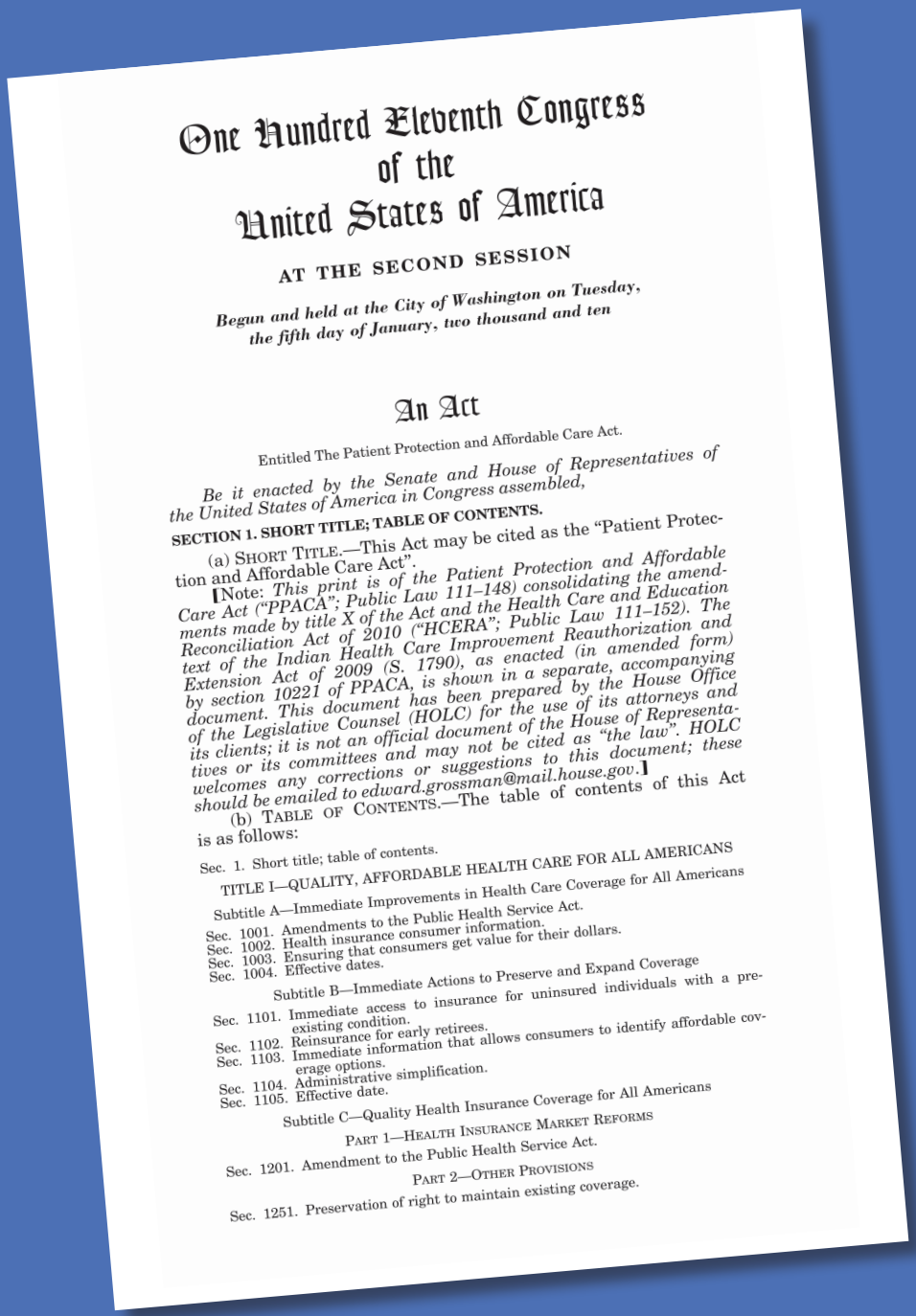

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

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

An Act

Entitled The Patient Protection and Affordable Care Act.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.
Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.
Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART 1—HEALTH INSURANCE MARKET REFORMS

Sec. 1201. Amendment to the Public Health Service Act.

PART 2—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.

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

Draft Final Report Pending US Supreme Court Decision

May 2012

Report by the
North Carolina Institute of Medicine

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

NCIOM

North Carolina Institute of Medicine
shaping policy for a healthier state

The North Carolina Institute of Medicine (NCIOM) is a nonpolitical source of analysis and advice on important health issues facing the state. The NCIOM convenes stakeholders and other interested people from across the state to study these complex issues and develop workable solutions to improve health, health care access, and quality of health care in North Carolina.

The full text of this report is available online at **http://www.nciom.org**

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Report by the North Carolina Institute of Medicine.

Supported by funding from the North Carolina Department of Health and Human Services Department and the North Carolina Department of Insurance.

Any opinion, finding, conclusion or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the view and policies of the North Carolina Department of Health and Human Services Department and the North Carolina Department of Insurance.

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CHAPTER 1
EXECUTIVE SUMMARY

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

The ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs. At the same time, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations. In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and the North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene workgroups to examine the new law and gather stakeholder input to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole.

NCIOM WORKGROUPS

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

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

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

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

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

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

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

This document is a compilation of reports from each of the health reform workgroups. Each report contains information about the applicable ACA provisions, findings, and recommendations. What follows is a summary of the recommendations from all the workgroups. The complete recommendations can be found in each of the workgroup chapters.

EXPANDING HEALTH CARE ACCESS TO THE UNINSURED

In North Carolina, there were approximately 1.6 million uninsured nonelderly individuals in 2010 (19%).[1] 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.[2] When the uninsured do seek care, some of the costs of their care are shifted to the insured population.

By 2014 the ACA requires most people to have health insurance or pay a penalty. To meet this requirement, the ACA builds on our current system of employer-sponsored insurance, individual coverage, and public coverage. Large employers (50 or more full-time equivalent employees) are required to offer employees coverage or pay a penalty.[d] Small businesses are not required to offer coverage, but the ACA provides tax credits to some small businesses to help offset some of their premium costs. Many North Carolina families will be eligible for subsidies to help them purchase private coverage, if they do not have access to affordable employer based coverage, cannot qualify for public coverage, and have incomes below 400% of the federal poverty guidelines.[e, f] In addition, the ACA expands Medicaid to cover more low-income adults. In the

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

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

first year alone, close to 800,000 uninsured people are expected to gain coverage. Of these, 41% will gain coverage through the private market, and 59% will gain coverage through Medicaid.[3]

Health Benefit Exchange Workgroup

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty. The ACA requires that each state have a Health Benefits Exchange that will offer information to help individuals and small businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own HBE, the federal government will create one to offer coverage to individuals and small groups in the state. The HBE was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The HBE also can help promote competition on the basis of comparative value, price, and quality of care and customer service, and reduce competition based on risk avoidance, risk selection, and market segmentation.

Qualified health plans (QHPs) offered through the HBE must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[g] Each state will be required to define its own essential health benefits package (using HHS defined benchmarks) that includes coverage of these services.[4] The ACA also creates a "patient navigator" role to provide information to the public about health plan choices and to help them enroll.

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based HBE. This bill did not pass the Senate in the 2011 Session, but is still eligible for consideration in the 2012 Session. Although the legislature did not pass legislation creating a HBE, it did pass legislation stating its intent to create a HBE within the state, and directing the North Carolina Department of Insurance (NCDOI) and the North Carolina Department of Health and Human Services (NCDHHS) to continue to develop a state-based exchange.[h] If North Carolina is going to operate a state-based HBE in 2014, it must show operational readiness by mid 2013. NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the HBE policy and design issues. The Health Benefit Exchange Workgroup is the only group that will continue to meet to consider some of the policy options the Health Benefits Exchange Board must consider, if established.

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

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

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

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (HBE). The effective and efficient operation of the HBE will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the HBE. The HBE workgroup and Overall Advisory Committee believe that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government, therefore, the Workgroup recommended:

RECOMMENDATION 2.1: STATE AND FEDERAL HBE OPERATIONAL RESPONSIBILITIES
The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based HBE should be responsible for most of the operational aspects of the HBE, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the HBE Board is created, the Board should consider whether there are limited functions which the federal government should assume.

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

RECOMMENDATION 2.2: HBE BOARD AUTHORITY FOR HBE CERTIFICATION
The North Carolina General Assembly should give the Health Benefits Exchange (HBE) Board the authority, beginning in 2014, to standardize terminology, benefit designs, or limit the number of plan offerings if needed to facilitate meaningful choice and promote competition among insurers, but only if the HBE Board determines there is a reasonable level of choice in the HBE market. The HBE Board should also have the authority, beginning in 2016, to require or incentivize insurers to meet state standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services (USDHHS). The HBE Board should give all QHP applicants that are not already accredited two years to meet the accreditation standards assuming that the insurer can show that it is making reasonable progress in obtaining accreditation.

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

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

RECOMMENDATION 2.4. HBE MONITORING OF ESSENTIAL COMMUNITY PROVIDER PROVISIONS

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

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

RECOMMENDATION 2.5: HBE FINANCIAL SUSTAINABILITY

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

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

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

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

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

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

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

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

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

The ACA creates a "no wrong door" enrollment process. Individuals can apply directly to the HBE, and if eligible for Medicaid or CHIP, enroll directly into those programs. Conversely, people can apply for Medicaid or CHIP first, and if ineligible for public coverage, but eligible for private coverage, can enroll into a QHP in the HBE. Many of the low-income uninsured will first seek information about insurance options through their local department of social services (DSS). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[k] In addition, if the person is determined to be ineligible for Medicaid, he or she must be screened to enroll into a qualified health plan, and, if eligible, must be able to enroll "without delay." [l, m] Thus, the workgroup recommended that DSS workers be trained and certified as navigators so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the HBE.

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

Medicaid Workgroup

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.

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.[n, o] 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

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

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

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

[n] 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.

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

offered through the Health Benefit Exchange (HBE). 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. This change in eligibility requirements will be a major expansion to the North Carolina Medicaid program, especially for low-income adults. The North Carolina Division of Medical Assistance estimates that 525,000 individuals will enroll in Medicaid or North Carolina Health Choice in SFY 2014.

