Of the 34 FQHCs, three are FQHC look-alikes providing services at 11 clinical sites.[4] A separate Migrant Voucher program provides grants and reimbursement for clinical and outreach services. FQHCs provided services to more than 450,000 patients, 52% of whom were uninsured. Ninety-five percent of North Carolina FQHC patients have incomes below 200% of the federal poverty level (FPL), and nearly 75% of them have Medicaid or no insurance. In addition to serving predominantly low income populations, North Carolina FQHCs also serve patients who are more racially and ethnically diverse than the state population.[5] Compared to other states, North Carolina FQHC patients are more likely to be uninsured (52% NC, 38% US). North Carolina FQHCs also rely more heavily on federal funding and self-pay than FQHCs in other states.[6,7]

FQHCs in North Carolina are cost-saving. The total annual cost per FQHC patient was $511 in 2011 compared to $569 for a single hospital emergency department visit. Medical visits are provided at an average cost of $124 per visit and just $165 per dental visit. In 2011, FQHCs brought $79 million federal dollars into the state of North Carolina. Health centers have been found to improve health outcomes, reduce health disparities, and lower the cost of treating patients with chronic illnesses.[8]

Local Health Departments

Public health departments are local government entities required by state law to provide certain core public health services. These services include communicable disease control, environmental health services, and vital records registration. They are a major source of care to the uninsured, but do not provide comprehensive primary care to all populations.[9]

There are 85 local public health departments in North Carolina. Of those, 79 are single county health departments while 6 multi-county district health departments cover the other 21 counties. All local public health departments provide child and adult immunizations, STD and HIV/AIDS testing and counseling, TB testing, family planning, and case management. Almost all health departments provide child health clinics, prenatal care, and nutrition services. Half of them provide dental services.[10] Health departments in North Carolina are more likely to provide clinical services than health departments in other states.[11,12] There are 39 local health departments that serve as primary care medical homes and 36 that offer adult primary care services.[13] Local health departments are funded largely through county funds, federal grants or Medicaid and NC Health Choice, and state funds. There is an accreditation process to ensure quality and consistency across the state. As of May 2012, 69 local health departments have been accredited.[14]

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. There is no specific free clinic model; rather free clinics are designed to meet the health care needs of the low-income uninsured in their local communities. Most free clinics offer primary care services and preventive services. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system—coordinated through local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.[15]

Volunteers are the cornerstone of the free clinic movement. Health care providers and staff volunteer their time to provide services and support to patients. Services are provided for free to the uninsured with incomes below a certain income threshold; others may be charged on a sliding fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.[16]

There are 81 free clinics in communities across North Carolina. Free clinics served approximately 79,500 patients in 2009, 87,000 patients in 2010, and 95,000 patients in 2011. Primary support for free clinics is through voluntary (donated) professional services and supplies, community fund raising, and the Blue Cross and Blue Shield of North Carolina Foundation. The Blue Cross and Blue Shield of North Carolina Foundation provided $18 million over eight years to expand and support free clinics through the North Carolina Association of Free Clinics.[17,18]

Rural Health Clinics

State-funded rural health clinics are nonprofit 501(c)(3) organizations with local boards of directors. They are located in geographic areas that do not have enough primary care resources to meet the needs of their communities. Rural health clinics provide primary care and routine

diagnostic and therapeutic care, including basic laboratory services, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental and behavioral health services or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.[19]

There are 86 certified rural health clinics in North Carolina. Of those, 28 rural health service delivery sites receive state funding from the Office of Rural Health and Community Care to help pay for indigent care. The funding is called the Medical Access Plan (MAP) for indigent patients. In order to receive MAP funding, rural health clinics must have a community board, agree to see the uninsured on a sliding scale basis, and be located in either a health professional shortage area (HPSA) or medically underserved area (MUA). The MAP funding is linked to uninsured patients with incomes below 200% FPL. Almost 65% of rural health clinic patients in North Carolina are uninsured.[20]

School-based or School-linked Health Centers

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.[21] A school-based health center is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration. Like other safety net organizations, not all health centers provide each of these services.[22] All centers require parents to sign written consents for their children to receive the full scope of services offered. Centers are monitored by advisory committees to ensure compliance with standards, to evaluate services offered, and to make policy recommendations.[23]

There are 55 school health centers serving 25 counties and 72 schools in North Carolina. Four additional counties are in planning stages. A growing number of centers serve as health access points for members of the community. Most of these are school-based health centers, several are school-linked health centers, a few health centers operate from traveling vans or buses enabling them to serve multiple schools, and five schools in western North Carolina are served through telemedicine. They are sponsored by health care organizations such as hospitals, health departments, universities, community health centers, and other non-profit health care organizations. School health centers are also partially funded by the School Health Center Unit in the Children and Youth Branch of the North Carolina Division of Public Health. Like health departments, there is a state credentialing process to provide standards for centers. As of November 2012, 24 school health centers have been credentialed.[24]

Other Safety Net Organizations

There are many other organizations that comprise the primary care safety net. Other communities have created non-profit safety net organizations to serve the needs of the uninsured. Examples include Guilford Child Health, Guilford Adult Health, and Alliance Medical Ministries. These organizations often work in partnership or are supported through local medical societies or hospitals. The North Carolina Medical Society Foundation recruits physicians, physician assistants, and nurse practitioners to underserved areas through the Community Practitioner Program. Participating providers must offer primary care services to uninsured

patients on a sliding fee scale. The program is funded by the Blue Cross and Blue Shield of North Carolina Foundation, Kate B. Reynolds Charitable Trust, The Duke Endowment, Golden Leaf Foundation, and other private donations. There are currently 40 private providers participating in the Community Practitioner Program in 33 communities across the state.

Specialty Care Referral Management Networks (Project Access Model)

Specialty care is often difficult for uninsured and underserved populations to access. Project Access organizes private providers and hospitals to expand the health care services that are available to low-income uninsured populations. The services offered vary across communities, but most focus on linking patients to volunteer primary care providers, specialists, and other services that are not available through existing primary care safety net providers. Services are typically provided for free or for a small fee. Project Access is financed primarily through donated services and goods, foundations, and other private funding sources. Safety net organizations and private providers often refer patients to the program in their communities. The Project Access model was developed in Asheville in 1996 and spread to 15 communities across the state.[25]

Care Share Health Alliance

Created in 2009, the Care Share Health Alliance works with state and local partners to facilitate and foster Collaborative Networks that improve the health of underserved people in North Carolina. A Collaborative Network is an entity comprised of multiple local partners who integrate medical, preventative, community, social, and economic resources to achieve collective outcomes through a coordinated system of care. The network has a shared vision and purpose, and priorities, strategies, and objectives are aligned to improve the health of the underserved.

Care Share's statewide technical assistance services help communities improve health by: 1) leveraging new and existing resources; 2) increasing the number of physician volunteers donating care; 3) increasing access to care and other health services; 4) developing common referral networks all providers can use; 5) expanding the continuum of care in local communities; 6) helping networks create efficient systems and become financially stronger; and 7) identifying new grant opportunities for the safety net.[26]

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1 Health Centers Consolidation Act of 1996, Pub L 104-299, amending Sec. 330 of the Public Health Service Act, 42 USC 254b.

2 North Carolina Institute of Medicine. Health Care Services for the Uninsured & Other Uninsured Populations: A Technical Assistance Manual. Morrisville, NC: North Carolina Institute of Medicine; 2008. http://www.nciom.org/wp-content/uploads/NCIOM/pubs/safetynet_tam.pdf. Accessed May 2, 2012.

3 North Carolina Institute of Medicine. Health Care Services for the Uninsured & Other Uninsured Populations: A Technical Assistance Manual. Morrisville, NC: North Carolina Institute of Medicine; 2008. http://www.nciom.org/wp-content/uploads/NCIOM/pubs/safetynet_tam.pdf. Accessed May 2, 2012.

4 FQHC look-alikes are organizations granted status by the Bureau of Primary Health Care (BPHC) for conforming to the structure and services of an FQHC. They receive no Section 330 grant funding but do receive FQHC Medicaid reimbursement rates and other benefits. Look-alikes do not report their service statistics to the BPHC and their data is not reflected in federal funds brought into the state.

5 North Carolina Community Health Center Association. Community Health Centers: Part of NC's Health Care Solution. http://ncchca.affiniscape.com/associations/11930/files/2012%20CHC%20report%20card%20-%20SINGLE%20SHEET.pdf. Published March 2012. Accessed April 12, 2012.

6 Health Resources and Services Administration. US Department of Health and Human Services. 2010 North Carolina Data. http://bphc.hrsa.gov/uds/view.aspx?year=2010&state=NC. Published May 10, 2011. Accessed April 9, 2012.

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[15] North Carolina Institute of Medicine. Health Care Services for the Uninsured & Other Uninsured Populations: A Technical Assistance Manual. Morrisville, NC: North Carolina Institute of Medicine; 2008. http://www.nciom.org/wp-content/uploads/NCIOM/pubs/safetynet_tam.pdf. Accessed May 2, 2012.

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[17] The Blue Cross and Blue Shield of North Carolina Foundation funding provides less than $30,000/year on average to free clinics, which is not enough to pay for one-full time administrative staff.

[18] North Carolina Association of Free Clinics. Fact Sheet. http://www.ncfreeclinics.org/siteres.aspx?resid=4721cb17-9ea1-40f4-b5c7-5d447d8e09aa. Accessed May 2, 2012.

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APPENDIX F
TRANSITIONS OF CARE SUBCOMMITTEE

INTRODUCTION

Effectively managing patient transitions between settings of care (eg, from hospital to primary care, or from community to nursing home) is one of the most important and most difficult challenges in improving the quality and reducing the cost of health care. The Patient Protection and Affordable Care Act (ACA) includes changes in Medicare payment meant to encourage hospitals to reduce readmissions. However, preventing readmissions and improving the success of transitions between other parts of the health care system will require strategies that bridge the traditional separation of providers across settings.

Under the ACA, hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions (heart attacks, heart failure, and pneumonia), and the Secretary of Health and Human Services is given the authority to expand the policy to additional conditions in future years. The Secretary is also directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).[1] The North Carolina Institute of Medicine (NCIOM) Health Reform Quality workgroup identified several gaps in addressing hospital readmissions, and the need to improve information transfer between providers to facilitate transitions in care. The workgroup also identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, shared savings models, information technology support, the forging of relationships between providers of care, and the need for new models of care within skilled nursing facilities that would reduce the number of patients transferred from skilled nursing facilities to emergency departments by facilitating assessment and care in place.

The ACA also includes many new provisions aimed at testing models to increase quality (without increasing spending), or reduce spending (without reducing quality). The Secretary is charged with evaluating these demonstrations to identify successful initiatives, and then will disseminate these financing and delivery models more widely throughout the country. One provision, Section 3026, appropriates $500 million for hospitals and community-based entities to furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

NCIOM's Quality and New Models of Care workgroups each recommended that a subcommittee discuss priorities and strategies for North Carolina to improve transitions of care in the context of the requirements and opportunities in the ACA.

The New Models of Care workgroup asked its subcommittee to:

- Explore the Transitional Care Model (Naylor),[2] and explore what DMA is implementing to determine if additional changes are needed to follow this evidence-based model.
- Explore the possibility of creating a multipayer demonstration for transition of care.

The Quality workgroup asked its subcommittee to:

- Discuss strategies for reducing preventable hospital readmissions, specifically in response to Sec. 3025 of the Affordable Care Act, which will start adjusting hospital payments in 2012 based on potentially preventable readmissions.

A joint subcommittee met on January 19, 2011. This document summarizes the subcommittee discussion and its recommendations for priority steps to improve transitions of care.

SUMMARY OF DISCUSSION

As the starting point for discussing existing transitions of care initiatives in North Carolina and exploring gaps, the subcommittee used a framework of evidence-based components of successful transitions of care compiled by Dr. Sam Cykert. See Table 1 for the subcommittee's working document, with notes on existing initiatives and gaps.

The subcommittee also discussed several cross-cutting issues and questions that affect the implementation of strategies to improve transitions of care. The subcommittee identified key elements to excellent care transitions for hospital discharge, high-risk patients, and outpatient settings, as well as across all care settings.

Key elements of hospital discharge transitions that prevent readmissions include:

1) Effective patient (or caregiver) education on medication management (including medications started, changed, or stopped).
2) Effective patient education on self-management including appropriate factors to monitor (eg, daily weights for CHF, fevers s/p pneumonia, etc.) and "red flags" that suggest a need for immediate care.
3) As part of the educational process, a teach-back approach that confirms patient understanding of these educational elements was highly recommended.
4) Effective selection of high-risk patients for intensified care management. It was acknowledged that CCNC care managers and transition methodologies were well developed and evidence-based though in most counties would not be available for patients covered by other payers, suggesting the need for creative solutions based on local resources (eg, the FirstHealth model[3]).
5) Some form of a personal health record should be provided pending the availability of robust HIE.

Key elements of high risk care management include:

1) Outpatient medication reconciliation with hospital discharge medications – preferably on home visit but at least by telephone visit.
2) Reaffirmation of self-management skills and recognition of red flags.
3) Extended telephone contacts, eg, four or more phone visits over the course of one month

Key elements of outpatient care transitions include:

1) An outpatient visit within 3 to 7 days of hospital discharge; therefore, practices must have a scheduling workflow that accommodates this need for access.
2) Components of the hospital follow-up visit should include:
   a. Reiteration of medication reconciliation and management.
   b. Reinforcement of self-management skills and "red flags."

c. Appropriate disease specific evaluation.
d. Review and incorporation of the personal health record into ambulatory records.
e. Whenever appropriate, discussions concerning palliative care are best initiated with patients in the environs of the medical home.
f. Systems of shared, after-hours, primary care access should be strongly considered.
g. Use of non-physician staff to manage care plans for some patients.

Key elements across all care settings include:

1) Emphasis on taking time with patients, maintaining relationships, building trust.

The most effective care model to date for improved transitions, decreased emergency department use, decreased overall hospitalizations, reduced unnecessary utilization, and improved quality of care is an integrated, patient-centered medical home (PCMH) with robust informatic systems, advanced ambulatory access, health literacy level appropriate education, a team-based approach led by primary care, and high intensity care management for well-defined high-risk patients. In these medical homes, the care team is aware of all transitions across the spectrum of care for member patients. These medical homes have core responsibility to ensure that red flag warnings, self-management skills, and the reconciliation of medications and records occur at the level of the medical home. Data regarding successes in cost efficiency and improved outcomes have been published within the last year by Geisenger Health System, Group Health of Seattle, and the VA Midwest Healthcare Network (VISN 23).[4] Community Care of North Carolina (CCNC) functionality is based on a medical home model with evidence-based transition services and includes NCQA PCMH recognition as one of the major pillars of its multi-payer demonstration pilot project in partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) and the North Carolina State Health Plan. NC Area Health Education Centers (NC AHEC) through its Regional Extension Center (REC) Primary Care Services offers EHR implementation, PCMH Recognition consultation, and workflow redesign tools including a specific "transitions" package.

Given local variation in resources and penetration of enhanced transition programs, members of the subcommittee raised several questions and concerns regarding funding, information, and stakeholders:

Funding

How can money saved by hospital or other providers from improved transitions be shared with the community to help support management and coordination?

Discussion: Hospitals cannot legally pay private practices, although they will be able to share savings if part of a formally constituted Accountable Care Organization. Hospitals may be able to contract with pharmacists in the community to help manage patients and do enhanced medication teaching (that must include medication reconciliation and teach back methodologies).

