

CHAPTER 3

MEDICAID

Many of the uninsured people who gain insurance coverage in 2014 will obtain their coverage through the state's Medicaid program. Beginning in 2014, the Affordable Care Act requires that states expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit. Children in families with incomes no greater than 200% FPL will continue to be eligible for Medicaid or North Carolina Health Choice (North Carolina's Child Health Insurance Program (CHIP)). Other people will gain coverage through private insurance offered through the Health Benefit Exchange (HBE) (discussed more fully in the HBE chapter). Further, it is likely that many individuals will move between these programs as their income fluctuates. Thus, the ACA includes provisions to streamline and coordinate the eligibility and enrollment processes between Medicaid, CHIP, the Basic Health Plan (if the state chooses to implement this option), and the HBE.

The Medicaid workgroup focused on the new Medicaid expansion, eligibility and enrollment requirements, new benefit mandates or options, and options for home and community-based services. However, Medicaid plays a critical role in almost all aspects of the ACA and is discussed in other sections throughout the report. For example, Community Care of North Carolina (CCNC), North Carolina's Medicaid care management program, is considered a national model of a patient-centered medical home. CCNC is a leader in testing new delivery and payment models (discussed more fully in the New Models of Care chapter). The Division of Medical Assistance (DMA) has implemented new policies aimed at improving health care quality and outcomes, and reducing fraud, abuse, and unnecessary utilization (discussed more fully in the Fraud, Abuse and Overutilization, and Quality of Care chapters respectively). Further, the ACA gives states a financial incentive to provide the same coverage of clinical preventive services as would be offered in the commercially insured population. This is discussed more fully in the Prevention chapter. DMA's payment policies also have a profound impact on the willingness and ability of health care professionals and other health care providers to participate in the Medicaid program. Thus, reimbursement rates must be adequate to ensure an adequate supply of health professionals to meet the health care needs of the newly insured. This is discussed more fully in the Health Professional Workforce and Safety Net chapters.

COVERAGE EXPANSION

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

This change in eligibility requirements will be a major expansion to the North Carolina Medicaid program, especially for low-income adults. To qualify currently, a person must be a citizen or lawful permanent immigrant in the United States for at least five years and must meet certain categorical, income and resource requirements. Medicaid is generally limited to children of low-income families, or adults who are either pregnant, have dependent children under age 19 living with them, disabled (under strict Social Security disability standards) or elderly (65 or older). Even if a person meets these categorical eligibility rules, the individual must also have an income below a certain income threshold and have limited resources or assets to qualify. Childless, nonelderly and nondisabled adults do not currently qualify for Medicaid, regardless of their income. However, in 2014, the eligibility criteria will change, and Medicaid will begin covering most adults with incomes up to 138% FPL. The ACA removes the categorical restrictions and resource limits for most adults. Instead, eligibility for children and most adults will be determined based on a person's citizenship (or lawful immigration status) and income (see Table 1). The ACA does *not* expand Medicaid coverage to undocumented immigrants.

To put this into perspective, a person working at minimum wage (\$7.25/hour), 40 hours week, and 50 weeks/year would earn \$14,500/year. The incomes of these low-wage workers are generally too high to qualify for Medicaid under North Carolina's current Medicaid eligibility rules.^c As noted earlier, a single nonelderly adult who is not disabled cannot currently qualify for Medicaid in North Carolina regardless of income. Parents can qualify, but 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 a person earns on minimum wage (see Table 3.1). However, beginning January 1, 2014, this adult would be able to qualify regardless of whether he or she had children.

^a 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.

^b The federal poverty levels, established by the federal government, are based on family size. It is usually updated annually. In 2012, the federal poverty levels for a family of one was \$11,170; for a family of two (\$15,130), family of three (\$19,090), and family of four (\$23,050). The federal poverty levels increase by \$3,820 for each additional family member. United States Department of Health and Human Services.

<http://aspe.hhs.gov/poverty/12poverty.shtml>. Accessed April 16, 2012. Because the federal poverty levels are updated annually, it is likely to be higher by 2014.