Federal regulations prescribe most of the new eligibility and enrollment processes, but left some areas of discretion for the state. The state has many options which could simplify the Medicaid eligibility and enrollment process, therefore, the Workgroup recommended:

RECOMMENDATION 3.1: SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES
The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage.

Further, it is likely that many individuals will move between 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. Educating the public about these new requirements and the various health insurance options and insurance affordability programs is one of these provisions. Therefore, the Workgroup recommended:

RECOMMENDATION 3.2: IMPLEMENT AN EDUCATION AND OUTREACH CAMPAIGN
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.

The workgroup discussed the important role that local Divisions of Social Services (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:

RECOMMENDATION 3.3: RETRAIN DSS ELIGIBILITY WORKERS
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. 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.

In addition to expanding Medicaid coverage to more of the uninsured, the ACA gives states a number of options to expand home and community-based services (HCBS) to older adults or people with disabilities. 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: EXPLORE THE HOME AND COMMUNITY-BASED SERVICES MEDICAID EXPANSION OPTIONS
The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the costs and benefits of options to expand home and community-based services, and should explore options to use existing state dollars to leverage federal Medicaid funding to expand home and community based services. DMA should give priority to support caregivers or otherwise provide services to help the frail elderly or people with disabilities to remain in their homes, and should give priority to those who have been identified as at-risk through the Adult Protective Services system. DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.

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

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

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

RECOMMENDATION 4.1: DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT

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

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

RECOMMENDATION 4.2: INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS

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

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

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

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

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

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

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

> **RECOMMENDATION 4.4: ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS**
> **The Health Benefits Exchange (HBE) should train and certify staff at safety net organizations to serve as patient navigators as long as these organizations meet the federal requirements for patient navigators. As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.**

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. Workgroup members recognized the need for safety net organizations to continue to meet, on a periodic basis, to facilitate ongoing collaborations and communication. Therefore, the workgroup recommended:

> **RECOMMENDATION 4.5: RECONVENE THE SAFETY NET ADVISORY COUNCIL**
> **The Care Share Health Alliance should reconvene the Safety Net Advisory Council to identify communities with the greatest unmet needs; increase collaboration among safety net agencies; monitor safety net funding opportunities; make a recommendation and plan for integrating safety net tools including the North Carolina Health Care Help website and the county level resources; and serve as a unified voice for the safety net.**

Health Professional Workforce Workgroup

While the ACA includes provisions to increase the number of physical, behavioral, and oral health practitioners to address current and future workforce needs, and authorized new programs to expand the number of health care providers, it does not include new appropriations to fund all of these provisions. Given limited federal funding for workforce initiatives, the Health Professional Workforce Workgroup focused on critical steps that the state could take to ensure an adequate workforce to meet the health care needs of North Carolinians.

The increase in the number of North Carolinians with health insurance will increase demands for health care, particularly primary care[5]). In addition to high demands for physical health care, changes in insurance rules and access to health insurance are expected to increase demands for

other services, particularly behavioral and oral health care. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, and behavioral and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. Furthermore, the provision of health care in the field is changing; therefore, education and training models must also change. Therefore, the Workgroup recommended:

RECOMMENDATION 5.1: EDUCATE HEALTH WORKFORCE USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE
The North Carolina Community College System (NCCCS), the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties should work together to create targeted programs and admissions policies to increase the number of students with expressed interested in primary care, behavioral health, and dentistry. AHEC should educate the existing workforce on new core competencies needed by the health care workforce including interdisciplinary team-based care, patient safety, quality initiatives, cultural competency, health information technology, and others.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[6] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health and may reduce costs. Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the workgroup recommended:

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

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

health professionals and match them with qualified HPSAs. Therefore, the Workgroup recommended:

RECOMMENDATION 5.3: STRENGTHEN AND EXPAND RECRUITMENT OF HEALTH PROFESSIONALS TO UNDERSERVED AREAS OF THE STATE
The North Carolina Office of Rural Health and Community Care (ORHCC) should maintain its independence and flexibility to respond to health workforce needs across the state in a timely manner. In order to support and strengthen the ability of the ORHCC to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina Department of Commerce should use $1 million annually of existing discretionary programs funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into NC.

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

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

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

RECOMMENDATION 5.5: SUPPORT COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS
The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. The North Carolina General Assembly should provide $550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.

IMPROVING POPULATION HEALTH

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA includes new funding to invest in prevention, wellness, and public health infrastructure. The ACA includes $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 for a new Prevention and Public Health fund to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina, which ranked 32 of the 50 states in 2011 based on a composite of 23 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[7]

Prevention Workgroup

The Prevention Workgroup focused on provisions of the ACA with immediate implementation requirements, or funding opportunities. These areas of focus included tobacco use, community infrastructure for responding to funding opportunities, maternal and child health, prevention of sexually transmitted disease (STD) and unplanned pregnancies, promotion of healthy lifestyles, worksite wellness, community transformation grants, and improved access to preventive care.

Two provisions of the ACA support efforts to reduce tobacco use including a provision that prevents states from excluding coverage for tobacco-cessation drugs from their Medicaid programs and one that requires states to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use and also prohibits cost-sharing for these services. North Carolina's Medicaid program currently covers some tobacco cessation drugs and is already in compliance with the provision on pregnant women. However, barriers to treatment still exist. Therefore, the Workgroup recommends:

RECOMMENDATION 6.1: INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS

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

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

RECOMMENDATION 6.2: SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

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

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

RECOMMENDATION 6.3: PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

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

The ACA includes provisions that aim to improve population health through benefits provided by employers. The ACA also includes worksite wellness provisions which allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or prevent disease. There is a need for education of employers and employees on these provisions, thus, the Workgroup recommended:

RECOMMENDATION 6.4: PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES

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

The Prevention Workgroup examined funding opportunities available through the ACA and explored strategies to target funding to communities of greatest need. Often the communities with the greatest health needs are those that lack the personnel or infrastructure to apply for grants or to implement new initiatives. Therefore, the Workgroup recommended:

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

The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should develop the infrastructure needed to allow communities of greatest need to respond to prevention-related funding opportunities.

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

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

IMPROVING THE QUALITY OF CARE

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

Quality Workgroup

The ACA includes new provisions aimed at improving the quality of care provided by different types of health care professionals and providers. For example, the ACA requires the Secretary of the United States Department of Health and Human Services 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.[q] Health care professionals and providers will be required to report data on these new measures to the Centers for Medicare and Medicaid Services. Ultimately, these data will be made available to the public. In addition, the ACA changes the Medicare (and in some cases, Medicaid) reimbursement structure to reward providers and health care professionals, in part, on the quality of services provided.

The Quality workgroup recognized the importance of educating health care professionals and providers about these changes, so that these groups can understand and be prepared to meet the new Medicare reporting and quality standards. In addition, consumers need to understand how to interpret the quality comparison data when they become available. Thus, the Workgroup made many recommendations about the need for education, including:

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

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

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

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

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

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

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

A concern addressed by the workgroup was the impact on providers of multiple requests or demands for quality indicator data, since the state and federal governments, and private insurers, will be requesting data. Further reduction in the reporting burden could be achieved through alignment of the state quality measure requirements (eg, CCNC, DMA) with the federal measures. To reduce this reporting burden on providers and ensure that the state has access to information to drive state for state level quality improvement initiatives, the workgroup recommended:

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

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

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

Workgroup, in partnership with a subcommittee of the New Models of Care Workgroup, reviewed models and existing programs that address transitions in care at different points in the health care system, and made recommendations about which models and programs could be used or expanded in North Carolina to reduce preventable readmissions and improve transitions in care. In order to improve transitions of care, the joint subcommittee recommended:

RECOMMENDATION 7.9: IMPROVE TRANSITIONS OF CARE
The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina (CCNC) to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms to evaluate outcomes. Solutions utilizing transition principles should be applied to all patients regardless of payer.

RECOMMENDATION 7.10: REIMBURSE NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES
The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.

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

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

North Carolina has many different pilots or demonstrations under development, both in the public and private sector, including, but not limited, to multipayer patient-centered medical homes, new payment models, value-based insurance designs, and broader population health interventions. The New Models of Care workgroup attempted to catalogue the different

initiatives under development across the state, but there is a need for such work to continue. Therefore, the Workgroup recommended:

RECOMMENDATION 8.1: DEVELOP A CENTRALIZED NEW MODELS OF CARE TRACKING SYSTEM
North Carolina state government and North Carolina foundations should provide funding to the North Carolina Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state.

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

RECOMMENDATION 8.2: EVALUATION OF NEW PAYMENT AND DELIVERY MODELS
Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that others can learn from these new demonstrations. North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

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

RECOMMENDATION 8.3: CAPTURE DATA TO SUPPORT NEW MODELS OF CARE
The North Carolina Department of Health and Human Services should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to identify options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market. The plan with recommendations, including a timeline and potential financing mechanisms, should be reported to North Carolina General Assembly no later than the start of the 2013 session.

While public and private health care organizations in North Carolina have sought to take advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. A broader group of stakeholders need to be involved in discussions to address potential barriers as well as solutions to overcome those barriers, including licensure boards, the North Carolina Department of Insurance, health professional associations, and health care systems. Thus, the workgroup recommended:

RECOMMENDATION 8.4: EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS
The NCIOM should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models. The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or the otherwise effectively use of electronic health records. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.

Fraud and Abuse Workgroup
The Affordable Care Act (ACA) includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs).

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went in to effect in 2010 or 2011. Many requirements of the ACA provisions were already being addressed in North Carolina, including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. To fulfill other requirements, the state will need to implement new enforcement procedures.

The Fraud and Abuse Workgroup broke down the requirements of each ACA fraud and abuse provision, then identified 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. The workgroup also helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the concept list, to draft its recommended fraud and abuse legislation. DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399.

CONCLUSION

North Carolina currently faces significant health challenges, including the growing numbers of uninsured, poor overall population health, rising health care costs, and the need to increase

access to care and improve quality. The Affordable Care Act begins to address some of these problems. If implemented, the numbers of uninsured will decline. Greater emphasis will be placed on improving overall population health and the quality of health care services. Further, the ACA includes provisions aimed at lowering the rate of increase in health care expenditures.