Information

What information is most important during a transition given current limitations involving exchanging accurate and timely information in the current system?

Discussion: Single, accurate, and complete, medication list; a hierarchy for resolving conflicts between multiple legitimate documents for a single patient; record of what each provider saw as the next step in patient's care; easy ways to navigate through electronic records (eg, single table of contents for record with direct links). Timeliness of information exchange is crucial. Previous attempts to develop standardized transfer forms have collapsed.

Stakeholders

Who should be at the table in communities when developing transitions of care programs?

Discussion: Home health, hospitals, physicians, public health, free clinics, long-term care, hospice care, Department of Aging/Area Organization on Aging (AOA), MH/DD/SA local management entities (LMEs), Critical Access Behavioral Health Access (CABHA) providers, end users (eg, nurses on duty in nursing homes, medical director that cares for patients), patients and families. All possible local resources should be leveraged to ensure safe and effective transitions.

Specific suggestions for patient and family representatives included LME consumer advisors, Department of Insurance consumer network through outreach work, hospital patient advisory councils, LTC facility residents councils, community advocacy organizations active in a particular community, Spanish speakers via ombudsman in governor's office

RECOMMENDATIONS

The subcommittee's review of existing initiatives highlighted the many programs to improve transitions of care that are in place at integrated health systems, such as CarePartners, CCNC, and FirstHealth.

Therefore, the subcommittee's recommendations address strategies that can be used for patients outside of an integrated system, with a particular focus on transitions for patients leaving the hospital, because of ACA incentives and requirements intended to reduce readmissions.

Recommendations:

- **Improve patient education at hospitals, with a focus on the health literacy checklist and teach-back methodology.**
- **Improve education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**
- **Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.**
- **Personal health records, in the possession of the patient, should be emphasized pending the availability of more robust HIE.**
- **Align existing initiatives that address care transitions at state and local level.**
- **In each community, stakeholder alliances including provider groups, CCNC, home health representatives, mental health providers, and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with**

pending improvements in telemonitoring and home use of health information technologies.

- **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.**
- **Encourage collaboration and contracts between hospitals, LMEs, CABHAs, and other community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.**
- **Solutions utilizing transition principles should be applied to all patients regardless of payer.**
- **Encourage formal development of Medical Home Models that include the use of non-physician extenders to work with some patients (eg, stable diabetics), with physicians focusing on higher need patients**

SELECTED RESOURCES AND MODELS ON TRANSITIONS OF CARE

Guided Care model developed by Chad Boult, MD, MPH, MBA, and colleagues at Johns Hopkins Bloomberg School of Public Health. Also by Boult: *Guided Care: A New Nurse-Physician Partnership in Chronic Care*. http://www.guidedcare.org/

Care Transitions Program developed by Eric Coleman and colleagues at University of Colorado, Denver, School of Medicine. http://www.caretransitions.org/

Nurses Improving Care for Healthsystem Elders program developed by Mary Naylor,PhD, RN, FAAN, and colleagues at the University of Pennsylvania School of Nursing. http://elearningcenter.nicheprogram.org/login/index.php

Hospital Elder Life Program (HELP) developed by Dr. Sharon K. Inouye and colleagues at the Yale University School of Medicine. http://www.hospitalelderlifeprogram.org/public/public-main.php

Center to Advance Palliative Care. http://www.capc.org/

Hospital to Home National Quality Improvement Initiative. www.h2hquality.org

National Transitions of Care Coalition: NTOCC Compendium. http://www.ntocc.org/Toolbox/default.aspx

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge. Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

”Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting” by David E. Weissman and Diane E. Meier. http://www.capc.org/tools-for-palliative-care-programs/national-guidelines/primary-palliative-care-trigger-criteria-capc-consensus.pdf

“The Ironic Business Case For Chronic Care In The Acute Care Setting” by Albert L. Siu and colleagues. *Health Affairs* January 2009.

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge – Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

“The Group Health Medical Home at Year 2: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers” by R. J. Reid and colleagues. *Health Affairs* 2010.

“Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial” by K. L. Rice and colleagues. *American Journal of Respiratory and Critical Care Medicine* 2010.

“Value and the Medical Home: Effects of Transformed Primary Care.” R. J. Gilfillan and colleagues. *American Journal of Managed Care* 2010.

Table 1
Subcommittee Working Document

Feature	**Evidence-Based Components** (compiled from literature)	**Existing Local Initiatives** (from discussion at 1/19/11 meeting and feedback on draft report)	**Committee Brainstorming – Gaps and Recommendations** (from discussion at 1/19/11 meeting and feedback on draft report)
Inpatient-Outpatient Communication	Direct electronic exchange		
	Record access (EHR or paper)	CarePartners uses Western NC HIE to access hospital records; CCNC has access to Datalink (also view only); View only access to hospital records but no ability to download, print, or communicate back; can access records of tertiary care facilities through the local care mger; care mgers can access different systems but means have to juggle multiple systems; University health system has 3rd party view only access for non-affiliated physicians; FirstHealth has access w/in system; will be adding access to home health record by primary care physicians; HC Facilities – receive several conflicting records; tried universal transfer form but couldn't keep ppl at table; discussion w/ UNC of real-time ER record access; electronic prescribing systems allow access to prescription fill history for NC Medicaid, other insurers, sometimes cash customers	
	Personal Health Record	CCNC relies a lot on personal health record – delayed access to claims-based info	
	Secure email system	No real time info exchange for nursing homes other than ad hoc phone calls	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Care Coordination	Identify high risk patients	LME Care Coordinators identify high risk/high cost consumers, coordinate and monitor success of services	
	Engaging patients	CCNC uses hospital assessment to determine best post-discharge follow-up	Pts more likely to accept home follow-up if physician recommends How to capture patients who initially decline in hospital (multiple contacts)? Importance of low tech activities to build and maintain trust with patients
	Range of preventable effect		
	Discharge med training	FirstHealth – Starts with bedside nurse as part of self-mgt training; pharmacist flags add'l needs for particular education [heart failure, COPD pilot]	Literature shows med adherence is most important in post-MI care
	Self-management training		Literature shows self-management skills most important in CHF patients
	Health literacy – teachback	FirstHealth – assesses depression and health literacy at baseline; uses teachback	
	Sequence of visits		
	In person vs. phone vs. telehealth	FirstHealth has telehealth grant from HRSA Telehealth has been effective in literature for COPD patients Health center in UHS area has telehealth system – most complex pts; decrease up to 70% in admissions over 18 mos with 6 months of telehealth	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
		CarePartners has been doing telehealth w/o extra funding; allows them to reduce visits Challenge to engage some patients to allow visits Koeble, in Alaska, used webcams to connect pharmacists with patients in remote communities CCNC care managers conduct home visits with patients after discharge, addressing range of issues including patient education, teaching, coordinating primary care visits, arranging specialist follow-up	
	One coordinator – one patient	A CCNC network pilot was successful with nurse care manager assigned to patient at hospital that followed patient through	
	Practice co-location		
	Timely info to practices		
	Home med reconciliation	FirstHealth does joint home visit with CCNC network CCNC care manager home visits after discharge may include med rec	For smaller communities and pts not under CCNC – could make arrangements with local pharmacies to help with med rec, but pharmacists can't bill Medicare for those services. (Limited option to bill now under NC Check Meds program) Hospitals could contract with pharmacists (Stark issue w/ paying referring physicians) – want to target the higher risk patients
	Use of visiting NPs or home health staff	Home health is already established Medicare benefit for patients who qualify;	How can home health visits be leveraged? (Not all Medicare

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
		NPs cost more	patients qualify for home health benefit)
	Proactive, prepared care team		Not all care teams and providers alike, but need to be trained and expected to perform necessary functions
Post – Discharge Ambulatory Access	Early outpatient follow up	FirstHealth – schedules 7 day follow up appt before patient leaves; facilitates transport, etc. if necessary	
	Components of outpatient visit	UHS – no protocols yet for what happens at the outpt visit	Define essential elements for post-discharge. Create protocols for particular diagnoses for outpt visit after discharge; set protocols could also help with home health taking on larger role
	After-hours access	UHS setting up after care clinics Began discussion about how to arrange extra access from private providers Main challenge has been access to appointments – need to pay for add'l providers; UHS has previously looked at partnering w/ Walmart on minute clinics but they are not set up to manage chronically ill Kaiser has set up after care clinics, staffed by hospitalists for first outpt visit	How to arrange after hours access in communities without academic medical system? Hospitals could engage own employees or hospitalists to ensure post-discharge care and follow ups. Legal challenges to having hospitals incentivize drs to provide extra access
	Timely transfer of information		Need for timely information – discharge summaries from hospital may not be available for 30 days – this makes it difficult to synthesize

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
			information for primary care provider. Need for full information – eg, retail pharmacists can be hesitant to share because of HIPAA concerns
Nursing Home & Assisted Living	Med communication		
	Facility employed NP	Patients from nursing homes go to hospital only with dr order, but dr not on site; often default to hospital visit based on telephone conversation with nurse on site	
	Connection to mental health	Nursing home regs don't allow admission of pts with primary need of mental health; no such restrictions for assisted living	
	Management sequence		
	Outpatient/MD connection		
	Clinical pathways (particularly pneumonia)		
Palliative Care	Advanced directives/palliative care discussions	Federal requirement to discuss this at admission to nursing home – but decisions are different than at time of event	Too political to include in regulations? Can still be included in protocols used for patients with chronic disease Needs to be education of providers and patients; currently too linked to hospice care Ctr for Palliative Care working on protocols for outpatient care, already have them for inpatient care Should separate palliative care discussion from hospice image – more emphasis on symptom amelioration; these symptoms bring

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
			them back to hospital
	"Good palliative – Geriatric Practice" algorithm		

Addendum:
North Carolina Department of Health and Human Services received funding in 2009 to develop a model(s) to improve the hospital discharge planning process. This will offer individuals information to make good decisions about their lives and post-hospital discharge, while maximizing their opportunities to live in the communities of their choice. This will build upon other initiatives: Community Resource Connections for Aging and Disabilities (CRCs) and Person-centered training. In conjunction with the grant, a Person-Centered Hospital Discharge Planning (PCHDP) Learning Partnership has been established to provide: 1) an inclusive process to develop parameters for common evidence-based benchmarks, critical data elements, and outcomes; 2) establish protocols; and 3) provide resources for local sites. Through a facilitated community engagement process, three local communities are implementing care transition programs designed to meet their community's needs and address issues related to hospital discharge. These communities are Surry, Forsyth, Chatham, and Orange counties. Key partners in this project are Community Care of North Carolina, the Forsyth, Northwest Piedmont, and Chatham-Orange CRCs, and the hospitals serving those communities.

[1] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3025, 10309.
[2] Transitional Care Model (TCM). TCM Overview. http://www.transitionalcare.info/index.html. Accessed April 16, 2012.
[3] First Health is a mid-sized health system based in Pinehurst, NC that has aggressively sought grant funding for transitions of care pilot programs that include home health and the local CCNC network.
[4] See Selected Resources section at end of document.

APPENDIX G
PRINCIPLES FOR NEW MODELS OF CARE

1. **Person-Centered, Family, and Community Focus.** Individual patients and their families should be at the forefront of any health system. The health of individuals is also strongly influenced by the broader community in which they live. Thus, new models of care should focus on the broader community and should include a strong population health emphasis.

2. **Improve Access, Quality, Health Outcomes, and Population Health and Reduce Costs.** North Carolina will be best served by developing models that will:
    a. Improve health care quality (including outcomes and population health)
    b. Increase access
    c. Reduce costs (ie, reduce absolute health care costs and/or moderate the levels of increase)

    The availability of funding sources should not solely drive the development of new models. Rather, once the key elements have been identified, funding sources should be pursued that will support the new models.

3. **Aggressively Test New Models to Improve Health.** North Carolina has a strong history of innovations that have led to improved access, quality, and patient outcomes with reductions in unnecessary health expenditures. However, there is a clear need for further progress. We need to build on current initiatives, while continuing to explore other options with the goal of further improvements in health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.

4. **Patient-Centered Interdisciplinary Teams.** North Carolina should support testing patient-centered interdisciplinary teams that include primary care, dental health professionals, behavioral health professionals, nutritionists, allied health professionals, pharmacists, and lay health advisors. These patient-centered teams should be positioned to address the health needs of the whole person. North Carolina should also support testing models that incorporate additional approaches (eg, health extenders such as lay health advisors or the use of group health visits) to determine if these models improve access, improve quality and health outcomes, and reduce costs.

5. **Involving Consumers More Directly in their Own Care.** North Carolina would be well served to explore options that involve consumers more directly in their own health and empower them to assume a more active role in their own health. Accordingly, consumers should be given the information, training, and support required to be active participants in managing their own health and to be informed consumers in a redesigned health system. Any model of care should ensure that consumers are given culturally and linguistically appropriate health education and that information is conveyed in a way that ensures that it is understandable to people with lower health literacy.

6. **Utilize Health Professionals and Paraprofessionals to their Fullest.** In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals and paraprofessionals to the fullest extent of their training.

7. **Protect Vulnerable Patients and Safety Net Providers Serving Large Proportions of Vulnerable Populations.** Models of care should be designed to improve quality, health care outcomes, and health care access for populations that have been traditionally underserved including, but not limited to, low-income populations, the chronically ill, racial and ethnic minorities, and people with disabilities. New models should be specifically evaluated to determine the impact of redesigned delivery or payment methodologies on these vulnerable populations as well as on safety net providers serving large proportions of vulnerable populations.

8. **Transparency and Data.** Data should be collected in a manner that allows for the ongoing redesign and improvement of our care delivery systems including data collected at the individual, provider, and community levels. The data collection tools, evaluation methods, and results should be available to consumers.

9. **Evaluation and Monitoring.** Models of care should be thoroughly evaluated to determine if these innovations are leading to the stated goals (increased access, better quality and health outcomes, improved population health, increased efficiencies, and/or reductions in health care costs). It is important to understand what models work best for different populations in different communities and with different configurations of providers.

10. **Use Existing Frameworks to Encourage and Enhance Dissemination of New Innovations**. Successful initiatives should be disseminated throughout the state using existing dissemination infrastructures. Any new model tested in the state should be transparent in terms of design, outcomes, and costs.

11. **Multi-payer, Multi-provider.** To the extent possible, the new models of care should involve other payers in addition to Medicaid and Medicare. Multi-payer, multi-provider initiatives that involve public and private providers and community-based organizations have a greater possibility of improving quality, access to care, health outcomes, and population health while reducing health care costs.

12. **Reinvest Savings.** If savings are realized from the changes in the health care delivery and financing systems, these savings should be reinvested to support additional improvements in access, quality, health care outcomes, and population health and/or shared with consumers, taxpayers, payers, and providers.

APPENDIX H
NEW MODELS OF CARE IN NORTH CAROLINA

The ACA includes funding to test new models of delivering and financing health services, with the goal of improving quality and patient outcomes and reducing the costs of health services. The ACA included $5 million in federal fiscal year (FFY) 2010, and $10 billion for FFY 2011-2019 to develop and evaluate new delivery and payment models through the new Centers for Medicare and Medicaid Innovation (Innovation Center), within the Center for Medicare and Medicaid Services (CMS).[1] All Innovation Center demonstrations are specific to Medicare, Medicaid, and CHIP. However, the ACA also includes other innovations that could be supported and/or tested with broader populations.

