

IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

INTERIM REPORT

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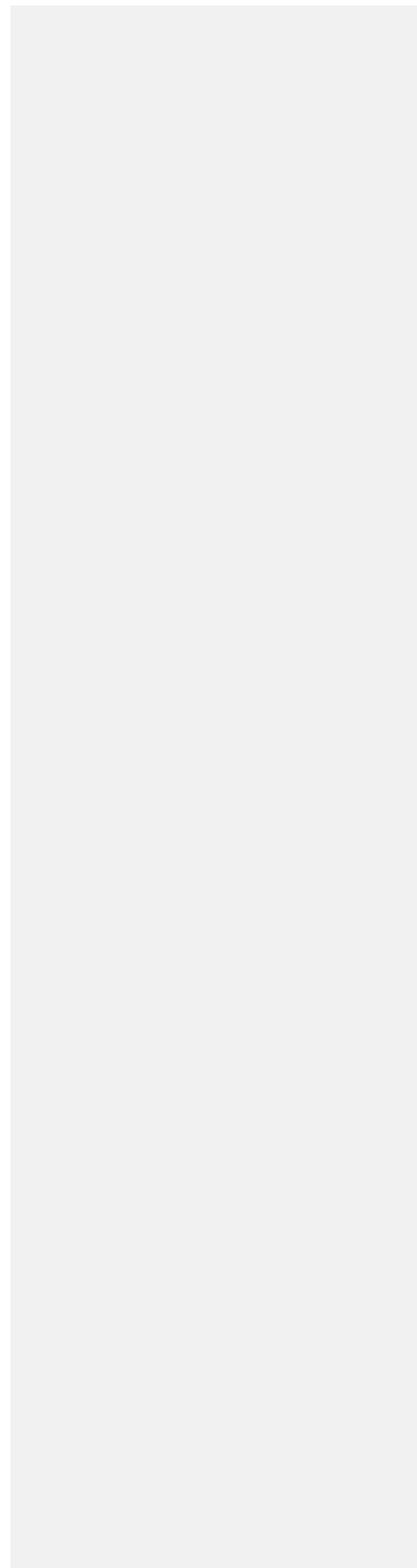


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EXECUTIVE SUMMARY

In March 2010, Congress passed the Affordable Care Act (ACA).¹ The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of people who lack health insurance coverage, rapidly rising health care costs, and health care quality. The ACA expands coverage to the uninsured, increases an emphasis on quality measurement and reporting, and focuses on prevention to improve population health. The ACA also has provisions to increase the supply of health professionals, strengthen the health care safety net, and expand access to and affordability of long-term care services. The federal legislation includes provisions to test new models of care delivery and financing that will improve the quality and health outcomes while reducing unnecessary or inappropriate health care expenditures.

The ACA is arguably the most comprehensive health legislation ever enacted. While the ACA offers the potential to improve health care access, quality, and population health, and reduce escalating health care costs, it creates new challenges for the state, families, businesses, health care professionals, and organizations. In order to implement the new law, the North Carolina Department of Insurance (NCDOI) and the North Carolina Department of Health and Human Services (NCDHHS) 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. The effort is being led by an Overall Advisory Group, which is chaired by Lanier M. Cansler, CPA, Secretary of the North Carolina Department of Health and Human Services and G. Wayne Goodwin, JD, Commissioner, North Carolina Department of Insurance.

The Overall Advisory Group is helping to coordinate the work of eight separate workgroups which have focused on different sections of the ACA: Medicaid; Health Benefits Exchange and Insurance Oversight; Health Professional Workforce; Prevention; Quality; New Models of Care; Safety Net; and Fraud, Abuse and Overutilization. These workgroups were charged with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions. These workgroups have also examined federal funding opportunities to ensure that the state or other applicable groups apply for any grant opportunities that will help improve health, health care access, quality of care, or that may help reduce rapidly escalating health care costs. The workgroups began meeting in August 2010 and have met approximately monthly since then. Altogether, 260 people from across the state are members or steering committee members of the Advisory Group or one or more of the eight workgroups. In addition, the meetings have been open to the public so that many others have participated in the meetings either in person or online through the Internet. Financial support for this effort has been provided by generous grants from Kate B. Reynolds Charitable Trust, Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, The John Rex Endowment, Moses Cone~Wesley Long Community Health, and Reidsville Area Foundation. The North Carolina Network of Grantmakers has also created a website that tracks new ACA grant announcements

¹ Throughout this report, we refer to the national health reform legislation as the Affordable Care Act. It is actually the combination of two pieces of legislation, the Patient Protection and Affordable Care Act (HR 3590), and the Health Care and Education Reconciliation Action (HR 4572).

to make it easier for North Carolina nonprofits and other organizations to learn about funding opportunities.²

I. Coverage provisions

One of the primary reasons for the passage of the ACA was to make health insurance more accessible and affordable. In North Carolina, there were approximately 1.7 million uninsured nonelderly individuals in 2009 (20.4%).³ Over the last ten years (2000-2009), more than 600,000 people were added to the ranks of the uninsured in North Carolina. The ACA expands coverage to more of the uninsured by building on our current system of public and private health insurance coverage. Most nonelderly North Carolinians obtain coverage through public insurance coverage (Medicaid, or NC Health Choice for children), employer-based insurance, or by purchasing insurance coverage directly from an insurance company. The ACA builds on existing systems to expand coverage to the uninsured by expanding Medicaid coverage to more low-income adults, strengthening the employer based health insurance system, and making it easier and more affordable for individuals and many small businesses to purchase private coverage. According to the Congressional Budget Office (CBO), 92% of all nonelderly people living in this country will have health insurance coverage by 2019.⁴ Assuming that North Carolina achieves a similar reduction in the numbers of uninsured, more than 1.1 million uninsured North Carolinians are likely to gain coverage by 2019.

A. Medicaid expansion⁵

The ACA requires that states expand Medicaid coverage to most uninsured adults with modified adjusted gross incomes no greater than 138% of the federal poverty level (FPL) beginning in 2014 (\$30,429/year for a family of four in 2010).⁶ The federal government will pay an enhanced match rate for the newly eligible, but not for those who would have been eligible under the state's existing Medicaid eligibility rules in effect in March 2010.

Projections suggest that there may be as many as 536,000 uninsured nonelderly North Carolina adults who could qualify for Medicaid coverage based on the expanded eligibility criteria in 2014.⁷ Of these, approximately 382,000 could be *newly eligibles* (i.e., they would not have qualified for coverage under the Medicaid eligibility rules in effect in March 2010), and approximately 154,000 could be *existing eligible, but newly enrolled* (i.e., they meet the state's

² For more information, register online at www.ncgrantmakers.org.

³ United States Census Bureau. Table HIA-6. Health insurance coverage status and type of coverage by state—persons under 65: 1999-2009. Washington, DC: US Census Bureau; 2009.

⁴ Congressional Budget Office. Selected CBO publications related to health care legislation, 2009-2010. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. CBO Publication no. 4228. Published December 2010. Accessed January 26, 2011.

⁵ The ACA includes “maintenance of effort” requirements—states must maintain their existing coverage for adults until 2014 and must maintain their existing coverage for children until 2019.

⁶ The ACA specifies that individuals will be eligible if their modified adjusted gross income is no more than 133% FPL, but the legislation also allows a 5% income disregard—effectively raising the income limits to 138% FPL.

⁷ Holmes M. Running the numbers. Project changes in North Carolina health insurance coverage due to health reform. *N C Med J*. May/June 2010;71(3):306-308. This estimate is based on the number of people projected to live in North Carolina in 2014.

current Medicaid eligibility rules but are not enrolled). In addition, there are approximately 213,000 uninsured children with incomes below 200% FPL who may already be eligible for Medicaid or NC Health Choice but are not enrolled. Although many North Carolinians will be income eligible for Medicaid or NC Health Choice, they may still not be eligible. The ACA prohibits states from covering undocumented immigrants or most legal immigrants who have been in this country for less than five years. In addition, not everyone who is income eligible for Medicaid or NC Health Choice may choose to apply for coverage.

The costs of covering new adults and children in Medicaid will increase costs to the state. DMA estimates that the expansion will cover **XX** new people. The state share of the coverage for the new enrollees is estimated to be **XX** from 2014-2019. **Note: We are still waiting for estimates of new eligibles and costs to the state for the expand Medicaid coverage.** North Carolina is also likely to incur additional costs in creating new eligibility and enrollment systems to ensure that individuals can apply simultaneously for Medicaid, NC Health Choice, or private subsidized coverage offered through the Health Benefit Exchange (explained more fully below). North Carolina may also incur new costs in expanding the array of services offered. However, there are also ways for the state to offset some of the new costs it is likely to incur from the expanded coverage. For example:

- The state is likely to gain **\$XX** from the enhanced federal match rate in the North Carolina Health Choice program between 2015-2019.
- The state may experience a \$30 million reduction in long-term care costs in the Medicaid program from the implementation of the new voluntary long-term insurance program, called CLASS (Community Living Assistance and Support Services).
- The state may experience a \$206 million reduction in payments to hospitals through the reduction in disproportionate share hospital (DSH) payments.
- The state may experience a decline in people who are eligible through other Medicaid programs. The state also has the option of reducing Medicaid coverage for some adults the state currently covers, and moving these individuals into subsidized private coverage.
- North Carolina could receive an enhanced federal match rate if it chooses to expand home and community based services or to offer comprehensive coverage of preventive services, which would offset some or all of the new costs of this service expansion.
- The state is likely to experience savings in the mental health, intellectual and developmental disabilities, and substance abuse services system, as more people with mental illness and substance abuse disorders move into the Medicaid program or private coverage.
- As more people gain coverage, the 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.
- The state may be able to save additional money to offset the costs of Medicaid coverage by creating a basic health plan for adults with incomes between 138-200% FPL.

The workgroups were unable to quantify the total net costs or savings to the state as a result of the Medicaid expansion. The workgroups will continue to work with the state to help quantify the net impact of the ACA provisions on state and local government.

B. Private coverage

Most of the other coverage changes occur in the private insurance market. The more immediate provisions focus on making coverage more affordable for people with preexisting conditions and for early retirees. For example, the ACA appropriated \$5 billion over five years (FFY 2010-2014) to create a federal high risk pool to provide more affordable coverage to people with preexisting health problems that have been uninsured for at least six months. North Carolina's share of this \$5 billion appropriation was \$145 million. The ACA appropriated an additional \$5 billion over five years (FFY 2010-2015) to create a temporary reinsurance pool to help offset the high claims costs to businesses (including state and local governments) that provide health insurance to early retirees, age 55 or older, who are not eligible for Medicare. As of December 20, 2010, 96 North Carolina employer groups, including the state of North Carolina (through the State Health Plan), 24 counties, and 19 North Carolina towns or cities, met the requirements to be eligible for reinsurance to offset part of the claims costs for early retirees. The State Health Plan estimates that it will receive \$22.7 million in SFY 2011, \$57.9 million in SFY 2012, and \$8.9 million in SFY 2013 from the federal reinsurance pool.⁸

In addition, beginning for health plans renewed after September 23, 2010, insurers are required to offer parents the option of continuing insurance coverage for their children up to age 26, regardless of whether their child is a full-time student. Insurers are also required to provide insurance coverage to children regardless of health status, are prohibited from imposing lifetime limits, and are subject to more stringent rate review. The ACA also includes enhanced consumer protections, including the creation of consumer ombuds programs. NCDOI obtained federal grants to strengthen the rate review process (\$1 million), and to strengthen its consumer assistance/ombuds program (\$850,000).

Most of the other insurance law changes go into effect in 2014. The Secretary ("Secretary") of the US Department of Health and Human Services (USDHHS) will define the essential benefits that private insurers must include in their non-grandfathered insurance plans. Over time, most people in the private market will be covered by the essential health benefits. Beginning in 2014, insurers will no longer be able to exclude people or to charge them more because of their preexisting conditions. In order to ensure that there is a large enough pool of individuals to cover the higher costs of individuals with preexisting health problems, the ACA requires that most people have health insurance coverage or pay a financial penalty. The ACA also provides subsidies to individuals to help make insurance coverage more affordable. Many middle class families (those earning up to 400% of the federal poverty level, or \$88,200/year for a family of four in 2010) will be eligible for premium tax credits and cost sharing reductions to help them pay for coverage purchased through the HBE. Individuals who are eligible for public coverage or affordable employer sponsored insurance are not eligible for the subsidy. Analysis of the Current Population Survey suggests that there may be as many as 712,000 *uninsured* nonelderly adults and 62,000 uninsured children in North Carolina with incomes too high to qualify for Medicaid (or NC Health Choice for children), but less than 400% FPL. Some, but not all, of

⁸ Mona Moon, electronic communication, January 18, 2011.

these individuals will be eligible for a subsidy to purchase coverage in the HBE.⁹ Others may gain coverage through their employer.

Beginning in 2014, the ACA also requires large employers, with 50 or more full-time employees, to offer health insurance coverage that meets certain standards or pay financial penalties. There were more than 52,000 private-sector establishments in North Carolina with 50 or more employees (28% of all private-sector establishments in the state) in 2009.¹⁰ North Carolina firms with 50 or more workers employ more than 2.3 million individuals. Approximately 97% of the employees in these larger businesses work for firms that offer insurance coverage, although we have no data on whether these health insurance plans would meet the minimum requirements of the ACA.

In contrast, smaller firms, with fewer than 50 full-time employees are not required under the ACA to offer health insurance coverage. In North Carolina, firms with fewer than 50 full-time workers employed approximately 880,000 workers in 2009. Only 53% of workers in small firms work for a company that offers health insurance coverage (33.8% of small businesses offered group health insurance coverage).¹¹ The ACA provides a sliding scale tax credit to some small businesses to help them afford coverage. Prior to the implementation of the HBE in 2014, small businesses with 25 or fewer employees and an average wage of no more than \$50,000 can receive a maximum tax credit of up to 35% of the costs of the employer-paid premium (or 25% for non-profit companies). The full tax credit is limited to businesses with 10 or fewer employees and average wages of \$25,000 or less. The NCIOM estimates that small businesses in North Carolina currently may be able to qualify for more than \$200 million in tax credits through the small business tax credit. After 2014, small businesses are eligible for a two-year tax credit with a maximum subsidy of 50% of an employer's premium costs (or 35% for nonprofit companies).

The ACA requires that each state have a Health Benefit Exchanges (HBE) which will offer information to help individuals and businesses compare health plans based on quality, provider networks, and costs, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own health benefit exchange, the federal government will create one to offer coverage to individuals and small groups in the state. The workgroup that examined these issues recommended that the state create its own HBE, rather than leave this responsibility to the federal government. Proposed legislation is included in Appendix D of the report. NCDOI received a \$1 million planning grant from the federal government to consider whether to implement an HBE, and if so, to help with some of the actuarial design issues.

⁹ Holmes M. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement [unpublished material].

¹⁰ Agency for Healthcare Research and Quality; Center for Financing, Access and Cost Trends. 2009 Medical Expenditure Panel Survey-insurance component. Tables II.A.1, II.A.1.a, II.A.2, II.B.1, II.B.1.a, II.B.2. MEPS counts all employees who work for the firm in determining firm size (including seasonal, part-time and full-time). Thus, the MEPS estimate of the number of small firms in the state may differ from other estimates that only include full-time employees or full-time equivalent employees.

¹¹ Agency for Healthcare Research and Quality; Center for Financing, Access and Cost Trends. 2009 Medical Expenditure Panel Survey-insurance component. Table II.A.2., II.B.1., II.B.2.

II. Improving Population Health

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA included 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 35th of the 50 states in the 2010 edition of the America's Health Rankings, a composite of 22 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.¹²

The ACA appropriated \$500 million in FFY 2010 to a new Public Health and Prevention Trust Fund to help fund new prevention efforts, as well as grants to strengthen the public health infrastructure. The North Carolina Division of Public Health has applied for, and been awarded ACA grants aimed at strengthening the public health infrastructure and improving population health, including:

- *Maternal, infant, and early childhood home visiting programs.* DPH received \$2,134,807 (July 15, 2010-September 30, 2012) to develop and implement one or more evidence-based maternal, infant, and early childhood visitation model. The goal of this initiative is to reduce infant and maternal mortality; improve prenatal, maternal, newborn, and child health; improve parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
- *Pregnancy Assistance Fund.* DPH received \$1,768,000 in funding to help pregnant and parenting women in high needs communities.
- *Personal responsibility education program (PREP).* DPH received \$1,544,312 in PREP funds to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.
- *Epidemiology-Laboratory Capacity Grants.* DPH received a grant of \$371,894 to improve surveillance for and responses to infectious diseases and other conditions of public health importance.
- *Clinical and community preventive services.* DPH received \$98,266 to support tobacco cessation through expanded use of the Quitline, as well as policy and media interventions. Additionally, the Appalachian District Health Department and Pitt County Health Department collectively received \$3,800,492 to support environmental and policy changes to promote physical activity and nutrition.
- *Public health infrastructure grants offered support to advance health promotion and disease prevention through improved information technology, workforce training, and*

¹² America's Health Rankings: North Carolina. 2010 edition results. America's Health Rankings Web site. <http://www.americashealthrankings.org/yearcompare/2009/2010/NC.aspx>. Accessed January 23, 2011.

regulation and policy development. North Carolina received \$400,000 to support the Public Health Quality Improvement Center, and \$1,503,858 for the State Center for Health Statistics to strengthen collection, reporting, and analysis of health statistics.

The Prevention workgroup is also examining other ACA provisions to: encourage Medicaid recipients to better manage their chronic diseases and engage in healthier lifestyles, promote worksite wellness programs, and to encourage the development of comprehensive community-wide efforts to promote individual and community health.

III. Expanding Access to Health Care Services

The ACA has provisions to expand the health professional workforce, including incentives to encourage professionals to practice in underserved areas. The ACA also has funding to expand the health care safety net.

A. Workforce Provisions

The ACA includes provisions to increase the number of health care professionals to address current and future workforce needs. The ACA authorizes new or expanded health professional training programs to expand the number of primary care professionals, nurses, public health workers, allied health, mental health and substance abuse, and dental health professionals, as well as direct care workers. In addition, the legislation attempts to change the way that health care professionals are trained to best meet the workforce needs of the future. However, while there are many new programs authorized, Congress did not appropriate a lot of new funding to support these new training programs. As a result, last year (FFY 2010), the Secretary used about half of the public health and prevention trust fund to support health professional workforce training programs.

State agencies as well as various schools and medical centers applied for grants from HRSA. The following is a summary of grants to increase the health professional workforce awarded to entities in North Carolina, as of November 19, 2010.

- *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. 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 the current four residents per year to six.
- *Expansion of Physician Assistant Training.* Duke University Medical Center's Physician Assistant Program (PA) received a five-year grant of \$1,320,000 to expand its entering class size from the current level of 72 per class to 80 per class. A total of 34 PA students will receive financial aid as part of this grant. In addition, Methodist University Physician Assistant Program received a five-year grant of \$1,888,000 to both increase class size and to provide support to students to strengthen the likelihood they will enter primary care

practice.

- *Advanced Nursing Education Expansion.* Duke University School of Nursing received a grant of \$1,276,000 to fund a five-year project to increase the number of Adult Nurse Practitioners and Family Nurse Practitioners.
- *Personal and Home Care Aide Training.* With this three-year \$578,745 personal and home care aide training grant, two pilot projects will be developed to train 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.
- *State Health Workforce Development.* The North Carolina Commission on Workforce Development was the recipient of a one year grant of \$144,595 to increase primary care supply. The grant was submitted by the Commission on behalf of UNC's Cecil G. Sheps Center for Health Services Research. The Sheps Center will be working with a panel of experts to identify strategies the State can employ to increase the per capita primary care workforce by 10% to 25% in the next ten years.

Although the ACA did not include new appropriations for most of the new workforce training programs, it did include \$1.5 billion over five years in new funding to expand the National Health Services Corps (NHSC). Of this, the ACA appropriated \$290 million in new funding in FFY 2011. Funding for the NHSC is not allocated to specific states. Thus, to take advantage of this funding North Carolina must aggressively recruit both individuals and sites, and must ensure that all eligible locations are designated as Health Professional Shortage Areas. The North Carolina Office of Rural Health and Community Care, which is the lead state agency involved in administering the NHSC in North Carolina, estimates that North Carolina will be able to use these funds to recruit an additional 20 health professionals in 2011 to practice in underserved areas and 20-25 more per year in 2011-2015.¹³

In addition to discussing the NHSC expansion and HRSA grant opportunities, the Workforce workgroup identified other short-term health professional needs that the state should address to ensure that North Carolina has sufficient health professionals to meet the state's growing population, as well as the expected increase in the numbers of people with insurance coverage in 2014. For example, the workgroup discussed the need to ensure the adequacy of the Medicaid reimbursement rates so that providers do not stop participating in the program. Additionally, the workgroup discussed the immediate need to recruit more mental health, substance abuse, and other behavioral health professionals to the state.

¹³ John Price, electronic communication, January 27, 2011. This estimate is based on the number of health professionals that NCORHCC recruits into health professional shortage areas. However, other practices or organizations can also recruit providers into health professional shortage areas. Thus, this is a conservative estimate of the number of health professionals who may obtain NHSC funding to practice in underserved areas of North Carolina during the next five years.

B. Safety Net

The ACA includes provisions to increase and strengthen the health care safety net. Safety net providers are those health care organizations with a mission, or a legal obligation, to provide health care services to the uninsured or other underserved populations. In North Carolina, safety net organizations include, but are not limited to federally qualified health centers (FQHCs, also known as community and migrant health centers), local health departments, school-based and school-linked health centers, free clinics, and hospitals.

The ACA appropriated a total of \$9.5 billion over five years to expand the number of community and migrant health centers, expand the array of services provided, and increase the number of people they serve. In addition, the ACA included \$1.5 billion for construction and renovation. North Carolina currently has 26 FQHCs and two FQHC look-alikes operating in 45 counties across the state.

North Carolina received ACA grant funds totaling \$19.2 million to support capital improvements, renovations, and to expand access to care through existing FQHCs. These funds are in addition to the \$33.3 million provided to 26 FQHCs through American Recovery and Reinvestment Act funds. In addition, the Health Resources and Services Administration (HRSA), within the USDHHS issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. It was designed to strengthen the health care safety net by establishing or expanding health centers in 1,200 of the nation's neediest communities. The North Carolina Community Health Center Association, with financial support from the Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. As a result, North Carolina submitted 30 applications for new access point grants. If funded, these applications would provide services in 24 new counties, bringing the total number of NC counties with an FQHC up to 69. HRSA is expected to announce the results of this round of competitive grants in August 2011.

HRSA issued another grant opportunity to support increased access to preventive services and primary care services at existing FQHCs. Some of the funding can also be used to expand oral health, behavioral health, pharmacy, vision, or other non-medical enabling services (such as transportation services). Funding will be distributed to health centers on a formula basis. Each of the 26 existing FQHCs will qualify for these funds.

In addition to the direct funding for federally qualified health centers, the ACA included new requirements for charitable hospitals to maintain their tax exempt status. Under the new provisions, charitable 501(c)(3) hospitals must conduct a community needs assessment and identify an implementation strategy to show that they are addressing community needs.¹⁴ Nonprofit hospitals are also required to have a financial assistance policy, provide emergency services, and limit charges to people eligible for assistance to amounts generally billed.

¹⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§9007, 10903.

IV. Quality, New Models of Care and Efforts to Reduce Health Care Costs

The ACA includes different provisions aimed at enhancing health care quality and reducing costs. Some of these provisions offer new funding opportunities—for example, to test new models of financing or delivering health care services. Others impose new requirements—for example, the ACA includes new reporting requirements for health care professionals, as well as more stringent oversight of fraud, abuse and overutilization within the Medicare, Medicaid, and CHIP programs.

North Carolina has many existing initiatives aimed at improving health care quality while reducing health care costs. Yet, more is needed to reduce North Carolina's rising health care costs, while working to improve quality, health outcomes, and population health. From 2003-2009, the average total single premium for employer sponsored insurance in North Carolina increased by 37% (from \$3,411 to \$4,676/year). The average premium costs for family coverage increased by 55% (from \$8,463 to \$13,087).¹⁵ At the same time, the average deductible increased 67% for individuals, and 37% for families. Nationally, wages only increased by 20%,¹⁶ and general inflation was only 16% during that same time period.¹⁷ The increase in premiums has eroded North Carolinians purchasing power.

A. Quality

The ACA includes many 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 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. Health care providers will be required to report data on these quality measures to the Secretary, and over time, these data will be made available to the public. In addition, the ACA provides greater investments in comparative effectiveness research to determine what treatments, medications, or services work best under what conditions. The ACA also begins to change the way that health care professionals and providers are reimbursed, from a system based largely on reimbursing providers based on the volume of services provided to one that is based, in part, on the quality and outcomes achieved.

North Carolina had already begun several initiatives aimed at improving quality of care prior to the enactment of the ACA. For example, the Community Care of North Carolina program (CCNC) was designed to improve quality and access to health services for Medicaid recipients

¹⁵ Schoen C, Stremikis K, How SKH, Collins SR. State trends in premiums and deductibles, 2003-2009: How building on the Affordable Care Act will help stem the tide of rising costs and eroding benefits. The Commonwealth Fund; 2010. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_20032009_ib_v2.pdf. The Commonwealth Fund Publication no. 1456. Published December 2010. Accessed Jan. 6, 2011.

¹⁶ Average wage index series and underlying data. Social Security Administration Web site. <http://www.ssa.gov/oact/cola/awidevelop.html>. Accessed January 6, 2011.

¹⁷ Consumer Price Index calculator. United States Bureau of Labor Statistics Web site. <http://data.bls.gov/cgi-bin/cpicalc.pl>. Accessed January 6, 2011.

while reducing health care costs (described more fully below). CCNC collects process and outcome indicators from primary care practitioners to measure the quality of care provided to Medicaid recipients. These data are reported back to the providers for quality improvement purposes. The North Carolina Healthcare Quality Alliance (NCHQA) is a collaboration of North Carolina health care professional associations, government agencies, public and private payers to improve the quality of care provided in the state, building off the work of CCNC. The NC Area Health Education Centers (AHECs) are involved in two initiatives that address system improvement in primary care practices by providing resources to enhance health care delivery, and to assist with implementation and meaningful use of electronic health record systems. These initiatives are called Improving Performance in Practice (IPIP) and Regional Extension Centers (REC). The NC Center for Hospital Quality and Patient Safety (NCCHQPS) is run through the NC Hospital Association. 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. Similarly, the North Carolina Center for Public Health Quality is aimed at improving quality of services provided by local health departments. Many other quality improvement initiatives also exist in North Carolina.

The Quality workgroup examined the ACA quality provisions to determine gaps between the ACA requirements and existing state efforts aimed at improving quality and patient safety. The workgroup will continue to meet to explore options to address gaps, as well as educational efforts needed for providers and the public to inform them of the new quality provisions.

B. New Models of Care

The ACA includes many new provisions aimed at changing the way that the Medicare, Medicaid, and CHIP programs deliver care and pay health care professionals and other health care organizations for services. The intent is to test 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 to disseminate these financing and delivery models more widely throughout the country. Over time, these new delivery models offer the potential to improve care and health outcomes, reduce unnecessary utilization and waste, and help “bend the cost curve.”

North Carolina is well positioned to obtain funding to test new models of delivering and financing health services. 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 it relates to patients with chronic or complex health problems.¹⁸ North Carolina has already been the recipient of several of the different demonstration opportunities and is well-positioned to compete for additional demonstration grants when these become available. In fact, North Carolina was selected as one of eight states in the first round of demonstration grants awarded through the Center for Medicare and Medicaid Innovations (CMMI). On November 16, 2010, the USDHHS announced the creation of the CMMI, along with the first round of grants intended to improve care for

¹⁸ The Kaiser Commission on Medicaid and the Uninsured. Community Care of North Carolina: Putting health reform ideas into practice in Medicaid. The Henry J. Kaiser Family Foundation; 2009. <http://www.kff.org/medicaid/upload/7899.pdf>. Published May 2009.

Medicare and Medicaid enrollees. Eight states were selected to participate in the expansion of the multi-payer advanced primary care practice demonstration.¹⁹ Under this grant, Medicare will pay an estimated \$11.8 million in per member per month payments to local primary care providers and to participating CCNC networks that are part of a public-private partnership, including DMA, the State Health Plan, Blue Cross Blue Shield of North Carolina, and North Carolina Community Care Network, Inc.

North Carolina has also been awarded two additional grants to test or expand existing models of delivering health care services:

- Roanoke Chowan Community Health Center received \$255,000 to expand its existing telehealth monitoring initiative.²⁰
- NCORHCC and Access II Care (Henderson, Buncombe, McDowell counties), have been awarded a \$297,710 AHRQ medical liability reform and patient safety planning grant to develop a system of near-miss reporting and improvement tracking in primary care.

The New Models of Care workgroup holds the strong conviction that the development and implementation of new models of care is essential to deal with the challenge we face today in improving the value delivered by our health care system. Thus, the New Models of Care workgroup is continuing to meet to examine funding opportunities, to encourage communities to test new models to see what is most effective in our state, to evaluate the success of these models, and to disseminate successful models throughout the state.

C. Fraud, Abuse and Overutilization

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). Many of these requirements will require the state to implement new enforcement procedures.

The Fraud and Abuse workgroup conducted a gap analysis, breaking down the requirements of each provision, then identifying ongoing efforts to address these requirements, and the gaps between what is currently underway in North Carolina and the new requirements. The workgroup is continuing to meet to determine what legislation is needed to comply with the new ACA requirements.

¹⁹ CMS introduces new Center for Medicare and Medicaid Innovation, initiatives to better coordinate health care [news release]. Centers for Medicare and Medicaid Services; November 9, 2010.

<http://innovations.cms.gov/innovations/pressreleases/pr110910.shtml>. Accessed January 5, 2011.

²⁰ Secretary Sebelius announces \$32 million to support rural health priorities [news release]. United States Department of Health and Human Services; August 23, 2010.

<http://www.hhs.gov/news/press/2010pres/08/20100823a.html>. Accessed January 5, 2011.

D. Other Cost Containment and Financing Provisions

The CBO estimated that the total costs of the coverage provisions would be \$938 billion over ten years (2010-2019). Although the ACA included \$938 in new spending, the CBO anticipates that the ACA will reduce the federal deficit by \$124 billion during that time period. That is because other health-related provisions reduce spending by \$511 billion, and increase revenues by \$420 billion.

The bill includes a number of provisions aimed at reducing health care costs, particularly in the Medicare program. For example, the ACA reduces Medicare payments by reducing annual inflationary increases for certain health care providers. The ACA also reduces payments to Medicare Advantage plans, home health, and creates a new Medicare Independent Payment Advisory Board (IPAB) with authority to implement changes to the Medicare program to reduce cost escalation unless Congress or the President overrides the proposal. The ACA also includes savings to the Medicaid program, including reductions in Medicaid due to implementation of the voluntary long-term care insurance program, and reduction in disproportionate share hospital payments.

While most of these cost savings will accrue to the federal government (Medicare), or to the state and federal government (Medicaid and CHIP), the ACA included other provisions which have the potential of reducing cost escalation in the private market. First, the bill includes efforts to streamline health insurance administration, implement health information technology, and change provider payments to encourage efficiency and quality. Many of the recommendations from the IPAB and efforts to reduce fraud and abuse may also be adopted by private insurers.

In addition to the \$511 billion in spending reductions, the ACA is also expected to generate \$420 billion in new revenues between FFY 2010-2019. Approximately \$107 billion of this amount will be generated through increased taxes or fees on the health sector. In addition, the ACA increases the Medicare Part A (hospital insurance) payroll tax for higher income wage earners, and includes additional revenues from other sources.

V. Conclusion

The ACA is complex and touches all aspects of our health care system. Not surprisingly, the legislation has been controversial. Any legislation that impacts 17% of the economy, and that affects how we finance and deliver health care services is likely to be controversial. Some argue that the bill does not go far enough towards ensuring universal coverage, others decry the lack of real cost containment. Some oppose the individual mandate, while others are concerned about the new requirements on employers and state government. Yet few people seriously argue that our existing health care system is sustainable. We, as a country, spend more per capita on health care than any other country, yet we have less value in terms of life expectancy or other health measures. We spend enormous sums of money on new technology and better “sick” care, but do not make the investments in prevention that could help keep people healthy. We continue to pay providers based on the volume of services provided, without ensuring the quality of services

provided. Further, millions of people remain uninsured, which has an adverse impact on the individual, their family, and society at large.

The ACA is not perfect, and is likely to be changed over time as we learn what works and what needs to be changed. However, it does provide the state with a unique opportunity to identify strategies that can expand health insurance coverage, and improve access to health services, quality, and population 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 need for further progress. Working together, North Carolina providers, consumers, insurers, businesses and community leaders can identify innovative strategies that will lead to further improvements in health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.

DRAFT

IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

I. INTRODUCTION

In March 2010, Congress passed national health reform, 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, and health care quality. The ACA expands coverage to the uninsured, increases an emphasis on quality measurement and reporting, and focuses on prevention to improve population health. The ACA also has provisions to increase the supply of health professionals, strengthen the health care safety net, and expand access to and affordability of long-term care services.²¹ The federal legislation also includes provisions aimed at reducing health care expenditures.

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 was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4572), which was signed on March 30, 2010. The Secretary of the United States Department of Health and Human Services (USDHHS) has responsibility to develop regulations or otherwise oversee the implementation of many of the provisions of the ACA. Throughout this report, references to the “Secretary” are to the Secretary of the USDHHS.

The ACA offers new opportunities to expand coverage, improve quality and population health, and reduce health care costs. At the same time, the legislation creates new challenges for the state, families, businesses, health care professionals and organizations. **In order to implement the new law, the North Carolina Department of Insurance (NCDOI) and the North Carolina Department of Health and Human Services (NCDHHS) 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.**

A. Background on the Uninsured and Health Care Costs

Nationally, approximately 50 million nonelderly people (ages 0-64) were uninsured in 2009 (18.8%). **In North Carolina, there were approximately 1.7 million uninsured nonelderly individuals in 2009 (20.4%).²² Over the last ten years (2000-2009), more than 600,000 people were added to the ranks of the uninsured in North Carolina. The percentage of nonelderly uninsured in North Carolina increased by more than one-third (38%) from 14.8% in 2000 to 20.4% in 2009.** Appendix A includes more information about the uninsured in North Carolina at the state and county level.

²¹ A more complete description of the ACA is available in the May/June issue of the NCMJ. Silberman P, Liao C, Ricketts TC III. Understanding health reform: a work in progress. *N C 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.

²² United States Census Bureau. Table HIA-6. Health insurance coverage status and type of coverage by state—persons under 65: 1999-2009. Washington, DC: US Census Bureau; 2009.

More than two decades of research has shown that 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.²³ When the uninsured do seek care, some of the costs of their care are shifted to the insured population. One study suggests that nationally insured individuals paid an additional \$368/year in premiums, and families paid an additional \$1,017/year for coverage to cover the costs of care provided to the uninsured.²⁴

The ACA also attempts to reduce rising health care costs. **From 2003-2009, the average total single premium for employer sponsored insurance in North Carolina increased by 37% (from \$3,411 to \$4,676/year). The average premium costs for family coverage increased by 55% (from \$8,463 to \$13,087).**²⁵ **At the same time, the average deductible increased 67% for individuals, and 37% for families.** Nationally, wages only increased by 20%,²⁶ and general inflation was only 16% during that same time period.²⁷ The increase in premiums has eroded North Carolinians purchasing power. The total cost of premiums constituted 20.3% of the median income for a single person household in North Carolina in 2009 (up from 16.6% in 2003), and 21.5% of the income of family household (up from 16% in 2003).

Most of the media attention and the legal challenges have focused on the coverage provisions of the ACA. Some of these provisions went into effect in 2010, but most of the more controversial provisions—including the Medicaid expansion and individual mandate are not scheduled to be fully implemented until 2014. The more immediate provisions focus on making coverage more affordable for people with preexisting conditions, small businesses, and larger businesses that offer coverage to early retirees. In addition, beginning for health plans renewed after September 23, 2010, insurers are required to offer parents the option of continuing insurance coverage for their children up to age 26, regardless of whether their child is a full-time student. Insurers are also required to provide insurance coverage to children regardless of health status, are prohibited from imposing lifetime limits, and are subject to more stringent rate review.

²³ The Kaiser Commission on Medicaid and the Uninsured. The uninsured: a primer. The Henry J. Kaiser Family Foundation; 2010. <http://www.kff.org/uninsured/upload/7451-06.pdf>. Accessed February 8, 2011.

²⁴ Nationally, the uninsured incurred \$116 billion in care from health care providers. The uninsured paid about one-third (37%) of this cost out-of-pocket. Government and charities paid another 26%, leaving 37% in uncompensated care. The amount of premiums attributable to cost shifting was calculated by taking the total amount of uncompensated care in 2008 (\$42.7 billion), and dividing it equally among people with private, non-governmental, health insurance. Families USA. Hidden health tax: Americans pay a premium. Washington, DC: Families USA; 2009. <http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf>. Accessed January 21, 2011.

²⁵ Schoen C, Stremikis K, How SKH, Collins SR. State trends in premiums and deductibles, 2003-2009: How building on the Affordable Care Act will help stem the tide of rising costs and eroding benefits. Commonwealth Fund; 2010; Publication 1456. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_20032009_ib_v2.pdf. Accessed Jan. 6, 2011.

²⁶ Social Security Administration. Average wage index series and underlying data. <http://www.ssa.gov/oact/cola/awidevelop.html>. Accessed January 6, 2011.

²⁷ United States Bureau of Labor Statistics. Consumer price index calculator. <http://data.bls.gov/cgi-bin/cpicalc.pl>. Accessed January 6, 2011.

The major coverage expansions in coverage are scheduled to go into effect on January 1, 2014. The ACA includes several provisions intended to expand public and private health insurance coverage to most Americans. On the public side, the ACA expands Medicaid coverage to cover more low-income adults, with incomes up to 138% of the federal poverty level²⁸ (\$30,429/year for a family of four in 2010). Most of the other changes occur in the private insurance market. The ACA creates a new health benefits exchange (HBE) where individuals and small businesses can compare and purchase insurance coverage. Many middle class families (those earning up to 400% of the federal poverty level, or \$88,200/year for a family of four in 2010) who do not have access to affordable employer sponsored insurance and who do not qualify for public coverage will be eligible for premium tax credits and cost sharing reductions to help them pay for coverage purchased through the HBE. The ACA also includes mandates—which have been the most controversial provisions of the legislation. These provisions require most individuals, unless exempt, to have insurance coverage or pay a penalty. Similarly, large businesses—with 50 or more full-time employees—are required to offer insurance coverage that meets certain standards or pay financial penalties.

Aside from the coverage requirements, the ACA included other provisions aimed at improving population health, increasing access to health services through new health professional training programs and strengthening the health care safety net, improving health care quality, improving the efficiency and value of the health care delivery system, and reducing unnecessary or inappropriate health care expenditures.

While there are many different estimates of the overall costs of the ACA, the Congressional Budget Office (CBO), the nonpartisan branch of Congress that is responsible for determining the cost impacts of any federal legislation, estimated that the ACA is expected to cost \$938 billion over ten years (FFY 2010-2019).²⁹ However, with the anticipated cost savings, reductions in certain provider payments, and new revenues, the legislation is actually anticipated to decrease the federal deficit by \$124 billion during the same time. More recently, the CBO released a preliminary analysis of the fiscal impacts of repealing the ACA. In that analysis, the CBO estimated that repealing the ACA would lead to an increase in the federal deficit of approximately \$145 billion.³⁰

B. NCIOM Workgroups

The ACA will have significant impacts on all North Carolinians. State government, particularly the NCDOT and the NCDHHS, have the primary roles in implementing provisions of the ACA. The NCDOT is responsible for regulatory oversight of health insurance (including the new insurance law protections). The Division of Medical Assistance (DMA) must implement the Medicaid expansion for new eligibles, create a new electronic enrollment system, and has

²⁸ The ACA specifies that individuals will be eligible if their modified adjusted gross income is no more than 133% FPL, but the legislation also allows a 5% income disregard—effectively raising the income limits to 138% FPL.

²⁹ Congressional Budget Office. Selected CBO publications related to health care legislation, 2009-2010. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. Published December 2010. Accessed January 26, 2011.

³⁰ Congressional Budget Office. Letter from Douglas W. Elmendorf, Director, to the Honorable John Boehner. January 6, 2011. http://www.cbo.gov/ftpdocs/120xx/doc12040/01-06-PPACA_Repeal.pdf. Accessed January 26, 2011.

options to expand home and community based services. The Division of Public Health (DPH) is eligible for ACA funding to strengthen the state's public health infrastructure and to implement new programs or strengthen existing programs to improve population health. Further, with the increased funding for the National Health Service Corps, the North Carolina Office of Rural Health and Community Care (ORHCC) will have greater opportunities to recruit new health care professionals into underserved areas.

It is not only the NCDOI and NCDHHS that must implement different sections of the ACA. Inclusive Health, a quasi-state organization that administers the state's high risk health insurance pool, was charged with implementing the federal high risk pool that went into effect July 1, 2010.³¹ Further, the University of North Carolina (UNC) System and North Carolina Community College System (NCCCS), along with the independent colleges and universities may have opportunities to obtain federal ACA grant funding to expand or create new health professional training programs. The ACA also requires that the state or federal government create a Health Benefits Exchange (HBE) in every state. If the state does not create its own HBE, the federal government will.

While state government plays the largest role in implementing the ACA, the bill will have an impact on almost everyone in the state. Aside from the new insurance mandates, which will impact families and businesses, insurers must change their insurance practices, and health professionals will be required to measure and report on quality measures.

At the request of the NCDOI and the NCDHHS, 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 is being led by an Overall Advisory Group, which is chaired by Lanier M. Cansler, CPA, Secretary of the North Carolina Department of Health and Human Services and G. Wayne Goodwin, JD, Commissioner, North Carolina Department of Insurance. The Overall Advisory Group includes an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, health care professional organizations, insurers, business representatives, consumer groups, and philanthropic organizations (see Appendix B). In addition to the Overall Advisory Group, there are eight other workgroups that are charged with studying specific areas of the new act: Medicaid and Elder Services; Health Benefits Exchange and Insurance Oversight; Health Professional Workforce; Prevention; Quality; New Models of Care; Safety Net; and Fraud, Abuse and Overutilization. These workgroups are described below:

- *Medicaid and Elder Services.* Co-chairs include: Craigan L. Gray, MD, MBA, JD, Director, NC DMA, NCDHHS; and Steven Wegner, MD, JD, Chair, North Carolina Community Care Network, Inc, President AccessCare, Inc. The workgroup includes 29 additional members. This group is charged with examining the Medicaid provisions that go into effect immediately, identifying the necessary implementation steps and costs to expand Medicaid, coordinating enrollment between Medicaid and the HBE, and exploring Medicaid state options to expand covered services. The names of the workgroup members and more information about the sections of the bill that the

³¹ NC Gen Stat §58-50-180(e).

workgroup examined can be found in Appendix C of this report.