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

Further, there are still unanswered questions. The ACA directed the Secretary of the United States Department of Health and Human Services to implement many of the provisions of the new law. The Secretary has issued both proposed and final regulations implementing many of the sections of the law, but further guidance on other sections is still pending. Of greater importance, we are awaiting the decision from the United States Supreme Court about the constitutionality of the entire law, or specific provisions of the law.

Regardless of how the Supreme Court rules, our current health care system cannot remain as is. Our state and our country are facing serious health system problems that must be addressed. If the ACA is ultimately determined to be unconstitutional—we will still have to address rising health care costs. There will still be pressures to address the health care needs of North Carolina's 1.6 million who lack insurance coverage. We will need to test new payment and delivery models to ensure that we achieve maximum value for our health care dollars. Moreover, we will need to invest more heavily in prevention if we want to have a healthy and productive workforce, reduce the growth in chronic illness, and limit the need for high-cost interventions. The ACA is a starting point, not an ending point. If implemented, it is likely to be amended over time as we understand what works and what needs to be changed.

While the focus of the Health Reform Workgroups was to address new requirements that are part of the ACA, many of the recommendations are applicable even if the ACA, or parts of it, are not upheld. The recommendations from these groups can help the state address concerns about the health practitioner workforce, test new ways to improve quality and reduce health care costs, strengthen the safety net, streamline the eligibility and application process for existing public programs, and increase prevention efforts to improve overall population health.

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CHAPTER 2
HEALTH BENEFITS EXCHANGE

OVERVIEW

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (HBE). The ACA requires that each state have a HBE that will offer information to help individuals and businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own HBE, the federal government will create one to offer coverage to individuals and small groups in the state.

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty.[a,b] Certain individuals are exempt from the mandate, including, but not limited to, those who are not required to pay taxes because their incomes are less than 100% of the federal poverty line (FPL), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.[c] Larger businesses, with 50 or more full-time equivalent employees, must also offer minimum essential coverage or pay a penalty for its full-time employees.[d]

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

Individual and small group plans, including qualified health plans (QHPs) offered through the HBE, must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and

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[a] The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016.

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

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

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

devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[e] Each state will be required to define its own essential health benefits package (using HHS defined benchmarks) that includes coverage of these services.[1] In addition, all insurance plans that are not grandfathered[f] must provide coverage of the clinical preventive services recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee for Immunization Practices with no cost sharing.[g] Insurers must also provide additional preventive services for infants, children, adolescents, and women.[h]

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

The ACA includes subsidies to make health insurance coverage more affordable. The subsidies are available to single individuals or families with modified adjusted gross income (MAGI) of up to 400% of the federal poverty level (FPL), if they do not have access to affordable employer-sponsored insurance (ESI) and do not qualify for public coverage such as Medicaid.[k] (Table 2.1) Families that qualify for subsidies may be eligible for an advanceable premium tax credit to help pay for health insurance coverage. The premium tax credit is based on the second lowest cost silver plan offered in the HBE. As long as the family purchases the second lowest cost silver plan then the maximum that the family would have to pay is based on a percentage of their income (ranging from 2% for lower income families to 9.5% for those whose incomes are

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

[f] Grandfathered plans—those that were in existence when the bill was signed into law on March 23, 2010, and which have not changed substantially since then. Over time, many insurance plans will lose their grandfathered status, and will be subject to the preventive services and minimum essential coverage requirements. 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 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.

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

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

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

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

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

between 300-400% FPL). Families who choose to purchase a higher cost plan would pay the specified percentage of their income, plus the difference in the premium cost between what they chose to purchase and the second lowest cost silver plan. Conversely, families that purchase a lower cost plan would pay less.

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

Individual or Family Income (as percent FPL)	Maximum premium for second lowest cost silver plan (Percent of family income)	Out-of-pocket cost sharing, on average[€]	Out-of-pocket cost-sharing limits (Proportion of the Health Savings Accounts (HSA) out-of-pocket cost-sharing limits)[¥] [β]
Families eligible for subsidy			
<133% FPL	2%	6%	$2,017 (individual)/ $4,033 (family) (1/3 HSA limits)
133-150% FPL	3-4%	6%	$2,017/$4,033
150-200% FPL	4-6.3%	13%	$2,017/$4,033
200-250% FPL	6.3%-8.05%	27%	$3,025/$6,050 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	$6,050/$12,000
300-400% FPL	9.5%	30%	$6,050/$12,100
Families not eligible for subsidies			
400%+ FPL	No limit	30%	$6,050/$12,100 (HSA limit)

[€] Out-of-pocket cost sharing includes deductibles, coinsurance, and copays.
[¥] Out-of-pocket limits do not include premium costs. Annual cost sharing limited to $6,050 per individual or $12,100 per family in 2012 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.
[β] The Center for Consumer Information and Insurance Oversight released Actuarial Value and Cost-Sharing Reductions Bulletin which indicated the United States Department of Health and Human Services' intent not to reduce out-of-pocket limits for those with incomes between 250-400% FPL. http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf. Accessed April 13, 2012.

Lower income individuals and families, those with incomes below 250% FPL, also receive subsidies to help pay for their out-of-pocket costs (such as deductibles, coinsurance, or copayments) if they enroll in a silver plan. American Indians with incomes below 300% FPL pay

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

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

The North Carolina Department of Insurance contracted with Milliman, Inc., an actuarial consulting firm, to develop estimates of the number of people who might gain coverage in the HBE and examine other HBE operational and design issues. According to Milliman, approximately 715,000 North Carolinians are expected to obtain their health insurance coverage through the HBE beginning in 2014.[2] (Table 2.2) Of these, slightly more than 51,000 people are expected to be covered by small businesses purchasing insurance for employees and their dependents through the HBE; more than 660,000 people are expected to purchase nongroup coverage through the Exchange. Approximately 300,000 of the individuals who are expected to enroll in the HBE in the first year are expected to have been uninsured in 2013.

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

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

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

Table 2.2
Changes in Insurance Coverage (2013-2014)

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

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

HBE REQUIREMENTS

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

- Certify, recertify, and decertify qualified health plans, Co-op plans, and federally approved multi-state plans as specified by the Secretary.[n, o]
- Operate a toll-free telephone hotline to respond to requests for assistance and to provide eligibility and enrollment in person, via phone or fax, or electronically.[p, q]
- Develop and maintain a website that provides standardized comparative information on plan options including costs, quality, and provider networks.[r, s]
- Assign a quality rating to each qualified health plan offered through the HBE using criteria developed by the Secretary.[t, u]

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[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1301, 1311, 1321, 1322, 1334, 10104.
[o] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.1010, 155.1075, 155.1080.
[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).
[q] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.
[r] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c), (d)(4)(B).
[s] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.205.
[t] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(d)(4)(D).

- Determine eligibility for the premium tax credit and cost-sharing subsidies.[v, w]
- Conduct outreach and education to inform people about eligibility requirements for Medicaid and North Carolina Health Choice and, if eligible, enroll them directly into these programs.[x, y]
- Establish and make available an electronic calculator for determining the costs of coverage after applicable premium tax credits and cost-sharing reductions.[z, aa]
- Certify individuals who are exempt from the requirement to purchase health insurance.[bb,cc]
- Provide information to the Secretary of the USDHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions and the level of coverage.[dd]
- Provide the Secretary of the Treasury with information about anyone who is exempt from the individual mandate, anyone who is receiving a subsidy who works for an employer required to offer insurance, and information about individuals who change employers and who cease coverage under a qualified health plan.[ee]
- Provide information to employers of any employee who ceases coverage under a qualified health plan.[ff]
- Establish a navigator program to provide information to the public about health plan choices and to help them enroll.[gg, hh]
- Consult with relevant stakeholders to carry out required activities.[ii , jj]
- Publish average costs of licensing, regulatory fees, and other payments to the HBE and administrative costs.[kk , ll]

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

[v] 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.

[w] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.300-155.355.

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

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

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

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

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

[cc] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.200(b), 155.705.

[dd] 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).

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

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

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

[hh] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.210-220.

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

[jj] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.130.

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

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

- Report on activities, receipts, and expenditures annually to the Secretary of the USDHHS.[mm]
- Consider information from employers that contest the imposition of penalties.[nn]

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

The federal government will pay for expenses associated with the establishment and operations of a state-based exchange until 2015 (with the exception of Navigator grants, discussed more fully below). However, the HBE must be financially self-sufficient beginning January 1, 2015.[qq,rr] The ACA envisions that the HBE would charge assessments or impose user fees to participating health insurance issuers, or the state must otherwise be able to generate sufficient funds to cover operating costs.[ss]

States that choose to operate their own HBE in 2014 must have an approved plan and be able to demonstrate operational readiness by January 1, 2013.[tt] The Center for Consumer Information and Insurance Oversight (CCIIO), within the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, provided states guidance as to what will be required to show operational readiness.[4] To be certified, HBEs must show their ability to perform the following core functions:

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

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

[oo] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(2)(3).

[pp] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.240(c); 155.705(b)(4).

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

[rr] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.160.

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

[tt] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.105.

- *Consumer Assistance,* including education and outreach, navigator management, call center operations, website management, consumer support assistors, and written correspondence with consumers to support eligibility and enrollment.
- *Plan Management*, including plan selection approach, collection and analysis of plan rate and benefit package information, issuer monitoring and oversight, ongoing issuer account management, issuer outreach and training, and data collection and analysis for quality.
- *Eligibility*, including the ability to accept applications, conduct verifications of applicant information, determine eligibility for enrollment into a qualified health plan and insurance affordability programs, connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP, and conduct redeterminations and appeals.
- *Enrollment*, including enrolling consumers into qualified health plans, transactions with QHPs and transmission of information necessary to initiate advance payment of the premium tax credits and cost-sharing reductions.
- *Financial management*, including user fees or assessments, or other arrangements to assure financial solvency, financial integrity, support of risk adjustment, reinsurance and risk corridor programs.