The following includes a short description of some of the new innovations that may be tested as part of the ACA. They are grouped into themes, including patient-centered medical homes, transition care models, accountable care organizations, all-payer payment models, coordination of care for dual eligibles, medication management, geriatric care, telehealth/telemonitoring, and use of health information technology, shared decision-making, malpractice reform, and nursing home culture change. This Appendix also includes a short description of some of the existing North Carolina initiatives that are similar to the models that may be tested through the ACA, along with contact information for each of the North Carolina initiatives.

The following is not an exhaustive list of all the examples of ongoing innovations in North Carolina. The demonstrations listed are matched as closely with New Models of Care provisions in the ACA as possible. Innovations not mentioned in the ACA or innovations addressing other provisions in the ACA, such as quality, are not included here. In addition, the NCIOM may be unaware of other innovative practices in the state. Thus, this list of innovations should be viewed as some of the initiatives currently underway in North Carolina.

PATIENT-CENTERED MEDICAL HOMES (PCMH)

Description of ACA Provisions

- *Health homes for people with chronic illnesses*.[2]
  A health home is a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. Health home services include comprehensive care management, care coordination and health promotion, transitional care, patient and family support, and referrals to community and social services. Note: This is a state option specific to Medicaid, not a demonstration program. States that agree to the terms are eligible for an enhanced federal match (90%) for payments to health homes for eight fiscal year (FY) quarters beginning once they have an approved state plan amendment. Eligible individuals include Medicaid enrollees with two chronic conditions, one chronic condition with a risk of a second chronic condition, or one serious and persistent mental illness.

- *Primary care payment and practice reform*.[3]
  This Innovation Center demonstration is intended to test broad payment and practice reform

in primary care including patient-centered medical homes for high-need individuals, women, and models that transition primary care practices away from fee-for-service (FFS) to more comprehensive payment or salary-based payment.

- *Optimal use of health professional credentials*.[4]
  This Innovation Center demonstration is intended to promote greater efficiencies and timely access to outpatient services through models that do not require a physician or other health professional to provide services or be involved in establishing the plan of care. Services must be provided by a health professional who has the authority to furnish the service under existing state law.

- *Community-based interdisciplinary, interprofessional health teams to support patient-centered medical homes*.[5]
  The health teams established by this section must be from a state, state-designated, or tribal entity and must establish a plan for financial stability after three years. This demonstration is not specific to Medicare or Medicaid, but entities must agree to provide services to Medicaid eligibles with chronic conditions. Health teams shall create contractual agreements with primary care providers to support services; collaborate with providers and area resources to coordinate prevention efforts, disease management, and transitions of care; and implement and maintain health information technology to facilitate coordination of care. Providers shall provide care plans for each patient, provide health teams with access to patient medical records, and meet regularly with the health teams to ensure integration of care.

North Carolina Initiatives

- *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*
  This demonstration, operated by CMS and HRSA, aims to improve care for Medicare beneficiaries through the use of more coordinated, team-based care. Participating FQHCs must achieve Level 3 patient-centered medical home status. FQHCs will be paid a monthly care management fee for each eligible Medicare beneficiary. The following 18 FQHCs in North Carolina are participating: Apex Family Medicine, Colerain Primary Care, First Choice Community Health Centers at Anderson Creek Medical Center, First Choice Community Centers at Angier Medical Center, First Choice Community Health Centers at Benhaven Medical Center, Gaston Family Health Services-Bessemer City Health Care Center, James Bernstein Community Health Center, Julian T. Pierce Health Center, Maxton Medical Center, Metropolitan Community Health Service, Inc., OIC Family Medical Center, PHS – Charles Drew Community Health Center, PHS Prospect Hill Community Health Center, Rock Quarry Family Medicine, Rural Health Group at Norlina, Rural Health Group at Twin County, Rural Health Group at Whitakers, and Snow Hill Medical Center.[6]

  Contact: Rebecca Whitaker, MSPH, Director of Health Policy and Governmental Affairs, North Carolina Community Health Center Association, whitakerr@ncchca.org.

- *Community Care of North Carolina (CCNC).*
  North Carolina is nationally known for the work it has done through CCNC in creating patient-centered medical homes for the Medicaid population. CCNC has led to improved health outcomes and reduced health care costs, particularly as costs relate to patients with

chronic or complex health problems. The program is funded through the Division of Medical Assistance (DMA) within North Carolina Department of Health and Human Services (NCDHHS), and the North Carolina Foundation for Advanced Health Programs, Inc. CCNC is a community-based approach that involves primary care providers, federally qualified health centers, and other safety net organizations, hospitals, social services, local health departments, and other community resources that work together to provide care coordination and high quality care for the enrolled population. There are 14 regional community health networks across North Carolina providing services to more than 1.2 million Medicaid and NC Health Choice beneficiaries. Providers in the network are responsible for delivering, coordinating, and managing the care of enrollees and receive a per-member-per-month (PMPM) payment from the state. CCNC also offers clinical improvement initiatives including specific disease management programs (eg, diabetes disease management), medication management programs, chronic care and transitional care programs, and emergency room initiatives. CCNC has been expanded to include a more comprehensive team-based approach, embedding care managers, pharmacists, psychiatrists or other behavioral health professionals, and nutritionists in the networks and in some of the larger patient practices. The team focuses on care for people with chronic or complex health conditions, working to improve the quality of care provided as well as patient self-management skills.[7]

Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org; Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, NCCCN, dlevis@n3cn.org.

- *CCNC Pregnancy Home.*
  CCNC's Pregnancy Home initiative aims to improve the quality of perinatal care by increasing healthy birth outcomes and thereby reducing Medicaid expenditures. The initiative is modeled after CCNC's primary care case management program. The goal is to reduce the low birth weight rate by 5% per year in the first two years and to achieve a primary c-section rate at or below 20%. Medicaid providers who choose to become a Pregnancy Medical Home must ensure there are no elective deliveries before 39 weeks, administer progesterone ("17P" project) to reduce premature births, decrease primary cesarean section rates, perform a standardized high-risk screening on all initial visits, integrate care with the pregnancy care manager from the local health department, and agree to open chart audits. All qualified Medicaid providers that provide prenatal care are eligible to become a Pregnancy Medical Home. Participating providers receive incentives such as exemption from prior approval for obstetric ultrasounds, a $50 incentive for each risk screening form, a $150 incentive for each post-partum visit, and an increased reimbursement rate for a vaginal delivery.

  Women who are determined to be at risk of poor birth outcome, specifically preterm birth (based on the screening), will be assigned a pregnancy care manager from the local health department. Priority patients include those with a history of preterm birth or low birth weight, chronic disease that might complicate the pregnancy, multifetal gestation, fetal complications, tobacco use, substance abuse, unsafe living environment, unanticipated

hospital utilization, two or more missed prenatal visits without rescheduling, or when a provider requests care management assessment.

Contact: Kate Berrien, RN, BSN, MS, Pregnancy Home Project Coordinator, North Carolina Community Care Networks, Inc., kberrien@n3cn.org.

- *North Carolina Community Care Networks, Inc. (NCCCN) 646 Demonstration.*
  Section 646 of the Medicare Modernization Act (MMA) created a five-year demonstration program to improve safety, effectiveness, efficiency, patient-centeredness, and timeliness of care for Medicare enrollees. NCCCN is one of two organizations currently receiving funding to test new models to achieve these goals. Eight of the 14 networks in NCCCN are participating in the demonstration, which began on January 1, 2010, and will end on May 31, 2014. NCCCN builds on CCNC's patient-centered medical home model by including dual-eligibles and Medicare-only beneficiaries. The program assigns beneficiaries to a primary care physician, provides community-based care coordination services, expands case management information systems, and uses a performance measurement and an incentive program to encourage improvements in care and reductions in cost.[8,9]

  The program is being implemented in 26 counties: Bertie, Buncombe, Cabarrus, Chatham, Chowan, Edgecombe, Gates, Greene, Hertford, Hoke, Lincoln, Madison, Mecklenburg, Mitchell, Montgomery, Moore, New Hanover, Orange, Pasquotank, Pender, Perquimans, Pitt, Sampson, Stanly, Union, and Yancey.[10]

  Contact: Angela Floyd, NCCCN, afloyd@n3cn.org.

- *CHIPRA Grant Demonstrations.*
  These grants were awarded to establish and evaluate a national quality system for children's health care that encompasses care provided through the Medicaid program and the Children's Health Insurance Program (CHIP). This grant is funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The CHIPRA statute mandates the experimentation and evaluation of several promising ideas to improve the quality of children's health care.[11] North Carolina was one of 18 states that received CHIPRA grant funds.

  North Carolina's CHIPRA grant is focused on three primary areas. The first is a statewide initiative to collect and report pediatric quality measures to CMS and to report these measures on a quarterly basis to the networks and practices to drive quality improvement. CMS has identified 24 measures. To date, the practices are reporting on 13 of the 24 measures and have plans to report on 23 of the 24 measures by the end of 2012. In addition, the state has voluntarily added five measures which it is collecting. As part of this statewide initiative, CCNC is working with DMA to develop and distribute an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) report card at the network and practice level which will report on rates of well-child (EPSDT) screens for children under age 21, as well as developmental, autism, vision, and hearing screens, Body Mass Index (BMI) measurement, and lead testing. CCNC has also hired 14 part-time Quality Improvement (QI) specialists through this grant. They are housed in the 14 CCNC networks to support primary

care practices throughout the state. The second component is focused in seven of the 14 CCNC networks. It is focused on strengthening the medical home for children, particularly for children and youth with special needs. This initiative began in 11 practices, and is providing learning collaboratives to help practices with community linkages and referrals, maternal depression screening, child and adolescent mental health risk factors and screenings, and developmental and autism screenings for children birth through age five. This work is supported through the NC Center for Excellence for Integrated Care and four full-time QI specialists. Finally, the third component focuses on developing and evaluating a pediatric electronic health record (EHR) model. Rather than work with a specific vendor to develop a software package, North Carolina's initiative is focusing on evaluating a set of best practice standards for effectiveness and improving quality child health care. Any EHR vendor can participate, and those that do will be more competitive, as national certification for meaningful use will be based on the model that North Carolina is helping develop.

Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *North Carolina's Health Home State Plan Amendment (SPA).*[12]
  The ACA gives states the option of creating "health homes" for Medicaid recipients with chronic health problems. States receive 90% enhanced Federal Medical Assistance Percentage (FMAP) rates for the health home services for up to eight fiscal quarters. DMA's SPA has been approved by CMS.[13] North Carolina's health home will strengthen the coordination between primary care providers and those who are meeting the needs of people with mental health or substance use disorders, or those with intellectual and developmental disabilities.

  Contact: Debbie Pittard, Debbie.pittard@dhhs.nc.gov

- *BCBSNC and UNC-CH Medical Home.*[14]
  Blue Cross and Blue Shield of North Carolina (BCBSNC), in partnership with the University of North Carolina-Chapel Hill (UNC-CH), designed a PCMH facility, Carolina Advanced Health, which is located in Orange County. The facility is part of a three-year pilot program. The home will serve 5,000 BCBSNC patients with a focus on the chronic care population with coronary artery disease, hypertension, hyperlipidemia (high cholesterol), diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure or asthma. The facility includes a pharmacy, a lab, a range of providers, extended hours, and state-of-the-art information technology. The model includes integrating administration with medical practice and a team-based care approach. Evaluation of the model will include patient satisfaction, carrier satisfaction, and clinical metrics.[15]

  Contact: Don Bradley, MD, Senior Vice President and Chief Medical Officer, BCBSNC, don.bradley@bcbsnc.com.

- *State Health Plan Maternity Case Management Incentive Program.*
  The State Health Plan implemented a two-year maternity care incentive pilot program to incentivize pregnant women to engage in care management in the first trimester. Women will receive telephone nurse support and education to support healthy birth outcomes and identify

high-risk conditions. Active participants will have their hospital inpatient copayment waived at time of delivery. The goal is to decrease pregnancy-related complications, preterm deliveries, low birth weight babies, and neonatal intensive care unit admissions.

Contact: Anne Rogers, RN, BSN, MPH, Director of Integrated Health Management, State Health Plan, Anne.Rogers@shpnc.org.

- *WellPath Models to Improve Quality and Value.*
  WellPath has entered into new agreements with health systems and medical group practices designed to improve the quality and value of services provided and enhance patient outcomes. WellPath believes that health care professionals are in the best position to redesign the health care delivery system to enhance quality, outcomes, and efficiency. As a result, WellPath has focused on designing and implementing collaborative approaches to support redesign efforts to remove barriers and financial disincentives that make it difficult for provider groups to achieve these goals. Some of the key elements include:

  - Support for patient-centered medical homes. For example, WellPath has worked with the provider organizations to change provider compensation to support necessary but previously non-revenue producing activities and to more closely align with evidence-based quality measures.
  - Support for provider-led system redesign by aligning benefit plan design and compensation systems for the purpose of meeting the comprehensive needs of the patient/members and providing increased affordability.
  - Comprehensive information sharing between WellPath and the provider organizations to support quality, improved health outcomes, and greater efficiency.

  Two of these arrangements will be operational early in 2012 to serve individuals within Medicare Advantage plans, small group and large group employer plans, and individual plans. Approaches for self-funded employers are anticipated to be available later in 2012.

  Contact: Peter Chauncey, FACHE, Executive Vice President and Chief Operating Officer, WellPath, A Coventry Health Care Plan. PWChauncey@cvty.com.

- *North Carolina Health Care Facilities Association's "Journey to National Best" demonstration of the effectiveness of nurse practitioners in skilled nursing care facilities*.
  One of the initial efforts as part of the *Journey to National Best* (described more fully in Nursing Home Culture Change), supported by NC DHHS, has been a carefully evaluated demonstration of the utility and effectiveness of nurse practitioners in skilled nursing care facilities. This project, implemented in a single facility in North Wilkesboro, NC, showed the impact of an on-site nurse practitioner, as evidenced by lower rates of re-hospitalization, lower medication errors, and higher levels of patient satisfaction. Efforts are underway to negotiate with federal Medicare fiduciary agents and DMA to work out procedures for payment for these services (as has been the case with NPs in primary care) when the NP is an employee of the nursing facility, but supervised by multiple physicians responsible for individual patient care. Although some North Carolina nursing homes already employ nurse practitioners and have reported similar results, widespread adoption of this innovation awaits

resolution of these payment arrangements with Title 18 and 19 authorities.[16]

- *FutureCareNC Oral Hygiene Demonstration.*
  FutureCareNC, the nonprofit research and educational foundation of the North Carolina Health Care Facilities Association, is sponsoring an oral hygiene demonstration in partnership with a multi-disciplinary team from UNC-Chapel Hill for participating facilities in 2010 and 2011. This project focuses on oral care procedures to improve oral and nutritional outcomes as well as training for promoting oral care with resistive individuals. Dedicated oral health aides have been trained to provide routine, daily oral health care for patients unable to provide these services for themselves. Projects employing similar approaches in other states have demonstrated both improved hygiene and health outcomes, as well as increased dietary intake and positive self-esteem of patients. Early results from the North Carolina demonstration projects have shown similar results.

  Contact: Craig Souza, President, North Carolina Health Care Facilities Association (NCHCFA), craigs@nchcfa.org.

TRANSITIONS OF CARE

Description of ACA Provisions

- *Community-based care transitions program*.[17]
  The ACA appropriated $500 million (FFYs 2011-2015) to CMS to support collaborative partnerships between hospitals and community-based organizations that provide improved care transition services to high risk Medicare beneficiaries. The initiative focuses on high risk traditional fee-for-service Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions. This demonstration began on January 1, 2011.