- *Health Benefit Exchange and Insurance Oversight.* Co-chairs include: Louis Belo, Chief Deputy Commissioner, NCDOI; and Allen Feezor, MA, Senior Policy Advisor, NCDHHS. This workgroup includes 25 additional members. The group is charged with providing guidance on the development of the Health Benefit Exchange and implementation of new insurance laws, and helping coordinate enrollment between Medicaid and the HBE. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix D of this report.
- *Prevention.* Co-chairs include: Jeffrey Engel, MD, State Health Director, Division of Public Health, NCDHHS; and Laura Gerald, MD, MPH, Executive Director, NC Health and Wellness Trust Fund. The workgroup includes 32 additional members. This group is charged with identifying funding opportunities for prevention and wellness programs, identifying communities of greatest need, and encouraging collaboration between the state and different communities in funding opportunities. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix E of this report.
- *Health Professional Workforce.* Co-Chairs include: Thomas J. Bacon, DrPH, Director, North Carolina Area Health Education Centers (AHEC) Program; Kennon Briggs, MPH, Executive Vice President and Chief of Staff, NCCCS; Alan Mabe, PhD, Senior Vice President for Academic Planning, General Administration, The University of North Carolina (UNC); and John Price, MPA, Director, NCORHCC, NCDHHS. This workgroup includes 29 additional members. The group is charged with examining funding opportunities for workforce development, reviewing outreach about loan repayment opportunities, fostering collaboration and coordinating implementation. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix F of this report.
- *Safety Net.* Co-chairs include: Chris Collins, MSW, Deputy Director, NCORHCC, Assistant Director, DMA-Managed Care, NCDHHS; and E. Benjamin Money, Jr., MPH, Executive Director, North Carolina Community Health Center Association. The workgroup includes 27 additional members. This group is charged with examining funding opportunities for safety net organizations, identifying areas of the state with the greatest unmet needs, and encouraging collaborations to expand access to care in those communities. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix G of this report.
- *Quality.* Co-chairs include: Alan Hirsch, JD, Executive Director, NC Healthcare Quality Alliance, CEO, Health Information Exchange, and Sam Cykert, MD, Associate Director for Medical Education, NC AHEC Program. The workgroup includes 25 additional members. This group is charged with understanding federal guidelines for patient outcome quality measures and reporting requirements, identifying strategies to improve

quality of care to meet the new quality reporting requirements, and building on existing state quality initiatives. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix H of this report.

- *New Models of Care*: Co-chairs include: L. Allen Dobson, MD, FAAFP, President, North Carolina Community Care Network, Inc., Vice President, Clinical Practice Development, Carolinas HealthCare System; Craigan Gray, MD, MBA, JD, Director, DMA, NCDHHS. This workgroup includes 30 additional members. This group is charged with examining opportunities that may become available under the ACA to test new models of financing or delivering health services to improve quality, health outcomes, overall population health, and reduce health care costs. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix I of this report.
- *Fraud, Abuse and Overutilization*. Co-chairs include: Al Koehler, Chief Investigator, NCDOI; and Tara Larson, MAEd, Chief Clinical Operations Officer, DMA, NCDHHS. This workgroup includes 17 additional members. This group is charged with examining the new program integrity provision under Medicaid, Medicare and private insurance; identifying implementation steps needed to meet the new federal requirements, and understanding and educating providers on financial integrity, fraud and abuse reporting requirements. The names of the workgroup members and more information about the sections of the bill that the workgroup examined can be found in Appendix J of this report.

The workgroups began meeting in August 2010 and most have met monthly since then. The workgroups plan on continuing their work through the spring of 2011. Some of the workgroups may continue their work over a longer period of time to provide guidance to the state in implementing other provisions of the Act. Financial support for this effort has been provided by generous grants from Kate B. Reynolds Charitable Trust, Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, The John Rex Endowment, Moses Cone~Wesley Long Community Health, and Reidsville Area Foundation.

Altogether, 260 people from across the state are members or steering committee members of one or more of the nine groups. In addition, the meetings have been open to the public so that many others have participated in the meetings either in person or online through the internet.

The workgroups were charged with identifying the decisions the state must make in implementing the ACA in each area. Some of the provisions are mandatory. For these, the workgroups are helping the state identify the steps needed to implement the provisions. Other provisions are optional to the state, and the workgroups are helping to weigh the pros and cons of these options. The ACA also includes new funding opportunities. Thus, the workgroups were also charged with examining potential funding opportunities that can improve population health, access to care, and health care quality, or reduce rising health care costs.

The Overall Advisory Group identified certain core principles to guide the work of the different workgroups:

- 1) **Improve Quality, Access, Health Care Outcomes and Reduce Health Care Costs.** Changes in our existing health care system should be designed to improve access, quality, and health outcomes, and help reduce rapidly escalating health care costs.
- 2) **Improving Population Health.** Health system reform should focus on improving the health of individual consumers, and on improving population health.
- 3) **Build on North Carolina's Strengths.** North Carolina has a long history of innovation, community collaboration and partnerships. Health system reform should build upon what works, and identify new strategies to enhance health care quality and outcomes, improve access to needed health services, increase efficiencies, and reduce health care cost escalation.
- 4) **Consumer Engagement.** Consumers should be actively engaged in their own self-management and in becoming more informed health care consumers. To accomplish this, we need to provide consumers with the information, skills and supports needed to make informed choices and to be more responsible stewards of their own care.

The following sections of this report describe the provisions of the ACA in more detail, along with the preliminary recommendations of the different workgroups.

- Section II Coverage Provisions focuses on the coverage provisions.
 - Section II.A. Public Insurance Coverage (Medicaid, NC Health Choice) describes the new Medicaid requirements.
 - Section II.B. Private Insurance Coverage describes the other insurance law changes, the new individual and employer mandates, and the Health Benefits Exchange.
- Section III Improving Population Health focuses on the public health and prevention provisions.
- Section IV Increasing Access to Health Services focuses on access.
 - Section IV. A describes the workforce provisions
 - Section IV.B covers the safety net provisions.
- Section V Enhancing Quality and Reducing Health Care Costs describes the provisions aimed at improving quality of care, testing new models of health care delivery and financing, reducing fraud and abuse, and other efforts to reduce health care costs.
 - Section V.A. focuses on the quality provisions,
 - Section V.B. describes opportunities to test new models of financing and delivering health care services,
 - Section V.C. reviews the fraud and abuse provisions of the ACA, and
 - Section V.D. describes other efforts to reduce health care cost escalation.

Each of the sections below include a broad overview of the relevant provisions of the ACA. The report then provides more detailed information about the provisions that went into effect in 2010 or will become effective sometime in 2011 (immediate implementation requirements). This is followed by information on the sections of the ACA which will not be implemented for several years (longer-term implementation requirements). The report sections include a description of mandatory and optional requirements, as well as the potential cost implications to the state, if

known. While the USDHHS has provided guidance to help with the implementation of many of the new provisions of the law, the USDHHS has not yet provided guidance on all the provisions. As a result, the workgroups have been unable to provide guidance to the state on how to implement certain provisions, as they are waiting for further guidance from USDHHS to understand the full implications. Each section highlights the areas that require further federal clarifications before implementation. In addition, each section also highlights federal funding opportunities, as well as information on whether North Carolina has obtained funding under these provisions. **The North Carolina Network of Grantmakers has created a website that tracks new ACA grant announcements to make it easier for North Carolina nonprofits and other organizations to learn about funding opportunities. For more information, register online at www.ncgrantmakers.org.**

This report generally focuses on those sections of the ACA that directly impact state government or other nonprofits, health care organizations, businesses or provider groups—either through new mandates, options, or funding opportunities. The report also highlights other areas of the new law that may require provider education. The report does not highlight sections of the ACA that the federal government has the sole responsibility to implement (for example, Medicare provider payment policies), unless North Carolina can take specific actions to prepare North Carolina providers for the new requirements (for example, by educating providers about the new Medicare and Medicaid quality requirements or fraud and abuse provisions). Also, this report does not generally describe the new Medicare coverage provisions, including expanded coverage of preventive services, or the phasing out of the Medicare prescription drug “donut-hole,” as the state has no direct role in implementing these requirements.

II. COVERAGE PROVISIONS

The ACA builds on our current system of public and private health insurance coverage. In 2009, most nonelderly North Carolinians obtained coverage in one of three ways: approximately 23% of nonelderly North Carolinians were enrolled in public insurance (of these, 15% received Medicaid or NC Health Choice, 3.6% received Medicare, 6% received military health care, and some had multiple sources of coverage).³² Approximately, 57% of North Carolinians received employer sponsored insurance (ESI), either through their own employer or that of another family member. A smaller percentage nonelderly, 6%, received their coverage individually, by purchasing non-group coverage directly from an insurance company. Approximately 20% of nonelderly North Carolinians were uninsured in 2009.

The ACA builds on existing systems to expand coverage to the uninsured, by expanding Medicaid coverage to more low-income adults, strengthening the employer based health insurance system, and making it easier and more affordable for individuals and many small businesses to purchase private coverage. According to the CBO, 92% of all nonelderly people

³² United States Census Bureau. Health historical tables. Table HIA-6. Health insurance coverage status and type of coverage by state—persons under 65: 1999-2009. <http://www.census.gov/hhes/www/hlthins/data/historical/index.html>. Accessed January 7, 2011.

living in this country will have health insurance coverage by 2019.³³ **Assuming that North Carolina achieves a similar reduction in the numbers of uninsured, 1.1 million uninsured North Carolinians are likely to gain coverage by 2019.**³⁴

A. Public Insurance Coverage (Medicaid, NC Health Choice, Other Public Programs)

1. Overview of the Medicaid provisions

The ACA requires that states expand Medicaid coverage to most uninsured adults with modified adjusted gross incomes no greater than 138% FPL beginning in 2014.³⁵ The federal government will pay an enhanced match rate for the newly eligible, but not for those who would have been eligible under the state's existing Medicaid eligibility rules in effect in March 2010. Children with family incomes no greater than 200% FPL continue to be eligible for Medicaid or NC Health Choice (the state's Children's Health Insurance Program or CHIP), and pregnant women with incomes up to 185% FPL will continue to qualify for Medicaid. The federal government will pay states an enhanced federal match for CHIP coverage beginning in 2015.

As part of the ACA provisions, states are required to develop an electronic enrollment and eligibility verification system, so that individuals can apply for Medicaid and NC Health Choice coverage online. This system must be implemented by 2014. NCDHHS was already in the process of creating a new electronic eligibility system, NC Families Accessing Services through Technology (NC FAST). This Medicaid and NC Health Choice enrollment and eligibility verification system will need to interface seamlessly with the enrollment system for the Health Benefits Exchange (described in more detail below), so that individuals can apply for either public or private insurance simultaneously, and be enrolled in the appropriate form of coverage based on income and other eligibility criteria.

The ACA also includes changes to the Medicaid covered services. Some of the changes are mandatory and go into effect immediately. Other changes are optional to the state, but provide higher federal match rates if the state chooses these options. The ACA also includes new Medicaid provisions related to prevention (described more fully in Section III below), quality of

³³ Congressional Budget Office. Selected CBO publications related to health care legislation, 2009-2010. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. Published December 2010. Accessed January 26, 2011.

³⁴ This estimate assumes that 20.4% of North Carolina's nonelderly population would continue to be uninsured in 2019 absent implementation of the ACA. The North Carolina nonelderly population is expected to increase to 9,045,015 by 2019. (Office of State Budget and Management. North Carolina population by age. http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/statesingleage_2010_2019.html). Of these, 1,845,183 would be expected to be uninsured if the state maintains the same 20.4% uninsurance rate as in 2009. (This is a conservative estimate, as the percentage of uninsured in North Carolina has generally increased over time). The CBO estimates that 92% of all nonelderly will have insurance coverage by 2019. Assuming the same percentage in North Carolina, 8,321,414 nonelderly North Carolinians would have coverage, leaving 723,601 uninsured. This reduces the numbers of uninsured by 1.1 million people.

³⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§2001, 2002, 10201, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §§1004(b)(1)(B), 1201(1)(B). The ACA specifies that individuals will be eligible if their modified adjusted gross income is no more than 133% FPL, but the legislation also allows a 5% income disregard—effectively raising the income limits to 138% FPL. To qualify, a person must be a US citizen or a lawfully present immigrant who has been in the US for five years or more.

health care services (described more fully in Section V.A. below), new models of care (described more fully in Section V.B. below), and fraud and abuse (described more fully in Section V.C. below)

2. Immediate implementation requirements (2010-2011)

The ACA included a number of new *Medicaid requirements* which went into effect in 2010 or will become effective sometime in 2011. For example:

- *Eligibility maintenance of effort requirements*: States are precluded from establishing more restrictive Medicaid enrollment and eligibility standards for adults than those that were in effect on March 23, 2010 (the date the Patient Protection and Affordable Care Act was enacted).³⁶ If a state chooses, it can expand coverage immediately to more low-income adults,³⁷ but it cannot implement more restrictive eligibility rules or administrative enrollment processes. This maintenance of effort requirement for adults stays in effect until 2014, when Medicaid is expanded to cover more adults. Similarly, states are required to maintain current Medicaid and CHIP enrollment and eligibility standards for children until 2019, although a state could choose to expand coverage to more children.³⁸
- *Benefit package*: The ACA mandated that states provide Medicaid coverage for: tobacco cessation services for pregnant women (effective October 1, 2010);³⁹ services provided by free-standing birth centers (effective immediately);⁴⁰ and concurrent coverage for hospice care for children receiving treatment for their illness (effective immediately).⁴¹ North Carolina was already in compliance with the tobacco cessation and birth center provisions. However, the state did not offer concurrent coverage of hospice services for children. DMA has made a policy change and it is expected to be implemented April 1, 2011.⁴²

In addition to the new coverage requirements, the ACA includes new *Medicaid options*:

- *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 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

³⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§2001, 2101(b), 10203.

³⁷ DHHS leadership has advised the workgroup that it could not pursue eligibility expansion to adults earlier than 2014 due to budget restraints.

³⁸ In 2014, Medicaid will be expanded to cover all children with family incomes no greater than 138% FPL. In North Carolina, this means that children, ages 6-18 with incomes between 100-138% FPL will be moved from NC Health Choice to Medicaid in 2014.

³⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4107.

⁴⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2301.

⁴¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2302.

⁴² Tara Larson, MAEd, electronic communication, January 10, 2011.

than a waiver, to men or women of childbearing age who meet the income guidelines that would apply for pregnant women (185% FPL).⁴³ There is less administrative burden in offering these services through a SPA rather than a waiver. DMA's initial estimates are that moving to a SPA would provide a small cost savings to the state and would provide more comprehensive coverage to enrollees.

- *Health Homes.* The ACA gives states the option of creating "health homes" for Medicaid recipients with chronic health problems.⁴⁴ A health home is a designated provider or team health care professionals that provides comprehensive care management, care coordination and health promotion, transitional care, patient and family support, referrals to community and social services, and that uses health information technology. Eligible individuals include Medicaid recipients with chronic illnesses, including mental health problems, substance use disorder, asthma, diabetes, heart disease or having a Body Mass Index of over 25. States that submit a 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 below). DMA is currently analyzing this provision to determine all options prior to submitting a SPA.
- *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 institutional level of care (nursing facility, intermediate care facility for people with intellectual and developmental disabilities, state developmental centers, or hospital care).⁴⁵ 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, if they would otherwise need institutional care (effective October 1, 2011).⁴⁶ States that implement this option are eligible for a six percentage point increase in their federal Medicaid match rate (called the Federal Medical Assistance Percentage (FMAP)) for covered home and community based services (HCBS).⁴⁷ If the state chooses

⁴³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2303.

⁴⁴ 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.

⁴⁵ DMA currently operates three HCBS waiver programs: CAP-DA (Community Alternative Placement for Disabled Adults), CAP-MR/DD (Community Alternative Placement for People with Mental Retardation or Developmental Disabilities), and CAP-C (Community Alternative Placement for Children with complex medical needs).

⁴⁶ 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.

⁴⁷ The Federal Medical Assistance Percentage, or FMAP, is the percentage of the Medicaid costs which is paid by the federal government for allowable health care services and supplies. In FFY 2011, the underlying North Carolina FMAP rate was 64.71%. However, the federal government is currently paying states an enhanced FMAP rate because of the economic recession (currently 75.30%). The enhanced FMAP rate is scheduled to expire in June 30, 2011, at which point, the federal government will revert to its regular FMAP rate. Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children's

this option, these HCBS would be an entitlement to eligible individuals (i.e., the state could not limit the number of people it would cover, as it can with existing Medicaid waiver programs).

- *State Balancing Initiative.* States can use this option to provide HCBS to individuals who would *not* otherwise need institutional level of support (effective October 2011).⁴⁸ Under the balancing initiative, states can provide a different set of HCBS or other non-institutionally based long-term services and supports for different target populations (e.g., people with mental illness, people with developmental disabilities, the elderly, or other people with disabilities who need help with activities of daily living). North Carolina would be eligible for up to a two percentage point increase in the federal matching rate for these non-institutionally based long-term services and supports for the incentive period (FFY 2012-2015). Again, if North Carolina chose this option, the services would become an entitlement to eligible populations.

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 home, or smaller community based settings, to receive services and supports rather than in a larger or institutional setting.^{49, 50} 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 current budget crisis. Both options provide 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, both the Community First Choice Option and the State Balancing Initiative are entitlement programs. 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 home and community based service program. Because of the state's current 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.

Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2010 through September 30, 2011. *Fed Regist.* 2009;74(227):62315-62317.

⁴⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10202.

⁴⁹ Substance Abuse and Mental Health Services Administration. Mental health: a report of the Surgeon General. United States Public Health Service; 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>. Accessed September 22, 2010.

⁵⁰ Bayer AH, Harper L. Fixing to stay. A national survey of housing and home modification issues. American Association of Retired Persons; 2000. http://assets.aarp.org/rgcenter/il/home_mod.pdf. Accessed February 8, 2011.

- Targeting new home and community based services 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 might 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 could potentially leverage new federal funds that could be used to provide services and supports to a broader population. The workgroup 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. One of the requirements of the ACA rebalancing provisions is that the state must implement an independent assessment process.

In order to understand the potential cost implications of any of these options, the state must get further clarification from the Centers for Medicare and Medicaid services as to how the federal government will calculate the enhanced payments. For example, if the enhanced payments were applied to all of the state's long-term care costs, then the additional revenues to the state might offset any new state costs of expanded coverage. However, if the enhanced payments are only for the new funds expended, then expansion may be more costly to the state.

3. Longer-term implementation requirements (2012 through 2014)

a) Coverage expansion

The ACA expands Medicaid coverage to most nonelderly individuals with incomes no greater than 138% of the federal poverty guidelines in 2014.^{51, 52} To qualify, a person must be a US citizen or a lawfully present immigrant who has been in the US for five years or more. Undocumented immigrants will not qualify for Medicaid coverage. Children will continue to receive publicly subsidized coverage in North Carolina through either Medicaid or NC Health Choice if their family income is no greater than 200% FPL.

⁵¹ 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.

⁵² The federal poverty limits, 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 2010, the federal poverty limits for a family of one was \$10,830; for a family of two (\$14,570), family of three (\$18,310), family of four (\$22,050). The federal poverty level increases by \$3,740 for each additional family member. United States Department of Health and Human Services. The HHS poverty guidelines for the remainder of 2010 (August 2010). <http://aspe.hhs.gov/poverty/10poverty.shtml>. Accessed January 17, 2010. Because the federal poverty limits are updated annually, it is likely to be higher by 2014.

This will be a major expansion to the North Carolina Medicaid program, especially for low-income adults. Currently, to qualify, a person must be a citizen or lawful permanent immigrant in the U.S. for at least five years, and must meet certain categorical, income and resource requirements. Medicaid is generally limited to low-income children, 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 incomes below a certain income threshold and have limited resources or assets to qualify. **Childless, nonelderly and non-disabled adults do not currently qualify for Medicaid, regardless of how poor they are. However, in 2014, this will change, and Medicaid will begin covering most adults with incomes up to 138% FPL.** The ACA removed 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 Chart 1 below).

To put this into perspective, currently most low-income adults working full time at minimum wage are ineligible for Medicaid in North Carolina. A person working minimum wage (\$7.25/hour), 40 hours week, 50 weeks/year would earn \$14,500/year in 2010. The incomes of these low wages workers are generally too high to qualify for Medicaid under North Carolina's current Medicaid eligibility rules.⁵³ As noted earlier, a single nonelderly adult who is not disabled cannot currently qualify for Medicaid in North Carolina, regardless of how poor he or she is. Parents can qualify, but it is extremely difficult to do so. A parent in a family of four would only qualify in North Carolina if his or her income was less than \$7,128/year, equivalent to less than half of what the person earns on minimum wage. (Chart 1) However, beginning January 1, 2014, this adult would be able to qualify regardless of whether he or she had children. The income guidelines for an individual (single adult without dependent children) would be \$14,945, or \$30,429 for a family of four if based on 2010 federal poverty limits. (These income limits are likely to increase by 2014, as they will be based on the 2014 federal poverty limits.) This is a major expansion and will provide coverage to many low-income adults.

⁵³ Medicaid has higher income thresholds for pregnant women, so a pregnant woman earning this amount would probably qualify for Medicaid.

Chart 1
Medicaid and NC Health Choice Eligibility, Different Family Sizes (Single, Family of Four)* (2010, 2014)
Using 2010 Medicaid Eligibility and Percent Federal Poverty Level

	2010 Income eligibility			2014 Income Eligibility (based upon the 2010 federal poverty limits)**		
	Percent Federal Poverty Level	Medicaid	NC Health Choice	Percent Federal Poverty Level	Medicaid	NC Health Choice
Child ages 0-5	200%	1: ≤\$21,660 4: ≤\$44,100		200%	1: ≤\$21,660 4: ≤\$44,100	
Child ages 6-18	100% (Medicaid) 100-200% (NCHC)	1: ≤\$10,830 4: ≤\$22,050	1: \$10,831-\$21,660 4: \$22,051-\$44,100	138% (Medicaid) 100-200% (NCHC)	1: ≤\$14,945 4: ≤\$30,429	1: \$10,831-\$21,660 4: \$22,051-\$44,100
Pregnant women	185%	2: ≤\$26,955 4: ≤\$40,793	Not eligible	185%***	2: ≤\$26,955 4: ≤\$40,793	Not eligible
Parent of dependent child <19 years old	1:40% 4:32%	1: ≤\$4,344 4: ≤\$7,128	Not eligible	138%	1: ≤\$14,945 4: ≤\$30,429	Not eligible
Adult without dependent children who is not disabled or elderly	Not eligible	Not eligible	Not eligible	138%	1: ≤\$14,945 4: ≤\$30,429	Not eligible
Medicare eligible adult (elderly or disabled)	100%	1: ≤\$10,830 2: ≤\$14,570	Not eligible	100%	1: ≤\$10,830 2: ≤\$14,570	Not eligible

*While the table generally shows the income limits for an individual (1) or for a family of four (4), the chart includes two 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 instead of one person. Elderly and disabled families are generally no larger than a family size of two people.

** The 2014 income eligibility limits are based on the 2010 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 limits (which increases with the cost of inflation).

*** In 2014, states have the option of changing the reducing the income eligibility guidelines for adults to 138% FPL and moving those adults with higher incomes into private subsidized coverage.

Projections suggest that there may be as many as 536,000 uninsured nonelderly North Carolina adults who could qualify for Medicaid coverage based on the expanded eligibility

criteria in 2014.⁵⁴ Of these, approximately 382,000 could be *newly eligibles* (i.e., they would not have qualified for coverage under the Medicaid eligibility rules in effect in March 2010), and approximately 154,000 could be *existing eligible, but newly enrolled* (i.e., they meet the state's current Medicaid eligibility rules but are not enrolled). While these individuals are estimated to be income eligible under the new Medicaid provisions, not all of these individuals will obtain coverage. Some are ineligible because they are undocumented immigrants, or are lawful immigrants who have been in the United States for less than five years. Others may not choose 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 unlikely that everyone who is eligible for Medicaid 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.

All newly eligible adults will be guaranteed a benchmark benefit plan that will be no less comprehensive than the essential benefits package (described more fully below).⁵⁵ The federal government will pay 100% of the Medicaid costs of *newly eligibles* for the first three fiscal years (2014-2016). After the first three years, the federal government will pay 95% of the costs in Federal Fiscal Year (FFY) 2017, 94% (FFY 2018), 93% (FFY 2019), and 90% thereafter.⁵⁶ The federal government will pay the regular FMAP, currently approximately 64% for those individuals who were *already eligible but newly enrolled*.⁵⁷

In addition, there are approximately 213,000 uninsured children with incomes below 200% FPL who may already be eligible for Medicaid or NC Health Choice but are not enrolled.

Again, most—but not all of these children—may obtain coverage once the new coverage provisions come into effect in 2014, as the expanded outreach and publicity about the new coverage options is likely to encourage people to apply who were already eligible for coverage. Beginning in 2015, the federal government increases the state's regular CHIP federal matching rate by 23 percentage points,⁵⁸ which will increase the federal contribution to the NC Health Choice program to almost 99%. This enhanced federal match rate is scheduled to stay in effect until 2019, when the CHIP program is scheduled to end. At that point, children will be either enrolled into Medicaid or private insurance (through the HBE or otherwise), depending on their families' income.

The costs of covering new adults and children in Medicaid will increase costs to the state. DMA estimates that the expansion will cover **XX** new people. The state share of the coverage for the new enrollees is estimated to be **XX** from 2014-2019. **Note: We are still waiting for estimates of new eligibles and costs to the state for the expand Medicaid coverage.** There will also be additional costs if the state expands coverage to include all the recommended preventive services and immunizations with no cost sharing (described more fully in Section III.3 below), or if the state chooses to expand coverage for home and community based services. However, there are

⁵⁴ Holmes M. Running the numbers. Project changes in North Carolina health insurance coverage due to health reform. *N C Med J.* May/June 2010;71(3):306-308. This estimate is based on the number of people projected to live in North Carolina in 2014.

⁵⁵ Health Care and Education Reconciliation Act, Pub L No. 111-152, §2001(a)(2).

⁵⁶ Health Care and Education Reconciliation Act, Pub L No. 111-152, §§1201(1)(B).

⁵⁷ The FMAP rate changes every year, based on a rolling three year average of the state's average per capita income.

⁵⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 10203(c)(1).

also ways for the state to offset some of the new costs it is likely to incur from the expanded coverage. For example:

- The state is likely to gain \$XX from the enhanced federal match rate in the North Carolina Health Choice program (CHIP enhancement) between 2015-2019.
- The state is likely to see a reduction in long-term care costs in the Medicaid program by \$30 million from the implementation of the federal CLASS Act (described in Section II.A.3.c below).
- The state is likely to see a \$206 million reduction in payments to hospitals through the reduction in DSH payments (described in Section V.D.1 below).
- The state may experience a decline in Medicaid medically needy expenditures. The Medicaid medically needy program covers some of the medical costs for people who are categorically eligible for Medicaid but have too much income to qualify under general program rules. 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 medically needy program will be covered through the regular Medicaid program, thereby reducing medically needy program costs.
- If the state expands home and community based services through the Community First Choice option or State Balancing Initiative, the state would receive an enhanced federal match rate which would offset some or all of the new costs.
- The state is likely to experience savings in the mental health, developmental disabilities and substance abuse services system, as more people with mental illness and substance abuse disorders move into the Medicaid program or private coverage.
- The state could also limit Medicaid coverage to pregnant women to those with incomes up to 138% FPL. Currently, the state provides Medicaid coverage to pregnant women with incomes up to 185% FPL.
- As more people gain coverage, the 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.
- The state may be able to save additional money to offset the costs of Medicaid coverage by creating a basic health plan (described in Section II.D. below).

The workgroups were unable to quantify the total net costs or savings to the state as a result of the Medicaid expansion. Nationally, some reports have estimated net savings to the state and local governments, but the extent to which a state has net costs or savings will vary.^{59 60}

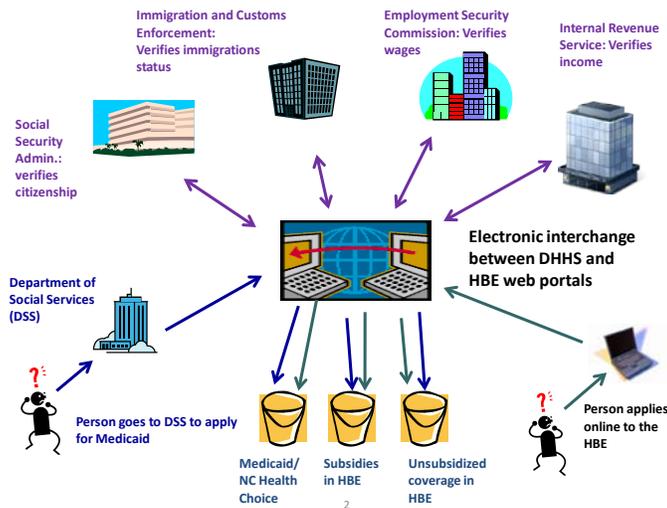
⁵⁹ Dorn S, Buettgens M. Net effects of the Affordable Care Act on state budgets. The Urban Institute. <http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf>. Published December 2010. Accessed February 4, 2011.

⁶⁰ The Council on Economic Advisers did an analysis of the impact of health insurance reform on state and local governments. They selected 16 states to examine, including North Carolina. At that time, their analysis was that North Carolina state and local governments could experience a net decrease in health care costs. However, this analysis was done before the ACA was passed. Thus, the findings may not be the same after passage of the ACA. Council of Economic Advisors; Executive Office of the President. The impact of health insurance reform on state and local governments. <http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf>. Published September 15, 2009. Accessed February 4, 2011.

b) Electronic eligibility and enrollment

The law requires the state to coordinate enrollment between Medicaid, NC Health Choice and the HBE.⁶¹ Essentially, there should be a “no-wrong door” approach to enrollment. Thus, if someone applies for a subsidy through the HBE, and is determined to be eligible for Medicaid, they 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 HBE—then they should be enrolled automatically into a subsidy program. Most people will be able to file their application online, and have income and citizenship (or immigration status) determined through a data match with other federal or state agencies. (See Figure 1 below)

Figure 1: Medicaid and Health Benefits Exchange Application and Enrollment System



The NCDHHS was already in the process of simplifying the Medicaid application and recertification process and streamlining eligibility requirements across all of the NCDHHS means-tested programs, including but not limited to the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF), and child care subsidies. In addition, NCDHHS is in the process of replacing different antiquated eligibility and enrollment systems with a new electronic information system—NC FAST—that will capture and share information across all the DHHS programs. Because of the

⁶¹ 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.

new ACA requirements, the timeline for implementing the new Medicaid electronic enrollment system will be expedited, so that it will be operational by January 2014.⁶²

NCDHHS reported to the workgroup that it did not have the staff, funding, or the time to be able to take on the new responsibilities of developing the HBE enrollment portal. To do so would disrupt the work of NCDHHS in developing electronic eligibility in other public programs. However, NC FAST will work collaboratively with the new Health Benefit Exchange, which will have responsibility for developing the electronic web portal for the HBE. (See Section II.B below for a more complete description of the roles and responsibilities of the HBE).

The workgroup recognized that the role of local Departments of Social Services (DSS) is likely to change because of this new enrollment and electronic verification system. Instead of processing all the new applications, DSS may play more of an outreach role and help people who are having difficulties having their applications processed electronically (for example, because of a recent change in circumstances that may not yet be reflected in administrative databases that have time lags). Health care providers, including hospitals, federally qualified health centers, and other health care organizations, may also be able to assist individuals in applying for Medicaid or private coverage. In addition, the Health Benefits Exchange is required to contract with certified and trained patient navigators, who will also help people apply for either public or private coverage (see HBE section below).

c. Long-Term Care

While not directly related to Medicaid, there is another provision of the ACA which is likely to reduce Medicaid spending in the future. The ACA creates a new *voluntary* long-term care insurance program beginning in 2011.⁶³ The program, called CLASS (Community Living Assistance Services and Supports), will be financed through a voluntary payroll deduction. To receive benefits, an individual must have paid into the system for at least five years, and have difficulties with at least two or three activities of daily living. The amount of the benefits will

⁶² North Carolina will need to be able to integrate Medicaid and SCHIP eligibility with the web portal offered through the HBE. DHHS already has a multi-year project to simplify and automate the eligibility and application of 13 income related programs (NC FAST). When implemented, NC FAST should not only lead to improved customer and beneficiary service but improved efficiencies. To comply with ACA's timeline of 2014 interoperable eligibility programs for public and private health coverage, DHHS has had to revamp its NCFASST timeline and scheduled implementation for Medicaid eligibility module. Some of the cost of planning such changes are being recognized in the Exchange Planning grant awarded through NCDOT. In addition the federal portion of the development and ongoing operational cost of this Medicaid/SCHIP component of NC FAST will rise from 50% to 90%. The increased funding is still pending final Federal approval. DHHS has been in communication with CMS regarding the increased funding, and they anticipate approval sometime later in the spring. At this time, CMS does not know if the increased funding will be approved retroactively, and, if so, to what date. While this increased share of federal money would be helpful, there will be attendant costs to added functionality and interoperability that will be required of NC FAST by the operations of the Exchange in 2012 and 2013. These will not be fully known until the exchange board specs out its needs. A portion of these changes may be recoverable from Exchange Development grants which are supposed to cover the costs of Exchanges through 2014. The draft legislation that would set up the exchange in NC also includes language that would allow the Exchange to contract with, and to reimburse, the Department for at least some of these added new operational and interface costs. This work is beyond the scope of the existing NC FAST expansion request.

⁶³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§8001-8002, 10801, enacting §§3201-3210 of the Public Health Service Act, 42 USC §§201 et seq.

vary, based on the level of a person's functional abilities. CLASS will provide cash assistance to individuals to help them purchase services and supports to remain independent. However, some of the funding will be used to reimburse the state and federal government for any Medicaid funds for long-term care services provided to the eligible individual.⁶⁴ The Congressional Budget Office (CBO) estimates that CLASS is estimated to save the federal government \$2 billion by 2019 in federal savings to the Medicaid program.⁶⁵ If North Carolina receives a proportionate share of savings, it may realize \$30 million in reduced outlays due to the implementation of the CLASS Act.⁶⁶

d. Basic Health Program

The ACA also allows states, with approval of the Secretary, to establish a basic health program for low-income nonelderly individuals whose income is too high to qualify for Medicaid but does not exceed 200% of the federal poverty level.⁶⁷ The basic health program would not be available to people who are eligible for affordable employer sponsored coverage that meets the minimum statutory requirements. States that are interested in establishing a basic health program must ensure that the amount of money the individual is required to pay would not exceed what he or she would have paid for premiums in the HBE with the application of the premium tax credit. Cost sharing amounts must also be limited. The basic health program must offer coverage that is at least equivalent to the essential health benefits (discussed more fully below). Coverage may be provided through a licensed health maintenance organization, insurer, or network of health care providers established to provide the basic health program. The federal government will pay states with approved basic health programs an amount equal to 95% of the premium tax credit and amount of the cost-sharing reductions that would have been provided to eligible individuals who purchased coverage through the HBE. North Carolina will need to do a cost-benefit analysis to determine if offering a basic health program would be beneficial to individuals and to the state.

4. Federal Funding

⁶⁴ CLASS eligible beneficiaries who are also receiving Medicaid for institutional care (i.e., nursing facility, hospital, intermediate care facility for people with intellectual or developmental disabilities or an institution for mental diseases) will be eligible to retain 5% of the CLASS beneficiaries cash benefit. The remainder will be applied to reduce the state and federal governments' contribution to the institution. CLASS eligible individuals who receive home and community based services can retain 50% of the cash payment and the other 50% is applied to the state's cost of providing such assistance. Patient Protection and Affordable Care Act, Pub L No. 111-148, §8002, enacting §3205(c)(1)(D) of the Public Health Service Act, 42 USC §§201 et seq.

⁶⁵ Congressional Budget Office. Letter from Douglas W. Elmendorf to the Honorable George Miller, Chairman, Committee on Education and Labor, dated November 25, 2009. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf> Accessed November 25, 2009.

⁶⁶ Assuming that North Carolina's long-term care expenditures would account for 2.7% of the savings (a proportionate amount of the savings based on the North Carolina state share of the national Medicaid long-term care expenditures), then CLASS savings for North Carolinians would account for approximately \$54 million of the \$2 billion in savings. Kaiser Family Foundation. Distribution of Medicaid spending on long-term care, FY 2008. <http://www.statehealthfacts.org/comparable.jsp?ind=180&cat=4>. Assuming that the \$54 million federal savings equals 64% of the total long-term care costs (federal and state share), then the total savings for North Carolinians might amount to \$84 million. Of this, the federal government would save \$54 million and the state approximately \$30 million.

⁶⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1331, 10104(o)(1).

The ACA also included funds to expand state Aging and Disability Resource Centers (ADRC). ADRCs act as a “no-wrong door” information, assistance and referral system for long term services and supports. ADRCs generally offer public information, options and benefits counseling, long-term care planning, and can assist with hospital discharge planning. In addition, ADRCs help families 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. There are currently eight ADRCs serving Forsyth, Surry, Chatham, Orange, Mecklenburg, Cabarrus, Guilford, Rockingham, Montgomery, Haywood, Jackson, Macon, and Wake counties. North Carolina received \$523,000 in ACA funding to support the development of training and core competencies for professionals who provide options and benefit counseling in ADRCs. The new curriculum and competency testing will be piloted in two ADRCs in Wake and Piedmont Triad (covering Guilford, Rockingham, and Montgomery counties). If successful, this will be rolled out to the remaining ADRCs.

B. Private Individual and Employer-Sponsored Insurance and Insurance Law Changes

1. Overview of the Private Coverage provisions

The ACA requires insurers to provide certain essential health benefits which will be equal to the scope of benefits provided under a typical employer plan.⁶⁸ The essential benefits will be defined by the Secretary, but the legislation specifies that it will include hospitalization, professional services, prescription drugs, rehabilitation and habilitative services, mental health and substance use disorders services and maternity care. In general, insurers will also be required to sell plans that provide payment for at least 60% of the actuarial value of the covered benefits, on average. (Persons with this minimum level of coverage would be responsible for the other 40% of the costs of covered services, on average, in addition to their premium.) However, the ACA expands on traditional coverage in some noteworthy ways. First, insurance plans were required to offer coverage of preventive services recommended by the US Preventive Services Task Force (USPSTF) and vaccines recommended by the Advisory Committee for Immunizations Practices (ACIP) with no cost sharing. This coverage of recommended clinical preventive services and vaccines went into effect for any new plan purchased on or after September 23, 2010. Health plans must also offer more extensive services for children under age 21 (including oral health and vision), and must provide additional preventive services for infants, children, adolescents and women.⁶⁹ Grandfathered plans—those that were in existence when the bill was signed into law on March 23, 2010—are not required to offer the essential health benefits package,⁷⁰ but over time, many insurance plans will lose their grandfathered status.⁷¹ Thus, ultimately, most Americans with private coverage will have coverage for the essential benefits package.

⁶⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302.

⁶⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 1302, enacting §2713 of the Public Health Service Act, 42 USC §§300gg.

⁷⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1251, 10103, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2301.

⁷¹ Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act; Interim final Rule and Proposed Rule. 75 Fed. Reg. 34538-34570. June 17, 2010. Amendment to Interim Final Rules for Group Health Plans and Health Insurance Coverage

Each state will have a Health Benefits Exchange (HBE), where individuals and small businesses can shop for health insurance coverage beginning in 2014. States can either create their own HBE or the federal government will do so. As discussed later in the report, the workgroup recommended that the state create its own HBE rather than leave it to the federal government to develop. States that choose to create a HBE can develop two exchanges: one for the non-group (individual market) and one for the small employer market, or it can combine both exchanges into one. While the HBE does not need to be operational until 2014, funding has been available to the states in 2010 to begin the planning and implementation of these exchanges. North Carolina obtained an initial planning grant and will be eligible for additional implementation grants if it is making progress on implementing a state HBE.

Health plans offered through the HBE must offer all the essential health benefits. There will be four levels of health plans offered through the HBE: bronze (covering 60% of the actuarial value of covered health care services),⁷² silver (70% actuarial value), gold (80% actuarial value), or platinum (90% actuarial value).⁷³ In addition, young adults (ages 18-30), and those who would have to spend more than 8% of their income on the lowest cost bronze plan, are also eligible to purchase catastrophic coverage through the HBE rather than standard health insurance coverage. Catastrophic plans generally have high deductibles, thereby lowering the costs of premiums to the enrollees. Health plans offered to individuals and to small employers through the HBE must offer mental health and substance abuse services in parity with other services, similar to what large employers are already required to cover.⁷⁴

States may mandate that plans sold through the HBE cover additional benefits (“mandated benefits”), but if a state chooses to do so, it must pay for the costs of the additional mandates for people who purchase coverage through the HBE.⁷⁵ Health insurance offered outside the HBE can still be required to include state mandated benefits in addition to the coverage required through the essential health benefits package. **The North Carolina General Assembly will need to decide whether to continue to require coverage of mandated benefits inside or outside the HBE.** If the North Carolina General Assembly takes no action, the state will need to pay for the added costs of the existing mandated benefits for anyone who purchases coverage through the HBE.

The ACA also provides subsidies to certain individuals and some small employers to help them pay for insurance coverage purchased in the HBE. Many individuals will be eligible to receive a premium tax credit and cost sharing reductions for coverage purchased in the HBE. Individuals are eligible for a sliding scale premium tax credit and cost-sharing reduction if their modified adjusted gross income is no greater than 400% FPL,⁷⁶ they are not eligible for public 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.

⁷² Actuarial value is the percentage of total average costs for covered benefits that a plan will cover.

⁷³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(d).

⁷⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(j).

⁷⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d), 1410(b)(3)(D).

⁷⁶ In 2010, 400% of the Federal Poverty Level was \$43,320/year for an individual, \$58,280/year for a family of two, \$73,240/year for a family of three, or \$88,200/year for a family of four. In 2010, North Carolina’s median income was \$38,656 for an individual, \$52,008 for a family of two, \$56,727 for a family of three, or \$67,056 for

and do not have access to affordable employer-sponsored insurance.⁷⁷ (Chart 2) Most North Carolina families have incomes below 400% FPL. **Analysis of the Current Population Survey suggests that there may be as many as 712,000 uninsured nonelderly adults in North Carolina with incomes between 138-400% FPL, and 62,000 uninsured children with family incomes between 200-400% FPL in 2014. Some, but not all, of these individuals will be eligible for a subsidy to purchase coverage in the HBE.**⁷⁸ Others may gain coverage through their employer, or would be ineligible for a subsidy if they are undocumented immigrants.

Chart 2: Sliding Scale Premium Tax Credit and Cost Sharing Reduction

Individual or Family Income (as percent FPL)	Maximum premium (Percent of family income)	Out-of-pocket cost sharing ⁷⁹	Out-of-pocket cost sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost sharing limits) ⁸⁰
<133% FPL	2% of income	6%	\$1,983 (individual)/\$3,967 (family) (1/3 rd HSA limits)
133-150% FPL	3-4%	6%	\$1,983/\$3,967
150-200% FPL	4-6.3%	13%	\$1,983/\$3,967
200-250% FPL	6.3%-8.05%	27%	\$2,975/\$5,950 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	\$2,975/\$5,950
300-400% FPL	9.5%	30%	\$3,967/\$7,934 (2/3rds HSA limit)

To put this in perspective, assume that a North Carolina family of three had a modified adjusted gross income of \$45,000/year (slightly less than 250% of the FPL). The maximum amount that family would pay in premiums would be \$3,622/year or \$301/month (this is 8.05% of their family income). This family would pay approximately 27% of covered health care expenses out-of-pocket (in a combination of deductibles, coinsurance or copayments), but in no event would the family have to pay more than \$2,975/year for any individual or \$5,950/year for the family in out-of-pocket costs. Families who qualify for subsidies with lower incomes (as a percentage of the FPL) would pay less in premiums and out-of-pocket costs, and those with higher incomes would pay more.

a family of four. United States Trustee Program. Census Bureau median family income.

http://www.justice.gov/ust/eo/bapcpa/20100315/bci_data/median_income_table.htm Accessed January 17, 2011.