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

Table 3.1
Medicaid and North Carolina Health Choice Eligibility for Different Family Sizes^a Using
2011 Medicaid Eligibility and Percent Federal Poverty Level (2011, 2014)

	2011 Income Eligibility/Year			2014 Income Eligibility ^b		
	Percent Federal Poverty Level	Medicaid	NC Health Choice	Percent Federal Poverty Level	Medicaid	NC Health Choice
Child age 0-5	200%	1: ≤\$21,780 4: ≤\$44,700		200%	1: ≤\$21,780 4: ≤\$44,700	
Child age 6-18	100% (Medicaid) 100-200% (NCHC)	1: ≤\$10,890 4: ≤\$22,350	1: \$10,891-\$21,780 4: \$22,351-\$44,700	138% (Medicaid) 100-200% (NCHC)	1: ≤\$15,028 4: ≤\$30,843	1: \$10,891-\$21,780 4: \$22,351-\$44,700
Pregnant woman	185%	2: ≤\$27,214 4: ≤\$41,348	Not eligible	185% ^c	2: ≤\$27,214 4: ≤\$41,348	Not eligible
Parent of dependent child <19 years old	1:40% 4:32%	1: ≤\$4,344 4: ≤\$7,128	Not eligible	138%	1: ≤\$15,028 4: ≤\$30,843	Not eligible
Adult without dependent children who is not disabled or elderly	Not eligible	Not eligible	Not eligible	138%	1: ≤\$15,028 2: ≤\$20,300	Not eligible
Medicare eligible adult (elderly or disabled)	100%	1: ≤\$10,890 2: ≤\$14,710	Not eligible	100%	1: ≤\$10,890 2: ≤\$14,710	Not eligible

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

^b The 2014 income eligibility limits are based on the 2011 FPL, as the 2014 FPL are unknown at this time. However, the actual income eligibility limits are likely to be higher, as they will be based on the 2014 federal poverty levels (which increase with the cost of inflation).

^c In 2014, North Carolina has the option of reducing the income eligibility guidelines of pregnant women to 138% FPL and moving those pregnant women with higher incomes into private subsidized coverage (ie, through the HBE).

The income guidelines for an individual (single adult without dependent children) would be \$15,028/year or \$30,843/year for a family of four if based on 2011 federal poverty levels. (These income limits are likely to increase by 2014, as they will be based on the 2014 federal poverty levels.) This change is a major expansion and will provide coverage to many low-income adults.

An analysis by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill indicated that there may be as many as 536,000 uninsured nonelderly adults in North Carolina who could qualify for Medicaid coverage based on the expanded income eligibility criteria in 2014.^{1, d} Of these, approximately 382,000 could be *newly eligibles* (ie, they would not have qualified for coverage under the Medicaid eligibility rules in effect in March 2010) and approximately 154,000 could be *existing eligibles, but newly enrolled* (ie, they meet the state's current Medicaid eligibility rules but are not enrolled). While these individuals would be potentially income eligible under the new Medicaid rules, 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 doubtful that everyone who is Medicaid eligible will enroll in the first year. Instead, Medicaid coverage is likely to grow over time as more people learn about the new Medicaid eligibility rules and coverage options. In addition, enrollment is also likely to depend, in part, in the state's education and outreach efforts.

All newly eligible adults will be guaranteed a benchmark benefit plan that will be no less comprehensive than the essential benefits package.^e States must at least cover the essential health benefits, but can cover additional services. In addition, states have flexibility to offer different benefit packages to different populations, as long as all of the newly Medicaid eligibles at least receive the essential health services.² The federal government will pay 100% of the Medicaid costs for *newly eligible* individuals for the first three fiscal years (2014-2016). After the first three years, the federal government will pay 95% of the costs in FFY 2017, 94% in FFY 2018, 93% in FFY 2019, and 90% thereafter.^f The federal government will pay the state's regular FMAP, currently approximately 64%, for those individuals who were *already eligible but newly enrolled*.^g

States are required to identify people who are newly eligible versus those who were already eligible but newly enrolled in order to determine which FMAP rate applies. New proposed federal regulations give states three options to determine who was previously eligible and who is newly eligible—without having to determine eligibility twice for each individual (using old and new eligibility rules).^h States can apply state specific eligibility thresholds and proxies, using a state-specified methodology approved in advance by CMS; conduct a statistically valid sample;

^d This estimate is based on the number of people projected to live in North Carolina in 2014.

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

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

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

^h United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51199-. To be codified at 42 CFR §§433.206, 433.208, 433.210, 433.212.

or use a state-specific rate which CMS determines. The state is required to make its selection by December 2012, and it must use the methodology it selects for at least three consecutive years before changing to another method. DMA will work with its actuarial firm to explore the financial implications of these three options.