North Carolina Initiatives

- *NCCCN's 646 Demonstration.*
  NCCCN, a community-based organization, coordinates patient care among providers, including hospitals, to improve overall quality of care for Medicare beneficiaries and dual-eligibles. One performance measure for quality involves transition of care. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[18]

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Description of ACA Provisions

- *Medicaid global payment system demonstration project*.[19]
  The US Department of Health and Human Services (HHS) Secretary, in conjunction with the newly established Innovation Center, shall establish the Medicaid Global Payment System Demonstration Project. This project, to be tested in no more than five states, will adjust state payments to an eligible safety net hospital from fee-for-service to monthly capitated payments for years FY2010 through FY2012. The

Innovation Center will test and evaluate patient outcomes and costs resulting from this model. Funds for this project have been authorized but not appropriated.

- *Pediatric ACO demonstration in Medicaid*.[20]
  Allows pediatric medical providers that meet specified requirements to be recognized as an accountable care organization (ACO) for purposes of receiving incentive payments. This demonstration is specifically for Medicaid and CHIP and lasts from January 1, 2012 to December 31, 2016. Money has been authorized but not appropriated.

- *Medicare shared savings program*.[21]
  Establishes a shared-savings program for Medicare providers no later than January 12, 2012. Providers meeting eligibility requirements determined by the Secretary can coordinate care for Medicare beneficiaries through an ACO. ACOs that meet quality requirements set by the Secretary can receive these capitation payments. ACOs are required to report measurement data as determined by the Secretary. This section was amended to allow for other methods of making payments such as partial capitation models. North Carolina Medicare Shared Savings ACO participants announced in April and July 2012 are listed below. CMS is expected to announce the next round of participants on January 1, 2013 which is likely to expand North Carolina's list of Medicare Shared Savings Program ACOs.[2223]

  Start Date: July 1, 2012

  Cornerstone Health Care, PA
  1701 Westchester Drive, Suite 850
  High Point, NC 27262
  Andrew Weniger, CPA
  andrew.weniger@cornerstonehealthcare.com

  Meridian Holdings, Inc.
  4477 West 118th Street, Suite 304
  Hawthorne, CA 90250
  Anthony C. Dike, MD, FACP
  323-295-5062

  Triad Healthcare Network, LLC
  1200 N. Elm St.
  Greensboro, NC 27403
  Steve Neorr
  855-484-6669

  Start Date: April 1, 2012

  Accountable Care Coalition of Caldwell County, LLC
  321 Mulberry Street, SW
  Lenoir, NC 28645
  Jim Korry

713-770-1121

Accountable Care Coalition of Eastern North Carolina, LLC
1315 South Glenburnie Road, Suite A-3
New Bern, NC 28562
Jim Korry
713-770-1121

Coastal Carolina Quality Care, Inc.
1020 Medical Park Avenue
New Bern, NC 28562
Carrie Hagan, MBA, CPC, CHCC
chagan@cchealthcare.com

North Carolina Initiatives

- *NCCCN 646 Demonstration.*
  The 646 Demonstration is a shared-savings ACO program, which offers the potential to share savings with CCNC networks. If NCCCN is able to show improved health outcomes and lower health care costs, then it can share in the savings with CMS. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[24]

- *CCNC.*
  While CCNC does not currently share savings with the state or federal government, CCNC could potentially meet the requirements for a Medicaid pediatric ACO. Providers participating in a CCNC network receive PMPM payments from the state. For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *Forsyth Medical Group Physician Group Practice Demonstration.*
  Forsyth Medical Group, located in Winston-Salem, was one of 10 sites selected for the CMS Physician Group Practice demonstration for Medicare beneficiaries. The five-year demonstration began in 2005. The demonstration was designed to improve coordination of Medicare hospital, physician, and outpatient services; promote quality and cost effectiveness; and reward physicians for positive patient outcomes. Providers receive incentive payments based on Physician Quality Reporting Initiative (PQRI) measures in diabetes, congestive heart failure, coronary artery disease, and preventive care. Each practice was allowed to design its own care programs in order to meet the quality measures.

  Forsyth Medical Group developed the COMPASS Disease Management Program and the Safe Med programs as a part of the demonstration. The demonstration program uses COMPASS Disease Management Navigators and Safe Med Pharmacists to identify patients at the time of hospital discharge who are at high risk for readmission and/or adverse events such as those with high- risk diseases and/or multiple/high-risk prescriptions. At-risk patients are identified at discharge and contacted for an assessment to determine their understanding and ability to follow discharge instructions and medication regime. Patients are also assessed for their understanding of their disease process and offered self-management tools and

coaching. The patients are directed back to their primary care provider for follow-up care. Another part of the program uses physician-led teams to promote programs and educate patients to improve quality and outcomes. All practices in the nationwide demonstration have met benchmark performance on at least 29 of 32 measures. Novant met 100% of the quality outcome measures for project year (PY) one and PY2. In PY3 and PY4 the group met 96% for the minimum quality targets. The data for PY5 is in the process of being analyzed.[25,26]

Currently, the CMS is allowing ACOs to apply for participation in this demonstration until the Medicaid Shared Savings Program begins on January 1, 2012.[27]

Contact: Nan Holland, RN, MPH, CPHRM, Senior Director, Clinical Excellence, Novant Medical Group, nlholland@novanthealth.org.

- *PACE Model.*
  The Program of All-Inclusive Care for the Elderly (PACE) model is designed to care for the frail elderly who want to receive long-term care services in their own community instead of in a nursing home. Patients receive adult day-center services and in-home services such as transportation, nutrition counseling, social services, case management, primary care, specialized therapies, and nursing care through the program. To receive PACE benefits, an individual must be 55 years of age or older, eligible for Medicaid under the state's criteria for nursing facility level of care, reside in a PACE-approved area, and be safely served in the community. Medicaid pays PACE a monthly fee for each recipient, allowing PACE to provide all services patients need without the limitations of fee-for-service systems. Medicare covers some of the costs for dual eligibles in addition to the Medicaid payments. Only nonprofit and public entities can have PACE models. All programs are monitored on an ongoing basis by the state and CMS to ensure compliance.

  There are currently four PACE models in North Carolina: Elderhaus, Inc. in Wilmington and Piedmont Health SeniorCare in Burlington, PACE of the Triad, Greensboro, LIFE (Living Independently For Seniors) at St. Joseph of the Pines in Fayetteville, and PACE at Home in Newton. Other PACE models are in development in Durham, Hickory, Statesville, Greenville, and Asheville.

  In general, PACE models in North Carolina have seen a majority of patients improve or maintain performance in activities of daily living and cognitive functions.[28]

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ALL-PAYER PAYMENT REFORM

Description of ACA Provisions

- *Allowing states to test and evaluate systems of all-payer payment reform.*[29]
  States can test and evaluate payment reform systems for the medical care of all residents in the state including dual eligibles. This demonstration is a part of the new Innovation Center.

North Carolina Initiatives

- *North Carolina Multi-payer Demonstration in seven rural counties.*
  North Carolina was one of the first eight states awarded a demonstration grant under the new Innovation Center. The demonstration is to test a multi-payer partnership between NC DHHS, CCNC, BCBSNC, and the State Health Plan. The demonstration will allow individuals in seven rural North Carolina counties (Ashe, Avery, Bladen, Columbus, Granville, Transylvania and Watauga) who are enrolled in Medicare, BCBS, or the State Health Plan to enroll in Community Care networks. Community Care medical homes in these seven counties currently serve over 112,000 Medicaid beneficiaries. The program is expected to expand the number of patients served to over 128,000 Medicare beneficiaries and over 121,000 privately insured or State Health Plan recipients.[30] Medicare will support this initiative by paying per member per month payments to primary care practices and CCNC networks to pay for care management and quality improvement activities.

  Contact: Torlen Wade, Executive Officer, NCCCN, Inc., twade@n3cn.org.

CO-LOCATION MODELS

Description of ACA Provisions

- *Co-location of primary and specialty care in community-based mental and behavioral health settings.*[31]
  Grants will be awarded to qualified community mental health programs to implement co-location of mental health and primary care services for special populations. Awards will be used for providing on-site primary care services in community-based mental health settings, paying for medically necessary referrals to specialty care, implementing information technology, and making facility modifications. No more than 15% of the grant money can be used for information technology and facility modifications. This section provides $50 million for FY2010 and then money as needed until FY2014. This demonstration is not specific to Medicare or Medicaid.

North Carolina Initiatives

- *CCNC Co-Location Pilot Program.*
  CCNC's co-location of mental health and primary care pilot program targets practices with high Medicaid enrollment (2,000 or more). The program aims to build practice infrastructure, increase the number of primary care providers who use evidence-based screening tools to identify patients with mental health needs, and increase the number of mental health patients with access to primary care services. Twelve CCNC networks participate in the program. Early evaluations show the program has improved functioning and increased screenings for Medicaid beneficiaries. Significant cost savings have also been identified due to early intervention for behavioral health problems. Medicare and DMA have created new coding to help sustain and expand this model.[32]

  Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org.

- *Foundation for Advanced Health Program's Center of Excellence for Integrated Care.*

The North Carolina Foundation for Advanced Health Programs (NCFAHP) was initially funded by the North Carolina Health and Wellness Trust Fund and DMA to create a Center of Excellence for Integrated Care. The work is now supported by other contracts and foundations, including funding from the federal CHIPRA Quality demonstration grant, Kate B. Reynolds Charitable Trust, and a contract with the Governor's Institute on Substance Abuse. The Center works to improve patient outcomes through integrating mental health, substance abuse services, and primary medical care. It provides trainings, learning collaboratives, and technical assistance to primary care and behavioral health providers, health departments, Local Management Entities (LMEs), and Critical Access Behavioral Health Agencies (CABHA) to help them implement integrated care models to better serve patients with underlying medical problems, mental health conditions, substance abuse disorders, and/or certain intellectual or developmental disabilities. The Center currently has funding to support integrative practices in primary care and mental health and substance abuse settings in seven of the 14 CCNC networks, including 27 primary care practices. The Center provides training, technical assistance, and learning collaboratives around integrated care processes; brief intervention and referral into treatment for substance abuse disorder, depression, and other forms of mental illness; identification and support for children with autism spectrum disorder; maternal depression; and childhood obesity.

Contact: Regina S. Dickens, Program Director, NC Center of Excellence for Integrated Care, regina.dickens@ncfahp.org; Maggie Sauer, President and CEO, North Carolina Foundation for Advanced Health Programs, Maggie.sauer@ncfahp.org.

COORDINATION OF DUAL ELIGIBLES

Description of ACA Provisions

- *Integrated care for dual eligibles.*[33]
  States are allowed to test and evaluate fully integrated care for dual eligible individuals, including management and oversight of all funds with respect to these individuals. This demonstration is a part of the Innovation Center.

North Carolina Initiatives

- *NCCCN 646 Demonstration (Medicare Shared Savings Program).*
  The 646 Demonstration is a five-year program that coordinates care for Medicare/Medicaid dual eligibles. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *CCNC Medicaid Payment for dual eligibles.*
  Medicaid pays CCNC a per-member-per-month payment for all dual eligibles. An increased PMPM payment is given to primary care providers and CCNC for all aged, blind, and disabled beneficiaries, including dual eligibles. This increase was to fund behavioral health integration, embedded care managers in large hospitals and practices, and network privacy and security officers. A portion of the payments are given to NCCCN to fund centralized clinical leadership and the Informatics Center.[34,35] For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *PACE Pilots.*
  When an individual enrolled in PACE is eligible for both Medicaid and Medicare, then both Medicaid and Medicare provide PACE with monthly capitation payments.[36] For a more detailed description of the PACE model, please see North Carolina initiatives under Accountable Care Organizations (ACOs).

MEDICATION MANAGEMENT

Description of ACA Provisions

- *Using medication therapy management services such as those described in Section 935 of the Public Health Service Act*.[37]
  This demonstration, which is a part of the Innovation Center, provides medication therapy management (MTM) by licensed pharmacists to treat chronic disease while improving quality and reducing cost. Targeted individuals include those taking four or more medications, taking any high-risk medications, having two or more chronic diseases, or having had a transition of care.

- *Medication management for people with multiple medications and/or chronic diseases*.[38]
  This demonstration is similar to the one above but it is not specific to Medicare or Medicaid. The HHS Secretary shall establish grants or contracts to provide medication management for people with four or more medications, high-risk medications, and/or chronic diseases to improve quality of care and reduce overall costs. The demonstration will be funded by Section 931 of the Public Health Service Act (PHSA), which authorizes $75 million for FY2010-2014.

North Carolina Initiatives

- *Health and Wellness Trust Fund's ChecKmeds NC***.**
  The ChecKmeds NC program, launched in 2007, uses a network of nearly 500 retail and community pharmacists to provide medication reviews to Medicare beneficiaries 65 and older who have a Medicare-approved drug plan. The program targets drug effectiveness, safety, adherence, and cost-effectiveness. Pharmacists under contract with the third party administrator, Outcomes Pharmaceutical Health Care, provide patient education and coordinate patient care among multiple providers. Some of the pharmacists also provide assistance with how to maximize Medicare-approved drug benefits; however, ChecKmeds does not reimburse for this service. When the Health and Wellness Trust Fund lost its funding, the ChecKmeds NC program was moved to the North Carolina Office of Rural Health and Community Care. The program is funded through mid-2012.[39]

  Contact: Ginny Klarman, Community Development Specialist, North Carolina Office of Rural Health and Community Care, ginny.klarman@dhhs.nc.gov.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home uses the Medication Reconciliation PLUS process to coordinate care among multiple providers. This process collects patient data from administrative claims, medical records, case managers, patients, and physicians. The data is then put into a virtual database, which can be accessed by CCNC case managers, pharmacists, and primary care

physicians. The system is used to identify potential adverse events due to drug interactions as well as poor medication adherence.

CCNC has been collecting information on the number and type of medication-related problems that are identified during the Medication Reconciliation PLUS program. The 18-month results through October 2011 indicate that CCNC staff identified 19,022 medication-related problems in 6,927 patients.[40] On average, there were 2.7 problems found per patient reviewed, including patients not taking their prescribed discharge medication (23% of problems identified); poor adherence to medications for chronic conditions (18%); or problems with the medication dose/frequency or duration (19%). Of these problems, 6% were deemed urgent (potentially leading to imminent hospitalization). Identifying these potential events allows the patient's providers to intervene before the events occur. This intervention reduces hospitalizations and re-hospitalizations.[41]

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- *North Carolina State Health Plan Medication Adherence Pilot Project***.**
  The State Health Plan also has a medication adherence pilot project.[42] Under this initiative, started in December 2009, all State Health Plan retirees using diabetes or cardiovascular medications were eligible for a reduction in their copayment. Retirees were targeted due to the high prevalence of these diseases among the retiree population and the potential to improve adherence through reduced cost sharing. By October 2011, approximately 26,000 retirees had participated in the program. Medco, the Plan's Pharmacy Benefit Manager, determined that the program saved members more than $1 million in co-payments, and reduced costs to the State Health Plan by more than $2.3 million. In addition, the medication adherence rate improved by more than 14% for oral diabetes and cholesterol medications, and by more than 19% for blood pressure medications.

  Contact: Sally Morton, PharmD, Clinical Pharmacist, State Health Plan. Sally.Morton@shpnc.org.