STATE DESIGN ISSUES

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.** The effective and efficient operation of the HBE will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the HBE. The HBE workgroup and Overall Advisory Committee believe that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government. In its interim report, the HBE workgroup and the Overall Advisory Committee recommended that the North Carolina General Assembly (NCGA) create a state based Health Benefits Exchange. The workgroup also recommended that the legislature create a separate quasi-state agency (public corporation), rather than house the HBE within an existing state agency.[5]

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

> **"DEPARTMENT OF INSURANCE AND AFFORDABLE CARE ACT**
> **"SECTION 23.3.** It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, collectively referred to as the Affordable Care Act (ACA). The Department of Insurance (DOI) and the Department of Health and Human

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

Based on this legislation, NCDOI submitted a Level I establishment grant to the federal government. North Carolina was successful in obtaining a $12.4 million dollar grant. Level I grants provide funding for one year to begin the process of creating a state-based HBE. North Carolina's Level I grant period runs from August 15, 2011 through August 14, 2012.

The state can submit a proposal for a Level II implementation grant to pay for further development, as well as start up and initial operational costs (through 2014). In order to apply for a Level II grant, the state must have authorized the creation of the HBE with an appropriate governance structure. In addition, the HBE must submit a budget through 2014, and an operational plan that includes—at a minimum—plans to provide consumer assistance, prevent fraud and abuse, and ensure financial sustainability beginning in 2015.[6] Recent pronouncements from CMS have extended the deadlines for Level II grant applications. This said, the HBE workgroup recommends that to be operational by 2014, the North Carolina General Assembly should create the HBE and pursue additional funding this summer.

If North Carolina is going to operate a state-based HBE in 2014, it must show operational readiness by mid-2013. The Level I establishment grant will be used to develop plans to build some of the key components needed to show operational readiness in 2013, including developing requirements for the necessary information technology (IT) systems, and strengthening the existing consumer assistance program. Specifically, the North Carolina Level I establishment grant will be used to:

- Engage stakeholders and perform policy analysis on policy issues.
- Expand NCDHHS eligibility IT system to include needed HBE functionality and expanded user base.
- Develop requirements to build or procure non-eligibility IT systems.
- Propose legislation and develop regulations for needed market reforms.
- Establish capacity to provide assistance to individuals and small businesses seeking health insurance.
- Develop required elements for a Level II application.
- Support start-up of the NCHBE, assuming that the NCGA creates a new legal entity during the Level I establishment period.

NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the HBE policy and design issues. NCDOI has created a separate Market Reform Technical Advisory Group (TAG) to consider the market reform issues—particularly those that will impact on insurance coverage or rating inside and outside the HBE. The two groups have been charged with examining different implementation and design issues. (Table 2.3) In general, the HBE workgroup is considering those issues unique to the HBE, and the NCDOI TAG is considering those issues which affect health plans both inside and outside the HBE. The work of the NCDOI TAG will be presented to the North Carolina General Assembly in a series of separate reports.

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

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

HBE WORKGROUP RECOMMENDATIONS

The HBE workgroup has met nine times since the beginning of August, 2011. In addition, a subcommittee met on four occasions to examine options for the navigator program. The following includes the recommendations from the HBE workgroup. This information will also be presented to the HBE Board (if created).

State-Based or Partnership HBE

As noted earlier, the ACA gives states the authority to create its own HBE or leave it to the federal government to operate an HBE on the state's behalf. However, in subsequent regulations and policy guidance, the United States Department of Health and Human Services (USDHHS) set forth a proposed hybrid approach—called a "partnership" HBE option.[74] With the partnership option, USDHHS gave states flexibility to assume some functions that they want to provide directly and those which they want the federal government to assume. The partnership option is considered a federally-facilitated, and not a state-operated Exchange. Table 2.4 gives a brief overview of the different HBE operational options: state operated, federally facilitated, or partnership. More detailed information is provided below.

Table 2.4
Overview of Different HBE Operational Arrangements

	State Operated HBE	Federally Facilitated HBE	State-Federal Partnership
Consumer Assistance	State	Federal, with some harmonization to state laws	State option on some functions
Plan Management	State	Federal, with some state interaction	State Option
Eligibility	State, with option for federal support	Federal, with state option for final Medicaid/CHIP determination	Federal, with state option for final Medicaid/CHIP determination
Enrollment	State	Federal	Federal
Financial Management	State, with option for federal risk adjustment	Federal, with option for state reinsurance	Federal, with option for state reinsurance
Sustainability	State option	Federal user fees	Federal user fees

The HBE workgroup examined the partnership option, as currently understood, to determine if there were any functions that could best be handled by the federal government. In general, as outlined below, the workgroup confirmed its earlier recommendation that North Carolina create and operate its own HBE. However, there were a few functions which work group members thought would better be handled by the federal government.

Consumer assistance. The workgroup recommended that the state provide consumer assistance directly to enrollees. A state-based exchange would be better equipped to provide outreach and education to North Carolinians, as a state organization would already have knowledge of the state, the insurance industry, key consumer and small business groups, and other consumer support and eligibility sources such as those provided by the North Carolina Department of Health and Human Services (NCDHHS) and local social services agencies. In addition, NCDOI already operates a successful consumer assistance program—Health Insurance Smart NC — which helps consumers with insurance related questions or complaints. Not only does Smart NC provide key services to North Carolinians, but the information it collects as part of the complaint process is essential for NCDOI's regulatory responsibilities. The workgroup also recommended that the HBE contract to operate the call-center in state, as North Carolinians have a better

understanding of the state's health insurance marketplace and health care infrastructure. In addition, workgroup members recommended operating a state-based call center so that the state would benefit from the new jobs created. Some of the HBE workgroup members thought the federal government might be in the better position to create the "shop and compare" interface for the HBE website, but they also recognized that the federal government would need to get a lot of the underlying data from the North Carolina Department of Insurance. Thus, there was more of a consensus that the state-based HBE take responsibility for creating the shop and compare website.

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

The HBE imposes new responsibilities that may not be fully addressed as part of the current NCDOI regulations. For example, the HBE must establish network adequacy standards to ensure that the QHP offers a sufficient choice of providers.[uu] If the state does not create its own network adequacy standards, the federal government will create standards for plans operating in the HBE.[4] The NCDOI does not have specific network adequacy rules; rather, it requires health plans with networks to develop their own standards and measures the plans against those standards.[vv] Additionally, there are protections in place for consumers who are not able to access network providers.[ww] Based on the final HBE regulations, it appears that North Carolina's current network adequacy standards will be sufficient. If North Carolina's existing network adequacy requirements are not considered sufficient to meet federal requirements, the workgroup recommended that the state create its own specific network adequacy standards, as it has a better understanding of the availability of health care professionals and providers across the state, as well as consumer access issues reported through NCDOI. Absent adoption of statewide standards, the HBE Board should have the authority to adopt standards for qualified health plans offered in the HBE. In addition, the workgroup also recommended that a state-based HBE assign quality ratings to the different plans, within the criteria established by the USDHHS. A state-based HBE should assume this responsibility to ensure that North Carolina can monitor the

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[uu] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.1050, 156.230.

[vv] 11 NCAC §§20.0301-.0302.

[ww] NCGS §58-3-200(d).

overall quality of the plans. One of the other advantages of having the state HBE assign quality ratings is that North Carolina would then have access to the underlying quality data. This would help ensure that the state has access to data that could drive state-level quality improvement activities, if it so chooses.

Eligibility for subsidy determinations. Workgroup members recommended that a state-based HBE take applications and help consumers with the verification process if questions arise. Workgroup members believed that this function could be handled better through a state-based HBE that could more easily establish working relationships with community based organizations serving as navigators, departments of social services, and local agents and brokers. Further, North Carolina should maintain its role in making final Medicaid/CHIP determinations, as the state is responsible for a share of the Medicaid and CHIP costs. While the workgroup members believed that the state should have primary responsibility for taking and processing the applications and making the final Medicaid/CHIP eligibility determinations, workgroup members did recommend that the federal government take the lead in determining eligibility for the premium tax credit and cost-sharing subsidies. Eligibility for the premium tax credit and cost- sharing subsidies is based on the IRS rules for modified adjusted gross income (MAGI). The IRS has responsibility for reconciling the amount of the premium tax credit that the individual received through the HBE with the amount they are ultimately eligible to receive based on year-end taxes. As the IRS will be responsible for this reconciliation function, work group members thought it made more sense for the federal government to also make the initial eligibility decision about the premium tax credit and cost-sharing subsidy. Similarly, the workgroup members recommended that the federal government determine whether a person is exempt from the mandate, as for many people, the person's MAGI will be critical to this determination. (The federal government has provided preliminary indications that it will provide this service as an option for state-operated Exchanges.[4])

In addition, the workgroup also recommended that the federal government assume responsibility for determining whether an employer is offering minimum essential coverage. In order to make this determination, the HBE will need to obtain a copy of the employer's health plan offering to determine if the coverage meets the 60% actuarial value standard and whether the coverage is affordable to all of the full-time employees. CMS is exploring whether they can assume this responsibility for states that choose to operate their own HBE.[4] The workgroup members believed it made more sense to let the federal government make this determination for North Carolina businesses, if this option is offered to states. This will be difficult for a state-based HBE to determine, as it has no mechanism to collect health plan information from employers (particularly for self-funded employers). The federal government will need to collect this data in other states (for federally-facilitated HBEs).

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

Financial management. Again, the workgroup members supported having the state-based HBE have primary responsibility for financial management of the HBE, specifically setting and collecting any assessments. Preliminary information from CCIIO suggests that the federal government will finance the operational costs of federally-operated HBE through assessments on insurers. The workgroup was particularly concerned that if the federal government operates the HBE, that North Carolinians not be assessed for costs that are incurred in other states. If the state operates the HBE, it has greater control over the costs of the HBE and how the HBE is financed. The operation of risk adjustment and reinsurance programs is also part of the financial management function. Due to their technical nature and impact both inside and outside the Exchange, these programs are being discussed with NCDOI's Market Reform TAG.