⁷⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1401, 1501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1001.

⁷⁸ Holmes M. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement [unpublished data].

⁷⁹ Out-of-pocket cost sharing includes deductibles, coinsurance, copays.

⁸⁰ Out-of-pocket limits do not include premium costs. Annual cost sharing limited to \$5,950 per individual and \$11,900 family in 2010 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.

Most individuals will be required to purchase coverage or pay a penalty beginning in 2014. This is often referred to as the individual mandate. Individuals who do not have public or private insurance coverage must pay a penalty that is equal to the greater of \$95/year or 1% of their income (2014), growing to \$695/year or 2.5% of their income (2016).⁸¹ This provision will be enforced through the Internal Revenue Service (IRS).⁸² Certain individuals are exempt from this mandate, including people whose income is so low that they are not required to pay taxes, and those for whom the premium for the lowest cost plan would exceed 8% of their family income.⁸³ This individual mandate has been the cornerstone of many of the challenges to the constitutionality of the ACA.⁸⁴ Ultimately, the question of the constitutionality of the individual mandate as well as other provisions of the ACA will likely be decided by the US Supreme Court.

The ACA requires businesses with at least 50 full-time employees to *offer* health insurance coverage or to pay a penalty.⁸⁵ **According to the 2009 Medical Expenditure Panel Survey-Insurance Component, US Agency for Healthcare Research and Quality, there were 52,185 private-sector establishments in North Carolina with 50 or more employees (28.1% of all private-sector establishments in the state).⁸⁶ Of these, 97.1% already offer health insurance, although we have no data on whether these health insurance plans would meet the minimum requirements of the ACA. The North Carolina firms with 50 or more workers employ more than 2.3 million individuals, 97% of whom work for firms that offer insurance coverage.⁸⁷**

If a company with 50 or more full-time employees does not offer coverage, the company is required to pay \$2,000/year for each full-time employee; however, the business does not pay a penalty for the first 30 full-time employees. If the company does offer coverage, but the coverage is not affordable to some of their employees, or the coverage is not at least equivalent to 60% of the actuarial value of the essential benefits, the company is required to pay \$3,000 for

⁸¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(c), 1401, 1402, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1001.

⁸² Patient Protection and Affordable Care Act, Pub L No. 111-148, §1502.

⁸³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1501(d)(2)-(4),(e).

⁸⁴ As of the middle of December, 2010, there have been at least 19 cases challenging various aspects of the ACA. Several of the lawsuits have focused on challenges to the individual mandate. Five of the cases have been dismissed by district courts, one case has been upheld, and one court denied in part, and granted in part, the motion to dismiss the court challenge. Several of the cases have been appealed to the Courts of Appeals. Ultimately, the challenge to the constitutionality of the ACA is likely to be decided by the US Supreme Court.

⁸⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1201, 1513, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1003.

⁸⁶ Center for Financing, Access and Cost Trends; Agency for Healthcare Research and Quality. 2009 Medical Expenditure Panel Survey-insurance component. Tables II.A.1, II.A.1.a, II.A.2, II.B.1, II.B.1.a, II.B.2. MEPS counts all employees who work for the firm in determining firm size (including seasonal, part-time and full-time). Thus, the MEPS estimate of the number of small firms in the state may differ from other estimates that only include full-time employees or full-time equivalent employees.

⁸⁷ Employees who work for firms that offer health insurance may not be eligible for coverage, if they are seasonal, part-time, or do not meet other requirements. In North Carolina, 80.8% of the private sector employees who work for firms that offer insurance with 50 or more employees are eligible for the coverage. Center for Financing, Access and Cost Trends; Agency for Healthcare Research and Quality. 2009 Medical Expenditure Panel Survey-insurance component. Table II.B.2.a.

each employee who purchases subsidized coverage through the HBE.⁸⁸ Health insurance is considered unaffordable if an employee has to spend more than 9.5% of their household income for the individual coverage. In addition, employers are required to offer employees a “free choice” voucher if the employee share of the premium is between 8-9.8% of the individual employee’s household income.⁸⁹ The employee can then decide whether to maintain the employer coverage, or to use the voucher to purchase insurance within the HBE.

Small businesses, with fewer than 50 employees are exempt from the mandate.⁹⁰ **Only 33.8% of smaller businesses in North Carolina that employ fewer than 50 employees, offered group health insurance coverage in 2009.**⁹¹ However, to make insurance coverage more affordable to the smallest companies, the ACA provides a sliding scale tax subsidy to small businesses with 25 or fewer employees, with an average wage of \$50,000 or less, if the company pays at least 50% of the premium costs.⁹²

The ACA also includes insurance reforms, some of which were effective in 2010-2011, and others which will become effective in 2014. The NCGA passed legislation in 2010 giving NCDOT the authority to enforce provisions of the ACA “to the extent that the provisions apply to persons subject to the Commissioner’s jurisdiction and to the extent that the provisions are not under the exclusive jurisdiction of any federal agency.”⁹³

2. Immediate Provisions (2010-2011)

Many of the insurance-related changes went into effect in 2010, or became effective for health plans that were newly purchased or renewed after September 23, 2010. Some of the major changes that went into effect already include:

- *Federal high risk pool:*⁹⁴ The ACA appropriated \$5 billion over five years (FFY 2010-2014) to create a federal high risk pool to provide more affordable coverage to people with preexisting health problems that have been uninsured for at least six months. **North Carolina’s share of this \$5 billion appropriation was \$145 million.**⁹⁵ States were given the option of operating the federal high risk pool themselves. If a state chose not to operate its own federal high risk pool, then the federal government would create one.

Rather than create a totally separate federally-operated high risk pool, the North Carolina General Assembly authorized Inclusive Health, North Carolina’s state high risk pool, to

⁸⁸ In no event would an employer be required to pay more than they would have paid if they did not offer insurance—i.e., \$2,000 per employee, excluding the first 30 employees.

⁸⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10108.

⁹⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1513(d)(2).

⁹¹ Agency for Healthcare Research and Quality; Center for Financing, Access and Cost Trends. 2009 Medical Expenditure Panel Survey—insurance component. Table IIA.2.

⁹² Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1421, 10105.

⁹³ NC Gen Stat §58-2-40.

⁹⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1101.

⁹⁵ United States Department of Health and Human Services. Fact sheet—temporary high risk pool program. http://www.hhs.gov/ocio/initiative/hi_risk_pool_facts.html. Accessed January 17, 2011.

also operate the federal high risk pool.⁹⁶ There are different eligibility requirements for the federal and state high-risk pool. **As of January 1, 2011, there were 5,137 people enrolled in the state high risk pool which predates the enactment of the ACA. There were 796 people enrolled in the federal high risk pool. The state high risk pool is generally more expensive than the federal pool, but does not have the federal pool requirement that an individual be uninsured for six months prior to enrollment. As of November, the date when the last comparison information was available, North Carolina was tied with California for enrolling the largest number of uninsured individuals with preexisting health problems into the federal high risk pool.**⁹⁷ The federal and presumably the state high risk pools will be phased out in 2014, when the other insurance provisions are fully phased in.

- *Reinsurance*: The ACA appropriated an additional \$5 billion over five years (FFY 2010-2015) to create a temporary reinsurance pool to help offset the high claims costs to businesses (including state and local governments) that provide health insurance to early retirees, age 55 or older, who are not eligible for Medicare.⁹⁸ **As of December 20, 2010, 96 North Carolina employer groups, including the State Health Plan, 24 counties, and 19 North Carolina towns or cities, met the requirements to be eligible for reinsurance to offset part of the claims costs for early retirees.**⁹⁹ **Assuming that the \$5 billion is not exhausted before 2014,**¹⁰⁰ **the State Health Plan estimates that it will receive \$22.7 million in SFY 2011, \$57.9 million in SFY 2012, and \$8.9 million in SFY 2013 from the federal reinsurance pool.**¹⁰¹
- *Tax credits for small employers*. The ACA offers two levels of sliding scale tax credits to small businesses that provide health insurance to their employees.¹⁰² The tax credits are available to small businesses with 25 or fewer employees that have an average wage of \$50,000 or less and that pay at least 50% of the premium costs. Prior to the implementation of the HBE in 2014, small businesses with 25 or fewer employees and an average wage of no more than \$50,000 can receive a maximum tax credit of up to 35% of the costs of the employer-paid premium (or 25% for non-profit companies). The full tax credit is limited to businesses with 10 or fewer employees and average wages of \$25,000 or less. The NCIOM estimates that small businesses in North Carolina currently may be able to qualify for more than \$200 million in tax credits through the small business tax credit. After 2014, small businesses are eligible for a two-year tax credit with a maximum subsidy of 50% of an employer's premium costs (or 35% for nonprofit

⁹⁶ NC Gen Stat §58-50-189(e).

⁹⁷ United States Department of Health and Human Services. State by state enrollment in the Pre-Existing Condition Insurance Plan, as of November 1, 2010. http://www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html. Posted November 5, 2010. Accessed January 19, 2011.

⁹⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1102.

⁹⁹ A current list of eligible employers can be found at the federal government implementation website at <http://www.healthcare.gov/law/provisions/retirement/states/nc.html>. Accessed January 3, 2011.

¹⁰⁰ As of January 13, 2010, more than \$4 billion of the \$5 billion appropriated was still available for disbursement. Common questions. Healthcare.Gov Web site. http://www.errp.gov/faq_misc.shtml. Accessed February 2, 2011.

¹⁰¹ Mona Moon, electronic communication, January 18, 2011.

¹⁰² Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1421, 10105.

companies) if they purchase coverage within the HBE.

- *Enhanced rate review and Medical Loss Ratio (MLR).* The ACA strengthened the premium rate review process and added new requirements related to the MLR. The MLR is the amount of the premium dollar spent on clinical services and quality, compared to all other non-claims costs (excluding state and federal taxes and licensing/regulatory fees). The ACA also includes requirements for greater transparency and public justification for rate increases that were deemed unreasonable.
- *Other impacts.* The new rating and grandfathering rules in the ACA resulted in a change in reserving assumptions by Blue Cross Blue Shield of North Carolina (BCBSNC) for its individual plans known as Blue Advantage and Blue Options HSA which, in turn, created a one-time circumstance enabling refunds to policyholders of these plans.¹⁰³ Because of these changes, BCBSNC distributed refunds totaling \$155.8 million to approximately 215,000 individual policyholders in 2010.¹⁰⁴

In addition, other insurance law changes became effective for plans purchased or renewed after September 23, 2010. Most of these new changes apply to both self-insured (ERISA) plans and to other health plans that an individual or employer purchases directly from insurers. Some of these provisions include:

- Insurers must offer parents the option of continuing coverage for adult children up to age 26 regardless of student status.¹⁰⁵
- Insurers are prohibited from imposing lifetime limits on the dollar value of the health insurance coverage and are restricted in the use of annual limits.¹⁰⁶
- Insurers are prohibited from rescinding coverage except in the case of fraud.¹⁰⁷
- Insurers are prohibited from denying coverage for children under the age of 19, or imposing pre-existing condition exclusions, based on pre-existing medical conditions.¹⁰⁸

¹⁰³ The refunds came from active life reserves, which are portions of the premium set aside in the early years of a policy to pay future claims and keep rates stable as customers' medical expenses rise during the life of the policy. BCBSNC adjusted its assumptions to recognize that policies purchased or substantially modified after March 23, 2010 will end in 2014 under the new health care reform law, which is when the new products under health reform will be introduced. Therefore, the reserves held for these products will cover a much shorter period of time, allowing for these funds to be released.

¹⁰⁴ More than 215,000 BCBSNC individual policyholders begin receiving refunds. North Carolina Department of Insurance News; December 1, 2010. <http://www.ncdoi.com/media/news2/year/2010/120110b.asp>. Published December 1, 2010 Accessed January 10, 2011.

¹⁰⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2301, enacting §2714 of the Public Health Service Act, 42 USC §§300gg.

¹⁰⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, 10101(a), as amended in the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2301, enacting §2711 of the Public Health Service Act, 42 USC §§300gg.

¹⁰⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, enacting §2712 of the Public Health Service Act, 42 USC §§300gg.

¹⁰⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1201, 1255, 10103(e), enacting §2704 of the Public Health Service Act, 42 USC §§300gg.

- Insurers must have an appeal process which includes external review of coverage questions.¹⁰⁹ (Note: North Carolina laws already meet this requirement).
- New private plans are required to provide coverage for clinical preventive services without cost sharing.¹¹⁰ This includes all preventive services that receive an A or B recommendation from the US Preventive Services Task Force, vaccines recommended by the Advisory Committee for Immunization Practices, and additional preventive care for infants, children, adolescents and women, as recommended by the Health Resources and Services Administration. (Note: this provision does not apply to “grandfathered” health plans as long as the plan maintains its grandfathered status).
- Protections for network-based plans, which allows enrollees to select any primary care provider from participating providers, limits the amount that insurers can charge for out-of-network emergency services, and allows individuals to self-refer to an OB-GYN.¹¹¹ (Note: North Carolina laws already meet this requirement.)
- Health plans are required to report their MLR to the Secretary of the USDHHS and the NCDOI for plan years beginning in 2010. Beginning in 2011, health plans must provide rebates to consumers if their MLR for the prior year was less than 85% for health plans in the large group market, or 80% for plans in the individual or small group market.¹¹²
- Beginning in 2011, insurers will also be required to provide justification of any “unreasonable” rate increases to USDHHS and the North Carolina Department of Insurance prior to implementation of the increase.¹¹³ Insurers will also be required to post information about these increases on their websites.

3. Longer Term Insurance Provisions (2012-2014)

As noted earlier, the ACA requires the creation of one or more state-based HBEs, and allows states to enforce new health insurance laws. These provisions are described more fully below:

a) Health Benefit Exchanges

¹⁰⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10101(g), enacting §2719 of the Public Health Service Act, 42 USC §§300gg.

¹¹⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, enacting §2713 of the Public Health Service Act, 42 USC §§300gg.

¹¹¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10101(h), enacting §2719A of the Public Health Service Act, 42 USC §§300gg.

¹¹² Patient Protection and Affordable Care Act, Pub L No. 111-148, §10101(f), enacting §2718 of the Public Health Service Act, 42 USC §§300gg.

¹¹³ The USDHHS has issued a notice of proposed rulemaking which sets out the process the federal government will use to decide whether a proposed rate increase in the individual and small group market is unreasonable. The first step is to determine if the rate filing, along or in combination with prior increases in the past 12 months, was 10 percent or more. The proposed rate increases that meet this initial threshold will be subject to a more thorough review to determine if the rate increase is unreasonable. This review process will consider whether the proposed rate increase is unjustified, excessive or unfairly discriminatory. USDHHS will adopt a state’s determination about whether a rate increase is unjustified, if USDHHS determines that the state has an effective rate review program. Rate increase disclosure review. *Fed Regist.* 2010;75(246):81004-81029. To be codified at 45 CFR §154. If NCDOI is deemed to have an “effective rate review program,” North Carolina’s definition of what is unreasonable will be used. When NCDOI is required to review and approve rates, it generally considers whether the rates are excessive, not inadequate (i.e., provides for the statutory reserves), not unfairly discriminatory, and exhibits a reasonable relationship to the benefits provided.

The ACA requires states to create HBEs which will provide information to individuals and businesses to enable them to compare the different insurance plans offered in the HBE and to facilitate enrollment into a plan. If a state chooses not to create its own health benefit exchange, the federal government will create one to offer coverage to individuals and small groups in the state. The HBE will offer information to help compare health plans based on quality, provider networks, and costs, and will help individuals and small businesses enroll in coverage.

The ACA mandates that HBEs perform many functions not currently performed in most states. For example, HBEs must:

- Certify, recertify, and decertify qualified health plans, coop plans, and federally approved multi-state plans as specified by the Secretary.¹¹⁴
- Operate a toll-free telephone hotline to respond to requests for assistance.¹¹⁵
- Assign a quality rating to each qualified health plan offered through the HBE, using criteria developed by the Secretary.¹¹⁶
- Develop and maintain an internet website that provides standardized comparative information on plan options, including costs, quality and provider networks.¹¹⁷
- Determine eligibility for the premium tax credit and cost sharing subsidies.¹¹⁸
- Inform people about eligibility requirements for Medicaid and NC Health Choice (North Carolina's CHIP program), and if eligible, enroll them directly into Medicaid or NC Health Choice.¹¹⁹
- Establish and make available an electronic calculator to determine the costs of coverage after applicable premium tax credits and cost sharing reductions.¹²⁰
- Certify individuals who are exempt from the requirement to purchase health insurance.¹²¹
- Provide information to the Secretary of DHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions, and the level of coverage.¹²²
- Provide the Secretary of the Treasury 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.¹²³
- Provide information to employers of any employee who ceases coverage under a qualified health plan.¹²⁴
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.¹²⁵

¹¹⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 1301, 1311, 1321, 1322, 1334, 10104.

¹¹⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(B).

¹¹⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).

¹¹⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(c),(d)(4)(C),(E).

¹¹⁸ 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.

¹¹⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(F), 1411, 1413.

¹²⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(G).

¹²¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(H).

¹²² 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).

¹²³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(I).

¹²⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(J).

- Consult with stakeholders relevant to carry out required activities.¹²⁶
- Publish average costs of licensing, regulatory fees and other payments to the HBE, and administrative costs.¹²⁷
- Report on activities, receipts, and expenditures annually to the Secretary of USDHHS.¹²⁸
- Credit the free choice voucher paid on behalf of qualified employees, and consider information from employers that contest the imposition of penalties.¹²⁹

The HBE must be self-sufficient beginning January 1, 2015.¹³⁰ Under the ACA, HBEs can 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.¹³¹ The federal government will pay the premium tax credits and the cost-sharing subsidies directly to health plans. The federal government will also pay for expenses associated with the establishment of the exchanges in a state, until 2015.

The HBE will play a critical role for many individuals and groups seeking health insurance coverage. Under the ACA, individuals seeking premium and cost-sharing subsidies can only obtain these subsidies if they purchase coverage through the HBE. Similarly, individuals who receive a free choice voucher from their employer can only use the voucher to purchase coverage in the HBE. Additionally, starting in 2014, small businesses can only qualify for the tax credit if they purchase their insurance coverage through the HBE. Other individuals or small employers may choose to purchase coverage through the HBE, including individuals and other small businesses.

The state has many options in implementing the HBE provisions of the ACA. First and foremost, the state must decide whether it wants to create its own HBE, or leave it to the federal government to implement. If the state chooses to implement its own HBE, then it has various other implementation options. For example, the state must decide:

- The organizational structure of the HBE (whether to house the HBE within an existing state agency, or to create a quasi-state or independent non-profit).¹³²
- The board composition.
- Whether to create or operate one or two HBEs (one for individual coverage, one for small group, or a combined HBE).¹³³
- The state must decide whether to create one or two separate rating pools, and the degree to which the individual and small group market should be treated as distinct programs.
- Whether to create regional HBEs or a statewide HBE.

¹²⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1311(d)(4)(K), 1311(i).

¹²⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(d)(6).

¹²⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(7).

¹²⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1313.

¹²⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10108(d)(2), 1411(f)(2).

¹³⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(a),(d)(5).

¹³¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(5).

¹³² Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(b)(2).

¹³³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(b)(2).

- The size of the small businesses that are allowed to purchase insurance coverage through the HBE. The ACA allows states to limit coverage in the HBE to employers with 50 or fewer employees from 2014-2016.¹³⁴ In 2016, the HBE must be offered to any business with 100 or fewer employees. Beginning in 2017, states have the option of opening up the HBE to larger employers. North Carolina insurance laws currently defines a small employer as having 50 or fewer eligible employees, including a self-employed individual.¹³⁵
- Whether the HBE should have the authority to set additional standards for qualified health plans in addition to those required under federal law. All HBEs are required to certify health plans that meet certain federal requirements, including offering the essential health benefits package, and meeting marketing, network and quality standards. HBEs are also required to provide comparison information to employers and individual consumers so that they can more easily compare the costs, quality and provider networks of the different plans. However, states also have the option of imposing additional standards that could further improve value, lower costs, and ensure that consumers have meaningful choice.

The workgroup that examined these issues recommended that the state create its own HBE, rather than leave this responsibility to the federal government. Some of the advantages of a state-created HBE include:

- Maintaining state regulatory authority over a large share of the commercial market.
- Greater ability to mitigate risk selection that can result from different rating and underwriting rules for insurance sold in and outside the HBE.
- Greater ability to coordinate eligibility and enrollment between the HBE, Medicaid and NC Health Choice.
- Greater ability to promote state health reform strategies and priorities through the HBE (including payment reform, support for patient centered medical homes), and to coordinate activities with other initiatives in the state.
- More control over the number and types of plans offered through the HBE.
- Greater oversight of the operations by state policy makers with the ability to modify the operations if they discover some aspects not working well for North Carolinians.
- Greater control over how the HBE will be financed, and how much monies are spent on administrative operations.
- If the federal government operates the HBE, carriers may be subject to two sets of rules and reporting requirements for policies sold in the HBE (federal oversight) and those sold outside the HBE (state oversight).

However, the workgroup recognized that there were some challenges in assuming the operational responsibilities of the HBE. Some of the disadvantages of a state-created HBE include the responsibilities of developing a new program within the federal parameters, and of identifying a financing source to ensure that the HBE will be self-sufficient in 2015.

¹³⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1312(f).

¹³⁵ NC Gen Stat §§58-50-110(21a) , (22).

The workgroup also examined the advantages and disadvantages of different administrative structures (state-operated, quasi-state, or independent non-profit). The North Carolina General Assembly does not have the statutory authority to create a totally independent non-profit corporation. In the past, when the General Assembly has created separate non-profit organizations, they operate as quasi-state organizations, operating with many of the state's accountability and oversight provisions. The state's high risk pool, Inclusive Health, is an example of a quasi-public agency. Inclusive Health is a non-profit, but board members are appointed by the North Carolina General Assembly, NCDOI and Governor's office. The authorizing legislation requires the board to meet many of the requirements of state agencies.¹³⁶ For example, Inclusive Health is audited by the state auditor, board members must meet the statutory ethics rules, and the Executive Director must make an annual report to the legislature.

The workgroup concluded that there were more advantages to establishing a quasi-state, public-private non-profit entity than a state agency. The new agency should be responsible for meeting open meeting rules, public record laws (with exceptions for proprietary information), ethics laws/training, and conflict of interest and financial disclosure rules. The non-profit should have statutory liability protection, be audited by the state auditor, have rulemaking authority, and be required to file a plan of operation with the NCDOI. However, the non-profit should be exempt from the bidding, contracting and purchasing requirements and the state personnel act (similar to Inclusive Health). Ultimately, the North Carolina General Assembly will need to enact enabling legislation to create a new state Health Benefit Exchange, if they want the state to create and provide oversight for the HBE rather than the federal government.

The workgroup has developed draft legislative language for a HBE. The underlying structure of the bill and many of the provisions are modeled after the National Association of Insurance Commissioner's (NAIC) model HBE legislation. However, the legislation varies from the NAIC model legislation in several aspects. First, the workgroup thought it was important to include references to existing state insurance laws, when appropriate. In addition, the workgroup thought it was important to include greater accountability and oversight protections to this quasi-state organization. Thus, the proposed legislation specifically requires the HBE Board to comply with state ethics laws, public meeting and public records requirements; to be audited by the State Auditor; to submit periodic reports to the General Assembly and Insurance Commissioner, and to make these reports available to the public. This is similar, in many respects, to the North Carolina legislation which created Inclusive Health (the state's high risk pool). The proposed bill also has strong conflict-of-interest protections, as well as references to other sections of the ACA, which were not included in the initial NAIC draft. Further, the proposed legislation includes provisions which the NAIC left open to the state (such as the Board composition). A copy of the draft legislation can be found in Appendix B.

The proposed legislation includes several placeholders, where the group needs additional information before making recommendations. NCDOI has a contract with Milliman Inc. to provide actuarial information to the state to help with some of the HBE design issues. For example, the ACA gives the states the option of whether to initially limit the HBE to small employers with 50 or fewer employees, or to allow firms with up to 100 employees to purchase coverage through the HBE. Opening it to larger employers would expand the number of people

¹³⁶ NC Gen Stat §58-50-175.

who might be covered through the HBE, potentially lowering costs to participating individuals or employers. Conversely, expanding the pool to include employers with 51-100 employees could create a potential for adverse selection, if employers with a sicker group of employees purchase coverage through the HBE, but those with healthier employees choose to self-insure. Similarly, the state has the option of whether to combine the individual (non-group) and small employer group risk pool or plan offerings. The workgroup is waiting for further feedback from Milliman before making recommendations around some of these design issues.

The workgroup was able to reach consensus on most of the provisions of the draft legislation, although there was not unanimous agreement for every provision. The major outstanding area of contention has to do with the Board composition. Some of the workgroup members, and many of the people from the public who offered comments, opposed the idea of having insurers on the board. These groups were afraid of the potential for a conflict of interest if the insurers could help shape HBE policies, given that some of the Board decisions could have direct financial impact on an insurers' bottom line. Similarly, some were also concerned about having agents serve on the board because of a potential conflict. Others were supportive of including both insurers and agents on the board because of the expertise they bring.

Other states have taken different approaches as it relates to the composition of their HBE governing boards. Thus far, only three states have enacted legislation (California, Massachusetts and Utah). Utah HBE operates as a state agency and does not have a governing board. Indiana created its HBE through an Executive Order. None of the three states that have HBEs with governing boards (CA, MA, or IN) have insurers on the Board, although Massachusetts recently changed its board composition to include an agent. Other states have introduced HBE legislation that is still pending. (Chart 3) Most of the bills that have been introduced as of February 4, 2011 do not include insurer representatives or do not specify whether insurers can serve on the board. The states are somewhat more mixed as it relates to agent representation on the board.

Chart 3
State Health Benefit Exchange Legislation (as of February 4, 2011)

	Board Size	Consumer or Advocates	Employer	Tech. Experts *	State Agency	Insurer	Agent	Health Care Provider
Enacted								
California (AB 1602/SB 900) (2010)	5	NS	NS	Yes	Yes	No	No	No
Indiana (Executive order)	NS	No	No	No	Yes	No	No	No
Massachusetts	11	Yes	Yes	Yes	Yes	No	Yes	NS
Pending								
Arizona (SB 1524)(2011)	9	Yes	NS	Yes	Yes	No	No	No
Hawaii (SB 1348) (2011)	15	Yes	Yes	Yes	NS	Yes	NS	NS

Hawaii (HB 1201)(2011)	7	NS						
Maryland (SB 182/ HB 166)(2011)	9	Yes	Yes	Yes	Yes	No	No	NS
Maryland (SB 107)(2011)	NS	NS	NS	NS	NS	NS	NS	NS
Mississippi (SB 2992)(2011)	16	Yes						
Montana (HB124)(2011)	7	Yes	Yes	Yes	Yes	No	No	NS
New Jersey (S2553/A 1930)(2010)	7	Yes	Yes	Yes	Yes	No	No	No
New Jersey (S1288/ A3561)(2010)	11	Yes	Yes	Yes	Yes	No	NS	NS
New Mexico (HB0033)(2011)	9	Yes	Yes	Yes	Yes	No	No	No
Oregon (SB99)(2011)	9	NS	NS	NS	Yes	NS	NS	NS
Pennsylvania (HB2759)(2010)	15	NS	NS	NS	Yes	NS	NS	NS
Rhode Island (SB87) (2011)	11	Yes	Yes	Yes	Yes	No	No	No
West Virginia (SB408)(2011)	10	Yes	Yes	NS	Yes	No	Yes	Yes

NS=Not specified.

*States that include technical experts often include people with actuarial experience, finance, or health policy.

Note: Vermont has a proposal to create a state agency, and would not have a governing board for the Exchange.

Source: Lerche J, FSA, MAAA, MSPH. Electronic communication. February 9, 2011. Information about pending state legislation from the National Association of Insurance Commissioners. American Health Benefit Exchange Act 2011 Legislation. February 4, 2011.

Because the workgroup was unable to reach consensus on board composition, the draft legislation includes several different proposed board composition proposals:

- *Large board with stakeholder representation:* 15-person board, including representation from most of the key stakeholders along with people with specific technical expertise in actuarial science, health economics or health care finance, information technology capable of conducting electronic fund transfers, and health policy or law. The 15-person board would include three employer representatives, three consumer representatives, two insurer representatives, one person representing agents or brokers, two representatives of health care providers, and four members with specific technical expertise. The group discussed two possible options for this board composition—one in which the insurer and agent representatives would be voting members of the board, and one in which the insurer and agent representatives would be non-voting members of the board (to reduce

the potential conflict of interest).

- *Smaller board with no insurers:* 8-person board, which includes two representatives of employers and two representatives of consumers, and four members with specific technical expertise. Insurers and agents would be expressly prohibited from serving on this board.

In either case, the workgroup recommended the creation of an Advisory Committee, with insurer, agent, provider and consumer representation, which would provide advice to the Board.

b) Insurance reform

In addition to the insurance reforms that have already been implemented or will be implemented in 2011, the ACA includes other insurance law changes that will not become effective until 2014. Many of these provisions, including the essential health benefits package and protections for people with preexisting health problems, apply to both state regulated insurers, and to self-insured plans. These reforms generally fall into four categories: creation of an essential health benefits package, protections for people with preexisting conditions, rating restrictions, and risk adjustment mechanisms to spread risk across insurance plans.

- *Essential benefits package:* As noted previously, the Secretary is responsible for developing an essential benefits package.¹³⁷ Over time, most people with private insurance coverage will be enrolled in plans that provide coverage for the essential benefits package.
- *Protections for people with pre-existing health problems:* Beginning in January 2014, insurers will no longer be allowed to discriminate against individuals because of their preexisting conditions. Insurers will not be able to deny coverage or charge individuals more because of their preexisting health problems.¹³⁸
- *Rating restrictions:* Insurers will only be able to allowed to vary premium rates based on age (3:1 variation allowed), geographic rating area, family composition and tobacco use (limited to 1.5:1 ratio).¹³⁹
- *Risk adjustment:* States must establish reinsurance and risk adjustment mechanisms that meet criteria established by the Secretary. Additionally, the Secretary must establish and maintain risk corridors. Insurers must participate in a reinsurance program for the individual (non-group) market in calendar years (CY) 2014-2016. In addition, insurers must participate in risk corridors (CY 2014-2016), and risk adjustment for individual and small group markets.¹⁴⁰ The reinsurance and risk corridors are temporary to help stabilize the health insurance market in and outside the HBE. Risk adjustment mechanisms are permanent.

¹³⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1302.

¹³⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1201, enacting §§2701, 2704, 2705 of the Public Health Service Act, 42 USC §§300gg.

¹³⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1201, enacting §2701 of the Public Health Service Act, 42 USC §§300gg.

¹⁴⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1341-1343.

4. Federal Grants

North Carolina was eligible to apply for three federal grants to plan for or implement the health benefits exchange, rate reviews and greater consumer protections. The Department of Insurance applied for and received grant awards in each of the categories:

- ***Premium Review Assistance Grant. NCDOI received a grant of \$1 million in FFY 2010 to enhance the rate review process.*** The Department is using these grant funds to review its current actuarial review procedures to determine what enhancements can be made to those review procedures to strengthen the rate review process. Currently, the statutory authority of the NCDOI to review proposed premium rates and rate increases differs under state law by the type of product and insurance carrier. All insurers marketing individual (non-group) insurance must submit a rate filing at least annually. Each submission is subject to review and approval or disapproval by NCDOI. Insurers marketing in the small employer group market must submit demographic rating factors (i.e., age, gender, location, industry, and family composition) for NCDOI review, and must include an actuarial certification of compliance with the small group rating requirements in their submission. Hospital and Medical Service Corporations (i.e., BCBSNC) and HMOs are subject to prior approval rate review for both their small and large employer group rates. Other types of health insurers marketing large employer group insurance must include initial rates when they make an initial filing of the product for approval or disapproval. The initial rates applicable to the produce must be accompanied by an actuarial certification that the rates are not excessive, not inadequate, and not unfairly discriminatory, and exhibit a reasonable relationship to the benefits provided by the policy. There is currently no statutory requirement for further NCDOI review of renewal rates applicable to this large employer group business. NCDOI is examining its current rate review process to determine whether all insurers should be subject to the same prior approval requirements, standardized data requirements for rate filings, and increased transparency in the rate review process. Additionally, the grant will be used to provide additional staffing for the Department to assist with health care reform implementation. This is a five year grant opportunity for states. The state will need to reapply for future grants, but is likely to continue to receive grant funds if the state meets the grant requirements.
- ***Exchange Planning and Establishment Grant Application. North Carolina received a grant of \$1 million in FFY 2010 to help the state study and determine whether to implement a Health Benefit Exchange.*** With these grant funds, the NCDOI is partnering with the NCDHHS, and the NCIOM to study the North Carolina market and how an Exchange might operate to the benefit of NC consumers. Funding is being used to pay for actuarial consulting services, to help determine the number of eligible individuals that may purchase coverage through an exchange, how to prevent adverse selection into the health benefit exchange, and the number of new Medicaid eligibles. The consultants will also provide a review of governance and other design and policy decisions required for an exchange to be operated in NC. This is a one-time grant. However, North Carolina would be eligible for additional grants in FFY 2011-2014 if the NCGA decides to

establish a HBE and the state makes adequate progress in implementing the HBE.

- **Consumer Assistance Program Grant. North Carolina received a grant of \$850,000 in FFY 2010 to support consumer assistance/ombuds activities.** This grant provides resources for the NCDOS to strengthen the state’s consumer assistance program to help consumers navigate the health insurance market and to offer assistance with enrollment, complaints, and the external review process. The Consumer Assistance grants were appropriated in FFY 2010 and are authorized in subsequent years.¹⁴¹ Thus, the availability of future grant funds is dependent on future Congressional appropriations. In January 2011, the federal government issued additional grant funding for the establishment of HBEs in the state which contemplates that states would request continued funding for the Consumer Assistance Program through 2014 under those grants.

III. IMPROVING POPULATION HEALTH

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA included 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 35th of the 50 states in the 2010 edition of the America’s Health Rankings, a composite of 22 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.**¹⁴²

1. Overview of ACA Provisions

The ACA creates a national prevention council to help set national prevention priorities.¹⁴³ One of the goals of the council is to develop evidence-based models, policies and systems to improve population health. The Council is also required to create priorities “on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the five leading disease killers in the United States.” Funding can be used to support grants to state and local agencies and nonprofits to support healthy lifestyle changes, maternal and child health, and worksite wellness; reduce and control chronic diseases; reduce health disparities, obesity, and tobacco use; improve oral health and public health infrastructure; and increase immunization rates.

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

¹⁴¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1002, enacting §2793 of the Public Health Service Act, 42 USC §§300gg-91 et. seq.

¹⁴² America’s Health Rankings. 2010 edition results.

<http://www.americashealthrankings.org/yearcompare/2009/2010/NC.aspx>. Accessed January 23, 2011.

¹⁴³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4001.

grants or to implement new initiatives. Additionally, 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 a separate subcommittee to look at these issues.

2. Immediate implementation requirements (2010-2011)

Most of the immediate prevention provisions related to grant funds (see Section III.4 below). In addition to the new grant opportunities, the ACA did include one mandatory provision for coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.¹⁴⁴ As noted in the Medicaid section (II.A. above), states must provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use (effective October 2010). Such services include diagnostic, therapy and counseling services, and prescription and nonprescription nicotine replacement agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. The ACA prohibits cost-sharing for these services. NC currently provides a risk analysis through the pregnancy medical home. NC Medicaid also provides coverage for smoking and tobacco cessation counseling visits. DMA has determined that the state is already in compliance with these provisions. However, the workgroup recommended further provider education, particularly those who are not enrolled in the medical home model, so they are aware of billing options for these services.

3. Longer term implementation requirements (2012-2014, or date to be determined)

The ACA included several other prevention provisions which will impact the state, and public and private employers.

- *Improving access to preventive services for eligible adults in Medicaid.* Under the ACA, beginning January 2013, states may provide Medicaid coverage for all preventive clinical services recommended by the USPSTF and immunizations recommended by ACIP.¹⁴⁵ This is similar to what insurers are required to provide in individual and group health plans,¹⁴⁶ and what Medicare began covering in 2011.¹⁴⁷ 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 FMAP rate for these services. DMA already covers most of the recommended services and immunizations, however it does not currently cover BRCA testing (to test for a gene mutation associated with a high risk of breast cancer), herpes zoster (shingles) vaccine, aspirin for cardiovascular disease prevention, folic acid supplementation for women of child bearing years and iron supplementation for at risk children, or human papilloma virus (HPV) immunizations for

¹⁴⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4107.

¹⁴⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4106.

¹⁴⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1001, 10101(a), enacting §2713 of the Public Health Service Act, 42 USC §300gg.

¹⁴⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4104, amending §1861(ddd) of the Social Security Act, 42 USC 1395x(ddd).

people ages 21-26. DMA is conducting a cost analysis to determine the costs involved in offering all the recommended clinical preventive services and immunizations without cost sharing versus the additional reimbursement it would receive from the enhanced FMAP rate. The workgroup members recommended that North Carolina provide the same coverage of preventive services for Medicaid recipients as is provided to other people with private coverage. Thus, the state should provide coverage of all of the preventive services or immunizations recommended by the USPSTF and ACIP without cost sharing.

The Prevention workgroup also discussed the fact that Medicaid recipients do not always receive appropriate clinical preventive services, even when they are covered services. Thus, merely extending coverage to new preventive services will not ensure their use. DMA, along with health care professional associations, will also need to engage in provider education to ensure that health professionals are aware of, and actively advise their patients to obtain appropriate clinical preventive services.

- *Reasonable Break Time for Nursing Mothers.* 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 child was born.¹⁴⁸ Employers with fewer than 50 employees need not comply with this requirement if it would cause an undue hardship in terms of difficulty or expense, considering “the size, financial resources, nature, or structure of an employer’s business.” The workgroup is exploring how to best educate employers and employees about this new provision.

4. Federal Grants

The ACA appropriated \$500 million in FFY 2010 to a new Public Health and Prevention Trust Fund to help fund new prevention efforts, as well as grants to strengthen the public health infrastructure. In FFY 2010, about half of the funding was used to support workforce provisions (see below). The ACA included additional appropriations for the Public Health and Prevention Trust Fund in FFY 2011-2015. It is unknown at this time whether the full funds will be available to support public health activities.¹⁴⁹ In addition, the ACA also included direct funding for other provisions. Some of the funding opportunities were made available in FFY 2010, others may be made available later. NCDHHS received funding for the following prevention activities:

- *Maternal, infant, and early childhood home visiting programs.*¹⁵⁰ **DPH received \$2,134,807 (July 15, 2010-September 30, 2012) to develop and implement one or more evidence-based maternal, infant, and early childhood visitation model(s).** Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and

¹⁴⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4207, amending Section 7 of the Fair Labor Standards Act of 1938, 29 USC §207(r)(1).

¹⁴⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4002.

¹⁵⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2951.

family economic self-sufficiency.

- *Pregnancy Assistance Fund*.¹⁵¹ **DPH? received \$1,768,000 in funding to help pregnant and parenting women in high needs communities through Project Connect.** The purpose of this fund is to award competitive grants to states to assist pregnant and parenting teens and women. Permissible uses of funds include programs such as those that help pregnant or parenting teens stay in or complete high school, assistance to states in providing intervention services, and outreach so that pregnant and parenting teens and women are aware of services available to them. Twenty-five million was appropriated for each of the fiscal years 2010 through 2019. In North Carolina, Project Connect funds will be distributed by DPH using a Request for Application (RFA) process to choose five counties from the 20 identified high-need counties to receive funding. Local projects will include different activities including improved referral and coordination with other agencies serving teens and women throughout the community; integration of one of three pre-selected, evidence-based home visiting models into existing services; integration of six pre-selected best practice areas into project activities; the formation of a Community Advisory Council; and the development of an action plan to strengthen the systems of care in their communities as it relates to services for pregnant and parenting teens and women. Funding will also be used for a public education and information campaign that will run in all five counties. This campaign will include a text message service, webisodes, PSAs and TV advertisements promoting healthy behaviors and resources for pregnant and parenting teens and women.
- *Personal responsibility education program (PREP)*.¹⁵² **DPH received \$1,544,312 in PREP funds to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.**
- *Epidemiology-Laboratory Capacity Grants*.¹⁵³ **DPH received a grant of \$371,894 to improve surveillance for and responses to infectious diseases and other conditions of public health importance.**
- *Clinical and community preventive services*.¹⁵⁴ **DPH received \$98,266 to support tobacco cessation through expanded use of the Quitline, as well as policy and media interventions. Additionally, the Appalachian District Health Department and Pitt County Health Department collectively received \$3,800,492 to support environmental and policy changes to promote physical activity and nutrition.**
- *Public health infrastructure grants offered support to advance health promotion and disease prevention through improved information technology, workforce training, and 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*

¹⁵¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§10212-10214.

¹⁵² Patient Protection and Affordable Care Act, Pub L No. 111-148, §2953.

¹⁵³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4304.

¹⁵⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4003.

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.

In addition to the grant funds that were made available in FFY 2010, there are other opportunities that will, or may become available in the future. The workgroup is focusing on several other prevention opportunities. The ACA requires the Secretary to make grant funds available to provide incentives to Medicaid beneficiaries to more actively engage in healthy lifestyles. Additionally, the Secretary may award community transformation grants. The workgroup is monitoring grant announcements to ensure that the state takes full advantage of all grant opportunities that could help improve population health. The ACA includes other prevention activities which the workgroup will follow, including mandating calorie information on restaurant menus and menu boards in restaurant chains with greater than 20 locations.¹⁵⁵

- *Incentives for prevention of chronic diseases in Medicaid.*¹⁵⁶ The ACA directs the Secretary to award grants to states in 2011 to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.
- *Community transformation grants.*¹⁵⁷ This section authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting healthy communities. Twenty percent of the Community Transformation Grants will be awarded to rural and frontier areas. The workgroup is particularly interested in this potential funding opportunity, as it would help support multi-level interventions, including environmental, community, programmatic, and policy interventions, and could be used to help implement *Prevention for the Health of North Carolina*, the state's prevention action plan.¹⁵⁸

¹⁵⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4205, amending §403(q)(5) of the Food, Drug, and Cosmetic Act, 21 USC §343(q)(5).

¹⁵⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4108.

¹⁵⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§4201, 10403.

¹⁵⁸ North Carolina Institute of Medicine. *Prevention for the health of North Carolina: prevention action plan*. Morrisville, NC: North Carolina Institute of Medicine; 2009. <http://www.nciom.org/publications/?prevention-for-the-health-of-north-carolina-prevention-action-plan-7725>. Published 2009. Accessed January 11, 2011.