- *Senior PharmAssist.*
  The mission of Senior PharmAssist is to "promote healthier living for Durham seniors by helping them obtain and better manage needed medications, and by providing health education, Medicare insurance counseling, community referral and advocacy."[43] The nonprofit program is funded primarily through private donations, with some small government contracts and earned income. This program assists seniors in Durham with medication management, medication access, and tailored health education and community referral that helps seniors remain in their homes. In addition, Senior PharmAssist helps Medicare beneficiaries select appropriate Medicare health and prescription drug plans as Durham County's Senior Health Insurance Information Program (SHIIP) coordinating site.

  The program is evaluated based on medication adherence, health services utilization, functional capability, and satisfaction. Data is collected every six months. After two years, the evaluations have shown a 51% reduction in the rate of any hospitalizations and a 27%

reduction in the rate of any emergency department use.[44]

Senior PharmAssist conducted an evaluation of their SHIIP counseling assistance with stand-alone Part D plan selection for 2010 benefits. Two-thirds of the seniors needed to switch drug plans for a mean savings of $522 (median of $343).[45] The 2011 findings were very similar and have been accepted for publication. These savings do not yet reflect the staff's recommendations for generic or therapeutic substitutions, clinical interventions, or referrals for other subsidies that could help reduce health care or pharmacy costs.

Currently, the program is working to expand its services further through providers in Durham, North Carolina, with a focus on decreasing hospital readmissions for Medicare beneficiaries. Senior PharmAssist has helped other communities begin similar programs and has a newly revised implementation guide. The program is also currently contemplating applying for grants related to the ACA.

Contact: Gina Upchurch, RPh, MPH, Executive Director, Senior PharmAssist, gina@seniorpharmassist.org.

GERIATRIC CARE

Description of ACA Provisions

- *Geriatric assessments and care plans*.[46]
  This Innovation Center initiative will test the use of geriatric assessments and care plans to coordinate care for people with multiple chronic conditions and an inability to perform two or more activities of daily living or a cognitive impairment.

- *Independence at Home Demonstration Program*.[47]
  This demonstration will test a payment-incentive service delivery model with eligible home-based primary care teams who serve eligible Medicare beneficiaries. No more than 10,000 beneficiaries will be served by the demonstration. The Secretary will determine quality and performance standards that the project teams must meet. Payments will be based on a target-spending standard based on the amount the Secretary estimates will be saved annually through the program. Incentive payments will be made to project teams if actual annual expenditures are less than the estimated spending target set by the Secretary. Five million dollars for each fiscal year 2010 through 2015 was appropriated for the demonstration. The demonstration is scheduled to begin no later than January 1, 2012. Agreements with practice teams will last no more than three years.

North Carolina Initiatives

- *Doctors Making Housecalls, LLC*
  Doctors Making Housecalls is a medical practice with 23 board-certified clinicians operating in the Triangle Region of North Carolina. Doctors Making Housecalls provides home-based clinical services to patients who are unable to leave the house, or prefer to receive care in their home. The practice specializes in treating older patients with more complex conditions. Doctors Making Housecalls is equipped with sophisticated technology which allows their

clinicians to perform many tests and procedures normally received in a physician's office in-home.[48]

Contact: 4220 Apex Highway, Suite 200, Durham, North Carolina 27713, (919) 932-5700.

- *Just for Us (JFU).*
  Just for Us is a collaboration of Duke University Health System and Lincoln Community Health Center (LCHC), a federally qualified health center. LCHC patients receive primary care in their home from the JFU-Duke care team. JFU is managed by Duke Community Health. LCHC's aging or disabled patient must be age 30 or older and have an access to care impediment. The care team is comprised of a physician, physician assistant, nurse practitioner, occupational therapist, social worker, community health worker, and phlebotomist. JFU currently serves 350 residents in 14 housing complexes.[49,50] An evaluation of the program two years after its implementation shows that it has substantially reduced emergency room use, inpatient hospital care costs, and improved quality indicators.[51]

  Contact: Frederick S. Johnson, MBA. Assistant Professor, Deputy Director, Division of Community Health, Department of Community and Family Medicine, Duke University Medical Center, johns427@mc.duke.edu.

- *CCNC home visits.*
  As part of CCNC's care-management program, care managers visit patients' homes to provide medication reconciliation, falls prevention assessments, chronic care assessments, home environment assessments, and/or patient education. Patients are given a severity screening and those categorized as "high risk" are given priority for home visitation. Outcome measures of the program include hospital admissions, readmissions, emergency department visits, and follow-up appointments with primary care providers. Home visits are covered in the PMPM payment to CCNC.[52]

  Contact: Denise Levis Hewson, RN, MSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

TELEHEALTH/TELEMONITORING AND HEALTH INFORMATION TECHNOLOGY

Description of ACA Provisions.

- *Supporting care coordination of chronically-ill individuals with health information technology*.[53]
  The Innovation Center is authorized to test care coordination for chronically-ill individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

- *Facilitate inpatient care of hospitalized individuals*.[54]
  The Innovation Center is also authorized to test the use of electronic monitoring by specialists based at integrated health systems to improve services to patients at local

community hospitals.

- *Using telehealth services in medically underserved areas and facilities of the Indian Health Service*.[55]
  Another potential initiative of the Innovation Center will be to use telehealth to treat behavioral health issues and stroke and to improve the capacity of non-medical providers to provide health services for people with chronic complex conditions.

North Carolina Initiatives

- *Roanoke-Chowan Telehealth Network Grant.*
  Roanoke-Chowan Community Health Center (RCCHC) received a grant from the North Carolina Health and Wellness Trust Fund in 2006 to establish a daily remote monitoring and chronic care management program. Phase I of the program began in September 2006 and targeted high risk patients with diabetes, cardiovascular disease (CVD), and hypertension. Patients are given monitoring equipment, including a scale, blood pressure/pulse monitor, blood glucose monitor, and a pulse oximeter to monitor their health status daily. Data from these devices, along with other information about a patient's health status and functioning, is sent via a phone line or Internet daily to a secure server. RCCHC RNs monitor data daily, contact the patient via phone and conduct a nursing assessment and education for any patient with abnormal readings. When the RN determines a potential need for a change in medical regimen, the RN informs the patient's primary care provider via the EHR. This program allows health professionals to intervene early if a patient's health begins to trend downward. An external evaluation showed a statistically significant reduction in hospital charges for patients who participated in this initiative. Patients in the program demonstrated a statistically significant reduction in diastolic blood pressure and have learned better self-management skills. During 2007-2009, additional funding was obtained by Kate B. Reynolds Charitable Trust, the Obici Foundation, Pitt County Foundation, and Roanoke Chowan Community Benefit to expand RCCHC's remote monitoring program and implement post-discharge remote monitoring and chronic care management for diabetes patients at Roanoke Chowan Hospital. Funding received by East Carolina University (ECU) School of Cardiology implemented remote monitoring for RCCHC/ECU cardiovascular disease (CVD) patients and funding received by Piedmont Health Services implemented remote monitoring for CVD patients.

  North Carolina Health and Wellness Trust Fund Phase II Health Disparities funding, received in July 2009, is targeting Medicaid and dual eligible patients with CVD in five additional Community Health Centers (Bertie Rural Health, Greene County Health Services, Kinston Community Health, Commwell Community Health and Cabarrus Community Health Center). In September 2010, RCCHC received a three-year HRSA Telehealth Network Grant and has expanded or will expand the pilot to North Carolina community health centers (First Choice Community Health Center, Piedmont Health Services, Robeson Community Health Center, Wake Health Systems), a rural hospital (Chowan Hospital), and Pitt County Memorial Hospital East Carolina Heart Institute. RCCHC is currently monitoring and managing patients in 14 North Carolina counties from Ahoskie.[56]

Contacts: Kim Schwartz, MA, CEO, Roanoke-Chowan Community Health Center, kschwartz@pcmh.com; Bonnie Britton, MSN, RNC, Telehealth Administrator, University Health Systems of Eastern Carolina. Bonnie.Britton@uhseast.com.

- *East Carolina University Telepsychiatry.*
  The ECU telemedicine program has been in continuous operation since its inception in 1992, making it one of the longest running clinical telemedicine operations in the world. The Telemedicine Center provides clinical telehealth services and support, conducts telehealth research, consults and oversees new and existing statewide telehealth networks and openly educates health care providers and the public on the utility of telehealth. Currently, ECU's telemedicine network consists of various sites across the state delivering direct patient care from multiple physician-read stations within the medical campus. The Telemedicine Center provides the necessary functions for conducting clinical telemedicine transactions, including scheduling, network operations, troubleshooting, training, and administrative support to those sites receiving medical services from ECU Physicians and other local health care providers.

  The telepsychiatry network includes sites in 13 Eastern North Carolina counties (Northampton, Gates, Hertford, Bertie, Edgecombe, Nash, Wilson, Pitt, Greene, Beaufort, Craven, Pamlico, and Jones). Three full-time equivalent psychiatrists provide services to patients through videoconferencing and face-to-face services. The psychiatrists also provide consultation and support for other clinical providers for complicated cases and coordinate with the mobile crisis teams in the 13 counties.[57]

  Contact: Sy Saeed, MD, MS, DFAPA, MAC*Psych*, Professor and Chairman, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University, Chief of Psychiatry, Pitt County Memorial Hospital, saeeds@ecu.edu.

- *Duke Telepsychiatry.*
  For the past six years, the Durham Child Development and Behavioral Health Clinic in the Department of Pediatrics, formerly the Community Guidance Clinic, has had a telepsychiatry program for children with Axis I diagnoses in three Durham public schools. Child psychiatry fellows offer on-site mental health services and staff enrichment each Tuesday morning in order to continue a child's education in a public school in a therapeutic environment. A maximum of 48 students are served through the program, 24 students from K-5th grade and 24 from 6th-12th grade. Duke faculty supervise the visits and provide consultation via telepsychiatry to each school while the fellows are with the children, teachers, counselors, case managers, and family members. The Department of Pediatrics charges Durham Public Schools for each hour the fellows are on site, billing semiannually. New grant funding has allowed Duke to begin a consultation service to two pediatric clinics through Southern Regional Area Health Education Center (AHEC).

  Contact: Richard E. D'Alli, MD, Med, ScM, Associate Professor of Psychiatry and Behavioral Sciences, Associate Professor of Pediatrics, Department of Pediatrics, Duke

University Medical Center, dalli003@mc.duke.edu

- *Foundation for Advanced Health Program Telehealth Grants.*
  A three-year grant to the North Carolina Foundation for Advanced Health Programs from The Duke Endowment, with matching funds from Medicaid, (totaling $434,000) funded three CCNC networks to test a telehealth program for congestive heart failure. Two of the networks (4C and Sandhills) completed the program. The program supplied telemonitoring equipment to patients at home in conjunction with patient self-management education. The goal was to improve outcomes in Medicaid patients by targeting transitions from acute illness to clinical stability. Case managers and network physicians identified patients to include in the program through hospital discharges and outpatient visits. The telemonitoring equipment transmitted data including weight, blood pressure, oxygen saturation, and clinical status daily to a CCNC nurse case manager. Patients who developed acute problems were managed according to CCNC heart failure protocols. An evaluation, available at the end of March 2011, will be based on patient hospitalization rates, re-hospitalization rates within 12 months, total cost per-member-per-month excluding drug costs, change in heart failure quality of life scores, change in self-management self-efficacy scores, patient satisfaction, and adherence rates.[58]

  Contact: Susan Yaggy, President and CEO, North Carolina Foundation for Advanced Health Programs, susan.yaggy@ncfahp.org.

- *CHIPRA Grant Demonstrations.*
  North Carolina's grant initiative was designed to test the use of new and existing measures of quality for children; provider-based models to improve the delivery of care; and demonstrate the impact of model pediatric EHRs on quality of health, quality and cost. The grant period of performance will be 60 months, from FY 2010 through FY 2015.[59]

  For more details on the CHIPRA Grant Demonstrations, please see North Carolina initiatives under Patient-centered Medical Homes.

  Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *Beacon Grant.*
  The Southern Piedmont Community Care Plan (SPCCP) in Concord was one of 15 communities awarded over $15 million to model a demonstration in HIT. The grant is a part of the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Three counties (Cabarrus, Rowan and Stanly) are participating in the grant and make up the Southern Piedmont Beacon Community. SPCCP will use the grant to improve community-level care coordination in high-risk populations such as diabetics, asthmatics, patients with congestive heart failure, and patients transitioning to medical homes. Objectives of the innovation include increasing EHR penetration (especially in free clinics, health departments, FQHC's and small practices), increasing provider and patient access to health data, reducing rates of duplicate testing, reducing readmission rates, improving chronic disease care, and increasing quality in pharmacotherapy. The Community will work closely with regional technology extension centers, the state, and the National Health Information Technology

Research Center to share experiences with HIT to future organizations implementing the technology. Evaluation will be based on cost, health and outcome measures in high-risk patients.[60] SPCCP will use a Health Record Bank that will allow patients to participate in their care and care managers to access information needed for coordination.[61]

Contact: Cindy Oakes, RN, BSN, Director, Southern Piedmont Community Care Plan, cindy.oakes@carolinashealthcare.org.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home will be expanding to include additional data and capabilities and will be expanded for use by all users of the Health Information Exchange (HIE), including providers who are not part of the CCNC system. North Carolina was just awarded an additional $1.7 million for the HIE to build a system to manage medication information from the HIE and other sources. This system will be built by CCNC on the Pharmacy Home model. The project will be piloted in 10 North Carolina counties: Ashe, Avery, Bladen, Cabarrus, Columbus, Granville, Rowan, Stanly, Transylvania and Watauga. All North Carolina counties will have access to the system by late 2012.[62]

  For more details on CCNC's Pharmacy Home Project, please see North Carolina initiatives under Medication Management.

  Contact: Troy Trygstad, PharmD, MBA, PhD, Director, Network Pharmacist Program, CCNC, troy@t2email.com.

SHARED DECISION-MAKING

Description of ACA Provisions

- *Program to facilitate shared decision-making*.[63]
  The ACA authorizes a demonstration to facilitate collaboration between patients, caregivers, or authorized representative and clinicians. A contracted entity will create standards for decision aids—educational tools to help patients, caregivers, and providers understand treatment options and make informed medical care decisions. Grants will be provided to organizations to develop and implement decision aids that meet standards, facilitate informed decision-making, present up-to-date information, explain any lack in clinical evidence for a treatment, and address decision-making across all age groups. The provision also provides grants to develop Shared Decision-Making Resource Centers. These centers will provide technical assistance to providers and develop and share best practices. This demonstration is not specific to Medicare or Medicaid and went into effect immediately. Money has been authorized for FY2010 and each subsequent fiscal year thereafter.

North Carolina Initiatives

- *CCNC Care Management.*
  Case Managers with CCNC coordinate care between patients and providers. A majority of patients can be taught by a case manager how to manage their own conditions and only need one or two follow-ups. However, patients that need more intensive case-management receive regular services. For more details on CCNC, please see North Carolina initiatives under

Patient-Centered Medical Homes.