In addition to the new adult Medicaid eligibles, there are approximately 213,000 uninsured children in families with incomes below 200% FPL who may already be eligible for Medicaid or North Carolina Health Choice but are not enrolled. Again, many—but not all of these children—will obtain coverage 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,ⁱ which will increase the federal contribution to the North Carolina Health Choice program to almost 99%. This enhanced federal match rate is scheduled to stay in effect until 2019, when CHIP is scheduled to end. At that point, children will either be enrolled in Medicaid or private insurance (through the HBE or otherwise) depending on their families’ income.

Covering new adults and children in Medicaid will increase costs to the state. Although there are approximately 750,000 uninsured adults and children who are income eligible for Medicaid, not all of these individuals are eligible, and even among those who are eligible, not everyone is likely to enroll. DMA estimates that the expansion will cover approximately 525,000 new people in SFY 2014 increasing to approximately 560,000 people in SFY 2019. Of the 525,000 who are likely to enroll in SFY 2014, approximately 79% (412,000) will be newly eligible, and 21% (113,000) will be already eligible but not enrolled. The state share of the coverage for the new enrollees is estimated to be approximately \$830 million total over six years (SFY2014-2019). This total cost to the state includes the savings North Carolina will receive from the enhanced federal match for North Carolina Health Choice in FFY 2015-2019 (see Table 3.2). In addition, the federal government will contribute more than \$15 billion over the same time period to pay for Medicaid services for the newly insured.

Table 3.2
Estimated Costs of Medicaid Expansion (SFY 2014-2019)

	Already eligible but not enrolled	Newly eligible	Total requirements	State Share	New Enrollment
SFY 2014	\$280,873,590	\$1,050,182,541	\$1,331,056,130	\$70,453,984	525,102
SFY 2015	\$583,612,491	\$2,185,679,873	\$2,769,292,365	\$155,142,855	532,135
SFY 2016	\$612,988,753	\$2,264,442,085	\$2,877,430,838	\$66,553,844	539,191
SFY 2017	\$645,948,115	\$2,340,141,825	\$2,986,089,940	\$123,217,961	545,980
SFY 2018	\$680,313,270	\$2,414,593,690	\$3,094,906,959	\$196,039,109	552,691
SFY 2019	\$716,145,765	\$2,487,665,424	\$3,203,811,189	\$218,766,556	559,252
TOTAL	\$3,519,881,983	\$12,742,705,438	\$16,262,587,421	\$830,174,308	

Source: Owen, S. Chief Business Operating Officer, DMA, DHHS. Written (email) communication. February 22, 2011.

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

The impact of health care reform with the expansion of Medicaid eligibility to 138% FPL will increase state appropriations and enrollment as reflected above. The table includes the increase in claims costs for the newly eligible under the 138% expansion, the “already eligible but not enrolled” population, and the net impact of moving 58,000 children from Health Choice to Medicaid in 2014. This chart reflects the net costs to the state after factoring in the changes in the federal CHIP match rate. This estimate does not include additional costs if the state chooses to implement the recommended preventive services and immunizations with no cost sharing (described more fully in the Prevention chapter) or home and community-based services (discussed below). Nor does it include other likely cost offsets. For example:

- The state is likely to see a \$206 million reduction in payments to hospitals through the reduction in disproportionate share hospital (DSH) payments.
- The state may experience a decline in Medicaid medically needy expenditures. The Medicaid program covers some of the medical costs for people who are categorically eligible for Medicaid but have too much income to qualify under general program rules (medically needy coverage). Individuals with excess income can qualify for Medicaid if they first meet a “spend-down” (ie, deductible) that is equal to the difference between their countable income and the Medicaid medically needy income limits. Some of the people who would otherwise be eligible for Medicaid under the medically needy coverage option will be covered through the regular Medicaid program 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 of these services.
- 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.
- As more people gain coverage, state and county governments could potentially reduce some of the expenditures to safety net providers currently used to help pay for services to the uninsured.
- The state may experience a decrease in unnecessary use of the emergency department and reduced hospitalizations as more people gain coverage and access to preventive and primary care services.