- *Worksite wellness initiatives.* The CDC will provide technical assistance and tools to evaluate employer-offered worksite wellness programs to promote the use of evidence-based and health promotion approaches.¹⁵⁹ Grants will be made available to businesses to offer comprehensive workplace wellness programs, if the employer has 100 or fewer employees and no existing program as of March 2010. The ACA authorized \$200 million for this provision (FFY 2011-2015), but the legislation did not include new appropriations.¹⁶⁰ Additionally, the ACA includes provisions that allow employers to include wellness programs as part of their insurance coverage. Employers can include requirements that enrollees satisfy health status factors (i.e., tobacco cessation or 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).¹⁶¹

IV. INCREASING ACCESS TO HEALTH SERVICES

A. Expanding the Health Care Professional Workforce

1. Overview of ACA Provisions

The ACA includes provisions to increase the number of health care professionals to address current and future workforce needs. The legislation created a National Workforce Advisory Commission to help develop national workforce strategy.¹⁶² Thomas C. Ricketts, III, PhD, Professor, Department of Health Policy and Management, Gillings School of Global Public Health and Deputy Director for Policy Analysis, Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill was one of the 15-members appointed to the Commission.¹⁶³

In addition, the ACA authorizes new programs to expand the number of primary care professionals, nurses, public health workers, allied health, mental health and substance abuse, and dental health professionals, as well as direct care workers. In addition, the legislation attempts to change the way that health care professionals are trained to best meet the workforce needs of the future. For example, the ACA gives priority to programs that educate health professionals using a team-based approach, focus on patient-centered medical homes, and that have a track record of training individuals from underrepresented minorities or rural/disadvantaged communities. The ACA also gives emphasis to programs that increase the supply of health care professionals in underserved areas. While the ACA included language authorizing new health professional training programs, it did not include appropriations to

¹⁵⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4303.

¹⁶⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10408.

¹⁶¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1201.

¹⁶² Patient Protection and Affordable Care Act, Pub L No. 111-148, §§5101, 10501.

¹⁶³ GAO announces appointments to new National Health Care Workforce Commission [newsrelease]. United States Government Accountability Office; September 30, 2010. http://www.gao.gov/press/nhcwc_2010sep30.html. Published September 30, 2010. Accessed January 11, 2011.

support most of the workforce provisions. As a result, in FFY 2010, the Secretary allocated half of the public health and prevention trust fund to support new workforce initiatives.¹⁶⁴

Although the ACA did not include new appropriations for most of the new workforce training programs, it did include \$1.5 billion over five years in new funding to expand the National Health Services Corps (NHSC).¹⁶⁵ The NHSC provides scholarships or loans to certain types of health care professionals in return for practicing in a health professional shortage area (HPSA) for a certain number of years. 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.

2. Immediate implementation requirements (2010-2011)

The ACA did not include any immediate implementation requirements around the health professional workforce. However, funding was made available to increase the number of new health professionals and to encourage health professionals to practice in underserved areas. Both of these types of funding opportunities can help address North Carolina's health professional workforce needs, both now and in the future. The most immediate impact may come from the expansion of the NHSC funding. The Health Resources and Services Administration (HRSA) also made grant funds available to expand health professional training programs (discussed more fully in Section III.A.4 below). In addition to discussing the NHSC expansion and HRSA grant opportunities, the Workforce workgroup identified other short-term health professional needs that the state should address to ensure that North Carolina has sufficient health professionals to meet the state's growing population, as well as the expected increase in the numbers of people with insurance coverage in 2014. For example, the workgroup discussed the need to ensure the adequacy of the Medicaid reimbursement rates so that providers do not stop participating in the program. Additionally, the workgroup discussed the immediate need to recruit more mental health, substance abuse and other behavioral health professionals to the state.

- *Expansion of the NHSC:* The ACA appropriated \$1.5 billion over five years to expand the NHSC.¹⁶⁶ Of this, the ACA appropriated \$290 million in new funding in FFY 2011. Funding for the NHSC is not allocated to specific states. Thus, to take advantage of this funding North Carolina must aggressively recruit both individuals and sites, and must ensure that all eligible locations are designated as HPSAs. The NHSC received a similar, albeit shorter term boost in funding from the American Recovery and Reinvestment Act (ARRA) of 2009. That funding helped North Carolina more than double the number of NHSC providers working in health professional shortage areas around the state from 70 to 145.¹⁶⁷ **The NCORHCC estimates that conservatively, North Carolina will be able**

¹⁶⁴ Sebelius announces new \$250 million investment to strengthen primary health care workforce. [news release]. United States Department of Health and Human Services; June 16, 2010.

<http://www.hhs.gov/news/press/2010pres/06/20100616a.html>. Accessed January 10, 2011.

¹⁶⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10503.

¹⁶⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10503.

¹⁶⁷ Don Pathman presentation to Workforce workgroup, December 15, 2010.

to use these funds to recruit an additional 20 health professionals in 2011 to practice in underserved areas and 20-25 more per year in 2011-2015.¹⁶⁸ The North Carolina Office of Rural Health and Community Care (ORHCC) is the lead state agency involved in administering this federal program in North Carolina.

The Workforce workgroup discussed the importance of maintaining and even ramping up current efforts to recruit individuals and sites into the NHSC. Thus, the workgroup recommended that the ORHCC maintain sufficient staff to ensure that North Carolina takes full advantage of the NHSC funds. The ORHCC plays three critical roles needed to successfully recruit health professionals to underserved communities. First, it is the state agency responsible for helping communities apply for and obtain HPSA designation. (The NHSC funds can only be used to recruit health professionals into HPSAs). Since October 2010, ORHCC has taken a proactive role in designating eligible HPSAs, utilizing one-time funding available through a federal grant to contract for an additional staff person to assist its one other staff member working on designations.

Additionally, under state law, the ORHCC receives state funding to help recruit certain types of health professionals into underserved areas (primary care professionals, dental professionals, and psychiatrists).¹⁶⁹ The workgroup noted that a lot of the success in recruiting and retaining NHSC health professionals in underserved areas has to do with how well communities are represented when recruits come to visit them and then how well the community embraces them when they arrive. Workgroup members recognized that many of North Carolina's health professional shortage areas need help when it comes to recruiting and retaining individuals in their communities. The workgroup recommended that North Carolina expand the work of the ORHCC in helping communities learn how to improve recruitment and retention of health professionals. Finally, even if ORHCC is not directly involved in the recruitment, the staff can help health professionals who are willing to serve in a HPSA obtain NHSC funding.

- *Medicaid reimbursement changes:* The workgroup was concerned that Medicaid reimbursement rates for primary care might be reduced, given the state's current economic crisis. The workgroup was concerned about the impact of any reductions on primary care practices serving large Medicaid populations, as well as the willingness of primary care providers to continue to see Medicaid recipients. The workgroup noted the

¹⁶⁸ John Price, electronic communication, January 27, 2011. This estimate is based on the number of health professionals that NCRHCC recruits into health professional shortage areas. However, other practices or organizations can also recruit providers into health professional shortage areas. Thus, this is a conservative estimate of the number of health professionals who may obtain NHSC funding to practice in underserved areas of North Carolina during the next five years.

¹⁶⁹ ORHCC is not limited by state statute as to the types of providers it can recruit for rural and underserved communities. The limitation comes from staffing issues and funding. Currently, ORHCC recruits all primary care specialties, including family physicians, internists, pediatricians, OB/GYN, nurse practitioners (NPs), and physician assistants (PAs), dental providers for safety net clinics (dentists and hygienists), and psychiatrists (including psychiatric PA and NP candidates). In the past (15-20 years ago), ORHCC also recruited specialists, but the office currently does not have staff resources to recruit specialists. The greater limitation is the state loan repayment funding. It can only be used for the primary care providers listed above. John Price, electronic communication, January 11, 2011.

importance of maintaining and expanding current primary care provider participation in the Medicaid program so that there will be sufficient numbers of primary care providers willing to serve the new eligibles in 2014.

- *Mental health, substance abuse professionals:* The Workforce workgroup also discussed the immediate need to increase the number of mental health, substance abuse and other behavioral health professionals practicing in the state. The workgroup discussed strategies that could help meet North Carolina's mental health needs over the next one-to-four years. On a short term basis, the workgroup agreed that it was important to maintain current Medicaid reimbursement rates for mental health visits. Adequate reimbursement is critical to maintain or expand access to mental health services for low-income populations. Additionally, North Carolina needs to do more to develop and strengthen recruitment strategies for mental health professionals. This includes publicizing the National Health Service Corp loan program for mental health professionals, and expanding the definition of mental health provider under the state loan program. The state should also continue to strengthen current efforts to support integrated practices where primary care providers and mental health/substance abuse professionals practice in a team-based environment in the same practice.

Over the a long-term, the workgroup recognized the need to encourage public and private colleges and universities to increase the number of students trained as social workers, health techs, substance abuse counselors and other professional and direct support workers to meet the increase in demand for mental health and substance abuse services. The workgroup also recognized the need to develop specific training requirements and career pathways for direct care workers and others who provide much of the care for individuals with mental health and substance abuse needs. Educational programs, current professionals, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), DMA, and relevant licensing bodies should be included in these discussions. Service definitions and billing rates (set by DMA) influence the mental health and substance abuse workforce significantly and more needs to be done to ensure that decisions being made about training requirements, service definitions, and billing rates are coordinated so that who can practice, the type of care they can deliver, and their training requirements are clear and help support career pathways for all levels of health professionals working in mental health. Further, the workgroup members noted that there is a need to analyze Medicaid data to see where savings could be achieved and reinvested to provide evidence-based services for people with mental health or substance abuse and addiction disorders.

- *Teaching Health Centers:* The ACA promotes the expansion and development of Teaching Health Center (THC) primary care residency programs (defined as those providing training in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics).¹⁷⁰ Examples of THCs include federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian

¹⁷⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §5508.

organization, and Title X family planning programs. The ACA includes appropriations to pay residents trained at THC's as well as authorizes grants to establish and expand THC's. Eligible entities must apply to HRSA to become THC's. In the FFY 2011 cycle, USDHHS designated 11 new THC's (none of which were in NC). The workforce workgroup will discuss what eligible entities in NC can do to achieve THC designation at a future meeting.

3. Longer-term implementation requirements (2012-2014)

North Carolina currently has a shortage of mental health,¹⁷¹ substance abuse professionals,¹⁷² and dentists,¹⁷³ and we are predicted to have a shortage of primary care providers in the coming years.¹⁷⁴ With health reform and the anticipated 1.1 million additional North Carolina residents who will gain insurance by 2019 under the ACA, North Carolina will need to significantly grow our health professional workforce to meet the health needs of residents.

The ACA focuses heavily on providing primary care to individuals through patient centered medical homes. Many of the tenets of the patient centered medical home (PCMH) are similar to the model developed in North Carolina through the CCNC program.^{175,176} Full implementation of a PCMH requires rethinking the mix of health professionals needed to staff a primary care practice and requires changes in the way that health professionals are trained. Most PCMH models have a team of health professionals providing patient care. This team consists of different types of health professionals working together to coordinate patient care. The ACA also promotes the use of electronic health records, which may require a different mix of skills or new types of workers in primary care medical practices. Currently, most health professional education programs are siloed without very much interaction between different types of health professionals. The new emphasis on patient-centered medical homes and team based care necessitates implementation of new strategies for health professional education.

North Carolina has a federal workforce planning grant, through the North Carolina Commission on Workforce Development (described more fully in Section III.A.4 below), that is working to

¹⁷¹ North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services; North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The workforce development initiative. <http://www.ncdhhs.gov/mhddsas/statspublications/reports/workforcedevelopment-4-15-08-initiative.pdf>. Published April 2009. Accessed February 8, 2011.

¹⁷² North Carolina Institute of Medicine. *Building a Recovery-Oriented System of Care: A Report of the NCIOM Task Force on Substance Abuse Services*. Morrisville, NC: North Carolina Institute of Medicine; 2009.

¹⁷³ Fraher E, Gaul K, King J, Hadley H, de la Varre C, Ricketts T III. Trends in the supply of dentists in North Carolina, 1996-2005. February 2007. North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill.

¹⁷⁴ North Carolina Institute of Medicine. *Providers in Demand: North Carolina's Primary Care and Specialty Supply*. NCIOM Task Force on Primary Care and Specialty Supply. Durham, NC: North Carolina Institute of Medicine; June 2007.

¹⁷⁵ McClellan M, McKethan A, Lewis J, et al. A national strategy to put accountable care into practice. *Health Affairs*;2009;29(5):982-990.

¹⁷⁶ McCarthy D, Mueller K; The Commonwealth Fund. Building community systems of care through state and local partnerships. Case study: organized health care delivery system. The Commonwealth Fund. http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jun/1219_McCarthy_CCN_C_case_study_624_update.pdf. Published June 2009. Accessed February 2, 2011.

develop a long-term plan for developing the state's health professional workforce. This group is working to identify new health professional roles, certifications and training, career pathways, and strategies to increase the supply of new health care professionals, as well as the racial/ethnic and linguistic diversity of the health professional workforce. Over the longer term, North Carolina should monitor federal grant opportunities as well as examine existing funds to determine if we can take advantage of any opportunity to expand the health care professional workforce and change the way health professionals are educated.

4. Federal Grant Funds

In addition to the NHSC funds, \$253 million in Prevention and Public Health Fund grants were allocated to the Health Resources and Services Administration (HRSA) to support workforce grants in FFY 2010.¹⁷⁷ State agencies as well as various schools and medical centers applied for grants from HRSA. The following is a summary of grants to increase the health professional workforce awarded to entities in North Carolina, as of November 19, 2010.¹⁷⁸

- **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 which are based there. The first four residents will be 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 the current four residents per year to six.** The expanded residency program will develop a partnership with the New Hanover Community Health Center, an federally qualified health center (FQHC), to serve as a second site for training residents.
- **Expansion of Physician Assistant Training.** **Duke University Medical Center's Physician Assistant Program received a five-year grant of \$1,320,000 to expand its entering class size from the current level of 72 per class to 80 per class. A total of 34 PA students will receive financial aid as part of this grant. In addition, Methodist University Physician Assistant Program received a five-year grant of \$1,888,000 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.
- **Advanced Nursing Education Expansion.** **Duke University School of Nursing received a grant of \$1,276,000 to fund a five-year project to increase the number of Adult Nurse Practitioners (ANP) and Family Nurse Practitioners (FNP).** The program,

¹⁷⁷ HHS awards \$320 million to expand primary care workforce [news release]. United States Department of Health and Human Services; September 27, 2010. <http://www.hhs.gov/news/press/2010pres/09/20100927e.html>. Last revised January 3, 2011.

¹⁷⁸ Tom Bacon, presentation to the Workforce workgroup, November 19, 2010.

called “Advancing the Number of Primary Care Clinicians through Nurse Practitioner Education” will increase the numbers of ANP and FNP students who enroll full time and graduate from the MSN program within two years and will accelerate the graduation rate of part-time MSN students in the ANP and FNP tracks. Financial barriers will be removed through the grant’s tuition support, allowing more students to graduate and complete national certification and licensure sooner.

- *Personal and Home Care Aide Training.* North Carolina was one of only six states to receive one of these grants, with the NCDHHS Office of Long Term Services and Supports being the grant recipient, and the Foundation for Advanced Health Programs as a subcontractor. **With this three-year \$578,745 personal and home care aide training grant, two pilot projects will be developed to train 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.**
- *State Health Workforce Development.* **The North Carolina Commission on Workforce Development was the recipient of a one year grant of \$144,595 to increase primary care supply.** The grant was submitted by the Commission on behalf of UNC’s Cecil G. Sheps Center for Health Services Research. The Sheps Center will be working with a panel of experts to identify strategies the State can employ to increase the per capita primary care workforce by 10% to 25% in the next ten years. The information gathered through this needs assessment will be used to identify “high priority” skill gaps; assess supply bottlenecks and barriers to increasing the primary care workforce; and identify potential interventions that could be implemented to address these workforce issues. Project findings will be disseminated through a Primary Health Care Workforce Implementation Plan for North Carolina. At the completion of the one-year planning grant the state will be able to compete for a much larger implementation grant if federal funding is available.

There may be additional grant opportunities in FFY 2011 related to increasing the health professional workforce and improving the quality of education programs. The Workforce workgroup has discussed grants as they have become available and has shared information on grants awarded to organizations in North Carolina. The group has also discussed ways to ensure eligible parties know about grants and how to encourage collaboration.

B. Safety Net

1. Overview of ACA Provisions

The ACA includes other provisions to increase and strengthen the health care safety net. Safety net providers are those health care organizations with a mission, or a legal obligation to provide health care services to the uninsured, or other underserved populations. In North Carolina, safety net organizations include, but are not limited to federally qualified health centers (FQHCs, also known as migrant and community health centers), local health departments, school-based and

school-linked health centers, free clinics, and hospitals. The ACA includes provisions aimed at strengthening access to FQHCs, school-based health centers (SBHCs), and hospitals.

2. Immediate Provisions (2010-2011)

- *Federally qualified health centers.* The ACA includes new appropriations to expand the number of FQHCs, and to increase the number of people they can serve. The ACA appropriated a total of \$9.5 billion over five years to expand the number of community and migrant health centers, expand the array of services provided, and increase the number of people they serve. In addition, the ACA included \$1.5 billion for construction and renovation.¹⁷⁹ Congress appropriated \$1 billion in new funding in FFY 2011, which increases to \$3.6 billion by FFY 2015. North Carolina currently has 26 FQHCs and two FQHC look-alikes operating in 45 counties across the state.
- *Hospitals and Emergency Care.* In addition to the direct funding for federally qualified health centers, the ACA included new requirements for charitable hospitals to maintain their tax exempt status. Under the new provisions, charitable 501(c)(3) hospitals must conduct a community needs assessment and identify an implementation strategy to show that they are addressing community needs.¹⁸⁰ Nonprofit hospitals are also required to have a financial assistance policy, provide emergency services, and limit charges to people eligible for assistance to amounts generally billed.
- *Regionalized trauma systems and emergency response.* The ACA appropriated \$24 million in each FFY 2010-2014 for competitive grants for regionalized systems of emergency response.¹⁸¹ The ACA appropriated \$25million in FFY2010, \$26.3 million (FFY 2011), \$27.6 million (FFY 2012), \$28.9 million (FFY 2013), and \$30.4 million (FFY 2014) to expand emergency services for children.¹⁸² The ACA also authorizes new funding for trauma centers that serve a substantial proportion of charity or self-pay patients.¹⁸³ However, the ACA did not provide new funding for this purpose.
- *340B drug discount program.* The 340B discount drug program was expanded to include more hospitals, including children's hospitals, free-standing cancer hospitals, critical access hospitals, and sole community hospitals (effective January 1, 2010).¹⁸⁴ The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers.

¹⁷⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10503, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2303.

¹⁸⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§9007, 10903.

¹⁸¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3504, enacting §1204 of the Public Health Service Act, 42 USC 300d et. seq.

¹⁸² Patient Protection and Affordable Care Act, Pub L No. 111-148, §5603, amending §1910 of the Public Health Service Act, 42 USC 300w-9.

¹⁸³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3505, enacting §1241 of the Public Health Service Act, 42 USC 300d-41.

¹⁸⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§7101, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2302.

- *Other Safety Net Providers:* The ACA appropriated \$50 million toward capital expenses for SBHCs in each FFY 2010-2013, although no funding for operating expenses.¹⁸⁵ The funding includes capital but not operational expenses. In addition, the ACA authorized \$50 million in FFY 2010-2014 for nurse-managed health clinics, but no funding was appropriated.¹⁸⁶

3. Longer Term Provisions (2012-2014).

Many of the immediate provisions have continuation funding through 2014. The ACA also included other safety net provisions that will take effect beginning in 2012.

- *Essential community providers.* In order to be certified as a qualified health plan in the HBE, the health plan must contract with essential community providers.¹⁸⁷ However, health plans are not required to contract with these providers if the provider fails to accept the generally applicable payment rates.
- *Federally qualified health centers.* The ACA includes special payment rules for FQHCs. Health plans that contract with federally qualified health centers must pay the center the same amount it would receive under Medicaid prospective cost-based reimbursement.¹⁸⁸ The ACA also requires the Secretary to develop a prospective cost-based reimbursement methodology in Medicare similar to that used for FQHCs in Medicaid.¹⁸⁹ The new methodology will be effective on or after October 1, 2014. There will be demonstration programs in up to 10 FQHCs to test individualized wellness plans.
- *Other Safety Net Providers.* The ACA authorized, but provided no funding for community-based collaborative networks of care.¹⁹⁰ A collaborative network of care is defined as a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services for low-income populations.

4. Federal Grants

¹⁸⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §4101(a).

¹⁸⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §5208, enacting §330A-1 of the Public Health Service Act, 42 USC 254b et. seq.

¹⁸⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C). Essential community providers include health care providers who qualify for 340B drug discount program. Eligible 340B organizations include federally qualified health centers, family planning organizations, Ryan White grantees, state operated AIDS drug assistance program, black lung clinics, hemophilia diagnostic treatment centers, Native Hawaiian health center, urban Indian organization, public health agencies (for treatment of STDs, tuberculosis, or family planning), disproportionate share hospitals, children's hospitals, critical access hospital, free standing cancer hospital, rural referral center, or sole community hospital. HRSA. Pharmacy Affairs and 340B Drug Pricing Program. HRSA Web site. <http://www.hrsa.gov/opa/introduction.htm>. Accessed January 11, 2011.

¹⁸⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(g), 10104(b)(2).

¹⁸⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10501(i), amending 1834 of the Social Security Act, 42 USC 1395m.

¹⁹⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10333.

- **Funding to upgrade and expand FQHCs: North Carolina received ACA grant funds totaling \$19.2 million to support capital improvements, renovations, and to expand access to care through existing FQHCs.**¹⁹¹ 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.¹⁹²
- **New FQHC Access Point Grants:** HRSA issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. It was designed to strengthen the health care safety net by establishing or expanding health centers in 1,200 of the nation's neediest communities. The North Carolina Community Health Center Association, with financial support from the Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. As a result, North Carolina submitted 30 applications for new access point grants. Of those applications, 14 were new start applicants and 16 were existing FQHCs applying for a satellite clinic. If funded, these applications would provide services in 24 new counties, bringing the total number of NC counties with an FQHC up to 69. HRSA is expected to announce the results of this round of competitive grants in August 2011.
- **Expanded Services grants.** HRSA issued another grant opportunity to support increased access to preventive services and primary care services at existing FQHCs. Some of the funding can also be used to expand oral health, behavioral health, pharmacy, vision, or other non-medical enabling services (such as transportation services). Funding will be distributed to health centers on a formula basis. Each of the 26 existing FQHCs will qualify for these funds.
- **School-Based Health Center Grants:** HRSA issued a grant opportunity to address capital needs to support school-based health centers (SBHC). Applicants were required to demonstrate how their proposal will lead to improvements in access to health services for children at a SBHC. HRSA expects to award approximately 200 grants equaling \$100 million in FFY 2011. HRSA has established a cap of \$500,000 as the maximum amount of federal funding that can be requested in a SBHC application. North Carolina organizations submitted at least 10 applications. If funded, they would serve an additional six schools bringing the total of counties with a school-based health center to 25.

In addition to examining these safety net provisions, the Safety Net workgroup spent time trying to identify the areas of the state with the greatest unmet needs for safety net services. The goal is

¹⁹¹ Community health centers award chart. United States Department of Health and Human Services Web site. http://www.hhs.gov/news/press/2010pres/10/chc_chart.html. Published October 8, 2010. Accessed January 24, 2011.

¹⁹² Recovery Act funding for community health centers in North Carolina. United States Department of Health and Human Services Web site. <http://www.hhs.gov/recovery/programs/hrsa/northcarolina.html>. Published January 24, 2011. Accessed January 24, 2011.

to try to identify those area of the state that are in greatest need of new safety net resources in order to target new funding opportunities.

V. ENHANCING QUALITY AND REDUCING HEALTH CARE COSTS

The ACA includes different provisions aimed at enhancing health care quality and reducing costs. Some of these provisions offer new funding opportunities—for example, to test new models of financing or delivering health care services. Others impose new requirements—for example, the ACA includes new reporting requirements for health care professionals, as well as more stringent oversight of fraud, abuse and overutilization within the Medicare, Medicaid and CHIP programs.

North Carolina has many existing initiatives aimed at improving health care quality while reducing health care costs. Yet, we could benefit from an enhanced effort to improve quality and reduce costs. **In 2004, the most recent data available, the average per capita health care costs in North Carolina were a little less than the national average (NC: \$5,191, US: \$5,283). However, our annual growth rate was higher.** See Chart 4.

Chart 4: Health Care Costs and Average Annual Growth Rates (NC, US)

	NC	US
Average cost per capita (by state of residence, 2004) ¹⁹³	\$5,191	\$5,283
Average annual growth per capita (1991-2004, by state of residence) ¹⁹⁴	8.6%	6.7%
Average annual growth by state of provider (1980-2004) ¹⁹⁵	10.3%	8.6%

Source: Kaiser Family Foundation. State Health Facts.Org.

Further, when compared to other states, North Carolina ranks 25th on potentially preventable use of hospitals and costs of care.¹⁹⁶ The Commonwealth Fund does an annual 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 41st in 2009 (with 1 being the highest performing state). This low ranking was due, in large part, to large 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 significant room for improvement. For example, the analysis

¹⁹³ Health care expenditures per capita by state of residence, 2004. Kaiser Family Foundation. StateHealthFacts.org Web site. <http://www.statehealthfacts.org/comparemactable.jsp?ind=596&cat=5>. Accessed January 30, 2011.

¹⁹⁴ Average annual percent growth in health care expenditures by state of residence, 1991-2004. Kaiser Family Foundation. StateHealthFacts.org Web site. <http://www.statehealthfacts.org/comparemactable.jsp?ind=595&cat=5>. Accessed January 30, 2011.

¹⁹⁵ Average annual percent growth in health care expenditures by state of provider, 1980-2004. Kaiser Family Foundation. StateHealthFacts.org Web site. <http://www.statehealthfacts.org/comparemactable.jsp?ind=264&cat=5>. Accessed January 30, 2011.

¹⁹⁶ State scorecard: North Carolina The Commonwealth Fund. CommonwealthFund.org Web site. <http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByState/State.aspx?state=NC>.

from the Commonwealth Fund 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 dollars.

A. Quality

1. Overview of the ACA Provisions

The ACA includes many provisions aimed at improving the quality of care provided by different types of health care professionals and providers. The legislation directs the Secretary to develop a national strategy to improve health care quality. As part of this strategy, the ACA provides funding 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.¹⁹⁷ 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. In addition, the ACA created a new Patient-Centered Outcomes Research Institute to develop research priorities and help fund comparative effectiveness research.¹⁹⁸ 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.¹⁹⁹ The goal is to understand what treatment modalities work best for different populations with different health conditions. Funding for comparative effectiveness research began through ARRA funds. The ACA included additional funding sources to support ongoing funding.

North Carolina had already begun several initiatives aimed at improving quality of care prior to the enactment of the ACA. For example, the Community Care of North Carolina program (CCNC) was designed to improve quality and access to health services for Medicaid recipients while reducing health care costs (described more fully below). CCNC collects process and outcome indicators from primary care practitioners to measure the quality of care provided to Medicaid recipients. These data are reported back to the providers for quality improvement purposes. The North Carolina Healthcare Quality Alliance (NCHQA) is a collaboration of North Carolina health care professional associations, government agencies, public and private payers to improve the quality of care provided in the state, building off the work of CCNC.²⁰⁰ The NC Area Health Education Centers (AHECs) are involved in two initiatives that address system improvement in primary care practices by providing resources to enhance health care delivery, and to assist with implementation and meaningful use of electronic health record systems. These

¹⁹⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3013-3014.

¹⁹⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6301-6302.

¹⁹⁹ Docteur E, Berenson R. How will comparative effectiveness research affect the quality of health care? Urban Institute Web site. http://www.urban.org/UploadedPDF/412040_comparative_effectiveness.pdf. Published February 2010.

²⁰⁰ More information about North Carolina Health Care Quality Alliance is available at <http://www.ncquality.org/>.

initiatives are called Improving Performance in Practice (IPIP)²⁰¹ and Regional Extension Centers (REC).²⁰² The NC Center for Hospital Quality and Patient Safety (NCCHQPS) is run through the NC Hospital Association.²⁰³ 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. Similarly, the North Carolina Center for Public Health Quality is aimed at improving quality of services provided by local health departments. Many other initiatives exist in North Carolina; existing North Carolina initiatives are listed in Appendix H.

The Quality workgroup completed two analyses. For the first analysis, the workgroup identified quality initiatives already in place in NC (see Appendix H), and the provider type and/or transitions between provider types affected by the initiative. This analysis provided the basic information required for the second analysis, as well as a clear indication of where quality initiatives are needed to improve transitions in care. The second analysis was a gap analysis. Specifically, the workgroup examined each provision to determine gaps between the ACA quality requirements and existing state efforts, legislation needed (if any) to address the gap, and any education needed for providers or the public to inform them of the new quality provisions. Subcommittees are working on recommendations for legislation, and to identify mechanisms to improve transitions in health care. In addition, another subcommittee is working on strategies to effectively educate providers about the new quality measures and potential impact on their practices or organizations, and how to effectively educate the public about how to understand new quality measures that will be made public.

2. Immediate Provisions (2010-2011)

The ACA included a number of new quality requirements which went into effect in 2010 or will become effective sometime in the next year. For example:

- *Payment adjustment for health care-acquired conditions.* This section prohibits Medicaid payment for services related to a health care-acquired condition. The Secretary will develop a list of health care-acquired conditions for Medicaid (effective July 2011).²⁰⁴ Hospitals will not lose reimbursement if the condition was already present when the person was first admitted to the hospital. The workgroup recognized the need to educate hospitals on the use of the “present on admission” indicator. The North Carolina Hospital Association (NCHA) has been recommended as the organization to track the definition of the health care-acquired conditions, and to educate hospitals on the use of the “present on admission” indicator.
- *Data on physicians’ and other practitioners’ performance will become publicly available.* The Secretary is required to develop a “Physician Compare” website where

²⁰¹ More information about North Carolina Improving Performance in Practice is available at http://www.med.unc.edu/ahec/pubs/IPIP_2010.pdf.

²⁰² More information about North Carolina’s Regional Extension Centers is available at http://www.med.unc.edu/ahec/pubs/REC_2010.pdf.

²⁰³ More information about the NC Center for Hospital Quality and Patient Safety is available at <http://www.ncqualitycenter.org/>.

²⁰⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2702.

Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures (effective Jan 2012).²⁰⁵ This quality reporting system will cover physicians, 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, and registered dietitians or nutrition professionals.

3. *Longer-Term Quality Provisions (2012-2014)*

a) Home health, hospice, and skilled nursing facilities

- The Secretary will develop a quality measure reporting programs for hospice in Oct 2013.²⁰⁶ In addition, the Secretary will develop a value-based purchasing program for skilled nursing facilities and home health agencies, and submit this plan to Congress in FFY 2012.²⁰⁷

b) Hospitals

- *Hospital value-based purchasing program.* Under this program, the Secretary shall develop a hospital value-based purchasing program which ties a percentage of hospital Medicare payments to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. The value-based incentive payments will also be based on efficiency and consumer satisfaction measures. The Secretary will develop the quality measures with input from external stakeholders, but these measures will not include measures of hospital readmissions (effective October 2012).²⁰⁸
- *Hospital readmissions reduction program.* The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. Specifically, hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions: heart attacks, heart failure, and pneumonia. The Secretary was given the authority to expand the policy to additional conditions in future years. The Secretary was also directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).²⁰⁹ The workgroup identified several gaps, including the need for unique patient identifiers to link records to assess readmissions (recommended responsible parties: the North Carolina Health Information Exchange or NCHIE). 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, a shared savings model,

²⁰⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §10331. This section of the ACA references to eligible professionals listed in 42 USC 1395w-4(m)(5), which further references 42 USC 1395u(b)(18)(C).

²⁰⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3004.

²⁰⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3006.

²⁰⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3001, 10335.

²⁰⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3025, 10309.

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). A subcommittee of the Quality workgroup is working with a subcommittee of the New Models of Care workgroup to review models and existing programs that address transitions in care at different points in the health care system. The combined subcommittee will make recommendations about which models and programs could be used or expanded in North Carolina to reduce preventable readmissions and improve transitions in care.

- *Payment adjustment for conditions acquired in hospitals.* Starting in FY 2015, hospitals in the top 25th percentile for rates of hospital acquired conditions would be subject to a Medicare payment penalty. The financial penalty would apply to hospital acquired conditions for certain high-cost and common conditions. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a health care acquired condition policy related 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.²¹⁰ The workgroup identified provider education as the primary gap. NCHA is working on the education of hospitals. Responsible parties for the education of other providers are still being determined.
- *Quality standards, reporting requirements, and testing of value-based purchasing for long term care hospitals, inpatient rehabilitation hospitals, certain cancer hospitals, and hospice.* Long term care hospitals, inpatient rehabilitation hospitals, specified cancer hospitals, and hospice 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) (effective October 2013).²¹¹

c) *Physician reporting*

- *Medicare reporting requirements.* The Physician Quality Reporting Initiative (PQRI) program payments, which provide incentives to physicians who report quality data to Medicare, are extended through 2014. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. Physicians may be eligible for an additional 0.5 percent increase to Medicare payments by meeting other reporting requirements (effective October 2012).²¹² The education subcommittee will address provider education.
- *Improvements to the physician feedback program.* Medicare's physician feedback program will be expanded to include the development of individualized reports. These reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized

²¹⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3008.

²¹¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3002, 3004-3005, 10326.

²¹² Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3002, 10327.

to take into account local health care costs (effective October 2012).²¹³ 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. The education subcommittee will address the education gap.

- *Quality measure development.* The Secretary, in consultation with the AHRQ and the CMS, will identify gaps in existing quality measures, and shall award grants to address these gaps.²¹⁴ The Secretary will develop at least 10 measures for acute and chronic diseases by March 2012, and at least 10 measures for primary and preventive care no later than March 2013.

The workgroup also recommended that the HIE Board consider whether North Carolina could develop a system to coordinate the submission of data to multiple sources, as well as to allow the state to use the data for state-level research and quality improvement initiatives. The workgroup recommended that the state explore steps to reduce reporting requirements for health care professionals and other providers, as it is likely they will be required to submit the same or similar quality data for both public (Medicare and Medicaid) and private insurers. Rather than require providers to submit the same data to multiple entities, the workgroup was interested in exploring whether North Carolina could create a system to capture these data automatically from electronic health records or through the Health Insurance Exchange, and then forward the information to the appropriate entity.

- *Value-based payments will be based on risk-adjusted performance data.* Medicare payments will be based on quality and cost of care (effective 2015).²¹⁵

d) Other providers

- *Ambulatory Surgery Centers.* The Secretary will develop a plan for value-based purchasing of ambulatory surgery centers (based on quality and efficiency of care) in the Medicare program (effective October 2011).²¹⁶

e) State reporting requirements

- *Adult health quality measures:* The Secretary is directed to develop 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. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis (effective January 2012).²¹⁷ The workgroup recommended that CCNC and DMA consider aligning quality measures

²¹³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3003.

²¹⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3013, 10303.

²¹⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3007.

²¹⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3006, 10301.

²¹⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2701.

currently used in North Carolina with the federal measures to reduce the data collection and reporting requirements. A second gap is the education of physicians on the anticipated reporting requirement. The workgroup recommended that the education subcommittee develop a plan on how to best educate physicians on the new quality measures. The workgroup identified consumer education as a gap, since the state's adult health quality measures will be made public.

f) Requirement for insurers

The ACA includes quality initiatives that relate to qualified health plans (effective when the HBE becomes operational in January 2014).²¹⁸

- *Accreditation of qualified health plans.* The Secretary must develop accreditation criteria for qualified health plans.²¹⁹ These criteria will include health plan performance measures, including quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), patient experience ratings on a Consumer Assessment of Healthcare Providers and Systems survey (CAHPS), consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy, and patient information programs.
- *Qualified health plan contracts with hospitals.* Beginning in January 2015, qualified health plans may only contract with hospitals with greater than 50 beds if the hospital utilizes a patient safety evaluation system, implements comprehensive patient-centered discharge education, and implements a quality improvement system.²²⁰
- *Market-based incentives.* Qualified health plans can include payment structures to increase provider reimbursement or provide incentives to improve health outcomes through quality reporting, preventing readmissions, reducing medical errors, implementing health and wellness promotion activities, or reducing health care disparities.²²¹
- *Health plan reporting requirements.* The Secretary will develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health (effective March 2012).²²²

B. New Models of Care

1. Overview of the ACA Provisions

²¹⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311.

²¹⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(D).

²²⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(h).

²²¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(g).

²²² Patient Protection and Affordable Care Act, Pub L No. 111-148, §1001, enacting §2717 of the Public Health Service Act, 42 USC §§300gg.

The ACA includes many new provisions aimed at changing the way that the Medicare, Medicaid, and CHIP programs deliver care and pay health care professionals and other health care organizations for services. The intent is to test models to increase quality (without increasing spending), or reduce spending (without reducing quality). For example, the bill creates a new Center for Medicare and Medicaid Innovations (CMMI). The bill appropriated \$10 billion, over ten years, to test innovative payment and service delivery models to improve clinical outcomes and reduce unnecessary expenditures in the Medicare, Medicaid, and CHIP programs.²²³ The Secretary may test new models including but not limited to: patient-centered medical homes;²²⁴ better care management and coordination for people with chronic illnesses,²²⁵ and the dually eligible Medicaid and Medicare recipients;²²⁶ use of technology to coordinate care across different health care settings;²²⁷ providing decision support to patients to help them make more informed choices;²²⁸ and improving transitions across care settings to prevent rehospitalizations.²²⁹ The ACA also directs the Secretary to develop Medicare and Medicaid shared savings programs with “accountable care organizations,” groups of health care professionals, providers and suppliers that work together to manage and coordinate care for a patient population.²³⁰ There is also funding in the ACA to test new models to reduce alternatives to tort litigation for resolving malpractice disputes.²³¹

2. Immediate Provisions (2010-2011)

Many of the new demonstration opportunities will be made available to states and to health care organizations beginning in 2011. While these models may not immediately lead to significant cost reductions—over time, they have the potential to identify new payment and delivery models that improve access, quality of care, patient outcomes, and population health while reducing unnecessary health care expenditures.

North Carolina is well positioned to obtain funding to test new models of delivering and financing health services. North Carolina is nationally known for the work it has done through CCNC in creating patient-centered medical homes for the Medicaid population.²³² CCNC has led to improved health outcomes and reduced health care costs, particularly as it relates to patients with chronic or complex health problems.²³³ CCNC is a community-based approach that

²²³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3021, 10306.

²²⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§2703, 3021, 3502, 10321.

²²⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3021.

²²⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2601.

²²⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3021.

²²⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3506.

²²⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3026.

²³⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§2705-2706, 3022, 10307.

²³¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6801, 10607.

²³² In 2007, Community Care of North Carolina won the prestigious Harvard Kennedy School of Government Innovation in American Government Award. Community Care of North Carolina. Harvard Kennedy School Ash Center for Democratic Governance and Innovation Web site. <http://www.innovations.harvard.edu/awards.html?id=85911>. Accessed January 6, 2011.

²³³ Artiga S; The Kaiser Commission on Medicaid and the Uninsured. Community Care of North Carolina: putting health reform ideas into practice in Medicaid. The Henry J. Kaiser Family Foundation; 2009.

involves primary care providers (physicians, nurse practitioners, and physician assistants), safety net organizations (including rural and community health centers), hospitals, social services, local health departments, and other community agencies in managing the care of a group of Medicaid patients. CCNC is organized into 14 regional networks of care that cover the entire state. Over the years, the state has expanded the initial model 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.

The state has taken several steps to expand this initiative to include other populations. In 2009, North Carolina Community Care Network, Inc. (NCCCN), the parent organization of the 14 regional Community Care networks, was one of only two entities awarded a Medicare demonstration waiver.²³⁴ (The waiver is commonly referred to as the 646 waiver as it was authorized under Section 646 of the Medicare Modernization Act). This is a 5-year demonstration program designed to improve patient safety, enhance quality, increase efficiency, and reduce unwarranted variation in medical practice that has resulted in lower quality and higher costs. This waiver expands the CCNC primary care medical home and chronic disease management model to Medicare and Medicaid dual eligibles, and then later to other Medicare beneficiaries. Enrollment began in January 2010. Initially, the initiative will begin in 26 counties. If NCCCN is able to demonstrate improved health outcomes and lower health care costs, then it can share in the savings with CMS. While this initiative was launched before the implementation of the ACA, it is similar to other potential demonstrations envisioned under the Act, including coordination of care for dual eligibles and accountable care organizations.

The workgroup holds the strong conviction that the development and implementation of new models of care is essential to deal with the challenge we face today in improving the value delivered by our health care system. The principles that should be embodied in these efforts are:

1. **Person-Centered, Family and Community Focus.** Individual patients and their families should be the forefront of any health system. The health of the individual is also strongly influenced by the broader community in which they live. Thus, new models of care should also 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 identifying the key elements and developing models that will:
 - a. Improve health care quality (including outcomes and population health)
 - b. Increase access
 - c. Reduce costs (i.e., reduce absolute health care costs and/or moderate the levels of increase)

<http://www.kff.org/medicaid/upload/7899.pdf>. Kaiser Family Foundation Publication no. 7899. Published May 2009.

²³⁴ Centers for Medicare and Medicaid Services. Medicare Health Care Quality Demonstration Programs, fact sheet. https://www.cms.gov/DemoProjectsEvalRpts/downloads/MMA646_FactSheet.pdf. Accessed January 6, 2011.

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. 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 and behavioral health professionals, nutritionists, allied health, 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 (e.g., 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. The goal of this is to empower people to assume a more active role in their own health. Accordingly, consumers should be given the information, training and support to be a active participants in managing their own health, and 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 to ensure 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, 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). We need to understand what models work best for different populations, in different communities, 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 aside from Medicaid and Medicare. Multi-payer, multi-provider initiatives that involve public and private providers and community based organizations, have 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.

Before testing new models of care, North Carolina should develop appropriate evaluation measures to determine whether the new delivery or financing model is helping improve quality, improve health care outcomes, increase access to care, and/or reduce health care costs. The workgroup is continuing to meet, and will be identifying common evaluation criteria that could be used to test different models of payment or health care delivery reform.