- *CCNC Palliative Care Initiative.*
  CCNC is proposing a new initiative to train care managers in palliative/end-of-life care to improve health care quality and resource utilization. The initiative aims to teach care managers clinical skills in care planning, cultural competency, and about important documentation tools in end-of-life planning (eg, power of attorney and DNR). The initiative will also create access to palliative care services through information resources, toolkits for care managers, and toolkits for primary care providers. Eight faculty members will develop the curriculum and toolkit for the training sessions. The one-day sessions will include patient communication, care planning, symptom distress screening, and palliative care services.[64]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

- *Stanford Self-Management Model.*
  The Division of Aging and Adult Services, within the NCDHHS, collaborated with CCNC to bring Stanford University's Chronic Disease Self Management Program to North Carolina. The program is offered through local Area Agencies on Aging and aims to educate patients with chronic conditions on living a healthy life. Participants in the program meet with two certified trainers once a week for six weeks. The curriculum includes exercise and nutrition, medication usage, stress management, communicating with health care providers, emotional health, problem solving, and supporting others. The evidence-based program helps patients feel better and decreases hospitalizations and emergency room use.[65]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

MALPRACTICE REFORM

Description of ACA Provisions

- *Medical Malpractice*.[66]
  The HHS Secretary is authorized to award $500,000 in demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. This demonstration is not specific to Medicare or Medicaid and is effective for a five-year fiscal period beginning FY 2011.

North Carolina Initiatives

- *NCORHCC and Access II Care system of near miss reporting and improvement tracking in primary care.*
  The North Carolina Office of Rural Health and Community Care (NCORHCC) and Access II Care (a CCNC Network) received a federal grant of $297,710 to conduct a preliminary study to determine the feasibility of creating a near miss reporting and improvement tracking

system in an ambulatory practice network. The near miss reporting and tracking system will be introduced into six diverse practices. The initiative has three components: 1) a standardized orientation for each practice; 2) reporting and collection of near-miss reports from each practice for six months, and 3) ongoing educational and quality improvement efforts aimed at understanding and learning from the near-miss events including ongoing staff prompts and reminders to use the system. Research aspects of the study include: a) evaluation of the implementation of the system in the six study practices; b) analysis of the types of near-miss events reported including their correlates and the validity of seriousness ratings; and c) evaluation of patient and provider reported behaviors regarding the influence of near-miss disclosure. As a result of this preliminary study, the research team expects to gain a better understanding about how to implement a near-miss reporting system in primary care settings; how practices respond to near-miss event reporting (eg, which types of events may be most amenable to improvement); how increased recognition of near-miss events relates to provider awareness and attitudes toward patient safety and practice change; and how provider disclosure might influence patient behavior in terms of seeking legal advice.[67]

Contact: Steven Crane, MD, Assistant Director, Division of Family Medicine, Mountain Area Health Education Center (MAHEC), steve.crane@pardeehospital.org.

NURSING HOME DEMONSTRATIONS

Description of ACA Provisions.

- *Nursing Home Culture Change*.[68]
  The ACA authorized two three-year demonstration projects by March 2011 to develop best practice models for culture change and use of information technology to improve resident care. This demonstration is not specific to Medicare or Medicaid. Funds have been authorized but not appropriated.

North Carolina Initiatives

- *NC NOVA.*
  The North Carolina New Organizational Vision Award (NC NOVA) was created under a Better Jobs, Better Care grant from the Robert Wood Johnson Foundation and The Atlantic Philanthropies to the North Carolina Foundation for Advanced Health Programs. NC NOVA was expanded to be a statewide program effective January 1, 2007, and program activities were integrated into the Department of Health and Human Services. NC NOVA is a voluntary, incentive-based special state licensure program. Any licensed nursing facility, adult care home, or home care agency whose operating license is in good standing may apply for the NC NOVA special licensure designation. NC NOVA encompasses a comprehensive set of workplace interventions to address the retention and recruitment of direct care workers and the quality of care they provide. The criteria for NC NOVA designation apply equitably across nursing homes, adult care homes, and home care agencies. The four domains of NC NOVA include: 1) supportive workplace, which covers six elements: orientation, peer mentoring, coaching supervision, management support, worker empowerment, reward and recognition; 2) training; 3) balanced workloads; and 4) career development. An applicant must demonstrate on paper and in practice, that it meets the established criteria for each domain.

NC NOVA's determination process is separate from the state's regulatory review and licensure process and is conducted by an independent review organization. The NC NOVA special license is issued by the state.

Staff turnover data from all three care settings, nursing home nurse aide wage data, and nursing home occupancy data are used to compare those organizations with NC NOVA to those who do not have the NC NOVA designation as a means to evaluate program impact. Although early in the analysis, NC NOVA designees tend to show a positive impact.[69]

Contact: Jan Moxley, Office of Long-Term Services and Supports, DHHS, jan.moxley@dhhs.nc.gov.

- *North Carolina Coalition for Long-Term Care Enhancement (NCCLTCE).*
  The NCCLTCE, formerly the North Carolina Eden Coalition, offers enhancement grants to nursing homes to support environmental and cultural changes through new health care innovations. The grants are funded by civil money penalty funds through the North Carolina Division of Health Service Regulation. Changes must improve the quality of life for residents of Medicare/Medicaid certified and Medicaid-only certified long-term care nursing facilities with a history of deficiencies.

  Contact: Becky Wertz, Secretary, NCCLTCE, becky.wertz@dhhs.nc.gov.

- *WIN A STEP UP.*
  WIN A STEP UP (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance) aims to increase recruitment and retention of nursing assistants in North Carolina. It is a partnership between the NCDHHS and the UNC-CH Institute on Aging. After a successful pilot, the program was implemented throughout the state. The pilot of the program was funded by a grant from the Kate B. Reynolds Charitable Trust, but currently the program is funded by civil monetary penalty funds. Nursing assistants are given 33 hours of clinical and interpersonal skills training and a pay-raise from their employer after agreeing to continue working for the employer for at least three months after completing the program. There are no legal penalties, however, for breaking the contract.

  Evaluations of the program show improvement in nursing care, team care, and ratings of career rewards. The most significant result of the program has been the reduction in turnover—participating facilities lower turnover rates by 15 percentage points.[70]

  Contact: Thomas Konrad, PhD, Research Scientist, Institute on Aging, University of North Carolina-Chapel Hill, bob_konrad@unc.edu.

- *North Carolina Health Care Facilities Association's "Journey to National Best".*
  Started in 2005, the *Journey to National Best* is North Carolina Health Care Facilities Association's (NCHCFA) effort to transition skilled nursing homes into facilities of the future. The Journey's goal is to develop strategies to exceed the demands and expectations of

long-term health care consumers and families. To strengthen and transform North Carolina nursing homes, NCHCFA focuses on the issues that are relevant to the lives of residents and the staff who care for them, and works to assure the highest level of health care relevant to the needs of the growing population needing this level of care. The program's mission is a collaborative effort between consumers, policy makers, stakeholders, and providers.

With a grant from The Duke Endowment, FutureCare of North Carolina, the nonprofit research and educational foundation sponsored by the Association, conducted a two-year project "Enhancing the Skills of Nursing Practice in North Carolina Long-Term Care Facilities," 2008-2010. In this project, FutureCareNC launched one of the first projects of its kind in the nation, employing a patient care simulator (PCS) mannequin and a nurse educator in 34 participating nursing homes in North Carolina for 3-5 days per facility. All nursing personnel (at every level: NA, LPN, RN) working in each facility were exposed to clinical modules simulating common patient care situations among older adults. Through these hands-on learning experiences, nursing home staff were exposed to the very best of both nursing education as well as the latest technologies for learning. Emphasis in these sessions was on observational and reporting skills, especially those essential to effective clinical teamwork and individual nursing staff self-efficacy. The experience gained in this initial FutureCareNC project led to a new initiative to use the same technology and approach in addressing the leading categories of medication errors in nursing homes.

For more details on *Journey to National Best*, please see North Carolina initiatives under Patient-Centered Medical Homes.

Contact: Craig Souza, President, North Carolina Health Care Facilities Association (NCHCFA), craigs@nchcfa.org.

HEALTH CARE INNOVATION AWARDS

From clinic to community: achieving health equity in the southern United States
Duke University, in partnership with the University of Michigan National Center for Geospatial Medicine, Durham County Health Department (Durham County, NC), Cabarrus Health Alliance (Cabarrus County, NC), Mississippi Public Health Institute (Quitman County, MS), Marshall University, and Mingo County Diabetes Coalition (Mingo County, WV) plans to use innovation grant funding to reduce death and disability from Type 2 diabetes mellitus among 57,000 underserved, at-risk people in four Southeastern counties.

To support intervention decision making and monitoring, the program will institute an informatics system. Patient-centered care will be coordinated through "local home care teams." Program implementers aim to reduce ED and hospital admissions and the need for amputations, dialysis, and cardiac procedures through preventive care.[71]

Contact: Robert M. Califf, MD, Project Lead, robert.califf@duke.edu.

Building a statewide child health accountable care collaborative: the North Carolina strategy for improving health, improving quality, reducing costs, and enhancing the workforce

North Carolina Community Care Networks, Inc., in conjunction with the Carolinas Medical Center-Charlotte, Duke University Health System, University of North Carolina Hospitals, Vidant Medical Center-East Carolina, and Wake Forest Baptist Health, as well as the children's units at Cape Fear Valley Health, Cone Health, Mission Hospital, New Hanover Regional Medical Center, Presbyterian Healthcare, and WakeMed Hospitals, plan to use innovation grant funding to form a Child Health Accountable Care Collaborative.

The Collaborative aims to improve continuity of care and health care access as well as reduce ED visits, hospitalizations, and pharmacy costs for 50,000 Medicaid and CHIP children with chronic diseases. Care coordination will occur through specialist office "special care managers" and through "parent navigators" (who will work with parents in the home).[72]

Contact:

Regional Integrated Multi-Disciplinary approach to Prevent and Treat Chronic Pain in North Carolina

The Mountain Area Health Education Center plans to use innovation grant funding to pilot "team-based enhanced primary care" for patients with chronic pain. The target population includes over 2,000 people across 16 counties in Western North Carolina. Program implementers expect to improve the health of patients, enhance patient ability to manage pain, and reduce the frequency of outpatient visits.[73]

Contact:

OTHER NORTH CAROLINA NEW MODELS

Value Based Insurance Product Design

Another "new model" that is being tested among private insurers is value based insurance design (VBID). With VBID, insurers encourage enrollees to use services or medications of higher value by reducing or eliminating the out-of-pocket cost sharing (for example, eliminating cost sharing for highly effective medications) or by increasing the cost sharing on services, procedures, or medications that are less useful.[74] VBID products can also be designed to provide financial incentives to enrollees to encourage them to obtain care from high quality, lower-cost health care providers. Unlike traditional Preferred Provider Organization (PPO) insurance products—which have differential cost-sharing arrangements for in-network and out-of-network providers—value based insurance products may have multiple tiers of cost sharing. The amount of the cost sharing may differ depending on the procedure/service and the provider. Thus, a large health care system may be considered a best value provider for open heart surgery, but not for knee or hip replacement. Blue Cross Blue Shield of North Carolina is testing a value-based insurance product design for one large employer group.

Contact: Don Bradley, MD, Senior Vice President, Chief Medical Officer, Blue Cross and Blue Shield of North Carolina. don.bradley@bcbsnc.com

Improving Population Health

In addition to the new models that focus on changes in the health care delivery system and payment methodologies, some communities are testing new models focused on improving overall population health. Population health programs include some of the changes in delivery and payment models discussed previously, but also include community-based efforts to address socioeconomics, transportation, literacy, and other broader societal issues that affect population health. The Durham Health Innovation (DHI) is an example of this broader community-focused health intervention. This is a collaboration between Duke Medicine, Durham County Health Department, Durham Center (Local Management Entity), Durham County Department of Social Services, Durham Public Schools, Durham Housing Authority, Durham Parks and Recreation, City of Durham, Lincoln Community Health Center, and numerous other community agencies and faith-based organizations that are working together to improve the health status of Durham County residents. In 2009, DHI funded 10 planning teams to find ways to reduce death or disabilities from diseases or other health problems prevalent in the community. The planning group selected seven neighborhoods as their pilot sites, focusing on areas in the county that are low-income, more heavily comprised of racial and ethnic minorities, and which have greater health problems. DHI involved the targeted communities in selecting priority interventions. Based on this feedback, DHI decided to develop a neighborhood health navigators program to help link community residents with existing health and social services programs; involve community agencies in providing health information; and engage community organizations, faith-based organizations, neighborhood and community leaders, business owners, and community members to ensure healthy foods in schools and neighborhoods and safe places to exercise. DHI is funded through an institutional commitment of $1 million from Duke University, support from the Clinical and Translational Science Awards which are funded by the National Institutes of Health, and in-kind contributions from numerous community organizations.[75]

Contact: Michelle Lyn, MBA, MHA, Associate Director, Duke Center for Community Research, Chief, Division of Community Health in the Department of Community and Family Medicine, Duke University Medical Center, michelle.lyn@duke.edu.

Medicaid Emergency Psychiatric Demonstration

This demonstration program aims to test whether Medicaid can improve patient care and lower costs by reimbursing private psychiatric hospitals for specific services for which Medicaid has been historically unavailable. North Carolina was one of 12 States to be selected to be part of this demonstration.[76]

Innovation Advisors Program

CMS' Innovation Center has selected "innovation advisors" from across the Country to test new models of care in their own organization and to create partnerships across the United States to share innovations and new delivery models.[77] Four advisors have been selected from North Carolina:

Rob Baird MS
Geriatric Practice Management, Inc.
Asheville, NC

Pamela Duncan PhD, PT, FAPTA, FAHA
Wake Forest Baptist Health
Winston Salem, NC

Suzanne Landis MD, MPH
Mountain Area Health Education Center (MAHEC)
Asheville, NC

Zeev Neuwirth MD, MHCM
Carolinas Healthcare System
Charlotte, NC

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1 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021, enacting Sec. 1115A of the Social Security Act, 42 USC 1315a.

2 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2703, enacting Sec. 1945 of the Social Security Act, 42 USC 1396w-4.

3 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(i) of the Social Security Act, 42 USC 1315a.

4 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(xvii) of the Social Security Act, 42 USC 1315a.

5 Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3502, 10321.

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7 Community Care of North Carolina. Overview. http://www.communitycarenc.com. Accessed February 1, 2011.

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16 Souza, C. President, North Carolina Health Care Facilities Association. Written (email) communication. February 16, 2011.

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18 Hewson D.L. North Carolina's 646 quality demonstration. Presented to: National Academy for State Health Policy's 23rd Annual State Health Policy Conference; October 5, 2010; New Orleans, LA.