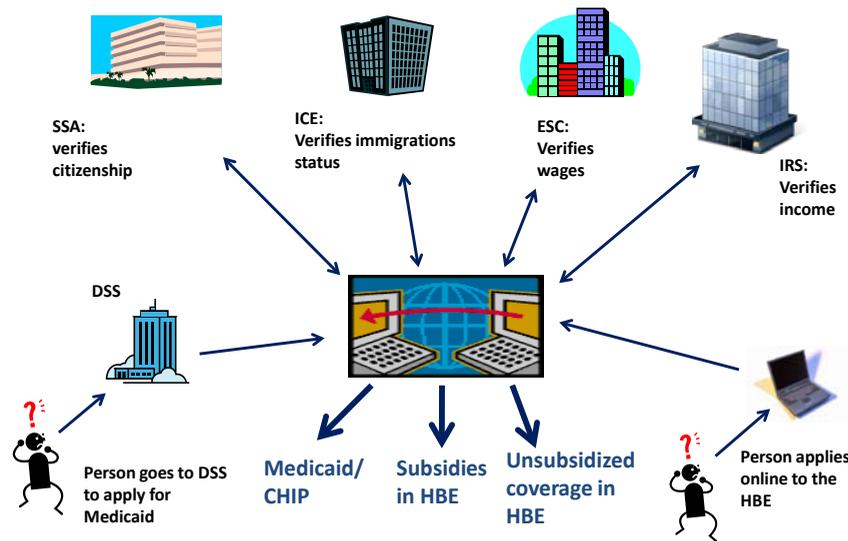
The workgroups were unable to quantify the total net costs or savings to the state as a result of the Medicaid expansion, as part of the costs or savings will be contingent on service options the state elects to pursue. Nationally, some reports have estimated net savings to the state and local governments, but the extent to which a state has net costs or savings will vary.^{3, j}

^j 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 concluded 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. Washington, DC: Council of Economic Advisors; Executive Office of the President; 2009. *The Impact of Health Insurance Reform on State and Local Governments*. <http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf>. Accessed February 4, 2011.

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

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

**Figure 3.1
Medicaid and Health Benefit Exchange Application and Enrollment System**



Prior to the passage of the ACA, NCDHHS was in the process of simplifying the Medicaid application and recertification process and streamlining eligibility requirements across all of NCDHHS’s means-tested programs including, but not limited to, the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Temporary Assistance for Needy Families (TANF), and child care subsidies. In addition, NCDHHS was already creating a new electronic eligibility and enrollment system to replace its existing, antiquated system. This new eligibility and enrollment system, NC FAST (North Carolina Families Accessing Services through Technology), will capture and share information across all NCDHHS programs.

^k 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.

Because of the new ACA requirements, the timeline for implementing the new Medicaid electronic enrollment system will be expedited so that it will be operational by the fall of 2013.¹ NC FAST will also serve as the eligibility and enrollment engine for people who apply for subsidies through the Health Benefit Exchange. The electronic eligibility and enrollment system must be operational by October 2013, as the Secretary has established an open enrollment period for Medicaid and the HBE beginning October 1, 2013 and running through March 31, 2014.^m

The federal government issued three notices of proposed rulemaking on August 17, 2011 which provided more detail for how the new eligibility and enrollment process will work across the different insurance affordability programs. The final Medicaid eligibility regulations were published on March 23, 2012,ⁿ and the final HBE eligibility regulations were published on March 27, 2012.^o These three sets of regulations are all interconnected, as under the ACA eligibility and enrollment for all the insurance affordability programs need to be coordinated. As family incomes fluctuate, families are likely to move between Medicaid and the HBE. A study showed that 50% of individuals with incomes below 200% FPL who did not have employer-sponsored insurance would have experienced a change in income necessitating a movement between Medicaid and the HBE within one year.⁴ Twenty-four percent would have experienced at least two eligibility changes within a year, and 39% would have experienced at least two changes within two years. Thus, there is a critical need to ensure that eligibility and enrollment is streamlined and coordinated between the different insurance affordability programs.

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

The federal regulations prescribe most of the new eligibility and enrollment processes, but left some areas of discretion for the state. The workgroup spent most of its time focusing on these

¹ North Carolina will need to be able to integrate Medicaid and CHIP eligibility with the web portal offered through the HBE. NCDHHS already has a multi-year project to simplify and automate the eligibility verification and application processes of 13 income-related programs (NC FAST). When implemented, NC FAST should not only lead to improved customer and beneficiary service, but also to improved efficiencies. To comply with ACA's timeline of 2014 interoperable eligibility programs for public and private health coverage, NCDHHS has had to revamp its NC FAST timeline and scheduled implementation for the Medicaid eligibility module. Some of the costs of planning such changes are being recognized in the Exchange Planning Grant awarded through NCDOT. In addition, the federal portion of the development and ongoing operational cost of this Medicaid/CHIP component of NC FAST will rise from 50% to 90%.