3. Recent Grant Awards

As noted previously, North Carolina has already been the recipient of several of the different demonstration opportunities and is well-positioned to compete for additional demonstration grants when these become available. In fact, North Carolina was selected as one of eight states in the first round of demonstration grants awarded through the CMMI. On November 16, 2010, the USDHHS announced the creation of the CMMI, along with the first round of grants intended to improve care for Medicare and Medicaid enrollees. Eight states were selected to participate in the expansion of the multi-payer advanced primary care practice demonstration.²³⁵ **Under this grant, Medicare will pay an estimated \$11.8 million in per member per month payments to local primary care providers and to participating CCNC networks that are part of a public-private partnership, including DMA, the State Health Plan, Blue Cross Blue Shield**

²³⁵ CMS introduces new Center for Medicare and Medicaid Innovation, initiatives to better coordinate health care [news release]. Centers for Medicare and Medicaid Services; November 9, 2010. <http://innovations.cms.gov/innovations/pressreleases/pr110910.shtml>. Accessed January 5, 2011.

of North Carolina, and NCCCN. The initiative will extend the CCNC patient-centered primary care medical home model to improve chronic disease management, patient education, and use of information technology to track outcomes for Medicare, State Health Plan and BCBSNC members in seven rural counties, including Ashe, Avery, Bladen, Columbus, Granville, Transylvania, and Watauga.²³⁶

North Carolina has also been awarded two additional grants to test or expand existing models of delivering health care services:

- Roanoke Chowan Community Health Center received \$255,000 to expand its existing telehealth monitoring initiative.²³⁷ Roanoke Chowan received funding in 2006 from the NC Health and Wellness Trust Fund to develop an initiative to provide telehealth monitoring equipment (i.e., scales, blood pressure and blood glucose monitors, and pulse oximeters) to their high risk low-income patients with diabetes or cardiovascular disease. Patients who are enrolled in this program monitor their health status daily, and this information is sent to the individual's primary care provider and a nurse case manager. The system is set up to provide alerts to the primary care provider and/or nurse if a patient's health data are outside normal parameters, so that they can intervene promptly to help the patient address their underlying health problem. As a result of this initiative, Roanoke Chowan has experienced a statistically significant reduction in hospital costs, and improved compliance with patient-self management of chronic diseases. This grant will be used to expand this initiative to hospitals and other community health centers. DMA is also planning on adding telehealth monitoring as a covered service. The goal is to offer these services beginning July 1, 2011.
- NCORHCC and Access II Care (Henderson, Buncombe, McDowell counties), have been awarded a \$297,710 AHRQ medical liability reform and patient safety planning grant to develop a system of near-miss reporting and improvement tracking in primary care. As part of this initiative, the NCORHCC and Access II Care will collect near-miss reports from six diverse practices over six months, analyze the types of near-miss events, and use this information to develop educational and quality improvement efforts to reduce further occurrences. (More information about this initiative is available in Appendix I).

In addition, other North Carolina health care systems or organizations have demonstrated the efficacy of models similar to those in the ACA for improving chronic disease management and health outcomes, reducing hospitalizations, or otherwise reducing health care costs. A description of some of these initiatives can be found in Appendix I.

The New Models of Care workgroup identified new models of care which the state might pursue to further improve health outcomes and reduce health care costs in the Medicaid, Medicare

²³⁶ North Carolina gets "go ahead" for innovative public-private partnership to improve health care in rural communities [news release]. North Carolina Department of Health and Human Services, Office of Public Affairs; November 17, 2010.

²³⁷ Secretary Sebelius announces \$32 million to support rural health priorities [news release]. United States Department of Health and Human Services; August 23, 2010. <http://www.hhs.gov/news/press/2010pres/08/20100823a.html>. Accessed January 5, 2011.

and/or NC Health Choice programs. The workgroup identified five promising models and created separate subcommittees to explore demonstration models to test:

- Decision supports and other ways to engage patients to be more proactive in their own care. Consumers should be given appropriately tailored information, training and support to be an active participant in managing their own health. For example, consumer engagement models should ensure that consumers are given culturally and linguistically appropriate health education, and that information is conveyed in a way to ensure that it is understandable to people with lower health literacy.
- New reimbursement models that encourage greater efficiency and enhanced value, including but not limited to pay-for-performance, value based purchasing, or episode of care payments.
- Transition of care models to reduce unnecessary readmissions. (Note: this subcommittee is meeting in conjunction with a subcommittee of the Quality workgroup).
- New strategies to create interdisciplinary, interprofessional teams of professionals to serve in patient-centered medical homes.

C. Fraud, Abuse, and Overutilization

1. Overview of ACA Provisions

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). Many of these requirements will require the state to implement new enforcement procedures.

The Fraud and Abuse workgroup conducted a gap analysis, breaking down the requirements of each provision, then identifying ongoing efforts to address these requirements, the 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.

2. Immediate implementation requirements (2010-2011)

Unlike many of the other ACA provisions, most of the fraud and abuse provisions go in to effect in 2010 or 2011. The ACA increased funding to the Healthcare Fraud and Abuse Control Fund by \$350 million over the next decade. These funds can be used for fraud and abuse control and for the Medicare Integrity Program.²³⁸

The ACA also included 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:

²³⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6402, 1303.

- *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.²³⁹ A period of enhanced oversight also is 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 excluded from participation.²⁴⁰
- *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.²⁴¹ 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 Jan 2011).^{242, 243}
- *Creation of risk categories*. The ACA requires the state Medicaid agency to create limited, moderate, and high risk categories for provider specialty types, and 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.²⁴⁴ 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 Jan. 1, 2011).^{245, 246}
- *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

²³⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6401, 10603.

²⁴⁰ 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. Tara Larson, MAEd, electronic communication, January 10, 2011.

²⁴¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6501.

²⁴² Patient Protection and Affordable Care Act, Pub L No. 111-148, §6502.

²⁴³ DMA already excludes providers from participating for these reasons. Tara Larson, MAEd, electronic communication, January 10, 2011.

²⁴⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6503.

²⁴⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.

²⁴⁶ DMA already implemented this registration requirement. Tara Larson, MAEd, electronic communication, January 10, 2011.

elements (effective for data submitted on or after January 1, 2010).²⁴⁷ For example, states are required to report all final actions including revocation or suspension of licenses, reprimands, or 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 Coding Initiative (effective March 2011).²⁴⁸ 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 whichever is later, one year after enactment or when regulations are published).²⁴⁹

- *Penalties and federal powers to investigate fraud and abuse are enhanced.* The penalties include those for persons who make false statements when making claims, involuntarily enroll or transfer beneficiaries, or do not provide timely access to information for audits, investigations, evaluations, or other statutory functions.²⁵⁰
- *Overpayments.* The state has an expanded period to recover overpayments (effective March 2010).²⁵¹ Individuals who receive overpayments through Medicare, Medicaid, and CHIP are required to report and return the overpayment within 60 days.²⁵² 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 Dec 31, 2010).^{253, 254}
- *Medicaid payments outside the US.* States are prohibited from providing Medicaid payment for services to entities outside the US (effective Jan 2011).²⁵⁵
- *Home health and suppliers of durable medical equipment (DME).* The ACA included 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 Jan. 1, 2010).²⁵⁶ 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).²⁵⁷ The ACA also

²⁴⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6504.

²⁴⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6507.

²⁴⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6403.

²⁵⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6402, 6408, 10606.

²⁵¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6506.

²⁵² Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.

²⁵³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6411.

²⁵⁴ 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. Tara Larson, MAEd, electronic communication, January 10, 2011.

²⁵⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6505.

²⁵⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6407, 10605.

²⁵⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6406.

required the surety bonds for DME and home health agencies be adjusted by billing volume.²⁵⁸ Payments to DME suppliers can be withheld for 90 days if there is a significant risk for fraud (effective Jan 2011).²⁵⁹ In addition, physicians or eligible professionals who are not enrolled in Medicare are prohibited from ordering home health services or DME for Medicare beneficiaries (effective Jul 2010).²⁶⁰

The Fraud and Abuse workgroup is continuing to work on developing new legislation that is needed to bring North Carolina into compliance with the new federal requirements.

3. Longer term implementation requirements (2012-2014) or date to be determined

The ACA also mandates that providers and suppliers establish anti-fraud and abuse compliance programs, however, the effective date for that provision is to be determined by the Secretary.²⁶¹

D. Other Cost Containment and Financing Provisions

The Congressional Budget Office (CBO) estimated that the total costs of the coverage provisions would be \$938 billion over ten years (2010-2019). The net cost for the coverage provisions is expected to be \$788 billion after including the expected penalty payments paid by uninsured individuals (\$17 billion), penalty payments paid by employers (\$52 billion), excise tax on high-premium insurance plans (\$32 billion), and other effects on tax revenues and outlays (\$48 billion).²⁶² Although the net cost of the coverage provisions is \$788 billion over ten years, the CBO anticipates that the ACA will actually reduce the federal deficit by \$124 billion during that time period. That is because other health-related provisions reduce spending by \$511 billion, and increase revenues by \$420 billion.²⁶³

1. Reductions in federal expenditures

The bill includes a number of provisions aimed at reducing health care costs, particularly in the Medicare program. For example, the ACA reduces Medicare payments by approximately \$157 billion over 10 years by reducing annual market basket updates for inpatient acute hospitals, home health agencies, skilled nursing facilities, hospice and certain other types of providers.²⁶⁴ The legislation also saves money by reducing payments to Medicare Advantage plans (\$136 billion over 10 years). Historically, Medicare Advantage plans have been overpaid by 9%, on

²⁵⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.

²⁵⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §1304.

²⁶⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §6405.

²⁶¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6401, 10603.

²⁶² Congressional Budget Office. Selected CBO publications related to health care legislation, 2009-2010. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. CBO Publication no. 4228. Published December 2010. Accessed January 26, 2011.

²⁶³ The education related provisions reduce the federal deficit by an additional \$19 billion from FFY 2010-2019.

²⁶⁴ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3401, 10319, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1105.

average, in comparison to traditional Medicare.²⁶⁵ The ACA reduces Medicare payments to home health (\$39.7 billion),²⁶⁶ and creates a Medicare Independent Payment Advisory Board (IPAB), with authority to implement certain changes to the Medicare program to reduce cost escalation unless Congress or the President overrides the proposal. This is expected to yield \$15.5 billion in savings.²⁶⁷

The bill also includes savings to the Medicaid program. For example, implementation of the CLASS Act, federal long-term care insurance, is expected to save the Medicaid program \$70.2 billion over the next ten years.²⁶⁸ The ACA also phases out Medicare and Medicaid disproportionate share hospital (DSH) payments to hospitals. DSH payments were initially designed to help hospitals pay for part of the uncompensated care the hospital provides to the uninsured. Thus, the DSH payments to hospitals will be reduced as more people gain insurance coverage (estimated savings include \$14 billion in Medicaid and \$22.1 billion in Medicare).²⁶⁹ North Carolina may be expected to save approximately \$206 million between 2010-2019 from reductions in Medicaid DSH payments, assuming North Carolina receives a proportionate amount of the total anticipated DSH savings.²⁷⁰ The ACA also increases the Medicaid drug rebates to the federal government (\$38.1B).²⁷¹

Most of these cost savings will accrue to the federal government (Medicare), or to the state and federal government (Medicaid and CHIP). However, the ACA also included other provisions which have the potential of reducing cost escalation in the private market. First, the bill includes efforts to streamline health insurance administration, implement health information technology, and change provider payments to encourage efficiency and quality. The CBO estimates that these provisions would save \$11.6 billion over 10 years to the federal government, but these provisions could also provide savings to private plans.²⁷² Many of the recommendations from the IPAB, or efforts to reduce fraud and abuse may also be adopted by private insurers. In addition, as noted earlier, beginning in 2018, the ACA includes an excise tax on so-called “Cadillac plans”—i.e., those plans that exceed \$10,200 for individual coverage and \$27,500 for family coverage.²⁷³ To put this in perspective, the average employer sponsored premium for single coverage in 2010

²⁶⁵ MedPac. Healthcare spending and the Medicare program: a data book. <http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf>. Published June 2010. Accessed January 10, 2011.

²⁶⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3131.

²⁶⁷ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3403.

²⁶⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§8001-8002.

²⁶⁹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§2551, 3133, 10201, 10316, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §§1104, 1203.

²⁷⁰ North Carolina accounts for 2.6% of the federal DSH spending in FY 2009 (\$297,344,835 out of \$11,376,678,510). Assuming that North Carolina receives a proportionate amount of the savings, then approximately \$366 million of the estimated \$14 billion in reduced federal DSH spending would be attributable to North Carolina. This equals the federal share of the DSH savings. However, the federal government would only realize 64% of the savings. Thus, the total DSH savings would be closer to \$572 million for North Carolina. Of this, \$366 million in savings would accrue to the federal government, and \$206 million would accrue to North Carolina.

²⁷¹ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2501, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1206.

²⁷² Patient Protection and Affordable Care Act, Pub L No. 111-148, §1104.

²⁷³ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§9001, 10901, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1401.

was \$5,049, and \$13,770 for family coverage.²⁷⁴ The CBO estimates that this is likely to produce \$32 billion in new revenues in 2018-2019, and more in later years. But additionally, this may encourage some employers to offer less expensive plans.

2. New federal revenues

In addition to the \$511 billion in spending reductions, the ACA is also expected to generate \$420 billion in new revenues between FFY 2010-2019. Approximately \$107 billion of this amount will be generated through increased taxes or fees on the health sector, including \$27 billion from the pharmaceutical industry, \$20 billion from durable medical equipment manufacturers, and \$60 billion from insurers.²⁷⁵ In addition, the ACA increases the Medicare Part A (hospital insurance) payroll tax for higher income wage earners (\$210 billion),²⁷⁶ and includes \$103 billion in other revenue provisions.²⁷⁷

VI. CONCLUSION

The ACA is complex and touches all aspects of our health care system. Not surprisingly, the legislation has been controversial. Any legislation that impacts 17% of the economy, and that affects how we finance and deliver health care services is likely to be controversial. Some argue that the bill does not go far enough towards ensuring universal coverage, others decry the lack of real cost containment. Some oppose the individual mandate, while others are concerned about the new requirements on employers and state government. Yet few people seriously argue that our existing health care system is sustainable. We, as a country, spend more per capita on health care than any other country, yet we have less value in terms of life expectancy or other health measures. We spend enormous sums of money on new technology and better “sick” care, but do not make the investments in prevention that could help keep people healthy. We continue to pay providers based on the volume of services provided, without ensuring the quality of services provided. Further, millions of people remain uninsured, which has an adverse impact on the individual, their family, and society at large.

The ACA is not perfect, and is likely to be changed over time as we learn what works and what needs to be changed. However, it does provide the state with a unique opportunity to identify strategies that can expand health insurance coverage, and improve access to health services, quality, and population 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 need for further progress. Working together, North Carolina

²⁷⁴ Kaiser Family Foundation and Health Research and Education Trust. Employer health benefits. 2010 summary of findings. <http://ehbs.kff.org/pdf/2010/8086.pdf>. Kaiser Family Foundation Publication no. 8086. Published 2010. Accessed January 10, 2011.

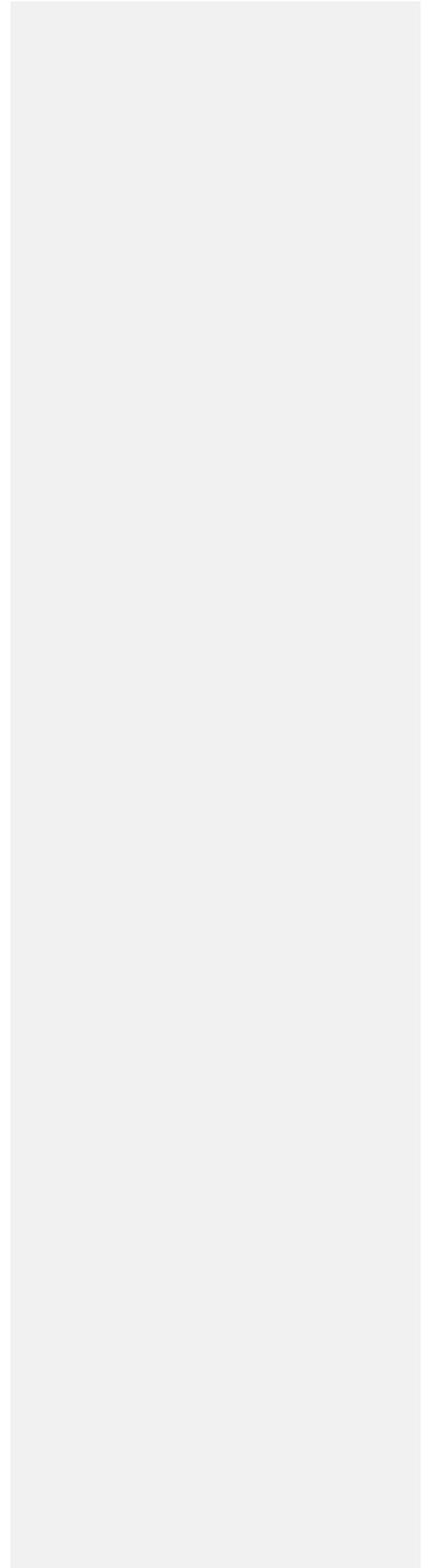
²⁷⁵ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§9008-9010, 9014, 9017, 10904-10905, 10907, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §§1404-1406.

²⁷⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §§9015, 10906, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §1402.

²⁷⁷ Congressional Budget Office. Selected CBO publications related to health care legislation, 2009-2010. <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. CBO Publication no. 4228. Published December 2010. Accessed January 26, 2011.

providers, consumers, insurers, businesses and community leaders can identify innovative strategies that will lead to further improvements in health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.

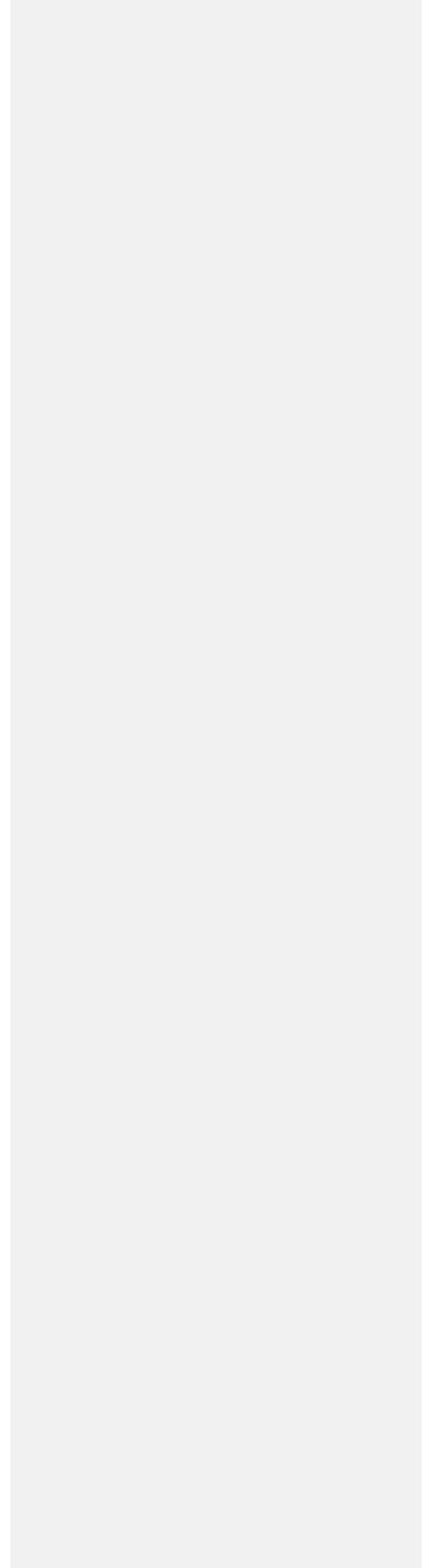
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APPENDIX A

1. State level data on the uninsured
2. County level data on the uninsured

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Characteristics of Uninsured North Carolinians

Prepared by the North Carolina Institute of Medicine and the Cecil B. Sheps Center for Health Services Research

2008-2009

Data Snapshot

The Patient Protection and Affordable Care Act (ACA) helps to make health insurance coverage more affordable to millions of Americans who are currently uninsured. (More information on the Affordable Care Act is available at: <http://www.nciom.org/task-forces-and-projects/?aca-info>) In North Carolina approximately 1.6 million non-elderly individuals were uninsured during 2008-2009. Many of these North Carolinians may gain access to affordable coverage through the legislation.

The ACA builds on several aspects of our current system to expand health insurance coverage to uninsured individuals. First, the ACA expands public insurance coverage for lower-income individuals. Beginning in 2014, Medicaid will be expanded to cover most individuals whose family income is less than 138% of the federal poverty guidelines (\$14,945/year for an individual or \$30,429 for a family of four in 2010). Second, the ACA requires businesses with 50 or more full-time workers to offer health insurance to their employees or pay a fee to help offset the costs of coverage. Of note, most businesses of this size in our state already offer coverage. Finally, most individuals will be required to purchase insurance coverage or pay a penalty. However, to make insurance coverage affordable, the ACA provides a subsidy to any individual with an income no greater than 400% of the federal poverty guidelines (\$43,320 for an individual or \$88,000 for a family of four), if they do not have access to affordable employer based coverage and are not eligible for public coverage.

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 2008-2009, using data from the US Census Bureau. Data are also provided to show the change in uninsured estimates over a five-year span from 2003-2004 to 2008-2009.

This information will be helpful to state policymakers, health care professionals, insurers, and community groups that are trying to understand the impact of the new federal legislation on coverage of the uninsured. County-level estimates of the uninsured are forthcoming.

Interpreting the Data

Consider the second row of data for the total of uninsured non-elderly persons in North Carolina:

Category	2008-2009 Rates			Change: 2003-2004 to 2008-2009		
	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured	Thousands of Uninsured	Percent of All Uninsured	Percent of Category Uninsured
<i>Income</i>						
<138% FPG	753	46.8%	38.7%	237	6.9	6.7

In 2008-2009

- There were 753,000 non-elderly uninsured with family incomes less than 138% of the federal poverty guidelines (FPG).
- 46.8% of the non-elderly uninsured have family incomes less than 138% FPG.
- 38.7% of the non-elderly with family incomes less than 138% FPG were uninsured.

From 2003-2004 to 2008-2009

- The number of non-elderly uninsured with family incomes less than 138% FPG increased by 237,000.
- The percentage of non-elderly uninsured with family incomes less than 138% FPG increased by 6.9 percentage points (i.e. 39.9% of the non-elderly uninsured had family incomes below 138% in 2003-2004 compared to 46.8% in 2008-2009).
- The percentage of the non-elderly with family incomes less than 138% FPG who were uninsured increased by 6.7 percentage points (i.e. 32.0% of non-elderly with family incomes below 138% FPG were uninsured in 2003-2004, compared to 38.7% in 2008-2009).



Published November 2010

Table 1: Ages 0-64

Category	2008-2009 Rates			Change: 2003-2004 to 2008-2009		
	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	1,608	100%	19.70%	317	0.0	2.5
<i>Income</i>						
<138% FPL	753	46.8	38.7	237	6.9	6.7
138-200% FPL	320	19.9	34.5	54	-0.7	4.7
200-400% FPL	377	23.5	14.2	16	-4.5	-1.1
400%+ FPL	157	9.8	6.0	10	-1.6	0.4
<i>Gender</i>						
Male	864	53.8	21.2	148	-1.7	1.9
Female	743	46.2	18.2	169	1.7	3.0
<i>Race/Ethnicity</i>						
White, Not Hispanic	758	47.2	14.5	125	-1.9	1.5
Black, Not Hispanic	379	23.6	20.3	97	1.7	3.4
Not White or Black or Hispanic	118	7.3	30.3	32	0.7	9.7
Hispanic	353	21.9	51.8	63	-0.5	-1.4
<i>Age</i>						
0-18	282	17.5	11.5	36	-1.6	0.7
19-29	485	30.2	36.0	89	-0.6	6.5
30-44	449	27.9	23.1	88	-0.1	2.8
45-54	229	14.3	17.4	46	0	1.6
55-64	162	10.1	14.7	61	2.2	3.9
<i>Citizenship</i>						
Citizen	1,331	82.8	17.2	299	2.9	2.5
Not a citizen	277	17.2	67.5	18	-2.9	11.4
<i>Rural/Urban</i>						
Urban	1,078	67.1	19.1	241	2.2	3.4
Rural	530	33.0	21.0	76	-2.2	0.0
<i>Self-Perceived Health Status</i>						
Excellent	366	22.8	13.6	-28	-7.8	-0.7
Very Good	469	29.2	18.0	70	-1.7	1.2
Good	555	34.5	27.5	203	7.3	6.5
Fair	168	10.5	28.9	60	2.1	6.0
Poor	49	3.1	19.0	12	0.1	1.1
<i>Family Workforce Status</i>						
No Workers	244	15.2	23.4	77	2.2	4.7
Only PT Workers	242	15.1	34.4	122	5.7	10.1
1 FT Worker	748	46.5	20.7	165	1.4	2.9
2+ FT Workers	374	23.2	13.4	-47	-9.4	-1.5
<i>Individual's Labor Force Status (ages 19-64)</i>						
Not in Labor Force	333	25.2	25.3	100	2.8	4.9
Unemployed	211	15.9	52.1	116	6.8	2.6
Part Time	247	18.6	37.5	81	2.7	11.6
Full Time	534	40.3	16.4	-16	-12.3	-0.9
<i>Firm Size (for ages 19-64 working part- or full-time)</i>						
1-24	394	49.4	35.3	9	-3.2	3.6
25-99	101	12.7	23.4	11	0.4	2.8
100-999	82	10.3	12.0	0	-0.9	-1.2
GT 1000	171	21.5	10.4	53	5.3	2.7
Unknown Size	49	6.1	39.4	-8	-1.7	-0.9



Table 2: Children Ages 0-18

Category	2008-2009 Rates			Change: 2003-2004 to 2008-2009		
	Thousands of Uninsured Children	Percent of All Uninsured Children	Percent of Category Uninsured	Thousands of Uninsured Children	Percent of All Uninsured Children	Percent of Category Uninsured
Children Ages 0-18	282	100%	11.50%	35	0	0.7
<i>Income</i>						
Less than 200% FPL	214	76.0	20.0	55	11.4	3.6
200-400% FPL	50	17.6	6.6	-18	-10	-2.5
400 or more% FPL	18	6.4	2.9	-1	-1.4	-0.6
<i>Gender</i>						
Male	157	55.8	12.5	35	6.3	1.9
Female	124	44.2	10.5	0	-6.3	-0.6
<i>Race/Ethnicity</i>						
White, Not Hispanic	115	40.7	8.0	5	-3.6	-0.1
Black, Not Hispanic	60	21.2	9.6	-1	-3.5	-0.5
Not White or Black or Hispanic	30	10.6	23.3	9	2.2	9.3
Hispanic	77	27.5	30.2	22	5	-3
<i>Citizenship</i>						
Citizen	267	94.5	11.1	49	6.3	1.2
Not a citizen	15	5.5	42.2	-14	-6.3	-3.2
<i>Rural/Urban</i>						
Urban	184	65.2	11.0	38	6	2
Rural	98	34.8	12.7	-2	-6	-2.9
<i>Self-Perceived Health Status</i>						
Excellent	104	36.9	9.0	-23	-14.8	-2.1
Very Good	85	30.3	10.8	18	2.9	1.1
Good	92	32.6	20.5	45	13.8	7.8
Fair	1	0.3	2.0	-5	-1.9	-8.2
Poor	0	0.0	0.0	0	0	0
<i>Living with Parents?</i>						
Both parents	134	51.5	8.6	35	5.4	1.3
Mother only	85	32.5	14.4	8	-3.2	1.1
Father only	11	4.4	13.6	-7	-4.3	-5.5
Neither parent	30	11.6	30.9	10	2.2	5.7
<i>Family Workforce Status</i>						
No Workers	29	10.4	11.7	-3	-2.7	-0.3
Only PT Workers	49	17.3	18.9	29	9.3	7.9
1 FT Worker	157	55.8	13.2	38	7.5	1.8
2+ FT Workers	47	16.5	6.2	-29	-14.1	-3.4



Table 3: Adults Ages 19-64

Category	2008-2009 Rates			Change: 2003-2004 to 2008-2009		
	Thousands of Uninsured Adults	Percent of All Uninsured Adults	Percent of Category Uninsured	Thousands of Uninsured Adults	Percent of All Uninsured Adults	Percent of Category Uninsured
Adults Ages 19-64	1,326	100%	23.20%	281	0	3.2
<i>Income</i>						
<138% FPL	599	45.2	51.2	189	5.8	8.3
138-200%	260	19.6	40.9	48	-0.7	4.2
200-400% FPL	328	24.7	17.2	35	-3.4	-1
400%+ FPL	139	10.5	7.0	11	-1.8	0.8
<i>Gender</i>						
Male	706	53.3	25.2	113	-3.6	2
Female	619	46.7	21.3	169	3.6	4.4
<i>Race/Ethnicity</i>						
White, Not Hispanic	643	48.5	17.0	120	-1.6	2.1
Black, Not Hispanic	319	24.1	25.6	98	2.9	5
Not White or Black or Hispanic	88	6.6	33.7	23	0.4	9.6
Hispanic	275	20.8	64.9	41	-1.6	2.8
<i>Age</i>						
19-29	485	36.6	36.0	89	-1.4	6.5
30-44	449	33.9	23.1	88	-0.8	2.8
45-54	229	17.3	17.4	46	-0.3	1.6
55-64	162	12.2	14.7	61	2.5	3.9
<i>Citizenship</i>						
Citizen	1,064	80.3	19.9	250	2.3	3.1
Not a citizen	261	19.7	70.0	31	-2.3	12.2
<i>Rural/Urban</i>						
Urban	894	67.5	22.5	203	1.3	3.9
Rural	432	32.6	24.7	78	-1.3	1.3
<i>Self-Perceived Health Status</i>						
Excellent	262	19.8	17.1	-5	-5.8	0.5
Very Good	383	28.9	21.1	52	-2.8	1.4
Good	463	35.0	29.5	158	5.7	6.2
Fair	167	12.6	30.7	64	2.7	6.3
Poor	49	3.7	19.9	12	0.1	1.3
<i>Family Workforce Status</i>						
No Workers	215	16.2	27.1	80	3.3	5.5
Only PT Workers	193	14.6	43.3	93	4.9	11.6
1 FT Worker	590	44.5	24.4	127	0.2	3.6
2+ FT Workers	327	24.7	16.0	-18	-8.4	-0.8

Table 3: Adults Ages 19-64 continued

Category	2008-2009 Rates			Change: 2003-2004 to 2008-2009		
	Thousands of Uninsured Adults	Percent of All Uninsured Adults	Percent of Category Uninsured	Thousands of Uninsured Adults	Percent of All Uninsured Adults	Percent of Category Uninsured
Adults Ages 19-64	1,326	100%	23.20%	281	0	3.2
<i>Individual's Labor Force Status</i>						
Not in Labor Force	333	25.2	25.3	100	2.8	4.9
Unemployed	211	15.9	52.1	116	6.8	2.6
Part Time	247	18.6	37.5	81	2.7	11.6
Full Time	534	40.3	16.4	-16	-12.3	-0.9
<i>Firm Size (for individuals working part- or full-time)</i>						
1-24	390	50.0	35.5	10	-3.1	3.5
25-99	101	13.0	23.7	11	0.4	2.7
100-999	80	10.2	11.8	1	-0.8	-1.3
GT 1000	167	21.3	10.3	51	5.1	2.6
Unknown Size	43	5.5	41.6	-8	-1.6	-5.3
<i>Industry</i>						
Agriculture	13	1.6	35.1	-20	-2.9	-5.3
Construction	125	16	40.9	-57	-9.5	-5.2
Manufacturing	69	8.8	14.0	4	-0.2	2.2
Transportation	16	2.0	10.6	-7	-1.1	-3.2
Trade	141	18.1	25.3	59	6.6	10.2
Health & Education	112	14.4	11.1	47	5.3	3.2
Finance	30	3.8	12.5	12	1.3	4.3
Government	6	0.8	2.9	1	0.1	0.1
Hospitality	142	18.2	41.0	48	5.0	4.5
Other	127	16.3	21.9	-21	-4.4	-2.5

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For more information on this publication or the NCIOM, contact Pam Silberman, JD, DrPH, President and CEO of the North Carolina Institute of Medicine at 919.401.6599, or visit <http://www.nciom.org>.



North Carolina County-Level Estimates of Non-Elderly Uninsured

Prepared by the North Carolina Institute of Medicine and the
Cecil B. Sheps Center for Health Services Research,
University of North Carolina at Chapel Hill

2008-2009

Data Snapshot

This data snapshot provides information about uninsured individuals in North Carolina by age and county of residence. Uninsured estimates are presented for 2008-2009, using data from the US Census Bureau and the North Carolina Employment Security Commission. 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 NCIOM 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.

County	Children (0-18)			Adult (19-64)			Total (0-64)		
	Number	Percent	Rank	Number	Percent	Rank	Number	Percent	Rank
Alamance	5,104	13.0%	High	22,075	24.5%	Mid-High	27,180	21.0%	Mid-High
Alexander	828	9.6%	Low	4,517	19.6%	Low	5,344	16.9%	Low
Alleghany	289	12.8%	High	1,742	26.8%	High	2,031	23.2%	High
Anson	655	11.1%	Mid-Low	4,103	26.5%	High	4,759	22.3%	High
Ashe	537	10.1%	Low	3,449	22.4%	Mid-Low	3,987	19.2%	Mid-Low
Avery	360	10.1%	Low	2,747	24.5%	Mid-High	3,107	21.0%	Mid-High
Beaufort	1,287	11.9%	Mid-High	6,331	23.5%	Mid-High	7,618	20.2%	Mid-High
Bertie	546	11.6%	Mid-High	2,750	24.0%	Mid-High	3,296	20.4%	Mid-High
Bladen	1,040	12.7%	High	4,311	22.3%	Mid-Low	5,351	19.4%	Mid-Low
Brunswick	2,176	10.4%	Mid-Low	14,640	22.8%	Mid-Low	16,816	19.8%	Mid-Low
Buncombe	5,279	10.4%	Mid-Low	30,324	21.1%	Low	35,603	18.3%	Low
Burke	2,356	10.9%	Mid-Low	11,058	20.5%	Low	13,414	17.7%	Low
Cabarrus	5,661	11.4%	Mid-High	22,780	21.9%	Mid-Low	28,441	18.5%	Low
Caldwell	1,899	10.1%	Low	10,281	21.2%	Low	12,181	18.1%	Low
Camden	245	9.1%	Low	1,259	21.5%	Low	1,503	17.6%	Low
Carteret	1,256	9.7%	Low	8,918	22.7%	Mid-Low	10,173	19.5%	Mid-Low
Caswell	543	10.7%	Mid-Low	3,322	23.3%	Mid-Low	3,865	20.0%	Mid-High
Catawba	4,677	11.7%	Mid-High	21,446	22.2%	Mid-Low	26,123	19.1%	Mid-Low



Published December 2010

County	Children (0-18)			Adult (19-64)			Total (0-64)		
	Number	Percent	Rank	Number	Percent	Rank	Number	Percent	Rank
Chatham	1,910	12.9%	High	8,757	21.6%	Low	10,667	19.3%	Mid-Low
Cherokee	517	9.6%	Low	3,441	22.9%	Mid-Low	3,959	19.4%	Mid-Low
Chowan	389	10.9%	Mid-Low	2,107	25.0%	Mid-High	2,496	20.8%	Mid-High
Clay	185	9.4%	Low	1,444	24.3%	Mid-High	1,628	20.6%	Mid-High
Cleveland	2,645	10.4%	Mid-Low	13,041	22.2%	Mid-Low	15,686	18.6%	Low
Columbus	1,622	11.5%	Mid-High	7,717	24.3%	Mid-High	9,340	20.4%	Mid-High
Craven	2,480	10.3%	Mid-Low	13,720	23.4%	Mid-Low	16,200	19.6%	Mid-Low
Cumberland	10,426	11.5%	Mid-High	47,561	24.5%	Mid-High	57,986	20.3%	Mid-High
Currituck	554	9.2%	Low	3,732	24.5%	Mid-High	4,286	20.2%	Mid-High
Dare	718	9.7%	Low	5,339	24.6%	Mid-High	6,058	20.8%	Mid-High
Davidson	4,337	10.9%	Mid-Low	20,863	21.5%	Low	25,200	18.4%	Low
Davie	1,105	10.8%	Mid-Low	4,956	20.0%	Low	6,061	17.3%	Low
Duplin	2,375	16.4%	High	8,972	28.3%	High	11,347	24.6%	High
Durham	8,745	12.8%	High	40,341	22.9%	Mid-Low	49,085	20.1%	Mid-High
Edgecombe	1,777	12.4%	High	8,020	25.4%	High	9,797	21.3%	High
Forsyth	11,996	12.7%	High	49,036	22.5%	Mid-Low	61,032	19.5%	Mid-Low
Franklin	1,761	11.5%	Mid-High	8,756	23.1%	Mid-Low	10,518	19.7%	Mid-Low
Gaston	5,664	10.7%	Mid-Low	28,890	22.5%	Mid-Low	34,554	19.0%	Mid-Low
Gates	305	10.0%	Low	1,683	23.8%	Mid-High	1,988	19.7%	Mid-Low
Graham	177	9.7%	Low	1,085	24.0%	Mid-High	1,262	19.9%	Mid-Low
Granville	1,591	11.5%	Mid-High	7,783	20.9%	Low	9,374	18.4%	Low
Greene	730	14.9%	High	3,738	28.1%	High	4,467	24.6%	High
Guilford	14,115	11.4%	Mid-High	67,982	22.9%	Mid-Low	82,097	19.5%	Mid-Low
Halifax	1,542	11.3%	Mid-High	8,660	27.0%	High	10,202	22.3%	High
Harnett	3,998	12.0%	High	17,337	24.2%	Mid-High	21,335	20.3%	Mid-High
Haywood	1,146	9.6%	Low	7,286	21.8%	Low	8,433	18.6%	Low
Henderson	2,665	11.8%	Mid-High	13,179	22.8%	Mid-Low	15,844	19.7%	Mid-Low
Hertford	656	11.5%	Mid-High	3,573	25.6%	High	4,230	21.5%	High
Hoke	1,775	13.1%	High	7,395	26.2%	High	9,170	21.9%	High
Hyde	111	11.0%	Mid-Low	1,069	31.6%	High	1,180	26.8%	High
Iredell	4,422	10.4%	Mid-Low	20,747	21.8%	Low	25,169	18.3%	Low
Jackson	894	10.5%	Mid-Low	5,538	24.3%	Mid-High	6,432	20.5%	Mid-High
Johnston	5,857	12.1%	High	24,617	23.7%	Mid-High	30,474	20.0%	Mid-High
Jones	255	11.4%	Mid-High	1,487	24.4%	Mid-High	1,743	20.9%	Mid-High
Lee	2,409	14.6%	High	8,673	24.8%	Mid-High	11,083	21.5%	High
Lenoir	1,783	12.2%	High	8,159	25.1%	Mid-High	9,942	21.1%	Mid-High
Lincoln	2,165	11.2%	Mid-Low	10,476	22.2%	Mid-Low	12,641	19.0%	Mid-Low
McDowell	1,045	10.3%	Mid-Low	5,360	20.0%	Low	6,405	17.4%	Low
Macon	712	10.3%	Low	4,256	23.4%	Mid-Low	4,968	19.8%	Mid-Low
Madison	441	9.5%	Low	2,611	21.2%	Low	3,052	18.0%	Low
Martin	656	11.5%	Mid-High	3,490	25.6%	High	4,146	21.5%	High
Mecklenburg	29,694	11.9%	Mid-High	137,826	23.6%	Mid-High	167,520	20.1%	Mid-High



County	Children (0-18)			Adult (19-64)			Total (0-64)		
	Number	Percent	Rank	Number	Percent	Rank	Number	Percent	Rank
Mitchell	341	10.2%	Low	2,004	21.8%	Low	2,345	18.7%	Low
Montgomery	1,112	15.5%	High	4,477	27.2%	High	5,589	23.6%	High
Moore	2,248	11.2%	Mid-Low	10,334	21.5%	Low	12,582	18.5%	Low
Nash	2,780	11.4%	Mid-High	13,070	23.4%	Mid-Low	15,850	19.7%	Mid-Low
New Hanover	4,448	10.1%	Low	29,794	24.0%	Mid-High	34,242	20.4%	Mid-High
Northampton	522	11.6%	Mid-High	2,978	25.6%	High	3,500	21.7%	High
Onslow	5,508	11.4%	Mid-High	32,121	28.6%	High	37,629	23.4%	High
Orange	3,573	10.9%	Mid-Low	18,281	22.1%	Mid-Low	21,854	18.9%	Mid-Low
Pamlico	231	10.0%	Low	1,730	23.5%	Mid-High	1,961	20.3%	Mid-High
Pasquotank	1,143	10.7%	Mid-Low	6,411	25.5%	High	7,553	21.1%	Mid-High
Pender	1,351	11.1%	Mid-Low	8,006	24.8%	Mid-High	9,357	21.0%	Mid-High
Perquimans	268	10.1%	Low	1,850	25.0%	Mid-High	2,118	21.1%	Mid-High
Person	930	10.2%	Low	4,881	21.1%	Low	5,811	18.0%	Low
Pitt	4,894	11.4%	Mid-High	25,589	25.6%	High	30,483	21.3%	High
Polk	402	10.8%	Mid-Low	2,267	21.0%	Low	2,669	18.4%	Low
Randolph	4,528	12.4%	High	19,319	22.4%	Mid-Low	23,847	19.5%	Mid-Low
Richmond	1,448	11.8%	Mid-High	6,973	25.7%	High	8,421	21.4%	High
Robeson	5,300	13.9%	High	22,325	28.9%	High	27,625	23.9%	High
Rockingham	2,424	11.1%	Mid-Low	12,333	22.2%	Mid-Low	14,757	19.0%	Mid-Low
Rowan	4,011	11.4%	Mid-High	18,640	22.0%	Mid-Low	22,651	18.9%	Mid-Low
Rutherford	1,519	10.0%	Low	8,180	22.0%	Mid-Low	9,699	18.5%	Low
Sampson	2,705	15.3%	High	10,556	28.0%	High	13,261	24.0%	High
Scotland	1,126	11.4%	Mid-High	5,666	26.0%	High	6,793	21.5%	High
Stanly	1,490	10.2%	Low	7,732	21.6%	Low	9,222	18.3%	Low
Stokes	1,026	9.6%	Low	5,424	19.3%	Low	6,450	16.6%	Low
Surry	2,277	12.7%	High	9,215	21.8%	Low	11,492	19.1%	Mid-Low
Swain	357	10.8%	Mid-Low	1,612	20.8%	Low	1,969	17.8%	Low
Transylvania	613	9.8%	Low	3,573	21.8%	Low	4,185	18.5%	Low
Tyrrell	106	13.2%	High	884	33.5%	High	990	28.8%	High
Union	6,997	11.2%	Mid-High	25,608	21.6%	Low	32,606	18.0%	Low
Vance	1,582	13.3%	High	6,858	27.4%	High	8,440	22.8%	High
Wake	27,701	11.1%	Mid-Low	123,891	21.6%	Low	151,592	18.4%	Low
Warren	491	11.8%	Mid-High	3,167	27.5%	High	3,658	23.3%	High
Washington	405	12.1%	High	1,893	26.0%	High	2,298	21.6%	High
Watauga	937	9.8%	Low	8,683	28.8%	High	9,621	24.2%	High
Wayne	3,736	12.1%	High	16,429	24.0%	Mid-High	20,164	20.3%	Mid-High
Wilkes	1,713	11.1%	Mid-Low	8,855	22.3%	Mid-Low	10,568	19.1%	Mid-Low
Wilson	2,684	13.0%	High	12,028	25.8%	High	14,711	21.9%	High
Yadkin	1,095	11.9%	High	4,850	21.5%	Low	5,945	18.7%	Mid-Low
Yancey	439	11.2%	Mid-High	2,580	23.5%	Mid-High	3,019	20.3%	Mid-High
NORTH CAROLINA	282,000	11.5%		1,326,000	23.2%		1,608,000	19.7%	

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North Carolina Department of Health &
Human Services

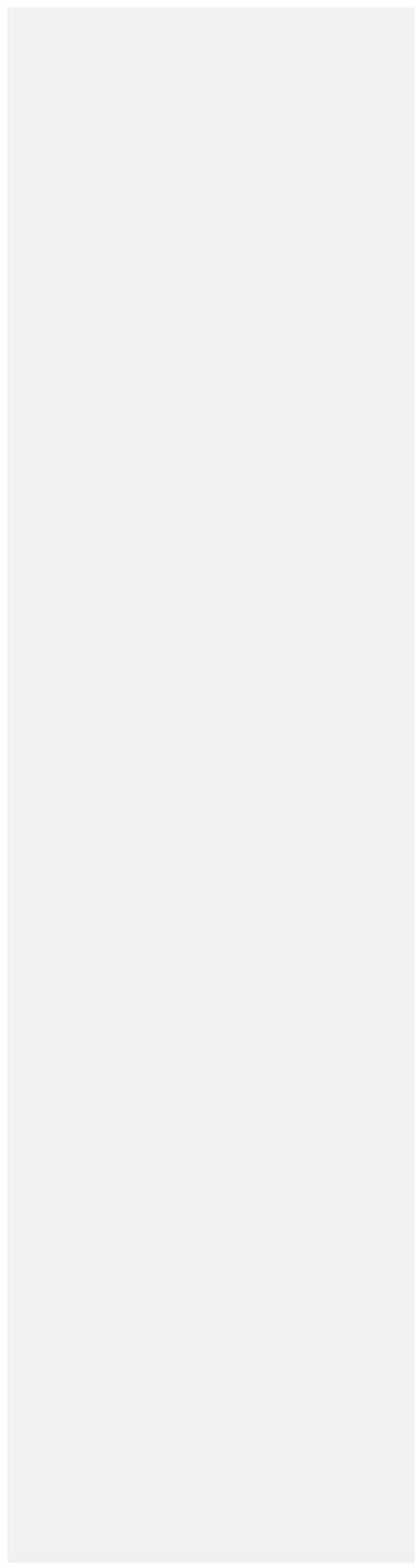
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Adult Services Section Chief
Division of Aging & Adult Services
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Chief of Facility & Community Care
Home & Community Services
North Carolina Department of Health &
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DRAFT



**MEDICAID AND ELDER SERVICES
PROVISIONS**

Waiver

Sec. 1332. Waiver for State innovation.