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APPENDIX I
ACA FUNDING CHART

Health Benefit Exchange					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Early Innovator Grants/ Planning Grants/ Establishment Grants	93.525	1311	North Carolina Department of Insurance	$1,000,000[1]	The North Carolina Department of Insurance was awarded a State Planning Grant in September 2010. Planning grants were awarded to help states plan for the establishment of insurance exchanges under the Affordable Care Act. NC plans to use planning grant funds to accomplish the following: • Form an interagency workgroup to study state exchange feasibility and to engage in planning activities; • Continue work to ensure the needs of the poor and "near-poor" are met; and • Consider NC FAST and its functionality with respect to a future insurance exchange.[2]
Early Innovator Grants/ Planning Grants/ Establishment Grants	93.525	1311	North Carolina Department of Insurance	$12,396,019[3]	The North Carolina Department of Insurance was awarded a Level 1 Insurance Exchange Establishment Grant in June 2011. NC plans to use establishment grant funds to accomplish the following: • Engage stakeholders; • Analyze remaining policy decisions; • Expand NC's current eligibility system; • Develop non-eligibility requirements; • Develop a consumer assistance program; • Develop a work plan, budget, and evaluation plan; • Develop a sustainability plan; and • Support operational activities related to the exchange.[4]
Affordable Care Act Grants to States for Health Insurance Premium Reviews	93.511	1003	North Carolina Department of Insurance	$1,000,000[5]	First round Health Insurance Premium Review Grants were awarded States in August 2011. Grant funds are to be used by States to review proposed health plan premium increases, take action against insurers pursuing unreasonable rate increases, and ensure health insurance consumers receive value for premium money spent.[6] North Carolina reported the following achievements under the first round of this grant program: • Expansion of the Commissioner of Insurance's prior approval authority; • Estimated beneficiary savings of $14.5 million; and • Staff expansion including adding seven rate review staff (including an actuary and an attorney).[7]
Affordable Care Act Grants to States for Health Insurance Premium Reviews	93.511	1003	North Carolina Department of Insurance	$3,984,080[8]	Second round Health Insurance Premium Review Grants were awarded States to continue work related to reviewing health insurance premiums. NC plans to hire three additional staff under Cycle II as well as continue rate filing legislative efforts and work to improve rate review IT infrastructure.[9]

Health Benefit Exchange					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Health Insurance Consumer Assistance Grants	93.519	1002	North Carolina Department of Insurance, Ombudsman Services Group	$850,000[10]	Health Insurance Consumer Assistance grants were awarded to states in 2010. States will use funds to continue current initiatives which aim to protect consumers from poor insurance industry practices. North Carolina plans to use its grant to accomplish the following: • Expand external review and consumer counseling services provided by the Healthcare Review Program; • Develop a NC Consumer Assistance Program; • Hire staff case managers to assist consumers in transitioning to new health insurance programs; and • Create a Community Advisory Board.[11]
Pre-Existing Condition Insurance Plan (PCIP)	93.529	1101	Individual enrollment through April 30, 2012: 3,907	estimated allocation $145,000,000[12] (July 1, 2010 - January 1, 2014)	The Pre-Existing Condition Insurance Plan (PCIP) makes health insurance available to those who have been unable to gain coverage due to pre-existing conditions. The PCIP program ends in 2014.[13]
Medicaid					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Aging and Disability Resource Centers (ADRCs)	93.517	2405	North Carolina	$523,000[14]	Aging and Disability Resource Centers (ADRCs) support seniors, people with disabilities, and their families understand and assess long-term care options. ADRC grant funding was announced in September 2010 for the following grant programs: • **ADRC Options Counseling Grants:** Assist individuals and families understand, evaluate, and manage community services and supports. • **ADRC Nursing Home Transition through Money Follows the Person Grants**: Strengthens the role of ADRCs in the CMS Money Follows the Person program and supports Medicaid agencies as they transition individuals from nursing homes to community-based care.[15]
Health Care Innovation Awards		3021	See below.		The CMS Innovation Center announced the first round of innovation awards in May 2012 and the second (and final) round in June 2012. Health Care Innovation grant recipients will implement projects which strive to improve health care delivery and to lower costs to individuals/families enrolled in Medicare, Medicaid, or Children's Health Insurance Programs (CHIP) – especially those with the greatest health care needs.[16]

Medicaid					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Duke University	$9,773,499 (2012 – 2015)[17]	**Project Title**: "From Clinic to Community: Achieving Health Equity in the Southern United States" **Geographic Reach**: Mississippi, North Carolina, West Virginia **Estimated 3-Year Savings**: $20.8 million **Summary**: Duke University, in partnership with the University of Michigan National Center for Geospatial Medicine, Durham County Health Department (Durham County, NC), Cabarrus Health Alliance (Cabarrus County, NC), Mississippi Public Health Institute (Quitman County, MS), Marshall University, and Mingo County Diabetes Coalition (Mingo County, WV) plans to use innovation grant funding to reduce death and disability from Type 2 diabetes mellitus among 57,000 underserved, at-risk people in four Southeastern counties. To support intervention decision making and monitoring, the program will institute an informatics system. Patient-centered care will be coordinated through "local home care teams." Program implementers aim to reduce ED and hospital admissions and the need for amputations, dialysis, and cardiac procedures through preventive care.[18]
			Mountain Area Health Education Center	$1,186,045 (2012 – 2015)	**Project Title**: "Regional Integrated Multi-Disciplinary approach to Prevent and Treat Chronic Pain in North Carolina" **Geographic Reach**: North Carolina **Estimated 3-Year Savings**: $2.4 million **Summary:** The Mountain Area Health Education Center plans to use innovation grant funding to pilot "team-based enhanced primary care" for patients with chronic pain. The target population includes over 2,000 people across 16 counties in Western North Carolina. Program implementers expect to improve the health of patients, enhance patient ability to manage pain, and reduce the frequency of outpatient visits.
			North Carolina Community Networks	$9,343,670 (2012 – 2015)	**Project Title:** "Building a statewide child health accountable care collaborative: the North Carolina strategy for improving health, improving quality, reducing costs, and enhancing the workforce" **Geographic Reach**: North Carolina **Estimated 3-Year Savings**: $24,089,682 **Summary:** North Carolina Community Care Networks, Inc., in conjunction with the Carolinas Medical Center-Charlotte, Duke University Health System, University of North Carolina Hospitals, Vidant Medical Center-East Carolina, and Wake Forest Baptist Health, as well as the children's units at Cape Fear Valley Health, Cone Health, Mission Hospital, New Hanover Regional Medical Center, Presbyterian Healthcare, and WakeMed Hospitals, plan to use innovation grant funding to form a Child Health Accountable Care Collaborative. The Collaborative aims to improve continuity of care and health care access as well as reduce ED visits, hospitalizations, and pharmacy costs for 50,000 Medicaid and CHIP children with chronic diseases. Care coordination will occur through specialist office "special care managers" and through "parent navigators" (who will work with parents in the home).[19]

Medicaid					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
State Demonstrations to Integrate Care for Dual Eligible Individuals – Design Contracts		3021	North Carolina	Up to $1,000,000 (2011 – 2012)	Approximately nine million Americans are eligible for both Medicare and Medicaid. The State Demonstration to Integrate Care for Dual Eligible Individuals was created to develop new strategies for meeting the needs of these individuals with complex, costly medical needs. Fifteen states received funding in 2011 to design/develop person-centered models of care which fully coordinate services – including primary, acute, behavioral, and long-term. CMS will work with states on implementing "plans which hold the most promise." The program aims to eliminate duplication of services, expand access to care, improve patient lives, while ultimately lowering costs.[20] **North Carolina's Approach:** North Carolina's design is based on, and builds upon, the Community Care of North Carolina (CCNC) infrastructure. "It is a public-private collaborative through which the State has partnered with community physicians, hospitals, health departments and other community organizations to build regional networks to improve the quality, efficiency and cost-effectiveness of care for Medicaid and Medicare beneficiaries." CCNC currently serves over 83,000 dual eligibles.[21]
Medicaid Emergency Psychiatric Demonstration		2707	North Carolina		This demonstration provides over $75 million in federal Medicaid matching funds for the reimbursement of private psychiatric hospitals for services which have been traditionally unallowable under Medicaid.[22]
Safety Net					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Grants for Operation of School-Based Health Centers	93.501	4101	Alamance-Burlington School System (Burlington, NC)	$137,990[23]	The School-Based Health Center Capital Program makes $200 million in funding available through a series of awards to address health center capital needs (to improve existing facilities or establish new sites) and to support the delivery and expansion of services offered through school-based health centers. The first in the series of grant awards were made in July 2011. Grants will be made through 2013.[24]
			Bakersville Community Medical Clinic Inc. (Bakersville, NC)	$126,017	See description above.
			FirstHealth Of The Carolinas (Pinehurst, NC)	$499,988	See description above.
			Lincoln Community Health Center Inc. (Durham, NC)	$50,000	See description above.

Safety Net					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Mitchell County Board Of Education (Bakersville, NC)	$148,459	See description above.
			Morehead Memorial Hospital (Eden, NC)	$242,915	See description above.
			West Caldwell Health Council Inc. (Collettsville, NC)	$411,900	See description above.
			Yancey County Schools (Burnsville, NC)	$500,000	See description above.
			Cherokee County Schools (Murphy, NC)	$250,000[25]	The School-Based Health Center Capital Program makes $200 million in funding available through a series of awards to address health center capital needs (to improve existing facilities or establish new sites) and to support the delivery and expansion of services offered through school-based health centers. The first in the series of grant awards were made in July 2011. Grants will be made through 2013.[26]
			Blue Ridge Community Health Services (Hendersonville, NC)	$160,000[27]	See description above.
			Wilmington Health Access For Teens, Inc. (Wilmington, NC)	$382,375	See description above.
Health Center New Access Point Grants			Bakersville Community Medical Clinic, Inc. (Bakersville, NC)	$595,833[28]	Health Center New Access Point Grants were announced in June 2012. Grant funds will be used to support the operation of full-time service delivery centers.[29]
			High Country Community Health (Boone, NC)	$608,333	See description above.
			Cabarrus Community Health Centers, Inc. (Concord, NC)	$379,167	See description above.

Safety Net					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Gaston Family Health Services, Inc. (Gastonia, NC)	$487,500	See description above.
			Blue Ridge Community Health Services (Hendersonville, NC)	$566,597	See description above.
			Robeson Health Care Corporation (Pembroke, NC)	$958,000	See description above.
			Rural Health Group, Inc. (Roanoke Rapids, NC)	$225,000	See description above.
			Opportunities Industrialization Center, Inc. (Rocky Mount, NC)	$650,000	See description above.
			Southside United Health Center (Winston-Salem, NC)	$650,000	See description above.
Community Health Center Capital Development Program Grants	93.526	4101	Roanoke Chowan Community Health Center Inc. (Ahoskie, NC)	$6,224,395[30]	The Capital Development (CD) program provides community health centers funds to address construction and renovation needs and to support service expansion. Under this grant program, $11 billion in awards are expected to be made over five years ($1.5 billion for major construction and $9.5 billion for service expansion). The first in this series of awards was made in October 2010. [31]
			Blue Ridge Community Health Services (Hendersonville, NC)	$5,000,000	See description above.
			First Choice Community Health Centers (Mamers, NC)	$3,500,000	See description above.

Safety Net					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Metropolitan Community Health Services, Inc. (Washington, NC)	$4,467,018	See description above.
Community Health Center Capital Development Grants – Building Capacity	93.526	4101	Goshen Medical Center, Inc. (Faison, NC)	$4,550,000[32]	The Capital Development (CD) program provides community health centers funds to address construction and renovation needs and to support service expansion. Under this grant program, $11 billion in awards are expected to be made over five years ($1.5 billion for major construction and $9.5 billion for service expansion). These awards were made in May 2012.[33]
			Rural Health Group, Inc. (Roanoke Rapids, NC)	$577,320	See description above.
			Carolina Family Health Centers, Inc. (Wilson, NC)	$3,507,460	See description above.
			West Caldwell Health Council, Inc. (Collettsville, NC)	$568,934	See description above.
Community Health Center Capital Development Grants - Immediate Facility Improvement	93.526	4101	Piedmont Health Services, Inc. (Carrboro, NC)	$500,000[34]	The Capital Development (CD) program provides community health centers funds to address construction and renovation needs and to support service expansion. Under this grant program, $11 billion in awards are expected to be made over five years ($1.5 billion for major construction and $9.5 billion for service expansion). These awards were made in May 2012.[35]
			The C.W. Williams Community Health Center, Inc. (Charlotte, NC)	$500,000	See description above.
			Goshen Medical Center, Inc. (Faison, NC)	$500,000	See description above.
			Rural Health Group, Inc. (Roanoke Rapids, NC)	$500,000	See description above.

Safety Net					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Stedman-Wade Health Services, Inc. (Wade, NC)	$200,028	See description above.
Health Center Expanded Services Supplemental Funding	93.527	10503	North Carolina	$15,324,939[36]	Health Center Expanded Services Supplemental Funding supports increased access to primary care and preventive health services (e.g., oral, behavioral, pharmacy, vision, and/or other "enabling services"). [37]
Workforce					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
ACA Primary Care Residence Expansion Program	93.510	1003	University of North Carolina at Chapel Hill (Chapel Hill, NC)	$3,715,684 (2010 – 2015)	The Primary Care Residence Expansion Program funds accredited primary care residency programs to increase residents trained in general internal medicine, family medicine, and pediatrics. Grantees have five years to extend stipend support to new residents enrolled in 3-year primary care training programs. It is estimated that the program will support the training of 889 new primary care residents by 2015.[38]
			New Hanover Regional Medical Center (Wilmington, NC)	$1,795,571 (2010 – 2015)	See description above.
ACA Expansion of Physician Assistant Training Program	93.514	5301	Duke University Medical Center (Durham, NC)	$1,320,000 (2010 – 2015)	The Expansion of Physician Assistant Training Program will fund 28 primary care physician assistant training programs over 5 years. Student stipends are $22,000 per student per year (for 2 years). It is estimated that the program will support the training of more than 700 physician assistants by 2015.[39]
			Methodist University, Inc. (Fayetteville, NC)	$1,188,000 (2010 – 2015)	See description above.
Demonstration Project to Develop Training and Certification Program for Personal or Home Care Aides	93.512	5507(b)	North Carolina Department of Health and Human Services	$2,100,000[40] (2010-2012)	The purpose of the Personal and Home Care Aides State Training Program (PHCAST) is to meet personal and home care occupational needs in shortage and or/high demand areas by training qualified personal and home care aides. Grants were made to States for the development of training curriculum and certification programs for personal and home care aides. These aides provide critical services to the geriatric, mentally ill, and disabled populations.[41]

Workforce					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Advanced Nursing Education Expansion Grant Program	93.513	5308	Duke University School of Nursing (Durham, NC)	$1,276,000 (2010 – 2015)	The Advanced Nursing Education Expansion Program will fund 26 nursing schools to increase full-time enrollment in primary care nurse practitioner (NP) and nurse midwife (NMW) programs. Student stipends are $22,000 per student per year (for 2 years). It is estimated that the program will support the training of more than 600 NPs and NMWs by 2015.[42]
Advanced Education Nursing Traineeships	93.358	5308	University of North Carolina at Chapel Hill (Chapel Hill, NC)	$90,365[43]	The Advanced Education Nursing Traineeships Program funds traineeships for nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse administrators, nurse educators, public health nurses, and other nurses requiring advance education through eligible institutions.[44]
			University of North Carolina at Charlotte (Charlotte, NC)	$43,357	See description above.
			Duke University School of Nursing (Durham, NC)	$85,088	See description above.
			University of North Carolina Greensboro (Greensboro, NC)	$97,320	See description above.
			East Carolina University (Greenville, NC)	$82,597	See description above.
			University of North Carolina Wilmington (Wilmington, NC)	$11,291	See description above.
			Winston-Salem State University (Winston-Salem, NC)	$73,874	See description above.
Nurse Anesthetist Training	93.124	5308	University of North Carolina at Charlotte (Charlotte, NC)	$24,385 (2011)[45] $29,313 (2012)[46]	Nurse Anesthetist Traineeships support licensed registered nurses enrolled (full-time) in their second year of eligible two-year nurse anesthetist master's programs.[47]
			Western Carolina University (Cullowhee, NC)	$ 2,369 (2011) $11,516 (2012)	See description above.