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

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

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

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

eligibility options, including Medicaid eligibility determinations for pregnant women, verification requirements, and determination of initial and ongoing eligibility if circumstances change:

- *Determining eligibility for pregnant women.* The ACA gives states the option of continuing to cover pregnant women with incomes up to 185% FPL (existing income eligibility rules) or reducing the income eligibility limits to 138% FPL in 2014. Similarly, the ACA gives states the option of counting the unborn child(ren) as part of the eligibility unit. Thus, a pregnant woman carrying one child would be a considered two people for the purpose of determining Medicaid eligibility. Counting the unborn child(ren) in the family unit helps more pregnant women qualify for Medicaid coverage. The workgroup recommended that the state maintain its existing coverage and continue to count the unborn child(ren) in the eligibility unit. North Carolina is trying to reduce infant mortality through the CCNC pregnancy home care management initiative. Through quality initiatives and other program components, the pregnancy managed care initiative should improve birth outcomes and reduce costs associated with poor birth outcomes. The fact that Medicaid covers 72,000 births a year means this initiative can have a profound influence on overall birth outcomes through improving the care that is provided. North Carolina can positively impact birth outcomes by maintaining existing eligibility coverage.
- *Verification requirements.* In order to determine eligibility for Medicaid, most individuals will only need to demonstrate proof of citizenship or lawful permanent residence, residency, household size, and income.^q The state will obtain most of the verification from secondary data sources (eg, through administrative data matches with the Social Security Administration, Department of Homeland Security, Internal Revenue Service, or state Employment Security Commission). In addition, applicants will be allowed to provide some information directly. For example, states must allow women to verbally attest to pregnancy status and families to attest to household composition without further written documentation (self-attestation). In addition, applicants must be given the opportunity to review and verify the information provided through the administrative data matches. The agency must use information from the applicant and the administrative data sources unless the two sources of information are not “reasonably compatible.” Reasonably compatible is defined in federal regulations as information that does not vary in a way that is meaningful for eligibility.^r Verification would not be considered reasonably compatible if the data from one source made the person eligible for coverage, but the data from another source did not. For example, if a person loses his or her job, the wage information that the state receives from an administrative data source may not comport with the individual’s attestation about current earnings. In those instances, the state must seek additional information to resolve the discrepancy.

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

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

States have the discretion of allowing self-attestation for date of birth (age) and for residency. The state currently uses self-attestation for date of birth, but existing state law requires two forms of residency for Medicaid. This requirement causes difficulties for some of the lowest income applicants who do not have utilities or rent listed in their names. In the past, the state was concerned that people would move to North Carolina from surrounding states to gain Medicaid coverage. That may be less of an issue with more standardized income eligibility thresholds across states. Also, the federal regulations change the residency requirements so that now all the applicant must show intent to reside in the state.⁵ Further, the United States Supreme Court has held that durational residency requirements are unconstitutional.[†] Thus, for example, North Carolina could not limit eligibility to individuals who had first resided in North Carolina for a specified period of time. The workgroup recommended that North Carolina continue to allow self-attestation for date of birth, and that DMA seek changes to state laws to allow it to accept self-attestation for residency, unless there is a reason to believe that a person does not have the intent to reside in North Carolina. The workgroup was mindful that there may be certain instances when people move to North Carolina and seek to establish residency in order to obtain services from North Carolina health care institutions. The workgroup recommended that DMA examine its existing caseload to determine if there were certain “high risk” cases when it would be appropriate for the state to seek additional verification of residency.

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

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

⁵ Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR § 435.403.

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

In addition, the final regulations give states the authority to count “reasonably anticipated” future changes in the eligibility determination process.^u For example, the state can consider the income someone would receive from a new job, and/or a layoff notice in determining eligibility. This could help reduce the number of times that a person would cycle on or off eligibility. The workgroup recommended that North Carolina include provisions to include reasonably anticipated changes, but that the state strictly define what it means by reasonably anticipated. Reasonably anticipated changes should include a new job, loss of a job, or change in the number of hours worked on a regular schedule. If the definition is not very clear, it could lead to an increase in appeals.