Electronic data exchange between Medicaid and other programs

Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.

Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.

Health Information Technology

Sec. 1561. Health information technology enrollment standards and protocols.

Plan for Medicaid expansion

Sec. 2001. Medicaid coverage for the lowest income populations.

Sec. 2002. Income eligibility for nonelderly determined using modified adjusted gross income.

Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance.

Foster care children

Sec. 2004, 10201. Medicaid coverage for former foster care children.

CHIP

Sec. 2101, 10203. Additional Federal financial participation for CHIP.

Sec. 2102. Technical correction for North Carolina.

Enrollment simplification

Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges.

Hospital presumptive eligibility

Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.

Free standing birth centers

Sec. 2301. Coverage for freestanding birth center services.

Hospice

Sec. 2302. Concurrent care for children.

Family planning services

Sec. 2303. State eligibility option for family planning services.

Explore Medicaid options, including community first choice option

Sec. 2401. Community First Choice Option.

Sec. 1205 of Reconciliation.

State plan amendment to expand home and community based services

Sec. 2402. Removal of barriers to providing home and community-based services.

Money Follows the Person

Sec. 2403. Money Follows the Person Rebalancing Demonstration.

Protection for home and community-based services against spousal impoverishment

Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.

Aging and disability resource centers

Sec. 2405. Funding to expand State Aging and Disability Resource Centers.

Prescription drug coverage

Sec. 2501. Prescription drug rebates.

Sec. 1206 of Reconciliation. Drug rebates for new formulations of existing drugs.

Sec. 2502. Elimination of exclusion of coverage of certain drugs.

Sec. 2503. Providing adequate pharmacy reimbursement.

Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2551. Disproportionate Share Hospital Payments.

Sec. 1203 of Reconciliation.

Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.

Protections for American Indians and Alaska Natives

Sec. 2901. Special rules relating to Indians.

Power of attorney

Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living.

Dual eligibles

Sec. 3306. Funding outreach and assistance for low-income programs.

Sec. 3309. Elimination of cost sharing for certain dual eligibles.

Adult preventive services

Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.

Tobacco cessation

Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.

Healthy lifestyle initiatives

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.

Nursing home complaint resolution process

Sec. 6105. Standardized complaint form.

Background checks for direct patient access employees

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Elder justice

Sec. 6703. Elder Justice.

State balancing incentive program

Sec. 10202. Incentives for States to offer home and community based services as a long-term care alternative to nursing homes.

CHIP Funding

Sec. 10203. Extension of funding for CHIP through fiscal year 2015 and other CHIP-related provisions.

Income definitions

Sec. 1004 of Reconciliation.

Federal funding for states

Sec. 1201 of Reconciliation.

Increase rates to primary care doctors

Sec. 1202 of Reconciliation.

APPENDIX D
HEALTH BENEFIT EXCHANGE AND INSURANCE OVERSIGHT

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North Carolina Department of Insurance

Rose V. Williams

Legislative Counsel
North Carolina Department of Insurance

HEALTH BENEFIT EXCHANGE AND INSURANCE OVERSIGHT
PROVISIONS

Insurance reform

- Sec. 1001. Amendments to the Public Health Service Act.
 - Sec. 2711. No lifetime or annual limits.
 - Sec. 2712. Prohibition on rescissions.
 - Sec. 2713. Coverage of preventive health services.
 - Sec. 2714. Extension of dependent coverage.
 - Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
 - Sec. 2715A. Provision of additional information.
 - Sec. 2716. Prohibition of discrimination in favor of highly compensated individuals.
 - Sec. 2718. Bringing down the cost of health care coverage.
 - Sec. 2719. Appeals process.
- Sec. 1002. Health insurance consumer information.
- Sec. 1003. Ensuring that consumers get value for their dollars.
- Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.

Enforce insurance oversight laws

Part I – Health Insurance Market Reforms

- Sec. 1201. Amendment to the Public Health Service Act.
 - Sec. 2701. Fair health insurance premiums.
 - Sec. 2702. Guaranteed availability of coverage.
 - Sec. 2703. Guaranteed renewability of coverage.
 - Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
 - Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.
 - Sec. 2706. Non-discrimination in health care.
 - Sec. 2707. Comprehensive health insurance coverage.
 - Sec. 2708. Prohibition on excessive waiting periods.
- Sec. 1251. Preservation of right to maintain existing coverage.
- Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.

Qualified health plans

- Sec. 1301, 10104. Qualified health plan defined.
- Sec. 1304. Related Definitions

Consumer Choices and Insurance Competition through Health Benefit Exchanges

- Sec. 1311. Affordable choices of health benefit plans.
- Sec. 1312. Consumer choice.
- Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

Enroll CO-Ops and multi-state plans into the HIE

Sec. 1322, 10104. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

Sec. 1334. Multi-State Plans.

Waiver for state innovation in health benefit exchange

Sec. 1332. Waiver for State innovation.

Offering plans in more than one state

Sec. 1333. Provisions relating to offering of plans in more than one State.

Participate in reinsurance, risk adjustment and risk corridors

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.

Sec. 1343. Risk adjustment.

Reporting to Secretary for refundable tax credits

Sec. 1401, Sec. 10105. Refundable tax credit providing premium assistance for coverage under a qualified health plan.

Sec. 1001 of Reconciliation. Tax Credits.

Determining exchange eligibility

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.

Premium tax credits and cost-sharing reductions

Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

Enrollment into HBE, Medicaid or CHIP

Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.

Sec. 2201. Enrollment simplification and coordination with state health insurance exchanges.

Small Business Tax Credit

Sec. 1421. Credit for employee health insurance expenses of small businesses.

Individual requirements for minimum coverage and reporting

Sec. 1501. Requirement to maintain minimum essential coverage.

Sec. 1502. Reporting of health insurance coverage.

Sec. 1002 of Reconciliation. Individual responsibility.

Employer responsibility to provide and report coverage.

- Sec. 1511. Automatic enrollment for employees of large employers.
- Sec. 1512. Employer requirement to inform employees of coverage options.
- Sec. 1513. Shared responsibility for employers.
- Sec. 1514. Reporting of employer health insurance coverage.
- Sec. 10108. Free choice vouchers.
- Sec. 1003 of Reconciliation.

Offering of exchange-participating qualified health plans through cafeteria plans

- Sec. 1515. Offering of exchange-participating qualified health plans through cafeteria plans.

Health Information Technology

- Sec. 1561. Health information technology enrollment standards and protocols.

Income definitions

- Sec. 1004 of Reconciliation.

Insurance reforms

- Sec. 2301 of Reconciliation.

High-Risk Insurance Pool

- Sec. 1101. Immediate access to insurance for people with a preexisting condition.

This group may also want to review the provision which allows the state to create a basic health plan for people under 200% FPL.

1. Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid. Draft Health Benefit Exchange Legislation

1 **NORTH CAROLINA HEALTH BENEFIT EXCHANGE ACT**

2
3 **Table of Contents**

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5 Section 1. Title
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7 Section 3. Definitions
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12 Section 8. Funding; Publication of Costs
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14 Section 10. Relation to Other Laws
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16
17 **Section 1. Title**

18
19 This Act shall be known and may be cited as the North Carolina Health Benefit Exchange Act.
20

21 **Section 2. Purpose and Intent**

22
23 The purpose of this Act is to provide for the establishment of the North Carolina Health Benefit
24 Exchange (Exchange). The Exchange shall assist both qualified individuals and the employees of
25 qualified employers in learning about and enrolling in qualified health plans offered through the
26 Exchange. The Exchange shall facilitate the purchase and sale of qualified health plans in the
27 individual market and shall assist qualified employers in this State in facilitating the enrollment
28 of their employees in qualified health plans offered in the Exchange. The intent of the Exchange
29 is to reduce the number of uninsured and promote improved competition in the health care
30 marketplace and consumer engagement in care and coverage choices. In carrying out its duties,
31 the Board of Directors of the North Carolina Health Benefit Exchange shall help promote
32 meaningful choice; increase competition based on comparative cost, value, quality of care, and
33 customer service; reduce competition based on risk avoidance, risk selection and market
34 segmentation; provide a transparent marketplace; increase consumer education and consumer
35 protections; and assist individuals and employers in accessing health coverage, premium tax
36 credits and cost-sharing reductions. The Board of Directors shall also seek to encourage greater
37 emphasis on health promotion/illness prevention, improved care and chronic condition
38 management, self management and more active engagement of patients in their own health, care
39 management and coverage decisions.
40

41 **Section 3. Definitions**

42
43 For purposes of this Act:
44

- 1 A. "Agent" has the meaning given to the term in G.S. 58-33-10(1).
2 B. "Board" means the Board of Directors of the North Carolina Health Benefit Exchange.
3 C. "Broker" has the meaning given to the term in G.S. 58-33-10(3)
4 D. "Commissioner" means the Commissioner of Insurance of North Carolina or the
5 Commissioner's authorized designee.
6 E. "Educated health care consumer" means an individual who is knowledgeable about the
7 health care system, and has information, background or experience in making informed
8 decisions regarding health, medical and scientific matters.
9 F. "Essential community provider" means a provider that serves predominantly low-income,
10 medically underserved individuals, such as health care providers defined in section
11 340B(a)(4) of the Public Health Service Act and providers described in section
12 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law
13 111-8.
14 G. "Essential health benefits" has the meaning given to the term in section 1302(b) of the
15 Federal Act.
16 H. "Exchange" means the North Carolina Health Benefit Exchange established pursuant to
17 section 4 of this Act and includes both the individual and the SHOP Exchanges, unless
18 otherwise specified.
19 I. "Executive Director" means the individual selected by a majority vote of the Board
20 members and hired to serve as the Executive Director of the Exchange.
21 J. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law
22 111-148), as amended by the federal Health Care and Education Reconciliation Act of
23 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance
24 issued under, those Acts.
25 K. "Grandfathered health plan coverage" or "grandfathered health plan" has the meaning
26 given the term in 45 CFR part 147.140(a).
27 L. "Health benefit plan" has the meaning given to the term in G.S. 58-3-167(a)(1).
28 M. "Health care provider" has the meaning given to the term in G.S. 58-50-270(3)(a).
29 N. "Individual Exchange" means the Exchange through which qualified individuals may
30 purchase coverage established under Section 6 of this Act.
31 O "Individual market" has the same meaning given the term in G.S. 58-68-25(a)(9).
32 P. "Insurer" has the meaning given to the term in G.S. 58-3-167(a)(2), and, for the purposes
33 of this Act, includes qualified nonprofit health insurance issuers (CO-OP Insurers) as
34 provided in section 1322 of the Federal Act, and multi-state qualified health plans as
35 provided in section 1334 of the Federal Act.
36 Q. "Navigator" means an individual who provides fair, accurate, and impartial information
37 about qualified health plans to individuals and employers, and who has been trained and
38 certified by the North Carolina Department of Insurance Consumer Assistance Program
39 in accordance with the standards set forth by the Secretary, as provided in section 1311(i)
40 of the Federal Act and subsection 6F of this Act.
41 R. "Plan of Operation" means the articles, bylaws, and operating rules and procedures
42 adopted by the Board in accordance with Section 4 of this Act.
43 S. "Principal place of business" means the location in the State where an employer has its
44 headquarters, or significant place of business and where the persons with direction and
45 control authority over the business are employed.

- 1 T. “Qualified dental plan” means a limited scope dental plan that has been certified in
 2 accordance with section 7E of this Act.
 3 U. “Qualified employer” means an employer that:
 4 (1) Elects to make its full-time employees eligible for one or more qualified health plans
 5 offered through the SHOP Exchange, and at the option of the employer, some or all
 6 of its part-time employees;
 7 (2) Has its principal place of business in this State;
 8 (3) Elects to provide coverage through the SHOP Exchange to all of its eligible
 9 employees, wherever employed; and
 10 (4) Employs no more than the maximum number of employees allowable, as determined
 11 by the Board and consistent with the provisions of this Act and the Federal Act.
 12 V. “Qualified health plan” means a health benefit plan that has in effect a certification that
 13 the plan meets the criteria for certification described in section 1311(c) of the Federal Act
 14 and section 7 of this Act and any additional requirements adopted by the Board pursuant
 15 to this Act.
 16 W. “Qualified individual” means an individual, including a minor, who:
 17 (1) Is seeking to enroll in a qualified health plan offered to individuals through the
 18 Exchange;
 19 (2) Is legally domiciled in the State on the date of enrollment for coverage;
 20 (3) At the time of enrollment, is not incarcerated, other than incarceration pending the
 21 disposition of charges; and
 22 (4) Is, and is reasonably expected to be, for the entire period for which enrollment is
 23 sought, a citizen or national of the United States or an alien lawfully present in the
 24 United States.
 25 X. “Secretary” means the Secretary of the federal Department of Health and Human
 26 Services.
 27 Y. “SHOP Exchange” means the Small Business Health Options Program established under
 28 section 6 of this Act.
 29 Z. “Small employer” has the meaning given to the term in G.S. 58-50-110(22), subject to
 30 the requirements of the Federal Act.
 31 AA. “Small group market” has the meaning given to the term in G.S. 58-68-25(a)(17).

Comment [U1]: We are waiting for input from actuaries to help determine whether to open SHOP exchange to groups of 51-100.

32
 33 **Section 4. Establishment of Exchange; Board of Directors; Plan of Operation**
 34

- 35 A. (1) The North Carolina Health Benefit Exchange (Exchange) is hereby established as a
 36 nonprofit entity which shall operate under the supervision and control of the Board of
 37 Directors of the Exchange (Board). Notwithstanding that the Exchange may be
 38 supported in whole or in part from federal or State funds, the Exchange is not an
 39 instrumentality of the State.
 40

41 **SMALL BOARD OPTION**

- 42 (2) (a) Each member of the Board shall have the responsibility and duty to meet
 43 the requirements of this Act, the Federal Act, and all applicable State and
 44 federal laws and regulations, to serve the public interest of the individuals
 45 and employers seeking health care coverage through the Exchange, and to
 46 ensure the operational well-being and fiscal solvency of the Exchange.

- 1 (b) Each member of the Board shall comply with all conflict of interest rules
2 and recusal procedures set forth in the Plan of Operation.
- 3 (c) A member of the Board or of the executive management staff of the
4 Exchange or their immediate family member shall not be employed by, a
5 consultant to, a member of the board of directors of, affiliated with, or
6 otherwise a representative of, an insurer, an agent or a broker while
7 serving on the board or on the staff of the Exchange. A member of the
8 Board or of the staff of the Exchange shall not be a member, a board
9 member, or an employee of a trade association of insurers while serving
10 on the Board or on the staff of the Exchange.
- 11 (d) No member of the Board or staff shall make, participate in making, or in
12 any way attempt to use his or her official position to influence the making
13 of any decision that he or she knows or has reason to know will have a
14 reasonably foreseeable material financial effect, distinguishable from its
15 effect on the public generally, on him or her or a member of his or her
16 immediate family or which will have a reasonably foreseeable material
17 effect on any business entity in which the member or his or her immediate
18 family is a director, officer, partner, trustee, employee, or holds any
19 position of management.
- 20 (3) The Board shall consist of the Commissioner, who shall serve as an ex officio
21 nonvoting member of the Board, the Director of the Division of Medical Assistance
22 or the Director's authorized designee, who shall serve as an ex officio voting member
23 of the Board, and 8 members appointed as follows:
- 24 (a) Two members appointed by the Governor, who represent employers of the
25 following sizes:
- 26 (i) One member representing an employer with no more than 50
27 employees.
- 28 (ii) One member representing an employer with more than 50
29 employees.
- 30 (b) Two members of the general public who can reasonably be expected to
31 enroll in a qualified health plan offered through the Exchange. The two
32 members of the general public shall be appointed by the General
33 Assembly, as follows:
- 34 (i) One member of the general public, upon recommendation of the
35 President Pro Tempore of the Senate.
- 36 (ii) One member of the general public, upon recommendation of the
37 Speaker of the House of Representatives.
- 38 (c) Four members appointed by the Commissioner, who have demonstrated
39 and acknowledged expertise and experience in one or more of the
40 following subject area groupings:
- 41 (i) Development and operation of State-scale information technology
42 systems capable of conducting electronic funds transfers, secure
43 data transfers, and other electronic functions relating to the
44 creation and ongoing operations of the Exchange.
- 45 (ii) Health economics or health care finance.
- 46 (iii) Actuarial science or risk management.

1 (iv) Health policy analysis or health law.

2 In making appointments to the Board under this sub-subdivision, the
3 Commissioner shall ensure that each of the subject area groupings listed in
4 this sub-subdivision is represented by at least one member with expertise
5 in that area and shall consider the expertise of the other members of the
6 Board and attempt to make appointments so that the Board's composition
7 reflects a diversity of expertise.

- 8 (4) (a) The initial appointments made pursuant to subdivisions (3)(a)(i) and
9 (3)(b)(i) of this subsection shall serve a term of two years. The initial
10 appointments made pursuant to subdivisions (3)(a)(ii) and (3)(b)(ii) of this
11 subsection shall serve a term of three years. The initial appointments
12 made pursuant to subdivisions (3)(c)(ii) of this subsection shall be for a
13 term of three years. The initial appointments made pursuant to
14 subdivisions (3)(c)(i) , (3)(c)(iii) and (3)(c)(iv) of this subsection shall be
15 for a term of four years. All succeeding appointments shall be for terms of
16 three years. Members shall not serve for more than two successive terms.
- 17 (b) A Board member's term shall continue until the member's successor is
18 appointed by the original appointing authority. Vacancies shall be filled by
19 the appointing authority for the unexpired portion of the term in which
20 they occur. A Board member may be removed by the appointing authority
21 for cause.
- 22 (c) The Board shall meet at least quarterly. A majority of the total voting
23 membership of the Board shall constitute a quorum.
- 24 (d) The Commissioner shall appoint a chair to serve for the initial two years
25 of Board operations, beginning with the first convening of the Board.
26 Subsequent chairs shall be elected by a majority vote of the Board
27 members and shall serve for two-year terms.
- 28 (e) Board members shall receive travel reimbursement under GS 138-5 when
29 traveling to and from meetings of the Board or for official business of the
30 Exchange, but shall not receive any per diem.

31
32 **LARGE BOARD OPTION**

- 33 (2) (a) Each member of the Board shall have the responsibility and duty to meet
34 the requirements of this Act, the Federal Act, and all applicable State and
35 federal laws and regulations, to serve the public interest of the individuals
36 and employers seeking health care coverage through the Exchange, and to
37 ensure the operational well-being and fiscal solvency of the Exchange.
- 38 (b) Each member of the Board shall comply with all conflict of interest rules
39 and recusal procedures set forth in the Plan of Operation.
- 40 (c) A member of the executive management staff of the Exchange or their
41 immediate family member shall not be employed by, a consultant to,
42 affiliated with, or otherwise a representative of, an insurer, an agent or
43 broker, a health care provider, or an essential community provider while
44 serving on the staff of the Exchange. A member of the staff of the
45 Exchange shall not be a member, a board member, or an employee of a
46 trade association of insurers, health facilities, health clinics, or health care

1 providers while serving on the staff of the Exchange. A member of the
2 executive management staff of the Exchange or their family members
3 shall not be a health care provider unless he or she receives no
4 compensation for rendering services as a health care provider and does not
5 have an ownership interest in a professional health care practice.

- 6 (d) No member of the Board or staff shall make, participate in making, or in
7 any way attempt to use his or her official position to influence the making
8 of any decision that he or she knows or has reason to know will have a
9 reasonably foreseeable material financial effect, distinguishable from its
10 effect on the public generally, on him or her or a member of his or her
11 immediate family or which will have a reasonably foreseeable material
12 effect on any business entity in which the member or his or her immediate
13 family is a director, officer, partner, trustee, employee, or holds and
14 position of management.

- 15 (3) The Board shall consist of the Commissioner, who shall serve as an ex officio
16 nonvoting member of the Board, the Director of the Division of Medical Assistance
17 or the Director's authorized designee, who shall serve as an ex officio voting member
18 of the Board, and 15 members appointed as follows:

- 19 (a) Three members who represent employers of the following sizes, and who
20 are not, and whose immediate family members are not, employed by or
21 affiliated with an insurer, an agent or broker, a hospital, or other health
22 care provider:

- 23 (i) One member representing an employer with no more than 50
24 employees, who is appointed by the General Assembly upon
25 recommendation of the President Pro Tempore of the Senate.
26 (ii) One member representing an employer with between 51 and 100
27 employees, who is appointed by the General Assembly upon
28 recommendation of the Speaker of the House of Representatives.
29 (iii) One member representing an employer with more than 100
30 employees, who is appointed by the Governor.

- 31 (b) Three members of the general public who represent consumer interests,
32 who are not, and whose immediate family members are not, employed by
33 or affiliated with an insurer, an agent or broker, a hospital, or other health
34 care provider, and who can reasonably be expected to enroll in a qualified
35 health plan offered through the Exchange. The three members of the
36 general public who represent consumer interest shall be appointed as
37 follows:

- 38 (i) One member who is appointed by the General Assembly upon
39 recommendation of the President Pro Tempore of the Senate.
40 (ii) One member who is appointed by the General Assembly upon
41 recommendation of the Speaker of the House of Representatives.
42 (iii) One member who is appointed by the Governor.

- 43 (c) Three **non-voting/voting** members appointed by the Commissioner, who
44 represent insurers or agents licensed to sell health insurance policies in the
45 State, and who, beginning in 2014, offer qualified health plans in the
46 Exchange, as follows:

Comment [U2]: Note: there was not a consensus in the group as to whether these Board positions should be voting or nonvoting members, or whether insurers and agents should be treated differently (i.e., on board, or as voting members).

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- (i) One member who represents an insurer who sells individual health insurance policies.
- (ii) One member who represents an insurer who sells small group health insurance policies. This member may not represent the same insurer as the member designated in sub-subdivision (c)(i) of this subdivision.
- (iii) One member who represents agents or brokers who sell health insurance policies in the individual and small group markets.
One member appointed pursuant to either sub-subdivision (c)(i) or sub-subdivision (c)(ii) of this subdivision shall represent the insurer who covers the largest number of persons in the State. Beginning in 2015, this member shall represent the insurer with the largest number of qualified individuals enrolled in the Exchange.
- (d) Two members who are either health care providers or essential community providers, as follows:
 - (i) One member who represents health care providers or essential community providers, who is appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate.
 - (ii) One member who represents health care providers or essential community providers, who is appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives.
- (e) Four members who are not employed by an insurer, an agent or broker, a hospital, or other health care provider, and who have demonstrated and acknowledged expertise and experience in the following subject area groupings:
 - (i) Development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange. This member shall be appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate.
 - (ii) Health economics or health care finance. This member shall be appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives.
 - (iii) Actuarial science or risk management. This member shall be appointed by the Commissioner.
 - (iv) Health policy analysis, public health, or health law. This member shall be appointed by the Governor.

In making appointments to the Board under this sub-subdivision, the appointing authority shall consider the expertise of the other members of the Board and attempt to make appointments so that the Board's composition reflects a diversity of expertise.
- (4) (a) The initial appointments under subdivisions (3)(a)(iii), (3)(b)(i), (3)(c)(iii), (3)(e)(i) and (3)(e)(iv) of this subsection shall serve a term of two years. The initial appointments under subdivisions (3)(a)(i), (3)(b)(2), (3)(c)(i), (3)(d)(ii), and (3)(e)(ii) of this subsection shall be for a term of three years.

- 1 The initial appointments under subdivisions (3)(b)(ii), (3)(b)(iii), (3)(c)(ii),
2 (3)(d)(i), and (3)(e)(iii) of this subsection shall be for a term of four years.
3 All succeeding appointments shall be for terms of three years. Members
4 shall not serve for more than two successive terms.
- 5 (b) A Board member's term shall continue until the member's successor is
6 appointed by the original appointing authority. Vacancies shall be filled by
7 the appointing authority for the unexpired portion of the term in which
8 they occur. A Board member may be removed by the appointing authority
9 for cause.
- 10 (c) The Board shall meet at least quarterly. A majority of the total voting
11 membership of the Board shall constitute a quorum.
- 12 (d) The Commissioner shall appoint a chair to serve for the initial two years
13 of Board operations, beginning with the first convening of the Board.
14 Subsequent chairs shall be elected by a majority vote of the Board
15 members and shall serve for two-year terms.
- 16 (e) Board members shall receive travel reimbursement under GS 138-5 when
17 traveling to and from meetings of the Board or for official business of the
18 Exchange, but shall not receive any per diem.

19
20
21 ****END OF BOARD OPTIONS SECTION, MODEL ACT CONTINUES HERE****

- 22
23 B. (1) The Board shall develop a Plan of Operation, in consultation with the advisory
24 committee, and submit it to the Commissioner in accordance with the requirements of
25 this subsection. The Board shall make the Plan of Operation open to public
26 inspection and provide an opportunity for public input prior to submitting the Plan of
27 Operation to the Commissioner.
- 28 (2) The Board shall submit to the Commissioner a Plan of Operation for the Exchange
29 and any amendments necessary or suitable to assure the fair, reasonable, and
30 equitable administration of the Plan of Operation. The Commissioner shall review
31 and approve or disapprove the Plan of Operation within ninety (90) days after its
32 submission or resubmission. The Commissioner may disapprove the Plan of
33 Operation only if the Commissioner determines that it does not comply with the
34 requirements of this Act, the Federal Act, or Chapter 58 of the General Statutes. If
35 the Commissioner disapproves the Plan of Operation, the Commissioner shall identify
36 the specific provision or provisions upon which the disapproval is based and shall
37 provide the Board an opportunity to revise and resubmit the Plan of Operation. If
38 the Board fails to submit a suitable Plan of Operation within 180 days after the
39 appointment of the Board, or at any time thereafter fails to submit needed
40 amendments as required by State or federal law to the Plan of Operation, the
41 Commissioner shall adopt temporary rules necessary or advisable to effectuate the
42 provisions of this section. The rules shall continue in force until modified by the
43 Commissioner or superseded by a Plan of Operation submitted by the Board and
44 approved by the Commissioner. [NOTE: CONTENTS OF PLAN OF OPERATION
45 SUBJECT TO CHANGE PENDING RESULTS OF NC HEALTH BENEFIT
46 EXCHANGE STUDY, DUE FEB. 2011; RFP #12-001065]

1 (3) The Plan of Operation shall:

- 2 (a) Establish procedures and policies for operation of the Exchange, including
3 at least the following:
- 4 (i) Process by which the Board sets policies and conducts business,
5 including bylaws.
 - 6 (ii) Process for determining qualified health plan participation in the
7 Exchange, consistent with the requirements of Section 7 of this
8 Act.
 - 9 (iii) Process for determining the role of the Exchange in collecting and
10 distributing premiums for qualified employers. In making this
11 determination, the Exchange shall consult with small employers,
12 and consider the added value, costs, and operational requirements
13 for the Exchange to accomplish this.
 - 14 (iv) The role and compensation of insurance agents and brokers in
15 assisting qualified individuals and employers with plan selection,
16 enrollment, and other relevant activities through the Exchange
17 consistent with the requirements of Section 6 of this Act and the
18 rules adopted by the Secretary pursuant to section 1312(e) of the
19 Federal Act. In considering and developing the role and
20 compensation, the Board shall consult with the Department of
21 Insurance and shall consider the impact on insurance coverage and
22 premium rates inside and outside the Exchange.
 - 23 (v) Plans for determining the need for and selection of eligible entities
24 with whom to contract for performance of Exchange functions or
25 operations.
 - 26 (vi) Fiscal operations of the Exchange, addressing the collection,
27 handling, disbursing, accounting, and auditing of assets and
28 monies of the Exchange and any eligible entity with whom the
29 Exchange contracts.
 - 30 (vii) Statement acknowledging the fiduciary duty owed by the
31 Exchange to persons receiving qualified health plan coverage
32 through the Exchange.
 - 33 (viii) Process for evaluating the effectiveness of the Executive Director
34 and the overall operations of the Exchange.
 - 35 (ix) Provide for conflict of interest rules and recusal procedures that
36 require a Board member to recuse himself or herself from an
37 official matter, whenever the Board member or his or her
38 immediate family has any financial involvement or interest in that
39 matter.
- 40 (b) Establish a process for review of:
- 41 (i) Individual appeals of Exchange premium tax credit and cost
42 sharing reductions and mandate exemption determinations. To the
43 extent possible, this appeals process shall be established in
44 collaboration with Medicaid eligibility determinations;
 - 45 (ii) Employer appeals of employer-sponsored plan availability or
46 affordability determinations; and

- 1 (iii) Decisions made by the Exchange that may appeal adverse
2 decisions affecting insurers.
- 3 (c) Identify an approach for coordinating efforts with the Department of
4 Health and Human Services to fairly allocate administrative costs for
5 eligibility determinations in the Exchange and Medicaid.
- 6 (d) Provide an approach to encourage broad participation from interested
7 insurers to offer qualified health plans through the Exchange.
- 8 (e) Develop policies by which the Board may place parameters on the plan
9 designs offered in order to promote competition, ensure meaningful choice
10 for individuals and employers, encourage positive innovations, and
11 prevent risk segmentation.
- 12 (f) Provide for other matters as may be necessary or proper for the execution
13 of the Executive Director's powers, duties, and obligations under this Act.
- 14 C. The Exchange may contract with an eligible entity for any of its functions described in
15 this Act. For the purposes of this Act, an eligible entity includes, but is not limited to, the
16 Division of Medical Assistance, the Department of Insurance, the North Carolina
17 Consumer Assistance Program, or an entity that has experience in individual and small
18 group health insurance, benefit administration or other experience relevant to the
19 responsibilities to be assumed by the entity, but an insurer or an affiliate of an insurer is
20 not an eligible entity.
- 21 D. The Exchange may enter into information-sharing agreements with federal and State
22 agencies and other State Exchanges to carry out its responsibilities under this Act
23 provided such agreements include adequate protections with respect to the confidentiality
24 of the information to be shared and comply with all State and federal laws and
25 regulations.
- 26 E. Neither the Board nor the employees of the Exchange are liable for any obligations of the
27 Exchange. There shall be no liability on the part of, and no cause of action of any nature
28 shall arise against, the Exchange or its agents or employees, the Board, the Executive
29 Director, or the Commissioner or the Commissioner's representatives for any action taken
30 by them in good faith in the performance of their powers and duties under this Act.
- 31 F. The members of the Board are public servants under G.S. 138A-3(30) and are subject to
32 the provisions of Chapter 138A of the General Statutes. [State Government Ethics Act]
- 33 G. All documents, papers, letters, maps, books, photographs, films, sound recordings,
34 magnetic or other tapes, electronic data-processing records, artifacts, or other
35 documentary material, regardless of physical form or characteristics, made or received in
36 connection with the operations of the Exchange are public records under G.S. 132-1(a)
37 and are subject to the provisions of Chapter 132 of the General Statutes except to extent
38 that these public records are protected under State or federal law. [Public records law]
- 39 H. The Board is a public body under G.S. 143-318.10(b) and is subject to the provisions of
40 Article 33C of Chapter 143 of the General Statutes. [Open meetings law]

41 42 **Section 5. General Requirements**

43
44 The Exchange shall make qualified health plans available to qualified individuals and qualified
45 employers beginning on or after January 1, 2014.

- 1 A. (1) The Exchange shall not make available any health benefit plan that is not a
2 qualified health plan, unless it is a qualified dental plan under subsection (2).
3 (2) The Exchange shall allow properly authorized insurers to offer limited scope
4 dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal
5 Revenue Code of 1986 through the Exchange, either separately or in conjunction
6 with a qualified health plan, if the plan provides pediatric dental benefits meeting
7 the requirements of section 1302(b)(1)(J) of the Federal Act.
8 B. Except to the extent that the Board has determined it is not in the public interest in
9 accordance with section 7A(7) of this Act, nothing in this section shall preclude a
10 qualified health plan from voluntarily offering benefits in addition to essential health
11 benefits, including wellness program.
12 C. As required by section 1311(d)(B)(II) of the Federal Act, to the extent that State law or
13 regulation requires that qualified health plans offer benefits in addition to the essential
14 health benefits, the State shall make payments to defray the costs of the additional
15 benefits directly to the individual enrolled in a qualified health plan in the Exchange or
16 on behalf of an individual directly to the qualified health plan in the Exchange in which
17 the individual is enrolled. To the extent that funding to defray the costs of the additional
18 benefits is not provided by the State, the qualified health plan shall not be required to
19 provide the additional benefits.
20 B. Neither the Exchange nor an insurer offering health benefit plans through the Exchange
21 may charge an individual a fee or penalty for termination of coverage if the individual
22 enrolls in another type of minimum essential coverage because the individual has become
23 newly eligible for that coverage or because the individual's employer-sponsored coverage
24 has become affordable under the standards of section 36B(c)(2)(C) of the Internal
25 Revenue Code of 1986.

26
27 **Section 5A. Consumer Choice**
28

- 29 A. Nothing in this Act or the Federal Act shall be construed to prohibit:
30 (1) A properly authorized insurer from offering outside of the Exchange a health
31 benefit plan to a qualified individual or qualified employer; and
32 (2) A qualified individual from enrolling in, or a qualified employer from selecting
33 for its employees, a health benefit plan offered outside of the Exchange.
34 B. Nothing in this Act or the Federal Act shall be construed to terminate, abridge, or limit
35 the operation of any requirement under State law with respect to any health benefit plan
36 that is offered outside of the Exchange.
37 C. Nothing in this Act or the Federal Act shall be construed to restrict the choice of a
38 qualified individual to enroll or not to enroll in a qualified health benefit plan or to
39 participate in the Exchange.
40 D. Nothing in this title shall be construed to compel an individual to enroll in a qualified
41 health plan or to participate in the Exchange.
42 E. A qualified individual may enroll in any qualified health plan, except that in the case of a
43 catastrophic plan described in section 1302(e) of the Federal Act, a qualified individual
44 may enroll in the plan only if the individual is eligible to enroll in the plan under section
45 1302(e)(2) of the Federal Act.
46

1 **Section 5B. Risk Pooling**
2

- 3 A. An insurer who delivers or issues for delivery any health benefit plan in this State shall
4 consider all enrollees in all health benefit plans other than grandfathered health plans
5 offered by the insurer in the individual market, including those enrollees who do not
6 enroll in individual plans offered through the Exchange, to be members of a single risk
7 pool.
8 B. An insurer who delivers or issues for delivery any health benefit plan in this State shall
9 consider all enrollees in all health benefit plans other than grandfathered health plans
10 offered by the insurer in the small group market, including those enrollees who do not
11 enroll in small group plans offered through the Exchange, to be members of a single risk
12 pool.
13 C. The Commissioner may require the individual and small group insurance markets within
14 the State to be merged or separated, if the Commissioner and the Board determine that
15 merger or separation of these markets is appropriate.
16 D. The Commissioner shall have the power and authority to enforce the provisions of this
17 section and any rules adopted to implement the provisions of this section.
18

19 **Section 6. Duties of Exchange**
20

21 The Exchange shall:
22

- 23 A. Facilitate the purchase and sale of qualified health plans;
24 B. Assist qualified individuals in this State with enrollment in qualified health plans;
25 C. Assist qualified employers in this State in facilitating the enrollment of their employees
26 in qualified health plans;
27 D. Maintain an accessible Internet website through which enrollees and prospective
28 enrollees of qualified health plans, Medicaid, or North Carolina Health Choice may:
29 (1) Obtain standardized comparative information on the aforementioned plans and
30 programs, as appropriate;
31 (2) Enter and submit information sufficient for facilitating eligibility determinations for
32 Medicaid and North Carolina Health Choice, and premium tax credit and cost-sharing
33 reduction determinations; and
34 (3) Enter and submit information sufficient for facilitating enrollment of individuals in
35 the plans or programs appropriate to their particular circumstances or selections.
36 E. Establish and make available by electronic means a calculator to determine the actual
37 cost of coverage after application of any premium tax credit under section 36B of the
38 Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the
39 Federal Act;
40 F. Award grants to Navigators, trained and certified by the North Carolina Department of
41 Insurance Consumer Assistance Program, to:
42 (1) Conduct public education activities to raise awareness of the availability of qualified
43 health plans;
44 (2) Distribute fair and impartial information concerning enrollment in qualified health
45 plans, and the availability of premium tax credits under section 36B of the Internal

- 1 Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal
2 Act;
- 3 (3) Facilitate enrollment in qualified health plans;
- 4 (4) Provide referrals to any applicable office of health insurance consumer assistance or
5 health insurance ombudsman established under section 2793 of the PHSA, or any
6 other appropriate State agency or agencies, for any enrollee with a grievance,
7 complaint or question regarding their health benefit plan, coverage or a determination
8 under that plan or coverage; and
- 9 (5) Provide information in a manner that is accessible, as well as culturally and
10 linguistically appropriate to the needs of the population being served by the
11 Exchange.
- 12 G. Provide for the operation of a toll-free telephone hotline to respond to requests for
13 assistance in a manner that is accessible to individuals with different communication
14 needs and that effectively communicates information in a manner that is culturally and
15 linguistically appropriate to the needs of the population being served by the Exchange;
16 and ensure that all Exchange employees interacting with the general public be trained and
17 certified as Navigators.
- 18 H. Allow properly licensed agents and brokers to:
- 19 (1) Enroll individuals and employers in any qualified health plans in the individual or
20 small group market as soon as the plan is offered through the Exchange; and
- 21 (2) Assist individuals in applying for premium tax credits and cost-sharing reductions for
22 plans sold through the Exchange.
- 23 I. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;
- 24 J. Assign a rating to each qualified health plan offered through the Exchange in accordance
25 with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act.
- 26 K. Implement procedures for the certification, recertification and decertification of health
27 benefit plans as qualified health plans, consistent with guidelines developed by the
28 Secretary under section 1311(c) of the Federal Act and section 7 of this Act;
- 29 L. Use a standardized format for presenting health benefit options in the Exchange,
30 including the use of the uniform outline of coverage established under section 2715 of the
31 Public Health Service Act (PHSA);
- 32 M. In accordance with section 1413 of the Federal Act, inform individuals of eligibility
33 requirements for the Medicaid program under title XIX of the Social Security Act, the
34 Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act
35 or any applicable State or local public program and if through screening of the
36 application by the Exchange, the Exchange determines that any individual is eligible for
37 any such program, enroll that individual in that program;
- 38 N. Establish an Individual Exchange through which qualified individuals may enroll in any
39 qualified health plan for which they are eligible.
- 40 O. Establish a SHOP Exchange through which qualified employers may make its employees
41 eligible for one or more qualified health plans offered through the SHOP Exchange or
42 specify a level of coverage so that any of its employees may enroll in any qualified health
43 plan offered through the SHOP Exchange at the specified level of coverage;
- 44 P. Subject to section 1411 of the Federal Act, grant a certification attesting that, for
45 purposes of the individual responsibility penalty under section 5000A of the Internal

1 Revenue Code of 1986, an individual is exempt from the individual responsibility
2 requirement or from the penalty imposed by that section because:

- 3 (1) There is no affordable qualified health plan available through the Exchange, or the
4 individual's employer, covering the individual; or
- 5 (2) The individual meets the requirements for any other such exemption from the
6 individual responsibility requirement or penalty;

7 Q. Transfer to the federal Secretary of the Treasury the following:

- 8 (1) A list of the individuals who are issued a certification under subsection P, including
9 the name and taxpayer identification number of each individual;
- 10 (2) The name and taxpayer identification number of each individual who was an
11 employee of an employer but who was determined to be eligible for the premium tax
12 credit under section 36B of the Internal Revenue Code of 1986 because:
 - 13 (a) The employer did not provide minimum essential coverage; or
 - 14 (b) The employer provided the minimum essential coverage, but it was determined
15 under section 36B(c)(2)(C) of the Internal Revenue Code to either be
16 unaffordable to the employee or not provide the required minimum actuarial
17 value; and
- 18 (3) The name and taxpayer identification number of:
 - 19 (a) Each individual who notifies the Exchange under section 1411(b)(4) of the
20 Federal Act that he or she has changed employers; and
 - 21 (b) Each individual who ceases coverage under a qualified health plan during a plan
22 year and the effective date of that cessation;

23 R. Provide to each employer the name of each employee of the employer described in
24 subsection Q(2) who ceases coverage under a qualified health plan during a plan year and
25 the effective date of the cessation;

26 S. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury
27 related to determining eligibility for premium tax credits, reduced cost-sharing or
28 individual responsibility requirement exemptions;

29 T. Develop proposals on how best to reduce unnecessary premium growth and any adverse
30 selection in the individual, small group and large group markets, and if needed to address
31 factors outside the Exchange, submit recommendations to the Department of Insurance
32 along with identification of any additional Departmental authority necessary to
33 implement the recommendations;

34 U. Credit the amount of any free choice voucher to the monthly premium of the plan in
35 which a qualified employee is enrolled, in accordance with section 10108 of the Federal
36 Act, collect the amount credited from the offering employer, and remit the amount of the
37 free choice voucher to the appropriate insurer;

38 V. Meet the following financial integrity requirements:

- 39 (1) Keep an accurate accounting of all activities, receipts and expenditures and annually
40 submit to the Secretary, the Governor, the Commissioner and the General Assembly a
41 report concerning such accountings;
- 42 (2) Fully cooperate with any investigation conducted by the Secretary pursuant to the
43 Secretary's authority under the Federal Act and allow the Secretary, in coordination
44 with the Inspector General of the U.S. Department of Health and Human Services, or
45 the Commissioner, to:
 - 46 (a) Investigate the affairs of the Exchange;

- (b) Examine the properties and records of the Exchange; and
- (c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications. For the purposes of this act, promotional giveaways shall not mean items of minimal value distributed for informational, public outreach, or other reasonable promotional purposes.