Workforce					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Duke University School of Nursing (Durham, NC)	$13,862 (2011) $20,819 (2012)	See description above.
			University of North Carolina Greensboro (Greensboro, NC)	$20,431 (2011) $50,750 (2012)	See description above.
			East Carolina University (Greenville, NC)	$11,816 (2011) $12,516 (2012)	See description above.
Nurse Faculty Loan Program	93.264	5311	University of North Carolina at Chapel Hill (Chapel Hill, NC)	$103,419 (2011)[48] $91,155 (2012)	The Nurse Faculty Loan Program, through grants to eligible institutions, offers partial loan forgiveness for registered nurses who are completing graduate education to become qualified nurse faculty.[49]
			Duke University School of Nursing	$104,755 (2012)	See description above.
Advanced Education Nursing Grant Program	93.247	5308	Western Carolina University (Cullowhee, NC)	$600,931[50]	The Advanced Education Nursing Grant Program supports registered nurses who are pursuing advanced nursing education specialty programs to become nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse-midwives, nurse educators, nurse researchers/scientists, public health nurses, and other nurse specialists.[51]
			Duke University (Durham, NC)	$212,965	See description above.
Graduate Nurse Education Demonstration		5509	Duke University Hospital (Durham, NC)		CMS is authorized to spend up to $50 million per year (2012-2015) under this demonstration program. CMS will reimburse eligible hospitals for clinical training costs for advanced practice registered nursing (APRN) students.[52]
Nursing Workforce Diversity			University of North Carolina at Chapel Hill (Chapel Hill, NC)	$210,185 (2012)[53]	The Nursing Workforce Diversity grant supports nursing schools in an effort to increase nursing education opportunities for those individuals with disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented in the nursing workforce. Grant assistance includes financial assistance, academic support, and mentoring.[54]
Interdisciplinary and Interprofessional Graduate Joint Degree			University of North Carolina at Chapel Hill (Chapel Hill, NC)	$253,061 (2012)[55]	Interdisciplinary and Interprofessional Graduate Joint Degree supports the integration of public health content into clinical curricula. This grant program supports collaboration efforts occurring in education settings, community-based training, as well as faculty development.[56]
Comprehensive Geriatric Education			Duke University School of Nursing (Durham, NC)	$261,717.00 (2012)[57]	The Comprehensive Geriatric Education program supports grant projects to train and educate those providing care for the elderly. Supported activities include curriculum development, faculty training, and continuing education.[58]

Prevention					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Maternal, Infant, and Early Childhood Home Visitation Grant Program (MIECHV)	93.505	2951	North Carolina Department of Health and Human Services	$2,263,162 (07/10/2012 – 09/30/2012)	The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) provides funding to states and jurisdictions to support evidence-based home visiting programs focused on improving family and young child well-being. Nurses, social workers, and other professionals determine family needs and circumstances, provide direct family support to foster healthy child development and parenting skills, and connect families to local resources and services which can improve and strengthen child and family health and well-being. Initial formula grants, made in February 2011, aimed to support states and jurisdictions in assessing existing home visiting programs and high-need areas.[59]
			North Carolina Department of Health and Human Services	$6,418,246 (9/30/11 – 9/29/14)[60]	Competitive MIECHV grant awards were made in September 2011. (See program description above.) **NC awardees**: Buncombe County Department of Health (Buncombe); Barium Springs for Children (lesser Burke County); Center for Child and Family Health (Durham); Northampton County Health Department (Northampton, Hertford, Halifax, and Edgecombe); Robeson County Health Department (Robeson and Columbus); Toe River Health District (Yancey and Mitchell).
			North Carolina Department of Health and Human Services	$1,943,112 (9/30/12 – 9/29/13)	Competitive Development: Awarded September 2012. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) provides funding to states and jurisdictions to support evidence-based home visiting programs focused on improving family and young child well-being. The funds are intended to support initiatives that build on the existing ACA Maternal, Infant and Early Childhood Home Visiting formula funding provided to states and territories to support quality implementation of home visiting programs. This funding will develop infrastructure to support evidence-based home visiting within the state, as grounded in implementation science.
Teen Pregnancy Prevention Program	93.297	2953	TPP Tier 1: Replication of Evidence-Based Programs Iredell-Statesville Schools	$807,597[61]	Teen Pregnancy Prevention Program funds were awarded through a competitive grant process in September 2010. Tier 1 grantees must implement evidence-based teen pregnancy prevention programs.[62]
			TPP Tier 1: Replication of Evidence-Based Programs: Family Resource Center of Raleigh, Inc.	$796,916	See description above.

Prevention					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			TPP Tier 2: Community Wide Adolescent Pregnancy Prevention of North Carolina	$1,163,553	Teen Pregnancy Prevention Program funds were awarded through a competitive grant process in September 2010. Tier 2 grantees are responsible for implementing community-wide programs (in partnership with the CDC).[63]
Personal Responsibility Education Program (PREP)	93.092	2953	North Carolina Department of Health and Human Services	$1,603,738 (10/1/12 – 9/30/15)[64]	Personal Responsibility Education Program (PREP) formula and competitive grant awards were made in September 2010. Formula awards were made to states for the implementation of evidence-based teen pregnancy and sexually transmitted infection prevention interventions. Interventions must include abstinence and contraception lessons. Additionally, programs must include other adulthood preparation components (e.g., healthy relationships, communication, and financial literacy). Competitive grant awards were made to test innovative strategies for reducing teen pregnancy and repeat pregnancy.[65]
Pregnancy Assistance Fund	93.500	10212	North Carolina Department of Health and Human Services	$1,768,000 (9/1/12 – 8/31/13)[66]	The Pregnancy Assistance Fund provides funding to states and tribes to support pregnant and parenting teens and women. States may use these grant funds to link pregnant and parenting teens and women to critical supportive services and local resources (health care, child care, housing, education, domestic violence etc.).[67] **North Carolina Project Description:** The North Carolina Department of Health and Human Services is implementing a program called **Young Moms Connect** in five high need counties (Bladen, Nash, Onslow, Rockingham, and Wayne). The Young Moms Connect program aims to : • Implement evidence-based strategies and practices into existing programs for pregnant and parenting women ages 13 – 24 years; • Provide accessible, high quality services which meet the needs of pregnant and parenting women ages 13 – 24 years; • Build effective local systems of care for pregnant and parenting women ages 13-24 years; • Improve the health and well-being of pregnant and parenting women ages 13 – 24 years and their families; • Identify lessons learned and replicable practices for statewide implementation.[68]
Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program	93.508	2951	Eastern Band of Cherokee Indians	$205,000 (July 1, 2011 – June 30, 2016)[69]	The Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program supports the development and implementation of evidence-based, culturally-appropriate home visiting programs to improve family and young child well-being in at-risk tribal communities.[70] **North Carolina Project Description:** North Carolina's Tribal Maternal, Infant, and Early Childhood Home Visiting Program funds will be used to support the development of a needs assessment and action plan for home visiting service needs of pregnant women and families (with children up to two years of age) among the Eastern Band of Cherokee Indians. The service area includes over 56,000 acres of mountainous land across five western NC counties.[71]

Prevention					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Communities Putting Prevention to Work (CPPW)	93.520	4002	North Carolina Division of Public Health: Appalachian District Health Department and Pitt County	$3,800,492[72]	Communities Putting Prevention to Work (CPPW) grants were awarded to 50 communities across the country to confront the two leading causes of preventable death in the United States – obesity and tobacco use. In North Carolina, the Appalachian District Health Department and Pitt County were awarded funds (totaling 3,239,600) for obesity prevention activities.[73] The Appalachian District Health District (ADHD) is using CPPW funds to increase community access to healthy foods and to support policy changes in schools and workplaces to promote nutrition and physical Activity. The Pitt County Health Department (PCHD) is using CPPW funds to improve access to nutritious foods through The Corner Store Initiative. PCHD also plans to use funding to support and encourage physical activity within the community.[74]
National Improvement Initiative (NPHII): Strengthening Public Health Infrastructure for Improved Health Outcomes	93.507	4002	North Carolina Division of Public Health	$2,941,636[75]	The National Public Health Improvement Initiative (NPHII) supports states, tribes, territories, and localities in making organizational improvements to enhance the delivery of public health services. The North Carolina Division of Public Health received $1,903,858 in 2010 and $1,037,779 in 2011. NPHII is a 5 year grant initiative.[76]
Prevention and Public Health Fund (Affordable Care Act) - Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance	93.539		North Carolina Division of Public Health	$1,023,484 (9/1/11 – 8/31/13)	The National Immunization Program within the Centers for Disease Control and Prevention is replacing the current vaccine ordering system. Because providers statewide order vaccines through the North Carolina immunization registry, an interface between the registry and the new system is critical in the timely receipt of vaccines. In addition, providers using electronic medical records need to interface their systems with the North Carolina immunization registry to avoid duplicate data entry and meet federal Meaningful Use requirements. The latter functionality will be accomplished through the state's health information exchange. The Division of Public Health will use these funds to accomplish both interfaces described above by August, 2013.
Community Transformation Grants (CTG) (Implementation Grant)	93.531	4201	North Carolina Division of Public Health	$7,466,092[77] (2011)	States and communities who received Community Transformation Grants will use funds to address the following areas: tobacco use; healthy eating; active living; evidence-based clinical and preventive services (with a specific focus on controlling high blood pressure and high cholesterol). The North Carolina Division of Public Health received an implementation grant under this grant program, which means funds must be used to implement evidence-based programs and interventions to improve citizen health and well-being.[78] The North Carolina Division of Public health will use funds to serve the entire State (with the exception of large counties). NC CTG grants will focus on expanding efforts related to tobacco-free living, active living and health eating, and quality clinical and preventive services.

Prevention					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Epidemiology Laboratory Capacity (ELC) for Infectious Disease Grants	93.521	4304	North Carolina Department of Health and Human Services	$371,894[79]	The Epidemiology Laboratory Capacity Grant Program (ELC) aims to increase local public health capacity and infectious disease preparedness. Grant funds can be used to hire staff, purchase laboratory supplies and equipment, and to build IT systems for reporting and monitoring.[80]
Extension of Family-to-Family Health Information Centers	93.504	5507	Exceptional Children's Assistance Center (Davidson, NC)	$191,000[81]	The Family-to-Family Health Information Center extension funding supports family-run organizations that provide information, education, peer support, and training to families with children who have special health care needs. Support includes helping families understand and connect to federal, state, and local health care resources. These grants, awarded in May 2011, will extend funding for grant recipient through 2012.[82]
Communities Putting Prevention to Work - CDC Tobacco Quitline Grant	93.520		North Carolina Department of Health and Human Services	$98,266[83]	As part of the overall effort to reduce the burden of chronic diseases and chronic disease risk factors, the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, provided this award of Affordable Care Act funds to create additional tobacco quitters, beyond what states and jurisdictions have projected to achieve in Recovery Act funded programs.
Affordable Care Act - Preparedness and Emergency Response Learning Centers (PERLC)	93.606	4002	The UNC Gillings School of Global Public Health (Chapel Hill, NC)	$937,657[84]	The UNC Gillings School of Global Public Health received funding to build an Emergency Response Learning Center (PERLC). Fourteen institutions received funding from the CDC under this initiative. UNC's PERLC aims to meet public health workforce training needs at the local, regional, and state levels. The UNC PERLC includes North Carolina, Tennessee, Virginia, and West Virginia. Funding began in September 2010.[85]
Quality					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
Partnership for Patients			North Carolina Hospital Association	$7,200,000 (optional 3rd year funded at $3,600,000)[86]	The Partnership for Patients initiative was launched by CMS in 2011. This initiative aims to support hospitals in reducing preventable hospital-acquired infections and reducing preventable hospital readmissions.[87]
			Carolinas Health Care System	$4,300,000[88]	See description above.
Partnership for Patients			Northwest Triad Care Transitions Community Program (NTCTCP) (North Carolina)		The Northwest Triad Care Transitions Community Program (NTCTCP) will address care transition needs of urban and rural North Carolinians through partnership with hospitals and other providers. NTCTCP will work with Forsyth Medical Center, Hugh Chatham Memorial Hospital, Lexington Medical Center, Medical Park Hospital, Northern Hospital of Surry County, Thomasville Medical Center, and Wake Forest Baptist Health. [89]

New Models					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
State Demonstrations to Integrate Care for Dual Eligible Individuals – Design Contracts		3021	North Carolina	Up to $1,000,000 (2011 – 2012)	Approximately nine million Americans are eligible for both Medicare and Medicaid. The State Demonstration to Integrate Care for Dual Eligible Individuals was created to develop new strategies for meeting the needs of these individuals with complex, costly medical needs. Fifteen states received funding in 2011 to design/develop person-centered models of care which fully coordinate services – including primary, acute, behavioral, and long-term. CMS will work with states on implementing "plans which hold the most promise." The program aims to eliminate duplication of services, expand access to care, improve patient lives, while ultimately lowering costs.[90] **North Carolina's Approach:** North Carolina's design is based on, and builds upon, the Community Care of North Carolina (CCNC) infrastructure. "It is a public-private collaborative through which the State has partnered with community physicians, hospitals, health departments and other community organizations to build regional networks to improve the quality, efficiency and cost-effectiveness of care for Medicaid and Medicare beneficiaries." CCNC currently serves over 83,000 dual eligibles.[91]
Independence at Home Demonstration			Doctors Making Housecalls, LLC (Durham, North Carolina)		CMS will work with participating providers who provide home-based care for chronically ill patients (over a three-year period). CMS will track and study patient care experience, quality measures, and Medicare savings.[92]
Medicare Shared Savings Program - Accountable Care Organizations (ACOs)			Cornerstone Health Care (High Point, NC)		The Centers for Medicare & Medicaid Services (CMS) has established a Medicare Shared Savings Program (Shared Savings Program) to better coordinate care for Medicare beneficiaries. Eligible providers, hospitals, and suppliers may participate through the creation of an Accountable Care Organization (ACO). Through this program, CMS hopes to: • Promote accountability for care of Medicare beneficiaries; • Require the coordination of care; and • Promote the redesign of care processes and investment in infrastructure.[93]
			Meridian Holdings, Inc.		See description above.
			Triad Healthcare Network, LLC (Greensboro, NC)		See description above.

New Models					
Grant Name	**CFDA**	**PPACA Section**	**Grantee Name**	**Award Amount**	**Description**
			Accountable Care Coalition of Caldwell County, LLC (Lenoir, NC)		See description above.
			Accountable Care Coalition of Eastern North Carolina, LLC (New Bern, NC)		See description above.
Medicare Shared Savings Program Advance Payment ACO			Coastal Carolina Quality Care, Inc (New Bern, NC)		The Advance Payment ACO Model issues monthly payments to physician and rural providers who aim to provide high quality, coordinated care to the Medicare beneficiaries they serve. Physicians can use these payments to invest in care coordination infrastructure.[94]
Innovation Advisors Program			Mr. Rod Baird, Geriatric Practice Management, Inc., Asheville, NC		The Innovation Advisors Program was created to help individuals develop and refine managerial and technical skills needed to drive delivery system reform for Medicaid, Medicare, and CHIP recipients. Specific areas of focus include: health care economics and finance; population health; systems analysis; and operations research.[95]
			Dr. Pamela Duncan, Wake Forest Baptist Health, Winston Salem, NC		See description above.
			Dr. Suzanne Landis, Mountain Area Health Education Center (MAHEC), Asheville, NC		See description above.
			Dr. Zeev Neuwirth, Carolinas Healthcare System, Charlotte, NC		See description above.

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