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

RECOMMENDATION 2.1: STATE AND FEDERAL HBE OPERATIONAL RESPONSIBILITIES

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

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

QHP Certification Requirements

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

With some caveats, the workgroup members reached consensus about giving the HBE Board the authority to either impose new requirements or to incentivize health plans to meet additional standards if needed to improve plan competition, enhance the functioning of the HBE, meet the

needs of consumers, reduce adverse selection into the HBE or among different insurers, or promote health plan innovation that could reduce costs or improve quality. However, HBE workgroup members only felt comfortable giving the HBE Board the authority to impose additional requirements if the Board was broadly constituted and included representation from consumers, employers, insurers, agents, providers, and other knowledgeable individuals.

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

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

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

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

imposed strict limits on the number or types of plan design, it could reduce consumer choice, and potentially create barriers to the introduction of innovative insurance models.

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

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

Require insurers participating in the HBE to meet quality standards in addition to those required by the ACA or Secretary of the US DHHS. The ACA requires that all plans be accredited, implement a quality improvement strategy, report certain quality measures, and limit contracts to providers that meet specified quality standards.[xx] HBEs must assign a quality rating to each plan

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

on the basis of relative quality and price.[yy] The Secretary of USDHHS will establish standards for the quality rating system, and will also collect enrollee satisfaction information on all health plans.[zz] In addition, the ACA directs the Secretary to develop strategies to further reward quality of care through market based incentives.[aaa]

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

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

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

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

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

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

[bbb] For purposes of the HBE workgroup discussion and decision making, we limited "consensus" decisions to those that were supported by at least two-thirds of the members.

[ccc] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.1045.

Network adequacy standards. The federal regulations require that HBEs establish network adequacy standards to ensure that enrollees have a sufficient choice of providers. The Secretary proposed that these standards be established at the state level, rather than at the federal level, because states have a better understanding of the geography, local patterns of care, array and distribution of health care professionals and providers, and market conditions.[ddd] Qualified health plans must meet the state established network adequacy standards.[eee] If the state does not have or create a network adequacy standard that meets federal requirements, the federal government will do so. As noted earlier, North Carolina's existing procedures may be sufficient to meet the federal network adequacy standard. If not, the workgroup discussed whether the HBE should establish standards for plans offered in the HBE, or whether the NCDOI should establish standards for all commercial insurers. The workgroup recommended that if needed, NCDOI establish objective minimum network adequacy standards that satisfy the requirements of the ACA, and that these standards should be the same for plans operating inside and outside the HBE. The workgroup also recommended that NCDOI include some flexibility in the network adequacy standards, if needed to test innovative or quality-driven delivery models.

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

[ddd] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 155.1050.

[eee] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.230.

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

[ggg] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031 referencing 42 USC §§256(b)(a)(4), 1927(c)(1)(d)(i)(IV) for definition of essential community provider.

[hhh] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475 at p. 18419.

[iii] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475 at p. 421.

[jjj] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.235.

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

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

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

RECOMMENDATION 2.2: HBE BOARD AUTHORITY FOR HBE CERTIFICATION

a) The North Carolina General Assembly should give the Health Benefits Exchange (HBE) Board the authority to:

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

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

c) Aside from allowing the HBE Board to standardize terminology, plan design or limit the number of different plan designs per metal level (Sec. a.i. above), the

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[kkk] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(2), 42 USC 13031

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

[mmm] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR 156.235(e).

HBE Board should not impose any other new requirements earlier than 2016. Thereafter, before imposing new requirements on health plans, the HBE Board should consider the likely impact of those requirements on the overall functioning of the HBE, the needs of consumers and/or employers purchasing in the HBE, administrative costs and premiums, consumer choice (including the ability of consumers to compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the HBE, participation of health plans in the HBE, adverse selection into the HBE and/or among participating plans in the HBE, and, in consultation with the North Carolina Department of Insurance, the impact of any changes on the health insurance market operating outside the HBE.

d) **The HBE Board should give all QHP applicants that are not already accredited two years to meet the accreditation standards assuming that the insurer can show that it is making reasonable progress in obtaining accreditation. The HBE Board can choose to extend this time for extenuating circumstances, for example, if the accreditation agencies are unable to make timely accreditation decisions.**

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

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

HBE Sustainability Options

Federal funding necessary to create and operate the HBE is only available through 2014. Thereafter, the HBE must be fully self-sufficient at the state-level. The ACA identifies certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[nnn] The federal regulations parallel the statutory requirements by noting that states may fund Exchange operations by charging assessments or user fees on participating insurers, or otherwise generate

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

funding for Exchange operations.[ooo] HHS guidance suggests that HHS will charge insurers users fees if the federal government establishes the HBE in a state.[7]

Milliman Inc. prepared a preliminary estimate of the HBE's ongoing operational costs beginning in 2014. Milliman estimated that the North Carolina HBE operations would cost approximately $23.8 million in 2014, $25 million in 2015, and $26.7 million in 2016. [2] The Milliman estimates were among the first estimates developed across the country, and did not reflect subsequent regulations and guidance or the experiences of some of the early adopter states. In addition, Milliman's estimates do not include the initial start-up costs. The estimates were based on the HBE providing bare minimum services, including functions related to HBE operations (such as plan administration, call center, eligibility processing, enrollment reporting, and plan performance and quality reporting), marketing (including exchange marketing, navigator program, outreach and education, and public relations), information systems, and finance (including actuarial analysis, accounting/financial reporting, and infrastructure).

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

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

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

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

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

[ooo] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR § 155.160.

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

In order to obtain a Level II grant, the state must have a detailed budget and plans to assure financial self-sufficiency in 2015. Thus, the workgroup examined options for different ways to raise the necessary revenues to support the HBE operations. The group recommended that any new premium tax revenues generated as a result of the implementation of the Affordable Care Act be put into a trust fund and designated for the HBE operations. This would include premium tax dollars raised as a result of the new people gaining coverage as well as the increase in costs of health insurance premiums due to ACA implementation.

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

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

[ppp] Lerche, J. Health Actuary, Actuarial Services Division, North Carolina Department of Insurance. Written (email) communication, April 15, 2012.

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

In contrast, the HBE workgroup recommended that the HBE receive only the new health insurance premium tax revenues generated as a result in the growth in the number of covered lives and the increase in costs of health insurance premiums due to the ACA over the 2013 baseline year. Because of the concern that this may not prove adequate to meet the HBE's budget requirements, the HBE workgroup also recommended that the North Carolina General Assembly pass through the revenues it uses to support Inclusive Health. According to staff in fiscal research, the state payment to Inclusive Health is scheduled to be approximately $15.2 million in SFY 2012, $24.4 million in SFY 2013, and $34.2 million in SFY 2014.[rrr] Beginning in 2014, individuals who were receiving coverage through the state or federal high risk pool will gain coverage through the HBE. Inclusive Health will no longer be needed to provide coverage to these high risk individuals. Thus, any remaining funds should be transferred to the HBE to support operations, net the reserves needed to pay outstanding health bills.

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

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

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

[qqq] NCGS §105-228.5B.

[rrr] Keough, M. Executive Director, Inclusive Health. Written (email) Communications. February 28, 2012.

- *Advertising fees*. These fees may not generate significant revenues. Further, the administrative costs of collecting and selling advertising would reduce the revenues that could be used for HBE operations. In addition, advertising health plans that were offered through the HBE could reduce the effectiveness of the HBE shop and compare website, if consumers are given the impression that the website is trying to promote one plan over another. Thus before accepting advertising revenues, the HBE board should establish criteria for the types and placement display of potential advertising.
- *User fees on insurers operating within the HBE*. Workgroup members discussed the imposition of additional user fees on insurers operating within the HBE. Some members were concerned that adding additional user fees on insurers offering coverage within the HBE might discourage health plans from participating in the HBE (depending on the size of the user fee). In addition, because insurers are required to charge the same premium for health plans offered inside and outside the HBE, an additional user fee charged to health plans operating in the HBE might result in higher premiums outside the HBE. On the other hand, it is possible that imposing an additional fee on insurers would be built into the premium costs, and therefore passed onto the federal government for people eligible for a subsidy. The workgroup members also discussed the possibility of charging additional user fees on health plans that offer more than a specified level of health plan options per metal level, in order to discourage insurers from offering large numbers of plan designs in each metal level. The additional fees would also help offset the additional administrative costs in certifying and overseeing all of the new plans offered within the HBE.
- *User fees on individuals purchasing within the HBE*. Workgroup members also discussed the possibility of charging a user fee to individuals who purchased coverage within the HBE, if allowed under federal law. However, workgroup members were concerned that imposing a fee on users in the HBE would discourage people from purchasing coverage in the HBE. Further, many individuals could be gaining the benefits of the HBE (for example, by using the shop and compare website to examine the costs and quality of different health plans), even if they ultimately choose to purchase coverage outside the HBE. Thus, workgroup members also discussed the option to charge fees for individuals both inside and outside the HBE.
- *Foundation funding*. The HBE should have the authority to seek foundation or other funding, particularly in the first few years, to support navigator grants (see discussion of navigators below). However, the workgroup members did not believe the HBE should rely on foundation funding to support ongoing operational expenses, as foundation funding is typically time limited.

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

Thus, the workgroup recommended:

RECOMMENDATION 2.5: HBE FINANCIAL SUSTAINABILITY

a) **The North Carolina General Assembly should establish a HBE Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the HBE Trust Fund to pay for reasonable HBE operations.**
   i. **The trust fund should include premium tax revenues generated as a result of the increase in the number of people who purchase health insurance coverage inside and outside the HBE from a base year of 2013.**
   ii. **The increase in the costs of the premium due to the implementation of the ACA.**
b) **The North Carolina General Assembly should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the HBE Trust Fund.**
c) **The North Carolina General Assembly should give the HBE Board the authority to raise other revenues if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for the reasonable HBE operations. These additional revenue sources should include, but not be limited to:**
   i. **Fees on individuals or insurers who offer or purchase coverage in the HBE, up to a maximum threshold established by the North Carolina General Assembly.**
   ii. **Fees on insurers who offer more than a specified number of health plans per metal level.**
   iii. **Advertising revenues**
   iv. **Grants from foundations or other philanthropic sources**

Education, Outreach, Navigators, and Enrollment Assistance

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. There are separate, but similar, requirements for the HBE and Medicaid agency. At the very general level, the HBE and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll. To make it easier for people to apply, the ACA and federal regulations specify that people can apply online, in person, by telephone, or by fax. [sss.] [ttt] Individuals can always seek informal help from family or friends. However, the ACA also envisions that there will be other sources of trained enrollment assistors, including trained navigators, DSS workers, and agents or brokers (at the state option). Further, the new law creates a "no wrong door" enrollment process. Individuals can apply directly to the HBE, and if eligible for Medicaid or CHIP, enroll directly into those programs, and conversely, people can apply for Medicaid or CHIP, and if ineligible, be screened and, if eligible, enrolled into a QHP in the HBE.