RECOMMENDATION 3.1: SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES

- a) The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage. To accomplish this, DMA should exercise state flexibility to:**
 - i. Provide Medicaid coverage to pregnant woman up to 185% of the federal poverty level and count the unborn child in the eligibility determination.**
 - ii. Use self-attestation to verify date of birth.**
 - iii. Use annualized income to determine ongoing eligibility.**
 - iv. Include reasonably anticipated changes in the eligibility determination process using a strict definition of what meets the threshold of a reasonably anticipated change.**
- b) DMA should seek changes in state law to allow it to accept self-attestation of residency, except when it has reason to believe that a person does not have the requisite intent to reside in the state.**
 - i. DMA should examine its current case load to determine if there are certain types of cases which raise questions about the applicant’s intent to reside in state. In those instances, DMA should have the flexibility to seek additional verification of residency.**
- c) The North Carolina Department of Health and Human Services should continue its work to create electronic data matches with the North Carolina Department of Revenue for North Carolina wage information, Vital Records within the State Center for Health Statistics for birth and death data, and other electronic sources that have information about wages, resources, or other eligibility factors.**
- d) DMA should work with the Health Benefits Exchange (HBE) to identify other strategies to ensure that individuals do not experience gaps in coverage when they have fluctuating income that requires them to change insurance coverage between Medicaid and the HBE.**

In addition to the new verification requirements, the ACA imposes requirements on state agencies and on the HBE to conduct outreach, provide consumer education, and assist people

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

with the eligibility and enrollment process. For example, the ACA charges state Medicaid agencies with:

“conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX [Medicaid] or for child health assistance under title XXI [CHIP], including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.”^v

State Medicaid agencies are also charged with helping people with the application and enrollment process.^w In addition, the ACA requires HBE to contract with patient navigators to conduct public education to raise awareness about qualified health plans in the HBE.^x The role of patient navigators is discussed more fully in the HBE chapter. Because of the need to coordinate eligibility and enrollment across all insurance affordability programs, the outreach, education, and enrollment processes must also be coordinated.

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

The workgroup also recommended that DMA, DOI, and the HBE work with different faith-based organizations, community-based organizations, provider groups, and government agencies to educate the broader population about different coverage options. Local DSS agencies, health departments, local management entities (LMEs), and safety net providers will play a critical role in helping to educate and enroll uninsured individuals into new coverage options, as these organizations have often worked with this population in the past. However, there are many uninsured who do not routinely seek health care or social services. To reach these people will require different outreach strategies and different messengers. Thus, the workgroup recommended that DMA and the HBE work through other community-based organizations that have ties to traditionally underserved populations. For example, DMA, DOI, and the HBE should help educate the faith community, the broader health care community, community-based organizations (eg, United Way, Goodwill, rescue missions, homeless shelters, day care programs, domestic violence agencies), and local governmental agencies (eg, employment

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

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

^x Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(i).

security commission, schools, cooperative extension, law enforcement agencies, area agencies on aging, aging and disability resource centers). DMA, DOI, and the HBE should also reach out to local Chambers of Commerce and other employer groups to educate employers—particularly small employers—about new insurance options available through the HBE.

In addition to the outreach and educational efforts, certain groups are charged with helping people enroll. This includes local DSS agencies, patient navigators (under contract with the HBE), and the Consumer Assistance Program within the NC DOI (NC Smart). Agents and brokers also play an important role educating small businesses and individuals about available health insurance options and helping them enroll. Some health care providers also have the authority to determine presumptive Medicaid eligibility for certain Medicaid eligibility groups. For example, the existing Medicaid statute gives states the authority to authorize certain qualified providers to make presumptive eligibility decisions for children, pregnant women, and breast or cervical cancer patients.^y Presumptive eligibility is an initial Medicaid determination, based on preliminary information provided by the applicant. If a person is determined to be presumptively eligible, he or she remains eligible pending verification of eligibility. In North Carolina, federally qualified health centers (FQHCs), rural health clinics, local health departments, and hospitals can make presumptive eligibility determinations for pregnant women, but the state does not allow for presumptive eligibility for children or breast and cervical cancer patients. The ACA modifies the statute to give states the option to allow these same providers to make presumptive eligibility determinations for other categories of Medicaid (including those who would be newly eligible under the ACA).^z In addition, any hospital that participates in Medicaid can elect to make presumptive eligibility decisions for any Medicaid applicant.^{aa} Thus, it is particularly important that these organizations receive training to ensure they understand all the eligibility requirements as well as different insurance options.