- W. Meet the requirements of this Act and the Federal Act, and any rules adopted pursuant to this Act or the Federal Act;
- X. Consider the impact that standardization of benefit designs would have on facilitating comparisons between benefit plans offered through the Exchange, facilitating meaningful choice, reducing risk segmentation and risk selection, and facilitating the success of the Exchange, and if appropriate, prescribe a variety of standardized, defined benefit plans to be offered through the Exchange;
- Y. Provide for a comprehensive publicity and outreach campaign to raise awareness of the existence of the Exchange and to disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost sharing reductions, small employer tax credits, and other relevant information; and
- Z. Establish an advisory committee to provide technical assistance concerning the operation of the Exchange, the formulation and implementation of Exchange policies or procedures, and any other function the Board deems relevant to the operations of the Exchange. The advisory committee shall consist of at least one representative of each of the following stakeholder groups:
 - (1) Insurers who sell individual health insurance policies;
 - (2) Insurers who sell small group health insurance policies;
 - (3) Agents or brokers who sell health insurance policies;
 - (4) Organizations that represent consumer interests;
 - (5) Educated health care consumers who are enrollees in qualified health plans, once these plans are available;
 - (6) Individuals and entities with experience in facilitating enrollment in qualified health plans, once these plans are available;
 - (7) Qualified employers, including small employers and self-employed individuals;
 - (8) Advocates for enrolling hard to reach populations;
 - (9) Health care professionals and provider groups;
 - (10) Essential community providers; and
 - (11) Any other representatives necessary to ensure that the Exchange receives appropriate advice and technical assistance.

Section 6A. Duties of Board

The Board shall:

- A. Employ and fix compensation of the Executive Director and other employees of the Exchange;

- 1 B. Consult with stakeholders relevant to carrying out the activities required under this Act,
2 including, but not limited to:
3 (1) Educated health care consumers who are enrollees in qualified health plans;
4 (2) Individuals and entities with experience in facilitating enrollment in qualified health
5 plans;
6 (3) Representatives of qualified employers, including small employers and self-employed
7 individuals;
8 (4) The Division of Medical Assistance;
9 (5) Advocates for enrolling hard to reach populations; and
10 (6) Health care professionals and provider groups, including essential community
11 providers.
- 12 C. Establish a process to appoint individuals with appropriate expertise, to serve on legal,
13 actuarial, or other committees as appropriate or necessary to provide technical assistance
14 in the operation of the Exchange, the formulation and implementation of Exchange
15 policies or procedures, and any other function the Board deems relevant to the operations
16 of the Exchange. These appointees may include representatives of stakeholder groups.
- 17 D. Take legal action as necessary and appropriate to:
18 (1) Recover any amounts erroneously or improperly paid by the Exchange.
19 (2) Recover any amounts paid by the Exchange as a result of mistake of fact or law.
20 (3) Recover other amounts due the Exchange.
- 21 E. Adopt bylaws, policies, and procedures as may be necessary or appropriate for the
22 implementation of this Act, the Federal Act, or the operation of the Exchange; and
- 23 F. Deliver a report annually in each of the three years following the effective date of this
24 Act, and biennially thereafter, upon the convening of the regular session of the General
25 Assembly, to the Speaker of the House of Representatives, the President Pro Tempore of
26 the Senate, the Commissioner, any appropriate legislative oversight or appropriations
27 committees. The report shall be prominently posted on the Exchange website. The
28 report shall summarize the activities of the Exchange since the last report, including the
29 enrollment of individuals in health benefit plans offered through the Exchange, the
30 movement of individuals into and out of health benefit plans offered through the
31 Exchange, the cost of operating the Exchange, comparison of premiums in and outside
32 the Exchange, and other matters relating to the operation of the Exchange, as determined
33 by the Board.

34 35 **Section 7. Health Benefit Plan Certification**

- 36
37 A. The Exchange shall certify a health benefit plan as a qualified health plan if the
38 Department of Insurance determines that it satisfies the requirements set forth in
39 subdivisions (1) through (6) of this subsection, unless the Board determines that it is not
40 in the public interest as specified in subdivision (7) of this subsection:
41 (1) The plan provides the essential health benefits package described in section 1302(a)
42 of the Federal Act, except that the plan is not required to provide essential benefits
43 that duplicate the minimum benefits of qualified dental plans, as provided in
44 subsection E, if:

- 1 (a) The Exchange has determined that at least one qualified dental plan is available to
2 supplement the plan's coverage; and
- 3 (b) The insurer makes prominent disclosure at the time it offers the plan, in a form
4 specified by the Exchange, that the plan does not provide the full range of
5 essential pediatric benefits, and that qualified dental plans providing those
6 benefits and other dental benefits not covered by the plan are offered through the
7 Exchange;
- 8 (2) The premium rates and contract language have been approved by the Commissioner,
9 and the level of coverage, as specified in section 1302(d)(1) of the Federal Act, has
10 been actuarially certified and calculated pursuant to regulations issued by the
11 Secretary under section 1302(d)(2)(A) of the Federal Act;
- 12 (3) The plan provides at least a bronze level of coverage, as specified in section
13 1302(d)(1)(a) of the Federal Act and determined pursuant to regulations issued by the
14 Secretary under section 1302(d)(2)(A) of the Federal Act, unless the plan is certified
15 as a qualified catastrophic plan, meets the requirements of the Federal Act for
16 catastrophic plans, and will only be offered to individuals eligible for catastrophic
17 coverage;
- 18 (4) The plan's cost-sharing requirements do not exceed the limits established under
19 section 1302(c)(1) of the Federal Act, and if the plan is offered to small employers,
20 the plan's deductible does not exceed the limits established under section 1302(c)(2)
21 of the Federal Act;
- 22 (5) The insurer offering the plan:
- 23 (a) Is licensed and in good standing and is authorized to offer health benefit plans in
24 this State;
- 25 (b) Offers at least one qualified health plan in the silver level and at least one plan in
26 the gold level through each component of the Exchange in which the insurer
27 participates, where "component" refers to the SHOP Exchange and the Exchange
28 for individual coverage;
- 29 (c) For each qualified health plan, charges the same premium rate without regard to
30 whether the plan is offered through the Exchange and without regard to whether
31 the plan is offered directly from the insurer or through an agent or broker;
- 32 (d) Does not charge any cancellation fees or penalties in violation of section 5C of
33 this Act; and
- 34 (e) Complies with the regulations developed by the Secretary under section 1311(d)
35 of the Federal Act and such other requirements as the Exchange may establish;
- 36 (6) The plan meets the requirements of certification as promulgated by regulation
37 pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the
38 Federal Act; and
- 39 (7) The Exchange determines that making the plan available through the Exchange is in
40 the interest of qualified individuals and qualified employers in this State, after
41 considering the factors specified in sections 2, 4B(3)(e) and 6X of this Act.
- 42 B. The Exchange shall not exclude a health benefit plan:
- 43 (1) On the basis that the plan is a fee-for-service plan;
- 44 (2) Through the imposition of premium price controls by the Exchange; or

- 1 (3) On the basis that the health benefit plan provides treatments necessary to prevent
2 patients' deaths in circumstances the Exchange determines are inappropriate or too
3 costly.
- 4 C. The Exchange shall require each insurer seeking certification of a plan as a qualified
5 health plan to:
- 6 (1) Submit a justification for any premium increase to the Department of Insurance
7 before implementation of that increase. The insurer shall prominently post the
8 information on its Internet website. The Exchange shall take this information, along
9 with the information and the recommendations provided to the Exchange by the
10 Commissioner under section 2794(b) of the PHSA related to patterns or practices of
11 excessive or unjustified premium increases, into consideration when determining
12 whether to continue to allow the insurer to make plans available through the
13 Exchange. The ability of the Exchange to consider premium increase information in
14 its certification decision does not constitute authority to regulate premiums. The
15 Commissioner has sole authority to regulate premiums and changes to premiums;
- 16 (2) (a) Make available to the public, in the format described in sub-subdivision (b) of this
17 subdivision, and submit to the Exchange, the Secretary, and the Commissioner,
18 accurate and timely disclosure of the following:
- 19 (i) Claims payment policies and practices;
20 (ii) Periodic financial disclosures;
21 (iii) Data on enrollment;
22 (iv) Data on disenrollment;
23 (v) Data on the number of claims that are denied;
24 (vi) Data on rating practices;
25 (vii) Information on cost-sharing and payments with respect to any out-of-
26 network coverage;
27 (viii) Information on enrollee and participant rights under title I of the Federal Act;
28 and
29 (ix) Other information as determined appropriate by the Secretary; and
- 30 (b) The information required in sub-subdivision (a) of this subdivision shall be
31 provided in plain language, as that term is defined in section 1311(e)(3)(B) of the
32 Federal Act; and
- 33 (3) Permit individuals to learn, in a timely manner upon the request of the individual, the
34 amount of cost-sharing, including deductibles, copayments, and coinsurance, under
35 the individual's plan or coverage that the individual would be responsible for paying
36 with respect to the furnishing of a specific item or service by a participating provider.
37 At a minimum, this information shall be made available to the individual through an
38 Internet website and through other means for individuals without access to the
39 Internet.
- 40 D. The Exchange shall not exempt any insurer seeking certification of a qualified health
41 plan, regardless of the type or size of the insurer, from State licensure or solvency
42 requirements and shall apply the criteria of this section in a manner that assures a level
43 playing field between or among insurers participating in the Exchange.
- 44 E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply
45 to the extent relevant to qualified dental plans except as modified in accordance with

1 the provisions of subdivisions (2), (3) and (4) of this subsection or by regulations
2 adopted by the Commissioner;

3 (2) The insurer shall be licensed to offer dental coverage, but need not be licensed to
4 offer other health benefits;

5 (3) The plan shall be limited to dental and oral health benefits, without substantially
6 duplicating the benefits typically offered by health benefit plans without dental
7 coverage and shall include, at a minimum, the essential pediatric dental benefits
8 prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and
9 such other dental benefits as the Exchange or the Secretary may specify by
10 regulation; and

11 (4) Insurers may jointly offer a comprehensive plan through the Exchange in which the
12 dental benefits are provided by an insurer through a qualified dental plan and the
13 other benefits are provided by an insurer through a qualified health plan, provided
14 that the plans are priced separately and are also made available for purchase
15 separately at the same price.

16 F. In accordance with section 1312(b) of the Federal Act, a qualified individual enrolled in
17 any qualified health plan may pay any applicable premium owed by the individual to the
18 insurer issuing the qualified health plan.

19
20 **Section 8. Funding; Publication of Costs; Audit; Taxation**

21
22 A. Beginning in 2014, the funding stream that supports the North Carolina Health Insurance
23 Risk Pool shall be made available to the Exchange to support the operations of the
24 Exchange in 2015 and subsequent years. The Exchange shall examine its operational
25 costs and propose to the Department of Insurance any additional changes to the funding
26 stream necessary to ensure its solvency.

27 (1) The Exchange, in consultation with the Department of Insurance, may charge
28 assessments or user fees on insurers, individuals, and employers participating in the
29 Exchange, to support its operations.

30 (2) The Department of Insurance, in consultation with the Exchange, may charge
31 assessments or user fees to insurers necessary to support the reasonable operations of
32 the Exchange provided under this Act. In establishing charges or assessments, the
33 Department of Insurance may consider any other user fees or assessment established
34 in subdivision (1) of this subsection.

35 (3) Any assessment or user fee shall be limited to the amount that is reasonable and
36 necessary to support the development, operations, and prudent cash management of
37 the Exchange, less funding from other sources. This assessment or user fee shall not
38 affect the requirement under section 1301 of the Federal Act that insurers charge the
39 same premium rate for each qualified health plan whether offered inside or outside
40 the Exchange..

41 B. The Exchange shall publish the average costs of taxes, assessments, licensing, regulatory
42 fees and any other payments required to finance the Exchange, and the administrative
43 costs of the Exchange, on an Internet website to educate consumers on such costs. This
44 information shall include information on monies lost to waste, fraud and abuse.

45 C. An audit of the Exchange shall be conducted annually under the oversight of the State
46 Auditor.

- 1 D. The Exchange is exempt from any and all State taxes.
2 E. Taxes, fees, or assessments required to be paid by a health carrier to finance the
3 Exchange shall be considered a state tax or assessment as defined in section 2718(a) of
4 the PHSA and its implementing regulations, and must be excluded from health plan
5 administrative costs for the purpose of calculating medical loss ratios or rebates as
6 defined in Section 2794 of the law.
7

8 **Section 9. Regulations**
9

10 The Board and the Commissioner may adopt rules pursuant to Chapter 150B of the General
11 Statutes, including temporary rules, to implement the provisions of this Act. Rules adopted by
12 the Board under this section shall not conflict with or prevent the application of rules adopted by
13 the Commissioner under this Act or under Chapter 58 of the General Statutes.
14

15 **Section 10. Relation to Other Laws**
16

17 Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed
18 to limit, preempt or supersede the authority of the Commissioner to regulate the business of
19 insurance within this State. Except as expressly provided to the contrary by federal law, all
20 insurers offering qualified health plans in this State shall comply fully with all applicable
21 insurance laws of this State and regulations adopted and orders issued by the Commissioner.
22

23 **Section 11. Exchange Studies and Recommendations**

24 *Uncodified provisions for inclusion in Act when introduced in bill format:*
25

26 The Exchange shall:
27

- 28 A. Study and make recommendations to the 2013 regular session of the 2013 General
29 Assembly regarding the Board operation of a fund for administrative expenses. The study
30 shall address potential operations costs and related issues.
31 B. Study and make recommendations to the Department of Insurance as to whether large
32 employers should be offered coverage through the Exchange in or after 2017. For the
33 purposes of this section, large employer means an employer who employed an average of
34 at least 101 employees on business days during the preceding calendar year and who
35 employs at least 1 employee on the first day of the plan year.
36 C. Collaborate with the Department of Insurance to study costs associated with the provision
37 of mandated coverage, following publication of the contents of the essential health
38 benefits package by the Secretary. The Exchange shall report the results of the study and
39 any recommendations to the General Assembly prior to the convening of the 2012
40 session of the 2011 General Assembly
41

42 **Section 12. Risk Adjustment; Reinsurance; Reporting**
43

44 Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections
45 to read:
46

1 **“58-3-300. Reinsurance and risk adjustment for qualified health plans.**

2 (a) Transitional reinsurance program for individual market. – No later than January 1, 2014,
3 the Commissioner shall establish, and continue to maintain, a program of reinsurance as
4 specified in Section 1341 of the federal Patient and Protection and Affordable Care Act (Public
5 Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-
6 152) for the individual market, as defined in G.S. 58-68-25(a)(9). The program of reinsurance
7 established pursuant to this subsection may be based upon the model regulation developed by the
8 Secretary of the United States Department of Health and Human Services.

9 (b) Risk adjustment. – Using the criteria and methods developed under Section 1343(b) of
10 the federal Patient and Protection and Affordable Care Act (Public Law 111-148) and the Health
11 Care and Education Reconciliation Act of 2010 (Public Law 111-152), the Commissioner shall
12 assess a charge on health plans and health insurers or make a payment to health plans and health
13 insurers depending upon whether the actuarial risk of the enrollees of the plans or coverage for a
14 year is more or less than the average actuarial risk of all enrollees in all plans or covered in the
15 State for that year that are not self-insured groups health plans (which are subject to the
16 provisions of the Employee Retirement Income Security Act of 1974). The risk adjustment
17 methodology may be based upon the model developed by the Secretary of the United States
18 Department of Health and Human Services.

19 (c) The Commissioner may adopt rules as necessary or appropriate to implement the
20 provisions of this section.

21 **“58-3-305. Transparency in health insurance coverage.**

22 (a) Insurers, as defined in the North Carolina Health Benefit Exchange Act, providing
23 coverage under a health benefit plan in the individual or group markets, as the terms are defined
24 in G.S. 58-68-25(a)(4c) and G.S. 58-68-25(a)(9), respectively, shall comply with the provisions
25 of section 1311(e)(3) of the federal Patient and Protection and Affordable Care Act (Public Law
26 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152),
27 except that a plan or coverage that is not offered through the Exchange, as established under the
28 North Carolina Health Benefit Exchange Act, shall only be required to submit the information
29 required to the Secretary of the United States Department of Health and Human Services and the
30 Commissioner and make such information public.”

31

32 **Section 13. Effective Date**

33

34 This Act shall be effective [insert date].

35

36 W:\Drafts\Model Laws, Regulations & Guidelines\New – American Health Benefit Exchange Model Act\Health Benefit Exchanges4
37 cleanadopted.doc

38

39

40

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PREVENTION**

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PREVENTION
PROVISIONS

Maternal, infant and early childhood home visiting program

Sec. 2951. Maternal, infant, and early childhood home visiting programs.

Postpartum depression

Sec. 2952. Support, education and research for postpartum depression.

Personal responsibility and abstinence education

Sec. 2953. Personal responsibility education.

AIDS drug assistance

Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.

Prevention and Public Health Fund

Sec. 4002. Prevention and Public Health Fund.

Clinical and community preventive services

Sec. 4003. Clinical and community preventive services.

Outreach and education efforts

Sec. 4004. Education and outreach campaign regarding preventive benefits.

Dental caries disease management

Sec. 4102. Oral health care prevention activities.

Medicaid

Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.

Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.

Healthy lifestyle initiatives

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.

Community transformation grants

Sec. 4201, 10403. Community transformation grants.

Healthy Aging grants

Sec. 4202. Healthy aging, living well.

Increasing child and adult immunizations

Sec. 4204. Immunizations.

Nutrition labeling

Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.

Individualized wellness plans

Sec. 4206. Demonstration project concerning individualized wellness plan.

Research for public health service delivery

Sec. 4301. Research on optimizing the delivery of public health services.

Understanding health disparities

Sec. 4302. Understanding health disparities; data collection and analysis.

CDC and employer-based wellness

Sec. 4303. CDC and employer-based wellness programs.

Epidemiology laboratory grants

Sec. 4304. Epidemiology-Laboratory Capacity Grants.

CHIPRA childhood obesity grants

Sec. 4306. Funding for Childhood Obesity Demonstration Project.

Eliminating Commissioned Corps cap

Sec. 5209. Elimination of cap on the Commissioned Corps.

Establishing Ready Reserve Corps

Sec. 5210. Establishing a Ready Reserve Corps.

Support for pregnant and parenting teens and women

Sec. 10211-10212. Definitions; Establishment of pregnancy assistance fund.

Sec. 10213-10214. Permissible uses of Fund; Appropriations.

Environmental health hazards

Sec. 10323. Medicare coverage for individuals exposed to environment health hazards.

Diabetes grants for diabetes prevention

Sec. 10407. Better diabetes care.

Sec. 10501(g). National diabetes prevention program.

Worksite wellness

Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.

Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.

Centers of Excellence for Depression

Sec. 10410. Centers of Excellence for Depression.

Congenital heart surveillance system

Sec. 10411. Programs relating to congenital heart disease.

Sec. 10412. Automated Defibrillation in Adam's Memory Act.

Young women's breast health awareness and support

Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.

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HEALTH PROFESSIONAL WORKFORCE
PROVISIONS

Quality Improvement and Patient Safety

Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.

Patient Navigators

Sec. 3510. Patient navigator program.

State Workforce Development Grants

Sec. 5102. State health care workforce development grants.

State and Regional Workforce Development Centers

Sec. 5103. Health care workforce assessment.

Federally Supported Student Loans

Sec. 5201. Federally supported student loan funds.

Sec. 10501. Amendments to Title V. (d) Loan repayment for faculty at schools that train physician assistants.

Nursing Workforce

Sec. 5202. Nursing student loan program.

Sec. 5308. Advanced nursing education grants.

Sec. 5309. Nurse education, practice, and retention grants.

Sec. 5310. Loan repayment and scholarship program.

Sec. 5311. Nurse faculty loan program.

Sec. 5312. Authorization of appropriations for parts B through D of title VIII.

Sec. 5404. Workforce diversity grants.

Pediatric Special Loan Repayment

Sec. 5203. Health care workforce loan repayment programs.

Public Health Workforce Loan Repayment Program

Sec. 5204. Public health workforce recruitment and retention programs.

Allied Health Loan Repayment

Sec. 5205. Allied health workforce recruitment and retention programs.

Mid-Career Public and Allied Health Professionals

Sec. 5206. Grants for State and local programs.

National Health Service Corp

Sec. 5207, 10501. Funding for National Health Service Corps.

Primary Care Grants to Schools

Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and

physician assistantship.

Direct Care Workforce

Sec. 5302. Training opportunities for direct care workers.

Dentistry

Sec. 5303. Training in general, pediatric, and public health dentistry.

Sec. 5304. Alternative dental health care providers demonstration project.

Geriatric Education

Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education

Mental and Behavioral Health Grants to Schools

Sec. 5306. Mental and behavioral health education and training grants.

Cultural Competence

Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.

Public Health

Sec. 5313. Grants to promote the community health workforce.

Sec. 5314. Fellowship training in public health.

Public Health Sciences Track

Sec. 5315. United States Public Health Sciences Track.

Family Nurse Practitioner Grants

Sec. 5316, 10501. Demonstration grants for family nurse practitioner training programs

Under-Represented Minorities

Sec. 5401. Centers of excellence.

Sec. 5402. Health care professionals training for diversity.

Interdisciplinary Community Based Linkages

Sec. 5403. Interdisciplinary, community-based linkages.

Primary Care Extension Grants

Sec. 5405. Primary care extension program.

Access to Primary Care and Surgery

Sec. 5501, 10501. Expanding access to primary care services and general surgery services.

Graduate Medical Education

Sec. 5503. Distribution of additional residency positions.

Sec. 5504. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.

Sec. 5505. Rules for counting resident time for didactic and scholarly activities and other

activities.

Sec. 5506. Preservation of resident cap positions from closed hospitals.

Low-Income Individuals Opportunities for Education, Training

Sec. 5507. Demonstration projects to address health professions workforce needs; extension of family-to-family health information centers.

Primary Care Residencies in Teaching Health Centers (FQHCs)

Sec. 5508. Increasing teaching capacity.

Graduate Nurse Education

Sec. 5509. Graduate nurse education demonstration.

Rural Physician Training Grants

Sec. 5606, 10501. State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.

Dementia and Abuse Prevention Training

Sec. 6121. Dementia and abuse prevention training.

Exclusion for Assistance Provided to Participants in State Student Loan Repayment Programs for Certain Health Professionals

Sec. 9024, 10908.

Preventive Medicine and Public Health Residency Programs

Sec. 10501 (m)(1). Preventive medicine and public health training grant program.

Community College and Career Training Grant Program

Sec. 1501 of Reconciliation. TAA for communities.

**APPENDIX G
SAFETY NET**

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SAFETY NET
PROVISIONS

Qualified health plans

Sec. 1302. Payments to Federally Qualified Health Centers.

Consumer choices and insurance competition through Health Benefit Exchanges

Sec. 1311. Requirement of Federally Qualified Health Centers to contract with essential community providers (if they are willing to accept generally accepted payment rates).

Trauma centers and emergency care coordination

Sec. 3504. Design and implementation of regionalized systems for emergency care.

Sec. 3505. Trauma care centers and service availability.

School-based health centers

Sec. 4101, 10402. School-based health centers.

National Health Service Corp funding

Sec. 5207, 10501. Funding for National Health Service Corps.

Nurse-managed health clinics

Sec. 5208. Nurse-Managed health clinics.

Federally qualified health centers

Sec. 4206. Demonstration project concerning individualized wellness plan.

Sec. 5508. Increasing teaching capacity in primary care residencies in teaching health centers (FQHCs).

Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).

Medically underserved areas and health professions shortage areas

Sec. 5602. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.

Wakefield Emergency Medical Services for Children program

Sec. 5603. Reauthorization of Wakefield Emergency Medical Services for Children Program.

Health care provider grants

Sec. 5606. State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.

340B discount drug program

Sec. 7101. Expanded participation in 340B program.
Sec. 2302 of Reconciliation. Drugs purchased by covered entities.

New requirements for charitable hospitals

Sec. 9007. Additional requirements for charitable hospitals.
Sec. 10903. Modification of limitation on charges by charitable hospitals

Community-based collaborative networks of care

Sec. 10333. Community-based collaborative care networks.

Infrastructure to expand access to care

Sec. 10502. Infrastructure to expand access to care.

Community Health Centers expansion funding

Sec. 10503. Community Health Centers and the National Health Service Corps Fund.
Sec. 2303 of Reconciliation. Community Health Centers.

Demonstration project to improve access

Sec. 10504. Demonstration project to provide access to affordable care.

Extension of malpractice coverage to free clinics

Sec. 10608. Extension of medical malpractice coverage to free clinics.

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QUALITY**

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QUALITY
PROVISIONS

Reporting requirements

Sec. 1001, 2717, 10101. Amendments to the Public Health Service Act. Ensuring quality of care.
Sec. 10329. Developing methodology to assess health plan value.

Affordable choices of health benefit plans – rating systems and rewarding of quality

Sec. 1311: Rating systems, rewarding quality through market incentives, quality improvement

State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.

Sec. 1331, Performance measures

Medicaid quality measures

Sec. 2701. Adult health quality measures.
Sec. 2702. Payment adjustment for health-care acquired conditions.

Hospital-based incentive payments under Medicare

Sec. 3001, 10335. Hospital value-based purchasing program.
Sec. 3004, 10322. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs.
Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
Sec. 3008. Payment adjustment for conditions acquired in hospitals.

Medicare physician reporting

Sec. 3002, 10327. Improvements to the physician quality reporting initiative.
Sec. 3003. Improvements to the physician feedback program.
Sec. 3007. Value-based payment modifier under the physician fee schedule.
Sec. 10331. Public reporting of performance information.

Quality measures for skilled nursing facilities

Sec. 3006, 10301. Plans for a value-based purchasing program for skilled nursing facilities and home health agencies.

Review responsibilities of Interagency Working Group on Health Quality

Sec. 3011, 10302. National strategy.
Sec. 3012. Interagency Working Group on Health Care Quality.

Development of quality measures

Sec. 3013, 10303. Quality measure development.

Sec. 3014, 10304. Quality measurement.

Collection, reporting of quality data

Sec. 3015, 10305. Data Collection; Public Reporting.

Hospital readmission reduction program

Sec. 3025, 10309. Hospital readmission reduction program.

AHRQ funding for patient safety

Sec. 3501. Health care delivery system research; Quality improvement technical assistance.

Health Care Quality Improvements

Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.

Pain management

Sec. 4305. Advancing research and treatment for pain care management.

Targeting enforcement

Sec 6112. National independent monitor demonstration project

Patient-centered outcomes research

Sec. 6301, 10602. Patient-Centered Outcomes Research.

Pilot testing pay-for-performance programs for certain Medicare providers

Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.

Data availability for performance measurement under Medicare

Sec. 10332. Availability of Medicare data for performance measurement.

ONGOING EFFORTS TO IMPROVE QUALITY

Quality Initiatives

Organization	Initiatives	Provider or transition target
AHEC	Improving Performance in Practice	Primary care
AHEC	Regional Extension Center	Primary care
American College of Cardiology	Hospital to Home	Transition from inpatient to outpatient care
American Hospital Association	CLABSI reduction (Central line associated blood stream infections)	Hospitals
BCBS	Blue Quality Physician Program	Primary care
Carol Woods, Chapel Hill, NC	Continuity of Care Coalition	Older adults: identifying unmet needs
Carol Woods, Chapel Hill, NC	Community Connections for Seniors	Older adults: community based services
Carol Woods, Chapel Hill, NC	National Transition of Care Coalition	Transitions for elderly adults
Carolinas Center for Medical Excellence (CCME)		Quality and cost-effectiveness of services
CCNC	646 waiver	Transitions for high-risk Medicare and dual-eligible (Medicaid/Medicare) patients
CCNC	NC Community Care Networks - Informatics	Transitions for Medicaid patients
CCNC	Physician Incentive Program	Primary care
Community Connections for Seniors	Chatham-Orange Community Resource Connections for Aging and Disabilities	Resources for seniors and disabled residents for staying safely at home
Community Connections for Seniors	Person-Centered Hospital Discharge Planning Model	Hospital to home
FutureCare of NC	Skilled nursing facility initiatives	Skilled nursing facilities
NC Center for Hospital Quality and Patient Safety	NC Prevent CAUTI (catheter-associated urinary tract infections)	Hospitals
NC Center for Hospital Quality and Patient Safety	Surgical Care Improvement Project	Hospitals
NC Center for Pharmaceutical Care	The Asheville Project	Pharmacist partnerships with other health care providers
NC Community Care Networks	CCNC	Primary care

(NCCCN) NC Office of Rural Health and Community Care		
NC Division of Medical Assistance	Children's Health Insurance Reauthorization Act	Transitions and medical homes for children with special health care needs
NC Foundation for Advanced Health Programs	ICare	Physical and mental health care integration
NC Health Care Facilities Association	Family Resource Center	Skilled nursing facilities
NC Health Care Facilities Association	Journey to National Best	Skilled nursing facilities
NC Hospital Association	NC Center for Hospital Quality and Patient Safety	Hospitals
NC Medical Society Foundation	NC Physician Institute for Quality Enhancement	Specialty care physicians, especially orthopedists
NC Office of Emergency Medical Services	Emergency Medical Services Performance Improvement Center (EMS Toolkits)	Emergency Medical Services
NC Office of Emergency Medical Services	Trauma Center designation program	Transitions between community hospitals and trauma centers. Quality improvement within trauma centers.
NC Public Health Foundation	NC Center for Public Health Quality	Quality initiative training and support
Novant Health	Quality and Safety	Hospitals

**APPENDIX I
NEW MODELS OF CARE**

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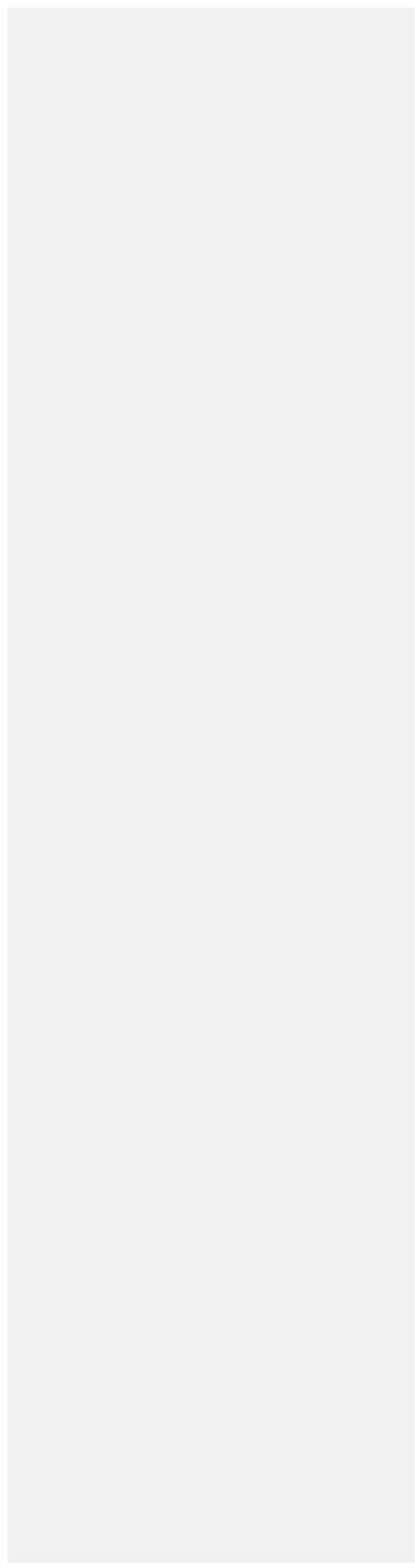
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NEW MODEL OF CARE
PROVISIONS

Improved coordination for dual eligible beneficiaries

Sec. 2601. 5-year period for demonstration projects.

Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.

Health homes for people with chronic illness

Sec. 2703. State option to provide health homes for enrollees with chronic conditions.

Payment bundling

Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.

Sec. 3023. National pilot program on payment bundling.

Sec. 10308. Revisions to national pilot program on payment bundling.

Global Payment system demonstration project

Sec. 2705. Medicaid global payment system demonstration project.

Accountable care organizations

Sec. 2706. Pediatric Accountable Care Organization Demonstration Project.

Sec. 3022. Medicare shared savings program.

Sec. 10307. Improvements to the Medicare shared savings program.

Emergency psychiatric demonstration project

Sec. 2707. Medicaid emergency psychiatric demonstration project.

Center for Medicare and Medicaid Innovation

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.

Sec. 10306. Improvements under the Center for Medicare and Medicaid Innovation.

Independence at Home program

Sec. 3024. Independence at home demonstration program.

Community-based transitions programs

Sec. 3026. Community-Based Care Transitions Program.

Hospice

Sec. 3140. Medicare hospice concurrent care demonstration program.

Community-based interprofessional health teams

Sec. 3502. Establishing community health teams to support the patient-centered medical home.

Sec. 10321. Revision to community health teams.

Medication management

Sec. 3503. Medication management services in treatment of chronic disease.

Sec. 10328. Improvement in part D medication therapy management (MTM) programs.

Shared decision making

Sec. 3506. Program to facilitate shared decision making.

Healthy lifestyle initiatives

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.

Co-location of primary and specialty care in community-based mental health settings

Sec. 5604. Co-locating primary and specialty care in community-based mental health settings.

Nursing homes

Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes.

Medical malpractice

Sec. 6801. Sense of the Senate regarding medical malpractice.

Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation.

Environmental health hazards

Sec. 10323. Medicare coverage for individuals exposed to environment health hazards.

FYI only

Sec. 3123, 10313. Extension of the Rural Community Hospital Demonstration Program.

Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.

DESCRIPTION OF SELECTED ACA NEW MODEL OF CARE PROVISIONS AND SIMILAR INITIATIVES UNDERWAY IN NORTH CAROLINA

The ACA includes funding to test new models of delivering and financing health services, with the goal of improving quality, patient outcomes, and reduce the costs of health services. The ACA included \$5 million in 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 (CMMI), within the Center for Medicare and Medicaid Services (CMS). (Sec. 3021) All CMMI 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 thematic groupings, 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:** 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, and patient and family support. Note: This is a state option, not a demonstration program, specific to Medicaid. States who agree to the terms are eligible for a 90% match for payments to health homes for eight fiscal year (FY) quarters beginning January 1, 2011. The total amount of payments made to states shall not exceed \$25M. (Sec. 2703)
- **Primary care payment and practice reform:** This CMMI 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. (Sec.

3021(b)(2)(B)(i))

- **Optimal use of health professional credentials:** This CMMI 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. (Sec. 3021(b)(2)(B)(xvii))
- **Community-based interdisciplinary, interprofessional health teams to support patient-centered medical homes:** 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. (Sec. 3502, 10321)

North Carolina Initiatives

- **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 it relates to patients with chronic or complex health problems. The program is funded through the Office of the Secretary and DMA, within NCDHHS, and the North Carolina Foundation for Advanced Health Programs, Inc. The Office of Research, Demonstrations and Rural Health Development provide technical assistance. CCNC is a community-based approach that involves primary care providers, safety net organizations, hospitals, social services, local health departments, and other community agencies in managing the care of a group of Medicaid patients. There are 14 regional community health networks across North Carolina providing services to over one million Medicaid and NC Health Choice beneficiaries. Providers in the network are responsible for their own performance and receive a per-member-per-month (PMPM) payment from the State. CCNC also offers clinical improvement initiatives including specific disease management programs (e.g. 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.²⁷⁸

²⁷⁸ Overview. Community Care of North Carolina Web site. www.communitycarenc.com. Accessed February 1, 2011.

Contact: Torlen Wade, Executive Director, NC-CCN, Inc., twade@n3cn.org; Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

- **CCNC Pregnancy Home**

CCNC's Pregnancy Home initiative aims to improve the quality of perinatal care increasing positive birth outcomes and reducing Medicaid expenditures. The initiative is modeled after CCNC's primary care case management program. Pregnant women on Medicaid who meet certain eligibility requirements are assigned a case manager. The case manager coordinates care between the provider and the patient. Medicaid providers are eligible to become a Pregnancy Home if they ensure there are no elective deliveries before 39 weeks, engage in the 17P project, decrease caesarian section rates in women having their first child, perform high-risk screening on all initial visits, integrate care with case manager, and are subject to open chart audits. All Medicaid providers that bill for pregnancy procedures are eligible to become a Pregnancy Home, not only obstetricians. Participating providers receive incentives such as exemption from prior approval for ultrasounds, a \$50 payment for each high-risk screen, a \$150 payment for each post-partum visit, and an increased reimbursement rate for a vaginal delivery.²⁷⁹

Contact: Debbie Pittard, PMP. NC Division of Medical Assistance.
Debbie.Pittard@dhhs.nc.gov.

- **North Carolina Community Care Networks' (NC-CCN) 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 beneficiaries. NC-CCN is one of two organizations currently receiving funding to test new models to achieve these goals. Eight of the 14 networks in NC-CCN are participating in the demonstration, which began on January 1, 2010, and will end on May 31, 2014. NC-CCN 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.^{280,281}

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,

²⁷⁹ Pregnancy home. North Carolina Department of Health and Human Services Web site. www.ncdhhs.gov/dma/services/pmh.htm. Updated February 8, 2011. Accessed February 8, 2011.

²⁸⁰ Centers for Medicare and Medicaid Services. Medicare Health Care Quality Demonstration Programs, fact sheet. https://www.cms.gov/DemoProjectsEvalRpts/downloads/MMA646_FactSheet.pdf. Accessed February 1, 2011.

²⁸¹ Centers for Medicare and Medicaid Services. Medicare Health Care Quality Demonstration Programs, North Carolina Community Care Networks fact sheet. http://www.cms.gov/DemoProjectsEvalRpts/downloads/MMA646_NC_CCN_Fact_Sheet.pdf. Accessed February, 2011.

Pitt, Sampson, Stanly, Union, and Yancey.²⁸²

Contact: Angela Floyd, NC-CCN, 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.²⁸³

One component of this demonstration grant aims to improve the quality of care through strengthening the medical home for Children with Special Health Care Needs (CSHCN), especially those with developmental, behavioral and/or mental health disorders. Three pilots, each with two to four practices, will evaluate coordination among primary care medical homes, subspecialists, local health departments, Children's Developmental Service Agencies (CDSA), local management entities, and community mental health providers. Systems of communication, including standardized referral and feedback, will be combined with collaboration among practices and co-management with assistance from case managers. The primary care medical homes will build relationships with subspecialists, local health departments, and families to develop care plans. ICARE and Assuring Better Child Development Services (ABCD) will supply training and assistance to participating practices.²⁸⁴

Contact: [Stacy](#) Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- **BCBSNC and UNC-CH Medical Home**

Blue Cross and Blue Shield of North Carolina (BCBSNC), in partnership with the University of North Carolina-Chapel Hill, are in the early stages of designing a PCMH facility which will be located in either Durham or Orange County. The facility is part of a three-year pilot program beginning late this year when the facility opens. The home will serve 5,000 BCBSNC patients with a focus on the chronic care population. The facility will include 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.²⁸⁵

Contact: Don Bradley, MD, Senior Vice President and Chief Medical Officer, BCBSNC, don.bradley@bcbsnc.com.

²⁸² Hewson DL. North Carolina's 646 quality demonstration. Presentation to the National Academy for State Health Policy's 23rd Annual State Health Policy Conference; October 5, 2010; New Orleans, LA.

²⁸³ Chris Collins, MSW, electronic communication, January 19, 2011.

²⁸⁴ Elizabeth Walker Kasper, MSPH, electronic communication, February 7, 2011.

²⁸⁵ Troy Arnold, presentation to the New Models of Care workgroup, January 23, 2011.

TRANSITIONS OF CARE

Summary of ACA Provisions

- **Community-based care transitions program:** The ACA appropriated \$500 million (FFY 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 will focus on high-risk traditional fee-for-service Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions. This demonstration begins on January 1, 2011. (Sec. 3026)

North Carolina Initiatives

- **NC-CCN's 646 Demonstration**
NC-CCN, 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.²⁸⁶

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

Description of ACA Provisions

- **Medicaid global payment system demonstration project:** The Secretary, in conjunction with the newly established CMMI, 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. CMMI will test and evaluate patient outcomes and costs resulting from this model. Funds for this project have been authorized but not appropriated. (Sec. 2705)
- **Pediatric ACO demonstration in Medicaid:** 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. (Sec. 2706)
- **Medicare shared savings program:** 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. (Sec. 3022, 10307)

²⁸⁶ Hewson DL. North Carolina's 646 quality demonstration. Presentation to the National Academy for State Health Policy's 23rd Annual State Health Policy Conference; October 5, 2010; New Orleans, LA.

North Carolina Initiatives

- **NC-CCN 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.²⁸⁷

- **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 ten 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 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.^{288,289}

²⁸⁷ Centers for Medicare and Medicaid Services. Medicare Health Care Quality Demonstration Programs, North Carolina Community Care Networks fact sheet. http://www.cms.gov/DemoProjectsEvalRpts/downloads/MMA646_NC_CCN_Fact_Sheet.pdf. Accessed February , 2011.

²⁸⁸ Centers for Medicare and Medicaid Services. Medicare Physician Group Practice Demonstration. www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf. Published December 2010. Accessed February 1, 2011.

²⁸⁹ Nan Holland, RN, MPH, CPHRM, electronic communication, February 9, 2011.

Currently, the CMS is allowing ACOs to apply for participation in this demonstration until the Medicaid Shared Savings Program begins on January 1, 2012.²⁹⁰

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 non-profit 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 two PACE models in North Carolina: Elderhaus, Inc. in Wilmington and Piedmont Health SeniorCare in Burlington. LIFE (Living Independently For Seniors) St. Joseph of the Pines in Fayetteville and PACE of the Triad in Greensboro will open in early 2011. Other PACE models are in development in Greensboro, Durham, Hickory, Statesville, Greenville, and Asheville.

Both current PACE models in North Carolina have seen a majority of patients improve or maintain performance in activities of daily living and cognitive functions. Neither site has had a hospital readmission as of November 2010.^{291,292}

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ALL-PAYER PAYMENT REFORM

Description of ACA Provisions

- **Allowing states to test and evaluate systems of all-payer payment reform:** 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 CMMI. (Sec. 3021(b)(2)(B)(xi))

²⁹⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, §3022.

²⁹¹ Program of All-Inclusive Care for the Elderly. North Carolina Department of Health and Human Services Web site. www.ncdhhs.gov/dma/services/pace.htm. Updated September 21, 2010. Accessed February 1, 2011.

²⁹² Michael Howard, electronic communication, February 1, 2011.

North Carolina Initiatives

- **NC Multi-payer Demonstration in Seven Rural Counties**

North Carolina was one of the first eight states awarded a demonstration grant under the new CMMI. 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 Watuga) 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.²⁹³ 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, NC-CCN, 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:** 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. (Sec. 5604)

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 the DMA have recently created new coding to help sustain and expand this model.²⁹⁴

²⁹³ North Carolina gets "go ahead" for innovative public-private partnership to improve health care in rural communities [news release]. North Carolina Department of Health and Human Services; November 17, 2010. www.ncdhhs.gov/pressrel/2010/2010-11-17-ruralhealth.htm. Accessed February 1, 2011.

²⁹⁴ Torlen Wade, electronic communication, January 31, 2011.

Contact: Torlen Wade, Executive Director, NC-CCN, Inc., , twade@n3cn.org.