The HBE workgroup created a subcommittee to consider education and outreach efforts; training for nonprofits and other groups who can refer individuals to appropriate assistance; navigator

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[sss] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.405.

[ttt] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.

training, certification, compensation and accountability; the role of agents and brokers; and how to create the "no wrong door" eligibility and enrollment process. The subcommittee reported its recommendations to the full committee.

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

The HBE workgroup recognized that the HBE might need to enlist the support of different groups to provide education and outreach to the nongroup market other than those who will be effective in targeting the small group market. For example, while nonprofits, human services agencies, community-based organizations, and faith groups may be enlisted to provide education and outreach to individuals, the HBE may need to enlist the support of Chambers of Commerce, professional associations, small business resource centers, community banks, or other organizations to reach small businesses.

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

Informal assistance. As noted earlier, individuals can seek help in the enrollment process from many different sources. Individuals can obtain help from certified navigators, agents, or brokers (discussed more fully below). However, an individual can seek help from other sources as well.

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

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

[www] PPACA Sec. 2201, amending Sec. XIX of the Social Security Act, 42 USC 1396w-3(b)(1)(F).

The new federal regulations state that the HBE must accept applications from the applicant, an authorized representative, or someone acting responsibly on behalf of the applicant.[xxx]

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

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

RECOMMENDATION 2.6. OUTREACH AND EDUCATION

a) **The Health Benefits Exchange (HBE), in conjunction with the North Carolina Department of Insurance (NCDOI), and North Carolina Division of Medical Assistance (DMA), and other appropriate organizations, should develop a standardized community outreach and education toolkit so that interested organizations and individuals can disseminate similar outreach and education materials. The toolkit should provide basic information about public insurance options (including Medicaid and North Carolina Health Choice), nongroup coverage available through the Health Benefit Exchange, eligibility for the premium tax credit and cost-sharing subsidies, different insurance options for small businesses, the small business tax credit, the computerized eligibility and enrollment system, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.**
b) **The HBE, in conjunction with the NCDOI and DMA, should offer workshops and other training opportunities to provide basic information about public and private insurance options, the HBE website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.**

Navigators. The ACA requires the HBE to provide grants to navigator *entities* to help people understand their insurance options and enroll into coverage in the HBE. To be eligible to receive a grant, the HBE entity must have existing relationships or show that they can establish relationships with individuals or small businesses likely to enroll in a QHP.[yyy] The regulations clarify that the HBE must contract with at least two of the following categories of eligible *navigator entities* to receive the navigator grants, including: consumer and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry organizations, ranching and farming organizations; chambers of commerce; unions; resource

[xxx] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.20.

[yyy] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(2)(A).

partners of the Small Business Administration; licensed agents and brokers (if they do not receive compensation directly or indirectly from insurers); and other public or private entities which may include Indian tribes, tribal organizations, and state or local human service agencies.[zzz]

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

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

Navigators must be able to perform specific responsibilities:

- Conduct public education activities to educate the public about coverage offered through the HBE.
- Distribute fair and impartial information about enrollment into QHPs, and the subsidies available through the HBE.
- Help people with enrollment into qualified health plans.
- Provide referrals to applicable health insurance consumer assistance, ombudsman programs, or other appropriate state agency or agencies that can address consumer questions or complaints.
- Provide information in a manner that is culturally and linguistically accessible.[aaaa]

The HBE workgroup used NCDOI's Seniors' Health Insurance Information Program (SHIIP) as a successful example of a navigator program. SHIIP counselors help provide information to older adults and people with disabilities about Medicare, Medicare Advantage plans, Medicare supplement plans, Medicare Prescription Drug Plans, and long-term care insurance. NCDOI contracts with 109 SHIIP coordinating organizations across the state. These organizations help coordinate the work of more than 800 volunteer SHIIP counselors. To serve as SHIIP counselor, individuals must complete required training and pass a competency exam. Currently, the training is provided online, includes 13 different modules, and takes approximately 24 hours to complete. SHIIP counselors must also meet continuing education requirements, and be recertified annually. Individual SHIIP counselors must also report certain information to NCDOI and must meet

[zzz] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.210(b)(2).

[aaaa] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(3).

minimum activity thresholds (such as providing a minimum number of one-on-one counseling sessions) to be recertified. SHIIP also has a complaint system so that people can provide feedback to NCDOI about specific SHIIP counselors, and individual volunteers can be terminated for cause. SHIIP counselors may not provide advice to individuals about plan selection, they only provide information so that individuals can make their own choice of Medicare Advantage, Medicare Prescription Drug Plans, Medicare supplement, or long-term care insurance plans.

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

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

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

Both the safety net workgroup (see Recommendation 4.4 in Chapter 4) and members of the HBE workgroup recognized the important role that safety net organizations could play in helping the uninsured enroll in appropriate health plans. Thus, the workgroup was concerned about creating too strict a definition of conflict of interest that could preclude staff from safety net organizations from serving as certified navigators. The workgroup recommended that the HBE create conflict of interest rules that would preclude an *entity* from serving as a coordinating navigator entity if they would derive financial benefit from steering an individual to a particular health plan or

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

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

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

[bbbb] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(i)(6).

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

and enrollment facilitation. The workgroup suggested that the HBE Board explore the question about whether individual navigators should receive any compensation for their services.

Thus, to ensure that the state operate an effective navigator system, the workgroup recommended:

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS

a) **The Health Benefit Exchange (HBE) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator program.**
   i. **The NCDOI, in conjunction with the HBE, should create a standardized training curriculum along with a competency exam to certify individual navigators.**
   ii. **Individual navigators should be recertified annually. To be recertified, the navigator must:**
      A. **Complete continuing education requirements and meet minimum activity thresholds, as specified by the NCDOI in conjunction with the HBE.**
      B. **Provide data to the state to ensure the overall functioning of the navigator system. Such data may include, but not be limited to, information on the number of people served and types of services provided.**
      C. **Be connected to a specific navigator entity.**
   iii. **Individual navigators can be terminated for cause.**
   iv. **Navigator entities should have a designated person who serves as the navigator coordinator. These coordinators must also be certified as navigators, but will have additional responsibilities and training to serve as a coordinator and oversee the work of individual navigators in their community.**

b) **The HBE Board shall create strong conflict of interest rules for individual navigators and navigator entities. The conflict of interest rules should:**
   i. **Preclude navigator entities from serving as a coordinating entity if they would derive financial benefit from steering an individual to a particular health plan or health insurer.**
   ii. **Allow employees of primary care safety net organizations (eg, FQHCs, free clinics, rural health clinics, or health departments) or other individuals to serve as individual navigators as long as the individuals, and their immediate families, do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not directly or indirectly based on the health plans which the individual selects. The HBE Board can allow employees of hospitals or other health care organizations to serve as navigators in rural or other underserved communities, but only if the HBE Board certifies that there is insufficient navigator capacity in those communities to meet the needs of individuals seeking navigator assistance. The HBE should adopt rules, guidance, education, and conflict of interest disclosure requirements, and should specifically monitor these provider-linked navigators to ensure that they comply with the ACA's prohibitions against steering patients to particular plans.**

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

d) **The HBE Board should seek funding from state philanthropic organizations or other sources to help pay small grants to navigator entities to help offset the administrative costs to coordinate and oversee the work of local navigators.**
   i. **In 2013, the HBE should pay each navigator coordinating entity a flat rate based on size of the targeted population.**
   ii. **Thereafter, the navigator grants should be based, in part, on outcomes so that navigator entities are rewarded for doing a good job with education, outreach, and enrollment facilitation.**
   iii. **The HBE Board may explore the option of compensating individual navigators for their services.**

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

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

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

[dddd] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.220.

Other agents are independent, but may still have a financial incentive to steer clients to a specific insurer. For example, some insurers pay higher commissions after an agent or broker places a certain level of business in that company.

Further, typical compensation arrangements make it financially prohibitive for agents and brokers to service the smallest employer groups (ie, those with <10 employees). It often costs more to agents and brokers and insurers on a per person basis to provide services to small groups, as there are certain fixed costs that are spread among a smaller group of covered lives. In addition, small groups generally lack human resource staff, so look to agents and brokers to handle many of the functions that larger organizations handle internally. If agents or brokers are paid a flat commission per covered life, the aggregate fee may be insufficient to cover the costs of servicing these small groups. To make it more difficult, some insurers pay agents or brokers progressively higher commissions, depending on the size of the group. The workgroup discussed the possibility of paying agents and brokers more for smaller groups, recognizing the higher costs in providing services to small employers. However, if insurers pay higher commissions for some groups over others, the additional commission rate will be spread over all of the insurers' small group business as insurers must essentially charge the same premium for different small businesses. (Insurers can only vary rates based on age and family composition of the covered individuals and geography. Insurers may not charge differential premiums based on differences in administrative expenses of covering different small employer groups).

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

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

To encourage agents and brokers to educate and enroll small businesses that had not previously offered insurance coverage, the workgroup recommended that NCDOI and the HBE examine whether agents should be paid differentially for enrolling small businesses that have not offered health insurance coverage within the last six months. The workgroup also recommended that the NCDOI and HBE examine whether agents and brokers should be paid a higher rate per person for the smallest groups, and a lower rate per person as the size of the employer increases.