Thus, the workgroup recommended:

RECOMMENDATION 3.2: DEVELOP A BROAD-BASED EDUCATION AND OUTREACH CAMPAIGN TO EDUCATE THE PUBLIC ABOUT NEW INSURANCE OPTIONS

- a) The North Carolina Division of Medical Assistance (DMA), North Carolina Department of Insurance (DOI), and North Carolina Health Benefit Exchange (HBE) should work together to develop a broad-based education and outreach campaign to educate the public about different health insurance options and insurance affordability programs. As part of this effort, DMA, DOI and the HBE should:**
- i. Develop educational materials that explain the different insurance options and how people can apply for help paying for health insurance coverage. The educational materials should be linguistically and culturally accessible, meet ADA accessibility standards, and be written at a level that is understandable to people with low health literacy.**

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

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

^{aa} Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2202.

- ii. Conduct education sessions and enlist the help of community-based organizations, provider groups, and government agencies to educate the general population about the different coverage options. Special efforts should be made to identify and educate organizations that have relationships with and ties to traditionally underserved communities, including the uninsured, as well as those who have ties to small businesses. These groups should be provided with educational materials and information about the new insurance coverage and different insurance affordability options.**
 - iii. Provide enhanced training to organizations that are charged with assisting people enroll into Medicaid, North Carolina Health Choice, or private insurance coverage offered through the HBE. This includes, but is not limited to, patient navigator organizations, hospitals, FQHCs, and agents and brokers.**
 - iv. Create a unified toll free telephone hotline that is widely advertised to provide information about the new insurance options.**
- b) DMA, DOI, and the HBE should seek federal, state, and/or private foundation funds to pay for media coverage to educate the public about the new insurance options.**

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

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

In addition to the role that DSS will play in assisting people in applying for insurance, they also will be called upon to help people who experience enrollment problems. This is most likely to occur when information provided by the applicant conflicts with other data obtained by the administrative data sources (eg, the data are not “reasonably compatible”). As envisioned, most individuals who apply will have their income, citizenship, and immigration status verified

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

through an administrative data match. For most individuals, this system should work well to verify eligibility. However, some people will have more difficulty, particularly those who have experienced a recent change in their income or household composition. For example, individuals who recently gained or lost a job may have a different household income than reflected in the prior year's tax filings or ESC wage information. Similarly, someone who recently got married or divorced may have different circumstances that are not reflected in the administrative data matches. In these circumstances, it is important to have people who can verify the change in circumstances (eg, by viewing new wage stubs or a marriage license). Local DSS agencies can help play this role, particularly as it relates to Medicaid and CHIP applicants. DSS staff will need to be trained to understand the new application and verification procedures, as well as the new roles they are likely to assume. Therefore, the workgroup recommended:

RECOMMENDATION 3.3: RETRAINING DSS ELIGIBILITY WORKERS

- a) **The North Carolina Division of Medical Assistance, North Carolina Division of Social Services, and the North Carolina Department of Social Services Directors should provide training to county Department of Social Services (DSS) eligibility workers to help them understand the new eligibility and enrollment processes that will go into effect in the fall of 2013, and the new roles and responsibilities of DSS workers under the Affordable Care Act.**
- b) **Local Departments of Social Services should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator in each DSS office, to ensure that local DSS offices know about all the available insurance affordability options.**

COVERED SERVICES

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

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

Family planning services. In the past, states needed to seek a waiver to provide family planning services to individuals with higher incomes than would traditionally qualify for Medicaid. North

^{cc} Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4107.

^{dd} Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2301.

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

^{ff} Larson, T. Chief Clinical Operations Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication. January 10, 2011.

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 than a waiver, to men or women of childbearing age who meet the income guidelines that would apply for pregnant women (185% FPL).^{gg} There is less administrative burden in offering these services through a SPA rather than a waiver. DMA submitted its SPA, converting its family planning waiver to a state plan covered service on August 18, 2011, and was still waiting for CMS approval (as of February 2012).