- **Foundation for Advanced Health Program's Center of Excellence for Integrated Care**
The North Carolina Foundation for Advanced Health Programs was funded by the NC Health and Wellness Trust Fund and DMA to create a Center of Excellence for Integrated Care. The Center builds upon the ICARE partnership program (Integrated, Collaborative, Accessible, Respectful and Evidence-based care project), which worked to improve patient outcomes through integrating mental health and substance abuse services, and primary medical care. The new Center of Excellence builds on that work by providing training and technical assistance to Medicaid providers to help them implement integrated care tools and techniques to better serve patients with mental health conditions and combined mental health and medical conditions. The Center of Excellence's work is focused on integrating care in hospital emergency departments, integrating medical screening into LME and Critical Access Behavioral Health Agencies, training targeted case managers in integrated care techniques, and integrating care in primary care practices that serve Medicaid patients but are not enrolled in CCNC.

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COORDINATION OF DUAL ELIGIBLES

Description of ACA Provisions

- **Integrated care for dual eligibles:** Allowing states to test and evaluate fully integrating care for dual eligible individuals, including management and oversight of all funds with respect to these individuals. This demonstration is a part of the CMMI. (Sec. 3021(b)(2)(B)(x))

North Carolina initiatives:

- **NC-CCN 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 NC-CCN to fund centralized clinical leadership and the Informatics Center.^{295,296} For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

²⁹⁵ Chris Collins, MSW, electronic communication, February 3, 2011.

²⁹⁶ Denise Levis Hewson, RN, BSN, MSPH, electronic communication, February 4, 2011.

- **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.²⁹⁷ 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:** This demonstration, which is a part of the CMMI, 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. (Sec. 3021(b)(2)(B)(vii))
- **Medication management for people with multiple medications and/or chronic diseases:** 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. (Sec. 3503, 10328)

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. The program is funded by the Health and Wellness Trust Fund, which has invested \$2 million over three years. It is currently scheduled to expire June 2011. The program has saved an estimated \$34 million since its launch.^{298,299,300}

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²⁹⁷ Program of All-Inclusive Care for the Elderly. North Carolina Department of Health and Human Services Web site. www.ncdhhs.gov/dma/services/pace.htm. Updated September 21, 2010. Accessed February 1, 2011.

²⁹⁸ Tracy Linton, electronic communication, January 18, 2011.

²⁹⁹ Programs: ChecKmeds NC. North Carolina Health and Wellness Trust Fund Web site. www.healthwellnc.com/ChecKmedsNC.aspx. Accessed February 1, 2011.

³⁰⁰ Gina Upchurch, RPh, MPH, electronic communication, February 1, 2011.

- **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, community referral and advocacy.” This program assists seniors in Durham with medication management, medication access, health insurance counseling, and tailored health education and community referral that helps seniors remain in their homes. The non-profit program is funded through private donations and government contracts.

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 hospitalizations and a 27% reduction in emergency department use. A report on monetary savings as a result from the program helping select Medicare Part D plans last year has recently been accepted for publication in the Journal of the American Geriatrics Society.

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.^{301, 302}

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- **CCNC Pharmacy Management Initiative: The Pharmacy Home Project**

The Pharmacy Home uses 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. Identifying these potential events allows the patient’s providers to intervene before the events occur. This intervention reduces hospitalizations and re-hospitalizations.³⁰³

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GERIATRIC CARE

Description of ACA Provisions

- **Geriatric assessments and care plans:** This CMMI initiative will test the use of geriatric assessments and care plans to coordinate care to people with multiple chronic conditions and an inability to perform two or more activities of daily living or cognitive impairment. (Sec.

³⁰¹ About us. Senior PharmAssist Web site. www.seniorpharmassist.org. Accessed February 1, 2011.

³⁰² Gina Upchurch, RPh, MPH, electronic communication, January 17, 2011.

³⁰³ Troy Trygstad, PharmD, MBA, PhD, electronic communication, January 25, 2011.

3021(b)(2)(B)(iii))

- **Independence at home demonstration program:** 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. (Sec. 3024)

North Carolina Initiatives

- **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.^{304,305} 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.³⁰⁶

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- **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.³⁰⁷

³⁰⁴ Yaggy SD, Michener JD, Yaggy D, et. al. Just for Us: an academic medical center-community partnership to maintain the health of a frail low-income senior population. *Gerontologist*. 2006;46(2):271-276.

³⁰⁵ Frederick S. Johnson, MBA, electronic communication, February 4, 2011.

³⁰⁶ Just for Us, providing medical care to Durham's older adults. Duke University Medical Center, Division of Community Health Web site. communityhealth.mc.duke.edu/clinical/?justforus. Accessed February 1, 2011.

³⁰⁷ Denise Levis Hewson, RN, BSN, MSPH, electronic communication, February 4, 2011.

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TELEHEALTH/TELEMONITORING AND HEALTH INFORMATION TECHNOLOGY

Description of ACA Provisions

- **Supporting care coordination of chronically-ill individuals with health information technology:** CMMI is authorized to test care coordination for chronically-ill individuals at high risk of hospitalization through health information technology-enabled provider network that includes care coordinators, chronic disease registry, and home telehealth technology. (Sec. 3021(b)(2)(B)(v))
- **Facilitate inpatient care of hospitalized individuals:** CMMI 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. (Sec. 3021(b)(2)(B)(xvi))
- **Using telehealth services in medically underserved areas and facilities of the Indian Health Service:** Another potential initiative of CMMI will be to use telehealth to treat behavioral health issues, stroke, and improve the capacity of non-medical providers to provide health services for people with chronic complex conditions. (Sec. 3021(b)(2)(B)(xix))

North Carolina Initiatives:

- **Roanoke-Chowan Telehealth Network Grant**
Roanoke-Chowan Community Health Center received a grant from the NC 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 the patients' 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 may be needed, the RN informs the patient's primary care provider with the electronic health record (EHR). This program allows health professionals to intervene early if a patient's health began 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 systolic 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 a post discharge remote monitoring and chronic care management for diabetes patients at Rowan Chowan Hospital. Funding received by East Carolina School of Cardiology implemented remote monitoring for RCCHC/ECU cardiac patients and funding received by Piedmont Health Services implemented remote monitoring

for CVD patients.

NC HWTF 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 three new and one existing NC community health centers (First Choice Community Health Center, Piedmont Health Services, Robeson Community Health Center, Wake Health Systems), one rural hospital (Chowan Hospital), and Pitt County Memorial Hospital Health Institute. RCCHC is currently monitoring and managing patients in 28 North Carolina counties from Ahoskie.³⁰⁸

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- **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 consist 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.³⁰⁹

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- **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

³⁰⁸ Kim Schwartz, MA, electronic communication, January 31, 2011.

³⁰⁹ Sy Saeed, MD, MS, DFAPA, *MACPsych*, electronic communication, January 18, 2011.

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 AHEC.

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- **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.³¹⁰

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- **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 (electronic health records) on quality of health, quality and cost. The grant period of performance will be 60 months, from FY 2010 through FY 2015.³¹¹

For more details on the CHIPRA Grant Demonstrations, please see North Carolina initiatives under Patient Centered Medical Homes on page **XX**.

³¹⁰ Susan Yaggy, electronic communication, February 1, 2011.

³¹¹ Chris Collins, MSW, electronic communication, January 19, 2011.

Contact: [Stacy](#) Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- **Beacon Grant for Pharmacotherapy**

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 going through transitions 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.³¹² The Community will use a Health Record Bank that will allow patients to participate in their care and care managers to access information needed for coordination.³¹³

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- **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 ten North Carolina counties: Ashe, Avery, Bladen, Cabarrus, Columbus, Granville, Rowan, Stanly, Transylvania and Watuga. All North Carolina counties will have access to the system by late 2012.³¹⁴

For more details on CCNC's Pharmacy Home Project, please see North Carolina initiatives under Medication Management on page [XX](#).

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³¹² Beacon communities. North Carolina Department of Health and Human Services Web site. www.ncdhhs.gov/healthit/beacon. Updated July 13, 2010. Accessed February 3, 2011.

³¹³ Vice President Biden, HHS Secretary Sebelius announce selection of 15 health IT pilot communities through Recovery Act Beacon Community program [news release]. Washington, DC: The White House, Office of the Vice President; May 4, 2010. www.whitehouse.gov/the-press-office/vice-president-biden-hhs-secretary-sebelius-announce-selection-15-health-it-pilot-c. Accessed February 1, 2011.

³¹⁴ Elizabeth Walker Kasper, MSPH, electronic communication, February 7, 2011.

SHARED DECISION MAKING

Description of ACA Provisions

- **Program to facilitate shared decision-making:** The ACA authorizes a demonstration to facilitate collaborative 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.. (Sec. 3506)

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 (e.g. 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.³¹⁵

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- **Stanford Self-Management Model**
The Division of Aging and Adult Services, within the Department of Health and Human Services, 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

³¹⁵ Torlen Wade, electronic communication, January 31, 2011.

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.³¹⁶

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MALPRACTICE REFORM

Description of ACA Provisions

- **Medical Malpractice:** 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. (Sec. 6801, 10607)

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 (ORHCC) 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 (e.g., 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.³¹⁷

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³¹⁶ Torlen Wade, electronic communication, January 31, 2011.

³¹⁷ Chris Collins, MSW, electronic communication, January 19, 2011.

NURSING HOME DEMONSTRATIONS

Description of ACA Provisions

- **Nursing Home Culture Change:** 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. (Sec. 6114)

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 NC 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. Applicants 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.³¹⁸

Contact: Jan Moxley, Office of Long Term Services and Supports, 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.

³¹⁸ Jan Moxley, electronic communication, February 2, 2011.

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 North Carolina Department of Health and Human Services and the UNC 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.³¹⁹

Contact: Thomas Konrad, PhD, Research Scientist, Institute on Aging, University of North Carolina-Chapel Hill, bob_konrad@unc.edu.

DRAFT

³¹⁹ Dill JS, Morgan JC, & Konrad TR. Strengthening the long-term care workforce: the influence of the WIN A STEP UP workplace intervention on the turnover of direct care workers. *J Appl Gerontol.* 2009. doi:10.1177/0733464809337413.

**APPENDIX J
FRAUD, ABUSE, AND OVERUTILIZATION**

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PROVISIONS

Sec. 1313. Financial integrity.

Sec. 1324. Level playing field.

Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

Sec. 6402. Enhanced Medicare and Medicaid program integrity provisions.

Sec. 6403. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.

Sec. 6407, 10605. Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.

Sec. 6408. Enhanced penalties.

Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.

Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.

Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.

Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.

Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.

Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.

Sec. 6506. Overpayments.

Sec. 6507. Mandatory State use of national correct coding initiative.

Sec. 6508. General effective date.

Sec. 6601. Prohibition on false statements and representations.

Sec. 6602. Clarifying definition.

Sec. 6603. Development of model uniform report form.

Sec. 6604. Applicability of State law to combat fraud and abuse.

Sec. 8002. Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).

Sec. 10606. Health care fraud enforcement.

Sec. 1302 of Reconciliation. Medicare prepayment medical review limitations.

Sec. 1303 of Reconciliation. Funding to fight fraud, waste and abuse.

Sec. 1304 of Reconciliation. 90-day period of enhanced oversight for initial claims of DME suppliers.

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FRAUD, ABUSE AND OVERUTILIZATION
GAP ANALYSIS

The Fraud and Abuse workgroup conducted a gap analysis, breaking down the requirements of each provision in to specific tasks, identifying what work toward these tasks is currently underway, the gaps, and required changes for implementation of the ACA provisions. The information in the next two sections reflect this work.

Immediate implementation requirements (2010-2011)

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Apply new screening, oversight, disclosures, and compliance rules in Medicaid and CHIP (Section 6401)	March 2011 On hold pending final federal rules.	Currently underway by the DMA enrollment vendor. Final implementation on hold pending final CMS rules	Revisions to 10A NCAC 22F. Legislation giving DHHS special rulemaking authority/ implement new statutory screening requirements for Medicaid providers/ creation of risk categories and criteria.
Develop mechanism to inform new providers and suppliers of services that they are subject to a period of enhanced oversight after enrollment. May include prepayment review and prepayment caps. (Sec 6401)	March 2011	None	Revisions to 10A NCAC 22F. Legislation giving DHHS special rulemaking authority/ enhanced oversight requirements for newly-enrolled Medicaid providers.
Educate providers and suppliers that they are required to disclose any past affiliation with a provider who has been subject to payment suspension, excluded from participation, or has had their billing privileges denied or revoked (Sec. 6401, 10603)	1/1/2011	DMA began this process with its vendor CSC in early 2010; it is currently part of DMA provider application process.	None
Simplifies procedures to initiate prepayment review for fraud and abuse (Sec. 1302 of Reconciliation)	1/1/2011	DMA currently has contractor engaged for pre-payment review. DMA	Rules/ Legislation

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
		considers it to be a preventive measure, not a sanction, but this position is currently being challenged in court.	
States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare or CHIP (Sec. 6501) (CMS will inform states of providers who have been terminated from participation in Medicare (Sec. 6401, 10603))	1/1/2011	Already in effect in DMA to the extent it has access to this information.	Feds creating central sanction database. Final implementation dependent on CMS.
Excludes providers and suppliers if they are owned by, or own, individuals or entities that: - 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. (Sec 6502)	1/1/2011	Already in effect in DMA to the extent it has access to this information.	Feds creating central sanction database. Final implementation dependent on CMS.
Groups submitting claims on behalf of providers must register with the state and CMS. (Sec 6503)	1/1/2011	New to NC	Legislation. Business license? Liability insurance? Mandated education/ training?
Expands the period, from 60 days to one year, states have to recover overpayments (Sec. 6506)	Effective date of PPACA	Implemented	None
Prohibits states from providing payment for services under Medicaid to entities outside the U.S. (Sec. 6505).	1/1/2011	In process of implementation at NCDHHS Controller's Office	None
Requires a face-to-face encounter before certification for home health services under Medicare and Medicaid, and payment for durable medical equipment (DME) under Medicare (Sec 6407, 10605). Encounters can be with: a	1/1/2011	Already required for Personal Care Services (PCS)	Will need to be implemented for rest of home health and NC-DMA. Will require Clinical Coverage Policy changes through

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant.			Physicians Advisory Group (PAG) pursuant to 108A-54.2
Providers and supplier are required to provide access to documentation about referrals to, orders for DME, and certification for home health services to entities at a high risk for fraud and abuse upon demand by secretary. (Sec 6406)	1/1/2011	None	Federal requirement only. No state action necessary
Requires adjusting the size of surety bonds for DME and home health agencies by billing volume (Sec. 6402)	1/1/2011	Provider Performance Bond Rules in process	Revise performance bond rules
Withholds payment to DME suppliers for 90 days if there is a significant risk for fraud (Sec. 1304 of Reconciliation)	1/1/2011	None other than current withhold requirements at 42 CFR 455.23	Waiting for federal rule
Individuals who receive overpayments through Medicare, Medicaid and CHIP are required to report and return the overpayment within 60 days (Sec. 6402).	1/1/2011	Currently in provider participation agreement. DHHS currently does federal and state tax intercepts for food stamps, workforce, overpayments.	22F Rule revision for providers. DSS education to recipients/ potential legislative change.
Providers and suppliers of services are required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid and CHIP (Sec. 6402)	1/1/2011	Already required	None (possible 22N rule revision)
States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (Sec. 6504)	1/1/2011	None	Waiting for CMS to define data elements in rule or transmittals
State Medicaid information systems must be compatible with the National Coding Initiative (Sec. 6507)	10/1/2010	In process	None

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Establishes a National Health Care Fraud and Abuse Data Collection Program for the reporting of all final actions against health care providers, suppliers, and practitioners (Sec. 6403)	Effective: whichever is later, one year after enactment or when regulations are published.	CMS is building the national repository.	None
States are required to report all final actions, which include: Revocation or suspension of licenses, reprimands, or probation Dismissal or closer of fraud and abuse proceedings Any other loss of license, or the right to apply for or renew a license, or other negative action State licensing, law, or fraud enforcement agencies will report any corrections to reported information.	1/1/2011	DMA already reporting certain actions	No rule or law required. Requires that someone at DMA-provider enrollment is responsible. Requires state coordination between integrity, provider enrollment, audit.
Withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System. (Sec 6402).	1/1/2011	N/A	Ensure reporting of enrollee encounter data/ coordinate with DSS

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
<p>Multiple Employer Welfare Arrangements (MEWAs) are subject to state anti-fraud and abuse laws and regulations (Sec. 6604)</p> <p>Employees of MEWAs who make false statements concerning the financial condition or solvency, benefits, or regulatory status of the plan are subject to civil penalties (Sec. 6601)</p> <p>Enables the Sec. of Labor to issue cease and desist orders, if there is evidence of fraud and abuse, to temporarily shut down MEWAs (Sec. 6605).</p> <p>Allows the Sec. of Labor to seize the MEWAs' assets if it is in a financially hazardous condition.</p>	1/1/2011	None	Waiting for federal guidance
<p>In order to prevent and fraud and abuse in the CLASS: (Sec. 8002)</p> <p>Establishes procedures to allow authorized representatives access to a beneficiaries' benefits that prevent fraud and abuse</p> <p>CLASS regulations will include provisions to prevent fraud and abuse .</p>	1/1/2011	Not funded. Federal only.	None.
<p>Payments, under Medicare and Medicaid, to providers can be suspended during investigations of fraud and abuse (Sec. 6402)</p> <p>Allows the Secretary to suspend the federal portion of payments, for services under Medicaid, to providers who are under investigation for fraud and abuse if the state does not suspend payments.</p>	1/1/2011	NC-DMA already suspending payments 30 days after notice of overpayment becomes final.	Legislation to specify NC payment suspension.
<p>Medicare, Medicaid and CHIP beneficiaries who participate in fraud and abuse can be subject to administrative penalties (Sec. 6402).</p>	1/1/2011	Federal	Waiting for guidance/ will ultimately need to coordinate with DSS/ potential legislation.

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Providers can be excluded from participation in Medicare, Medicaid, and CHIP if they make false statements when applying for, or making, claims and bids and can be subject to civil penalties up to \$50,000 per false claim (Sec. 6402, 6408).	1/1/2011	Federal/ OIG	None
Also subject to civil penalties are Medicare Advantage or Part D plans that involuntarily enroll beneficiaries, transfer individuals between plans to earn commissions, do not comply with marketing regulations, or contract with individuals that engage in these activities (Sec. 6408).	1/1/2011	Federal/ OIG	HBE group
Persons who do not provide timely access to information for audits, investigations, evaluations, or other statutory functions can be subject to monetary penalties of \$15,000 per day (Sec. 6408).	1/1/2011	Federal requirement	Legislation for similar state requirement? Have to wait for Feds to define "reasonable request."
Changes the intent requirement for health care fraud so that individuals do not need to know that their actions are fraudulent in order to be prosecuted for fraud and abuse (Sec. 10606).	1/1/2011	Federal change	None.
Organizations that investigate fraud and abuse, under the Medicare and Medicaid Integrity Programs, are required to provide performance statistics (Sec. 6402). Such as: the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities.	1/1/2011	TBD (still under analysis)	TBD
Directs the National Association of Insurance Commissioners to develop a uniform reporting form	1/1/2011	None	Refer to HBE group

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
that private health insurance issuers will submit to state insurance departments in to report suspected fraud or abuse for investigation (Sec. 6603)			

Longer term implementation requirements (2012-2014) or date to be determined

Providers and suppliers will be required to establish an anti-fraud and abuse compliance program (Sec. 6401, 10603)	TBD	None. This may be similar to anti-kickback requirements. The Office of the Inspector General (OIG) has been putting out compliance programs since 2000 for hospitals, nursing homes, and home health to help employees and companies comply with federal laws. These have been voluntary for some providers, but now they will be mandatory.	1) Attestation that providers are in compliance. 2) Should NCDHHS participate in developing model compliance programs? Should NCDHHS approve provider's compliance program? 3) Employee education 4) Ensure that Medicaid requirements match Medicare requirements.
Requires the Integrated Data Repository (IDR) of CMS to include claims and payment data from Medicare, Medicaid, CHIP, the Dept. of Veterans Affairs, the Dept. of Defense, the Social Security Administration, and the Indian Health Services (Sec. 6402) Data in the IDR will be matched to identify fraud and abuse in Medicare and Medicaid.	TBD	CMS is building the national repository.	None

APPENDIX K
ACRONYMS AND GLOSSARY

<u>Acronym</u>	<u>Full Name</u>
ACA	Affordable Care Act. Note: when used in this report, it refers to the combination of the two health reform bills, including PPACA and HCERA.
ACIP	Advisory Committee for Immunization Practices
AHEC	Area Health Education Centers
AHRQ	Agency for Healthcare Research and Quality, US DHHS
ANP	Adult Nurse Practitioner
ARRA	American Recovery and Reinvestment Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems survey
CAP	Community Alternative Placement Program.
CBO	Congressional Budget Office
CCME	Carolinas Centers for Medical Excellence
CCNC	Community Care of North Carolina
CHIP	Children’s Health Insurance Program (in North Carolina, the Children’s Health Insurance Program is called North Carolina Health Choice)
CLASS	Community Living Assistance Services and Supports
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services, US DHHS
CY	Calendar Year
DMA	Division of Medical Assistance, NC Department of Health and Human Services
DMHDDSAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NC Department of Health and Human Services
DME	Durable Medical Equipment
DPH	Division of Public Health, NC Department of Health and Human Services
DSH	Disproportionate Share Hospital
DSS	Division of Social Services. Can also refer to local county departments of social services.
ED	Emergency Department
ESC	Employment Security System
ESI	Employer sponsored insurance
FMAP	Federal Medical Assistance Percentage
FNP	Family Nurse Practitioner
FPL	Federal Poverty Level
FFY	Federal Fiscal Years
HBE	Health Benefits Exchange
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act
HEDIS	Healthcare Effectiveness Data and Information Set
HPSA	Health Professional Shortage Area

HRSA	Health Resources and Services Administration
HSA	Health Savings Accounts
ICE	Immigration and Customs Enforcement
I/DD	Intellectual and Developmental Disabilities
IDR	Integrated Data Repository
IPAB	Independent Payment Advisory Board
IPIP	Improving Performance in Practice
IRS	Internal Revenue Service
MEWA	Multiple Employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
NCAFP	North Carolina Academy of Family Physicians
NCCCN	North Carolina Community Care Network, Inc.
NCCHQPS	North Carolina Center for Hospital Quality and Patient Safety
NCDHHS	North Carolina Department of Health and Human Services
NCDOI	North Carolina Department of Insurance
NC FAST	North Carolina Families Accessing Services Through Technology
NCHA	North Carolina Hospital Association
NCHIE	North Carolina Health Information Exchange
NCHQA	North Carolina Healthcare Quality Alliance
NCIOM	North Carolina Institute of Medicine
NCMS	North Carolina Medical Society
NCPS	North Carolina Pediatric Society
NHSC	National Health Service Corps
NP	Nurse Practitioner
OB-GYN	Obstetrician-Gynecologist
OIC	Office of Inspector General
ORHCC	Office of Rural Health and Community Care, NC Department of Health and Human Services
PA	Physician Assistant
PCMH	Patient Centered Medical Home
PCS	Personal Care Services
PPACA	Patient Protection and Affordable Care Act
PQRI	Physician Quality Reporting Initiative
RAC	Recovery Audit Contractor
REC	Regional Extension Centers
SBHC	School Based Health Centers
SNAP	Supplemental Nutrition Assistance Program (formerly known as Food Stamps)
SNF	Skilled Nursing Facility
SPA	State Plan Amendment
TANF	Temporary Assistance to Needy Families
THC	Teaching Health Center
USDHHS	United States Department of Health and Human Services
USPSTF	United States Preventive Services Task Force

GLOSSARY

340B Drug Discount Program	Refers to 340B of the Public Health Service Act, which offers reduced price outpatient drugs to federally-qualified health centers and look-alikes, certain hospitals, local health departments, and other safety net organizations. The program is administered by the Health Resources and Services Administration (HRSA). The cost savings to qualified providers from this program may equal between 20-50% on pharmaceuticals. More information is available at http://www.hrsa.gov/opa/introduction.htm
Accountable Care Organization (ACO)	A network of health care providers, including physicians and other health professionals, hospitals and other providers, that are accountable for the cost, quality and care provided to a group of patients. ACO models are still in the developmental stages, so there is not one fixed model of an ACO. The goal is to provide a structure and incentives for providers to coordinate care, improve health care quality and outcomes, and reduce health care costs.
Actuarial Value	The actuarial value is the percentage of total average costs for covered benefits that a plan will cover.
Adult Protective Services	In North Carolina, the North Carolina county departments of social services offer protection for disabled adults who have been victims of abuse, neglect or exploitation.
Benchmark Plan	Insurance coverage which state Medicaid agencies will provide to people who gain Medicaid coverage under the Affordable Care Act. Benchmark plans need not be as comprehensive as traditional Medicaid, but may be no less comprehensive than the essential benefits package.
Centers for Medicare and Medicaid Services	The federal agency responsible for administering the Medicare and Medicaid programs. CMS is part of the U.S. Department of Health and Human Services.
Children's Health Insurance Program (CHIP)	CHIP is jointly financed between the federal and state governments, and provides free or reduced cost health insurance for low-income uninsured children birth through age 18. States determine program design, benefit packages and income levels for coverage. North Carolina's CHIP program is called NC Health Choice.
Coinsurance	A percentage of the costs of a covered health care service that the insured individual must pay. Coinsurance usually applies after a person reaches his or her deductible. For example, if the health insurance plan normally allows \$100 for an office visit, and an insured person has a 25% coinsurance, then he or she would be responsible for paying \$25 and the insurer would pay \$75.
Community Care of North Carolina (CCNC)	CCNC provides a patient-centered medical home for Medicaid recipients. It is a collection of 14 networks of care that provide care management, quality improvement, and chronic disease management to Medicaid recipients across the state. Each network is composed of health care professionals, hospitals, health departments, social services department and other agencies that work together to improve the health of the Medicaid population in their region. More information is available at http://www.communitycarenc.com/ .

Community Living Assistance Services and Supports (CLASS)	A voluntary long term care insurance program for adults with cognitive and/or physical limitations who require long-term care. The program will provide cash benefits to individuals who have paid into the program for at least five years, and who have certain functional limitations with activities of daily living. Funding is to help pay for non-medical services and supports in the community.
Comparative Effectiveness Research	A type of research used to compare two or more drugs, medical devices, medical services or procedures, in order to determine the relative effectiveness, benefit and harm of each alternative. The goal of the research is to make informed policy decisions about medical care.
Copayment	A fixed amount that the insured individual must pay for a covered health care service. Generally, the insured individual is required to pay the copayment when he or she receives the service. For example, a person may need to pay \$25 when he or she receives services from a primary care physician. The amount of the copayment may vary by the type of covered health care service. (NAIC)
Cost Sharing	A generic term used to describe any payment the member must make for covered services. Different cost-sharing methods include deductibles, coinsurance and copayments.
Current Population Survey (CPS)	The CPS is a monthly survey of about 50,000 households nationwide that is conducted by the US Census Bureau. The March survey includes information about insurance coverage. More information is available at http://www.census.gov/hhes/www/hlthins/hlthins.html .
Deductible	The amount that the insurer individual must pay for health services before the health insurance begins to pay. For example, if a person has a health insurance plan with a \$1,000 deductible, the insurer will not pay for any service until the individual incurs \$1,000 for covered health care services. At that point, the insurer will pay for the costs of care that exceed the \$1,000 deductible. Insurance plans may set different deductibles for different services (such as inpatient services or prescription drugs), or an overall deductible for all covered services.
Disproportionate Share Hospital Payments	Disproportionate Share Hospitals (DSH) are hospitals that provide care to a high proportion of low-income and uninsured individuals. Both Medicare and Medicaid pay DSH hospitals higher reimbursement, in order to help offset uncovered costs provided to low-income and uninsured patients.
Dual Eligibles	Individuals who are eligible for both Medicare and Medicaid.
Durable Medical Equipment	Equipment and supplies that a health care professional orders for everyday or extended use. DME may include crutches, wheelchairs, hospital beds, oxygen equipment, or testing strips for diabetics.
Entitlement Program	A government program that includes a legal obligation to provide services or benefits to every individual who applies and meets the program's eligibility criteria. Medicaid, Medicare, and Social Security are all examples of entitlement programs.
Episode of Care Payment	A payment system in which a provider or set of providers receive a bundled payment for all services provided for a specific condition or for treatment during a specific time period. This may mean that one provider receives a

	<p>bundled payment that covers a series of services for one patient’s condition (e.g., all the services given for a patient related to his or her diabetes for a certain period of time). Alternatively, an episode of care payment may cover services provided by a set of providers for one condition (e.g., an episode of care payment for knee replacement surgery could include hospital facility charges; diagnostic imaging and lab costs; and charges for professional services pre-operative, during surgery and post surgical care).</p>
Essential Benefits	<p>Health services that must be offered as part of all private health insurance offered in the nongroup or small group market, except for “grandfathered” health insurance plans. Insurers must cover essential health benefits whether the health insurance is offered inside or outside the Health Benefits Exchange.</p>
Federal Medical Assistance Percentage (FMAP)	<p>The FMAP is the amount of the Medicaid health care costs paid by the federal government (in contrast to the state or local government). The FMAP is based on the per capita income of a state, so that states with lower per capita income receive higher FMAP payments, and those with higher per capita incomes receive lower FMAP payments. The FMAP rate is recalculated every year.</p>
Federal Poverty Limit (FPL)	<p>Measure of poverty in the U.S. used by the federal government to set financial eligibility guidelines for certain federal and state programs. Also commonly referred to as the federal poverty guidelines. For more information, see http://aspe.hhs.gov/poverty/09poverty.shtml.</p>
Federally Qualified Health Centers (FQHC)	<p>Federally funded FQHCs provide comprehensive primary care, behavioral health services, and dental services to uninsured or medically underserved populations in medically underserved areas. FQHC services are available to all individuals based on ability to pay. Community health centers and migrant health centers are examples of FQHCs.</p>
Grandfathered Health Plan	<p>Health insurance plans that existed on or before March 23, 2010, and that stay in continuous existence after that date. Grandfathered health plans are not required to meet all the same requirements as other insurance plans. For example, grandfathered health plans are not required to offer the essential health benefits. Health plans that make substantial changes in either the services covered or in cost sharing may lose their protected grandfather status. For more information on regulations regarding grandfathered plans, see http://www.hhs.gov/ociio/regulations/grandfather/index.html.</p>
Habilitation Services	<p>Health care services that help a person maintain, learn or improve skills and functioning for daily living. For example, a child with special health needs may need speech, occupational or physical therapy to help them gain certain life skills.</p>
Health Benefits Exchange (HBE)	<p>Beginning in 2014, Health Benefits Exchanges will provide standardized information for individuals and employers, to help them compare and enroll in health insurance coverage. HBEs will act as a market place for health insurance, certify that health insurance plans offer the essential benefits package, and provide assistance to consumers in purchasing insurance. Some individuals and small businesses will also qualify for tax credits to help pay for the costs of health insurance coverage purchased through the HBE.</p>
Health Care Acquired	<p>Conditions that develop while an individual is receiving care in a health care facility such as a hospital or nursing facility.</p>

Conditions	
Health Disparities	Differences in health status, service utilization, or quality of care that exist between specific groups within a larger population. Health disparities can exist based on gender, race, ethnicity, geography, socioeconomic status, or a combination of different factors.
Health Information Technology (HIT)	HIT encompasses the broad framework of electronic systems for sharing and collecting health information and data.
Health Home	A health home is a designated provider or team health care professionals that provides comprehensive care management, care coordination and health promotion, transitional care, patient and family support, referrals to community and social services, and that uses health information technology.
Health Professional Shortage Area	Health professional shortage areas (HPSA) are federally designated areas identified as having a shortage of certain types of health professionals. There are separate HPSA designations to indicate shortages of primary physicians, dentists, and mental health providers. HPSAs may be geographic (county or health service areas), demographic (specific population groups), or institutional (public or nonprofit medical facilities). More information is available at http://bhpr.hrsa.gov/shortage/index.htm .
Health Resources and Services Administration (HRSA)	HRSA is the agency within the US Department of Health and Human Services responsible for programs that provide care and services to uninsured and medically needy populations. For instance HRSA operates the National Health Service Corps, the Community and Migrant Health Center program, and rural health programs. More information is available at http://www.hrsa.gov/index.html .
High Risk Pool	High risk pools are insurance plans offered to individuals with pre-existing health conditions. People with preexisting health problems generally use more health care services and have higher health care costs. Thus, in the past, some insurers would deny coverage or charge people with preexisting coverage much higher rates to offset the increased costs of covering these individuals. High risk pools provide insurance coverage to these individuals at a more affordable rate. Many states currently operate state high risk pools, including North Carolina (See Inclusive Health). Additionally, the ACA created federally funded high risk pools operated by the states. These state and federal high risk pools are set to expire when the health benefits exchanges are established in 2014. For more information: Inclusive Health. http://www.inclusivehealth.org/
Home and Community Based Services (HCBS)	Services provided at home or in the community to individuals who would otherwise need institutional level of care (i.e., nursing facility care, hospitals, intermediate care facilities for people with intellectual and developmental disabilities). Home and community based services may include, but not be limited to homemaker or health aide services, personal care services, adult day health services, or respite care.
Hospital Readmission	Admission to the hospital for a treatment of condition for which the patient was previously admitted within a specified time period (e.g., 30 or 60 days).

Inclusive Health	Inclusive Health is a “High Risk Pool” which provides affordable insurance coverage to individuals in North Carolina who are unable to afford insurance coverage in the private market due to preexisting health problems. Individuals who are not eligible for insurance through their employer and otherwise face high individual insurance costs because of a pre-existing condition are eligible to purchase individual coverage through Inclusive Health. For more information: Inclusive Health. http://www.inclusivehealth.org/stateoption/index.htm
Mandated Benefits	Certain health services that insurers and HMOs must cover because of either state or federal laws. North Carolina law currently mandates that insurers and HMOs cover emergency services, pap smears, mammograms and PSAs, along with other mandated benefits.
Medicaid	A governmental health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state’s Medicaid population.
Medical Expenditure Panel Survey (MEPS)	The Medical Expenditure Panel Survey is a national survey that collects information from individuals, health care providers, and employers concerning the use, cost, and payment method for health services. MEPS data are collected by the Agency for Healthcare Research and Quality, US Department of Health and Human Services More information is available at http://www.meps.ahrq.gov/mepsweb/ .
Medical Loss Ratio (MLR)	The percentage of the health plan’s premiums that is used to pay for health care services in contrast to profit or administrative overhead.
Medicare	The national health insurance program provided to older adults (65 or older) and some disabled people who are eligible for Social Security, Railroad Retirement, or Disability benefits. Medicare has four parts: Part A, which is hospital insurance, Part B, which covers the cost of physicians and other providers, Part C (Medicare Advantage), which allows individuals to buy private insurance coverage to cover Medicare benefits, and Part D, which covers prescription drugs.
Modified Adjusted Gross Income	Adjusted gross income refers to an individual’s or household’s yearly taxable income, income less certain tax deductions and exclusions. Modifications to the adjusted gross income, referred to as modified adjusted gross income, are used for the purposes of determining eligibility for governmental health care programs, such as Medicaid.
North Carolina Families Accessing Services through Technology (NC FAST)	NC FAST is a new electronic information system that is currently being implemented by NC DHHS. NC FAST will facilitate coordination of eligibility and enrollment between NC DHHS programs, such as Medicaid, SNAP, and TANF. More information concerning specific projects available at: http://www.ncdhhs.gov/ncfast/index.htm
National Health Service Corps (NHSC)	The NHSC provides scholarships and loan repayment to medical, dental, and mental health care providers that agree to work for two to four years in Health Professional Shortage Areas. The NHSC is a federally funded program

	administered by HRSA. More information is available at http://nhsc.hrsa.gov/about/
NC Health Choice	The name of the North Carolina Children’s Health Insurance Program (CHIP). North Carolina’s CHIP program is called NC Health Choice and covers children ages 6 through 18 with family incomes between 100-200% FPL. (Younger children with family incomes up to 200% FPL, and children ages 6-18 with incomes no greater than 100% FPL are eligible for Medicaid).
Out-of-Pocket Cost Sharing Limits	Maximum amount that an individual member or his or her family will have to pay toward their medical care in a given year in deductibles, coinsurance and co-payments. Out-of-pocket cost sharing limits do not include premiums. Once this limit is met, the plan will pay 100 percent of the costs of the future covered health services until the new policy year begins.
Patient-Centered Medical Home	A model of primary care delivery in which a patient has a primary care provider or team of providers that acts as their “home” and coordinates all primary care for that individual. Although examples vary, all models are patient-centered, provide comprehensive and coordinated care, offer comprehensive access to care, and use a systems-based approach to quality and patient safety. More information is available at: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483 .
Preexisting Conditions	Mental or physical conditions for which an individual sought medical advice, care or treatment within six months prior to the enrollment in the health plan.
Premium	The amount that an insured individual or his or her employer must pay for health insurance. Premiums are usually paid on a monthly basis, but may also be paid quarterly or yearly.
Preventive Services	Medical care provided to protect against, minimize the risk of, or help in the early detection of health problems or diseases. Examples of preventive care include immunizations, pap smears and mammograms.
Preventable Hospitalizations	Hospitalizations that could have been prevented if a person received timely and high quality preventive and primary care services. Some examples of preventable hospitalizations are hospitalizations for vaccine preventable conditions (e.g., pneumonia, measles), uncontrolled diabetes or asthma.
Qualified Health Plan	Insurance plans that are certified by a health benefits exchange, and provide essential health benefits, adhere to cost sharing limits, and meet other requirements of the exchange.
Quasi State	An entity that is not officially a state agency, but is subject to certain state regulations and similar duties as state entities.
Rating Methodologies	The factors that health insurers use in establishing premium rates. Depending on state law, insurers may vary rates based on a person’s age, gender, geography (i.e., where the person lives), and family composition (i.e., enrollee only, enrollee and spouse, family coverage). Group rates may also vary by industry. In many states, including North Carolina, insurers can also consider a person’s health status in setting the premium rate. Under the ACA, beginning in 2014, insurers will only be able to consider a person’s age, geography, and family status in setting premium rates. Insurers will not be able to use gender or health status to determine rates, and will not be able to vary rates based on age by more than a 3:1 factor (i.e., the rate charged a 64

	year old cannot be more than 3 times the rate charged an 18 year old).
Rehabilitative Services	Health care services that help a person gain or restore skills and functioning for daily living that were lost or impaired due to illness or accident. These services may include speech, occupational or physical therapy, or psychiatric rehabilitation services.
Reinsurance	Reinsurance plans, or pools, provide retrospective adjustments to insurance plans for losses associated with high cost individuals or groups. These plans can be either privately purchased by an insurance plan or governmentally funded. Government reinsurance plans are intended to help subsidize health care costs and lower premiums for insurance plans that enroll individuals with high health care costs.
Risk Adjustment	Risk adjustment is a method to pay insurance plans more or less according to the level of risk among individuals enrolled in the plan. The level of risk refers to the likelihood an individual will require health care services and what types and intensity of services an individual is likely to use. Through risk adjustment insurance plans are paid more to cover individuals with a higher likelihood of needing services and paid less for individuals with a lower risk.
Risk Corridor	Risk corridors are financing agreements where insurance plans agree to share both their losses and savings with a state or governmental agency. If an insurance plan experiences losses over a certain threshold the governmental agency reimburses a portion of the loss. Conversely, if a plan experiences savings over a threshold the plan is required to return a portion of the savings to the governmental agency.
Risk Selection	Risk selection is when either healthy or sick insured individuals enroll in specific health plans or insurers at a rate that is more than would be expected. Adverse risk selection is when a higher proportion of high risk individuals (i.e., those with costly medical conditions) enroll in a specific health plan or with a specific insurer, and beneficial risk selection is when a higher proportion of healthy individuals enroll in a specific health plan or with a specific insurer.
Safety Net Organization	Health care organizations that have a mission or a legal obligation to provide health care and other related service to the underserved, regardless of their ability to pay. Examples of safety net organizations in North Carolina include federally qualified health centers, free-clinics, local health departments, school based health centers, and hospitals.
School Based Health Centers (SBHC)	SBHCs work in schools or on school grounds to provide comprehensive primary care, behavioral health services, and health education to students. More information is available at http://www.nasbhc.org/ .
Supplemental Nutrition Assistance Program (SNAP)	Formerly known as the Food Stamp Program, SNAP provides food assistance to eligible low income individuals and families. The SNAP program is a federal entitlement program that is administered by each state. More information is available at: Division of Social Services, NC Department of Health and Human Services. http://www.ncdhhs.gov/dss/foodstamp/index.htm
Telehealth	Telehealth is the use of electronic information and telecommunications

	technologies to support long-distance clinical health care or health education. Through telehealth, a provider can offer services to a patient at a remote location through a device that uses a transmitted signal to allow patient and provider to communicate. Additionally, health professionals can use telehealth technology to consult with specialists around the care for specific patients. More information is available at http://www.hrsa.gov/telehealth/ .
Telemonitoring	Telemonitoring is a method of communication between health care professionals and their patients, in which patient data is transmitted remotely for the purpose of monitoring the patient's condition from a long-distance. For example, patients with chronic illnesses can use telemonitoring technology to monitor their blood glucose, blood pressure, or weight, and these data can be transmitted simultaneously to their health care professional to monitor the individual's health.
Temporary Assistance to Needy Families (TANF)	A governmental program that provides cash benefits, and employment assistance, to low income families and children. TANF is administered by each state and funded through block grants from the federal government. In North Carolina the TANF program is called Work First. More information is available at: NC Department of Health and Human Services. http://www.ncdhhs.gov/dss/workfirst/#WFB
Underwriting	Underwriting is the process that insurers use to calculate the potential costs that a prospective enrollee might be expected to incur. Health insurers use underwriting to determine whether to cover a particular person, and/or the premiums that an individual would be charged. In the past, health insurers might consider age, sex, geographic location, and health status in determining whether to enroll the individual or the premium that would be charged. Under the ACA, underwriting is more limited.
US Preventive Services Task Force	The US Preventive Services Task Force (USPSTF) is an independent panel composed of experts in prevention and evidence based medicine. The USPSTF reviews the scientific evidence regarding various preventive health services and develops and publishes recommendations for primary care providers. More information is available at: AHRQ, US DHHS. http://www.ahrq.gov/clinic/uspstfix.htm .
Value Based Purchasing	Payment system in which providers are paid for the value of health services provided (e.g., based on health outcomes), rather than payment purely based on the number and type of service provided. For example, under a value based payment system, hospitals may no longer be reimbursed for excess readmissions or for treatment of hospital acquired infections.

Common sources for the glossary:

- Glossary. Centers for Medicare and Medicaid Services Web site. <http://www.cms.gov/apps/glossary/>.
- Glossary of health insurance and medical terms. National Association of Insurance Commissioners Web site.

http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf.

- North Carolina Institute of Medicine. Health care services for the uninsured and other underserved populations: a technical assistance manual to help communities create or expand health care safety net services. Morrisville, NC: North Carolina Institute of Medicine; April 2008. http://www.nciom.org/wp-content/uploads/NCIOM/pubs/safetynet_tam.pdf.
- North Carolina Institute of Medicine. Consumers guide to health insurance and health programs in North Carolina. Morrisville, NC: North Carolina Institute of Medicine; 2003. <http://www.nciom.org/wp-content/uploads/2003/01/C25.pdf>
- Glossary. HealthCare.gov Web site. United States Department of Health and Human Services. www.healthcare.gov.

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