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

To address these concerns, the HBE workgroup recommended:

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

a) The Health Benefits Exchange Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the HBE.
   - **i. The HBE should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The training and certification should include, but not be limited to, information about the different insurance affordability programs (including Medicaid, CHIP, and insurance subsidies offered through the HBE), how to use the HBE website, and the small business tax credit.**
   - **ii. Small businesses that contact the HBE or call center, that need additional information and advice, should be directed to an agent or broker rather than an individual navigator. However, the HBE should only refer small businesses to independent agents or brokers who are able to sell any of the qualified health plans offered in the HBE.**

b) The North Carolina Department of Insurance, in conjunction with the HBE, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the HBE, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage. As part of this analysis, NCDOI and NCHBE should consider the impact of any changes in agent and broker compensation on overall agent/broker compensation, insurers' medical loss ratio, and on premium prices in the nongroup and small group market. As part of this analysis, NCDOI and the HBE should consider whether to:
   - **i. Pay agents and brokers a standard commission per enrollee regardless of the insurer.**
   - **ii. Require insurers to pay agents and brokers the same standard commission, whether placing business inside or outside the HBE.**

[eeee] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.705(b)(10).

iii. **Pay agents and brokers a standard commission for each individual whether enrolling in a nongroup plan or group plan.**
iv. **Require insurers to appoint all licensed agents and brokers in good standing who have been certified to offer insurance inside the HBE as part of the insurers' panel.**
v. **Pay agents and brokers a higher per person commission or other compensation to encourage agents and brokers to enroll very small groups (eg, groups of under 10 employees).**
vi. **Pay higher commissions or other compensation to encourage agents and brokers to enroll small businesses that had not offered health insurance in the last six months.**

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

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

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

The HBE workgroup recognized that many of the low-income uninsured will first seek information about insurance options through their local department of social services. DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[llll] In addition, if the person is determined to be ineligible for

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[ffff] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.907.

[gggg] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.405

[hhhh] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.

[iiii] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(b)(3).

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

[kkkk] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §155.345.

[llll] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.908.

Medicaid, he or she must be screened to enroll into a qualified health plan, and, if eligible, must be able to enroll "without delay."[mmmm, nnnn] Thus, the workgroup recommended that DSS workers be trained and certified as navigators so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the HBE. To make it easier for DSS offices to serve as navigator entities, the HBE workgroup recommended that the state develop data capture mechanisms so that all or most of the data needed for reporting and accountability to the state would be captured through the NCFAST system. Further, the HBE Board should examine options to help offset some of the administrative costs for DSS workers in providing enrollment assistance to individuals who have been determined to be ineligible for Medicaid or North Carolina Health Choice.

The workgroup recognized that not every DSS office would want, or have the resources, to take on the additional workload that could be created by providing advice to people about HBE insurance options. Thus, the workgroup wanted further clarification on what the federal government meant by ensuring that a person was eligible to enroll "without delay." The workgroup members were concerned that absent immediate assistance, many of the people who seek services from the local social services office might fall through the cracks if they were directed to another agency for care. Assuming that there is some flexibility, the workgroup recommended that the HBE Board create other mechanisms to ensure a "warm hand-off" so that people who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from a trained navigator or other trained staff outside of the local social services office.

RECOMMENDATION 2.9: "NO WRONG DOOR" ELIGIBILITY AND ENROLLMENT

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

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

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

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

[nnnn] United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.1200(e).

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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.

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[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;

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[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]

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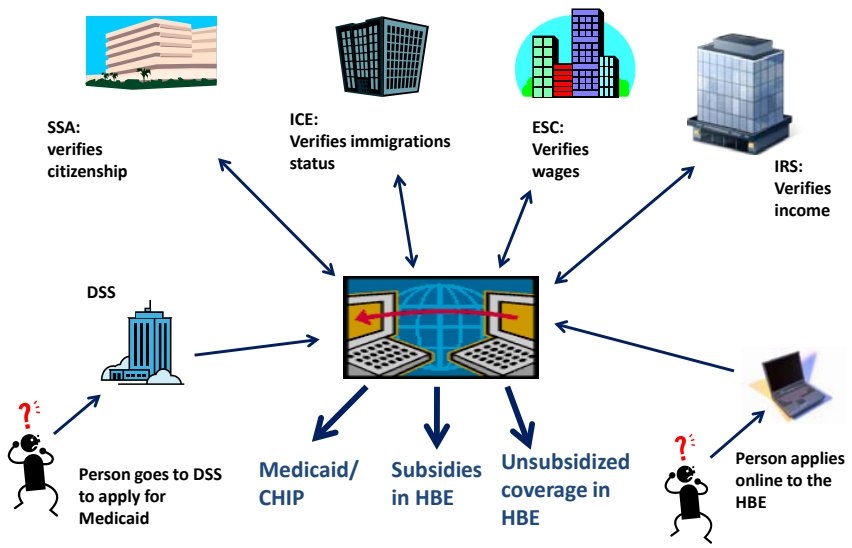
[j] The Council on Economic Advisers did an analysis of the impact of health insurance reform on state and local governments. They selected 16 states to examine, including North Carolina. At that time, their analysis concluded that North Carolina state and local governments could experience a net decrease 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.[l] 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

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[l] 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 NCDOI. In addition, the federal portion of the development and ongoing operational cost of this Medicaid/CHIP component of NC FAST will rise from 50% to 90%.

[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.

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[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 is intent to reside in the state.[s] Further, the United States Supreme Court has held that durational residency requirements are unconstitutional.[t] 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.

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[s] 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.

[t] 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

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[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.

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[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

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[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

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[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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CHAPTER 4
SAFETY NET

OVERVIEW

One of the major goals of the ACA was to increase access to care. Of the more than 1.7 million North Carolinians who are currently uninsured, 1.1 million are expected to qualify for insurance coverage if the ACA is implemented as the law is written.[1] Many of these people are already receiving some type of medical care from safety net organizations and private providers.
The safety net is composed of organizations that have a mission or legal obligation to provide health care and other related services to uninsured and underserved populations. They include federally qualified health centers (FQHCs), school-based or school-linked health services, public health departments, rural health clinics, hospitals, free clinics, and other community-based organizations. [2] Safety net organizations have a track record of providing care to low-income, uninsured, and diverse populations that may not receive care from private community providers.[3]

Different safety net organizations provide primary and preventive services, access to specialty services, pharmaceutical services, dental and behavioral health services, and hospital services. Some safety net organizations work together to create integrated delivery systems of care for the uninsured. In many safety net organizations, services are provided for free or at reduced cost.[2] In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers, school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations. The Office of Rural Health and Community Care through the North Carolina HealthNet initiative provides technical assistance and flexible mini-grants to local communities to support efforts to increase access and quality of care for the uninsured through a coordinated system of care, and to share and conserve limited resources through collaborative partnerships so that resources can be directed to needs that have no alternative funding source (ie, care/disease management, enrollment). HealthNet links Community Care of North Carolina's administrative infrastructure and networks of physicians and care managers with local and regional safety net organizations and indigent care programs that are providing free and discounted health care for the uninsured. However, communities are highly dependent on providers' donations for access to care and significant gaps remain. In addition, communities are often unable to leverage other resources or align resources for efficiencies across agencies.

North Carolina may not have sufficient numbers of new health care professionals to meet the increased demand for services that is likely to arise as people gain coverage. (See Health Professional Workforce chapter.) Further, many of the people who are currently uninsured have transportation and other barriers which will make it difficult to access private providers. Safety net organizations have traditionally served these populations, and will be needed to meet the health care needs of the newly insured. The ACA recognizes the important role of safety net providers and requires all Qualified Health Plans (QHPs), offered through the Health Benefit Exchange (HBE), to contract with safety net providers that serve predominantly low-income,

medically-underserved individuals.[a] In addition to the role that safety net organizations will play in meeting the health care needs of the newly insured, safety net organizations will be needed to meet the health care needs of the uninsured. In North Carolina, more than 700,000 nonelderly people are likely to remain uninsured. More than half (56.1%) of those uninsured are likely to have an income below 138% of the federal poverty level.[4] Safety net providers will need to continue to provide care for many uninsured individuals who cannot afford private insurance or are ineligible for public programs.

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

SAFETY NET ORGANIZATIONS AS PROVIDERS OF CARE FOR THE NEWLY INSURED

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the United States Bureau of Primary Health Care under section 330 of the Public Health Services Act.[b] FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers. FQHCs must provide comprehensive primary and preventive health care services, and are required to provide enabling services including transportation, case management, outreach, and interpretation and translation. In addition, FQHCs are required by law to provide services to the uninsured on a sliding scale basis. In 2011, there were 28 FQHCs in North Carolina delivering care at 150 different sites. There were also three FQHC look-alikes providing services at twelve clinical sites[c] and a Migrant Voucher program that provides grants and reimbursement for clinical and outreach services.[53] More than 50% of the FQHC patients served in North Carolina were uninsured, and 95% had incomes below 200% FPL in 2010.

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

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

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

Congress created special payment rules for FQHCs because they are less able to cost-shift the costs of caring for the uninsured to other private payers. Thus, FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted medications through the 340B federal prescription drug discount program (see 340B program expansion section).

Expanding and Strengthening FQHCs

The ACA includes new appropriations to expand the number of FQHCs and to increase the number of people they can serve. As noted earlier, FQHCs have historically been a major provider of primary care and other health services to the uninsured. They are also likely to play a prominent role in providing services to the people who gain coverage in 2014. In Massachusetts, the numbers of patients that FQHCs served increased by almost 10% after the state passed its health reform legislation in 2006.[6] FQHCs in Massachusetts also continued to serve many of the state's uninsured patients. In fact, while the total number of uninsured patients that FQHCs served declined after its coverage expansion, the proportion of all remaining uninsured seen by FQHCs increased by 14%.[6]

Congress recognized the continued importance of FQHCs after the coverage expansion in 2014. The ACA initially appropriated a total of $9.5 billion over five years to expand the number of community and migrant health centers nationally, expand the array of services provided, and increase the number of people they serve. The Bureau of Primary Health Care (BPHC) within the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. The North Carolina Community Health Center Association, with financial support from Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. North Carolina submitted 30 applications; however, after the applications were submitted Congress cut the level of ACA funding available to support new FQHCs. The federal budget compromise reduced operational funding for existing FQHCs by $600 million. Rather than cut services at existing centers, some of the $9.5 billion ACA FQHC funds were diverted to keep existing FQHCs operating at the same level of funding.[7] Because of this reduced funding, North Carolina only received funding to create two new FQHCs through Greene County Health Care (Snow Hill) and Albemarle Regional Hospital Authority (Elizabeth City). The combined total of these two grants was $1.5 million. Additionally, two other organizations were awarded $80,000 planning grants to prepare plans to transition to FQHC: Triad Adult and Pediatric Medicine (Greensboro) and Community Health Interventions and Sickle Cell Agency (Fayetteville). [8]

In addition, the ACA includes $1.5 billion for construction and renovation of FHQCs. Congress appropriated $1 billion in new funding in FFY 2011, which increases to $3.6 billion by FFY 2015.[d] North Carolina FQHCs received ACA grant funds totaling $19.2 million to support capital improvements and renovations, and to expand access to care through existing FQHCs.[9] This funding was provided to support four FQHCs: Roanoke Chowan Community Health Center (Ahoskie), Blue Ridge Community Health Services (Hendersonville), First Choice Community

[d] 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.