Health homes. The ACA gives states the option of creating “health homes” for Medicaid recipients with chronic health problems.^{hh} A health home is a designated provider or team of health care professionals who provides comprehensive care management, care coordination and health promotion, transitional care, patient and family support, referrals to community and social services, and who uses health information technology. Eligible individuals include Medicaid enrollees with two chronic conditions, one chronic condition with a risk of a second chronic condition, or one serious and persistent mental illness. States that submit an SPA to operate a health home are eligible for an enhanced federal match of 90% of the payments to health care providers for up to eight fiscal quarters. This provision is very similar to the way North Carolina operates the Community Care of North Carolina (CCNC) program (described more fully in New Models of Care chapter). DMA has submitted its SPA which will strengthen the coordination between primary care providers and those who are meeting the needs of people with mental health or substance use disorders, or those with intellectual and developmental disabilities. DMA is currently waiting for approval from CMS.

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

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

- *Community First Choice Option.* North Carolina currently provides home and community-based waiver services to individuals who would otherwise be eligible for Medicaid and need an institutional level of care (nursing facility, intermediate care

^{gg} Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2303.

^{hh} 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.

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

- *State Balancing Initiative.* States can use this option to provide HCBS to individuals who would *not* otherwise need an institutional level of support (effective October 2011).^{ll} 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 (eg, 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.

Money Follows the Person (MFP)

- *Money Follows the Person (MFP).* DMA received \$389,952 in federal funding through the ACA to support MFP, a demonstration project that supports eligible Medicaid recipients to transition out of qualified institutional facilities and into their homes and communities with appropriate supports. MFP also has the long-range objective of expanding the use of home and community services (HCBS) and identifying policy barriers that impact the provision of HCBS.

Over the past two years, North Carolina MFP has received additional federal

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

^{jj} 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.

^{kk} The Federal Medical Assistance Percentage, or FMAP, is the percentage of the Medicaid costs that are paid by the federal government for allowable health care services and supplies. In FFY 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 on 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 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.

^{ll} Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10202.

supplemental funding. This additional federal funding is intended to strengthen both North Carolina's transition practices and its ability to support individuals with long-term care needs to return to and remain in their communities. Accordingly, the North Carolina MFP has recently allocated over \$2M to the North Carolina Division of Aging and Adult Services and their local partners within the Community Resource Connections Network. This funding will support outreach and options counseling to nursing facility residents interested in returning to their communities.

- *Aging and Disability Resource Centers (ADRCs)*. The ACA includes funds to expand state Aging and Disability Resource Centers (ADRCs). ADRCs act as a “no-wrong door” information, assistance, and referral system to streamline consumer access to long-term services and supports. ADRCs generally offer public information, options and options counseling, and 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 twelve ADRCs serving Ashe, Beaufort, Buncombe, Cabarrus, Chatham, Cherokee, Clay, Forsyth, Graham, Guilford, Haywood, Henderson, Jackson, Macon, Madison, Mecklenburg, Montgomery, Orange, Pitt, Rockingham, Stoke, Surry, Swain, Transylvania, Wake, and Yadkin counties. Two additional programs are in development to serve Bladen, Greene, Hoke, Lenoir, Onslow, Richmond, Robeson, and Scotland counties and will become operational in the fall of 2012. The Division of Aging and Adult Services submitted a 5-year strategic plan to the Administration on Aging to expand the program statewide by 2016. The Office of Long-term Services and Supports, NCDHHS, has 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 has been piloted in two ADRCs in Wake County and Piedmont Triad (covering Guilford, Montgomery, and Rockingham counties). Twenty-seven professionals from various agencies in these counties were a part of the pilot group and are expected to complete their certification by the end of December 2011. This initiative will be rolled out to the remaining ADRCs in early 2012.

The Medicaid workgroup discussed the HCBS options as well as the potential cost impact to the state. Studies show that most people would prefer to remain in their homes or smaller community-based settings to receive services and supports rather than in a larger or institutional setting.⁵⁶ 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 the Community First Choice and the State Balancing Initiatives 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 of these HCBS options 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.
- Targeting new HCBS to older adults or people with disabilities who have been identified through the Adult Protective Services system (either as abused or neglected, or at risk of abuse and neglect). This targeting may help reduce state and county expenditures in providing services needed to protect these vulnerable adults from abuse, neglect, or exploitation.

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

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

RECOMMENDATION 3.4: EXPANDING HOME AND COMMUNITY-BASED SERVICES

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

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

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