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.[10]

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

Enhancing the Quality of Care Provided by FQHCs

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

- *Bureau of Primary Health Care's Patient-Centered Medical Home (PCMH) Supplemental Funding Opportunity*. The Bureau of Primary Health Care announced supplemental awards to approximately 900 FQHCs nationwide to support the practice changes needed to transition to patient-centered medical homes. Eighteen FQHCs in North Carolina received this $35,000 grant award. (FQHC look-alikes were not eligible for participation.) Grantees must "agree to seek recognition, increase their recognition level, or maintain the highest level as a PCMH through a national or State-based recognition or accreditation program."[11] The following North Carolina Health Centers received this additional funding: Roanoke Chowan Community Health Center (Ahoskie); Medical Resource Center for Randolph County (Asheboro); Western North Carolina Community Health Services (Asheville); Piedmont Health Services (Carrboro); C.W. Williams Community Health Center (Charlotte); Lincoln Community Health Center (Durham); Stedman-Wade Health Services (Fayetteville); Gaston Family Health Services, (Gastonia); Blue Ridge Community Health Services (Hendersonville); First Choice Community Health Centers (Mamers); CommWell Health (Newton Grove); Robeson Health Care Corporation (Pembroke); Wake Health Services (Raleigh); Rural Health Group (Roanoke Rapids); Greene County Health Care (Snow Hill); Metropolitan Community Health Services (Washington); New Hanover Community Health Center (Wilmington); and Carolina Family Health Centers, Inc (Wilson). (See Chapter 8 for more discussion of patient centered medical homes.)

- *FQHC Advanced Primary Care Practice Demonstration*. This is a three-year demonstration project for FQHCs and FQHC look-alikes offered to approximately 500 health centers nationally. Funding is provided from the Center for Medicare and Medicaid Innovation, within the Centers for Medicare and Medicaid Services (CMS) and

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

[f] Patient Protection and Affordable Care Act, Pub L No. 111-148, §10501(i)(3), amending 1834 of the Social Security Act, 42 USC 1395m.

the Health Resources and Services Administration (HRSA). The demonstration project is "designed to evaluate the effectiveness of the advanced primary care practice model, commonly referred to as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care" by moving sites toward NCQA Level 3 recognition by the end of the three years.[12] CMS received more than 800 applications, and 18 sites representing ten FQHC organizations were selected for participation in North Carolina, including: First Choice Community Health Center (Spring Lake, Angier, Cameron); Gaston Family Health Services (Bessemer City); Greene County Health Care (Snow Hill, Greenville); Metropolitan Community Health Services (Washington); Opportunities Industrialization (Roanoke Rapids); Piedmont Health Services (Burlington, Prospect Hill); Roanoke Chowan Community Health (Colerain); Robeson Health Care Corporation (Pembroke, Maxton); Wake Health Services (Raleigh, Apex); and Rural Health Group (Norlina, Hollister, Whitakers). To help participating FQHCs undergo practice transformation and progress toward PCMH recognition, they will receive an $18 quarterly care management fee per eligible Medicare beneficiary receiving primary care services. These quarterly payments are in addition to Medicare's per visit payments. CMS and HRSA will provide technical assistance, and FQHCs are required to submit NCQA Readiness Assessment scores every six months.

School-based or School-linked Health Centers

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.[13] A school-based health center (SBHC) is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health services, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration.[2] Nationally, a majority (64%) of school health centers provide services to children and families in the community as well as students at the affiliated schools. [14] There are 52 school health centers serving 22 counties in North Carolina. Most of these are school-based health centers, several are school-linked health centers, and a few health centers operate from traveling vans or buses to serve several schools.[g]

The ACA appropriated $50 million toward capital expenses for SBHCs in each FFY 2010-2013, although it did not appropriate funding for operating expenses.[h] HRSA awarded $95 million to 278 school-based health center programs across the country in July 2011. In North Carolina, nine sites were awarded more than $2 million including Alamance-Burlington School System (Burlington); Bakersville Community Medical Clinic, Inc. (Bakersville); Blue Ridge Community Health Services (Hendersonville); FirstHealth of the Carolinas (Pinehurst); Lincoln Community Health Center, Inc. (Durham); Mitchell County Board of Education (Bakersville); Morehead Memorial Hospital (Eden); West Caldwell Health Council, Inc. (Collettsville); and Yancey County Schools (Burnsville).[15] The second round of awards was made in December 2011. HRSA awarded more than $14 million to 45 school-based health center programs across the

[g] Parker C. Executive Director, North Carolina School Community Health Alliance. Oral communication. April 12, 2012.

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

country including more than $600,000 to two North Carolina SBHCs—Cherokee County Schools (Murphy) and Wilmington Health Access for Teens, Inc. (Wilmington).[16]

Rural Health Clinics

State-funded rural health clinics are nonprofit 501(c)(3) organizations that provide primary care, routine diagnostic and therapeutic care, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental, behavioral health, or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.[2] There are 86 certified rural health clinics in North Carolina.

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

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

Hospital Emergency Departments and Other Services

Hospital emergency departments and outpatient and inpatient clinics are a major part of the health care safety net. Despite increasing capacity in primary care safety net providers, many people go to the emergency room for care. According to Table 89 of a recent CDC report, in 2009, more than 21% of adults over the age of 18 had at least one emergency department visit in the past year, and 8% had two or more visits.[17] A recent CDC study reports that only 8% of emergency patients have a medical condition that is not urgent.[18] Having an urgent medical condition is not the same as having an emergency medical condition. Other studies report that 60% of patients in the emergency department could be treated elsewhere.[19] Emergency department utilization was 93% higher among people with a family income below the poverty level compared with those with a family income at least four times the poverty level, according to Table 89 of the CDC report.[17] Emergency departments are not the optimal place for people to get routine primary care.

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[i] Gilbert R. Primary Care Systems Specialist, Office of Rural Health and Community Care, Department of Health and Human Services. Oral communication. April 12, 2012

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

The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for Medicaid patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The Committee identified categories of patients who might present to an emergency department for treatment who could be more appropriately treated in another health care setting.[k] The patient categories include dental complaints, chronic pain complaints, and behavioral health complaints.[20] Preliminary planning for the project between the Committee and the Community Care of North Carolina has already begun.

The ACA appropriated $24 million per year for five years beginning in FY 2010 for competitive grants for regionalized systems for emergency response.[l] It also authorized $100 million per year for six years beginning in FY 2010 in grants for trauma care centers and to expand service availability[m] and $25M in FY2010 for emergency services for children[n]. Based on the work of the Access to Care Committee and in response to the funding opportunity, the Safety Net Workgroup recommends:

RECOMMENDATION 4.1: DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT

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

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

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[k] All patients who present to an emergency department are required by law to have a medical screening exam to ensure that an emergency medical condition does not exist. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub L No. 99–272, § 9121, enacting Sec. 1867 of the Social Security Act, 42 USC 1395dd.

[l] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3504.

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3505.

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

Enhancing Hospital Community Benefits

Hospitals also help meet the health care needs of the broader community. For example, North Carolina hospitals provide charity care to many low-income uninsured patients, make cash and in-kind contributions to community groups, and get involved in other community health activities.[21]

The ACA establishes new requirements for charitable hospitals. These hospitals must have a publicly available financial assistance policy including information on how charges are calculated, billed, and collected. The charges for emergency or other medically necessary care for the uninsured were limited to what a person with insurance would be charged.[o]

The North Carolina Hospital Association works with hospitals to help meet these requirements. The Hospital Community Benefits Report webpage voluntarily lists the financial assistance policies for all North Carolina hospitals that have made them public since 2007.[22] Guidance is available to help hospitals calculate their community benefits so that data may be reported uniformly across hospitals. In FY 2010, North Carolina hospitals provided $853 million in free care.[23]

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health".[p] The required health assessment is similar to the community health assessment that each health department in North Carolina is required to conduct. The North Carolina Hospital Association and North Carolina Division of Public Health are working together to encourage community hospitals and local health departments to collaborate in conducting their community health needs assessments.[24] In response to the collaboration between hospitals and health departments, the Workgroup recommends:

RECOMMENDATION 4.2: INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS

a) As part of the hospital and local health department community health assessments, these organizations should:
   - **i. Solicit input from patients and a broad range of stakeholders and community leaders.**
   - **ii. Include data from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area.**
   - **iii. Examine access to quality care issues along with population health and other community health needs through broad, open solicitation input from multiple partners.**
   - **iv. Use stakeholder and patient input to develop common criteria for determining priorities for implementation.**

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[o] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007.

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

b) **In implementing community health needs priorities, hospitals and public health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.**
c) **Local communities should use the community health assessment action plan to pursue funding resources and strategically allocate existing resources.**

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers including FQHCs and hospitals that receive Medicare disproportionate share hospital (DSH)[q] payments. The program was expanded to include children's hospitals, free-standing cancer hospitals, critical access hospitals, and sole community hospitals[r] In North Carolina, 29 of the currently eligible FHQCs[s] and 70 of the currently eligible hospitals are participating in the program. The Office of Rural Health and Community Care assists critical assess hospitals in the state process. The savings the 340B program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the Workgroup recommends:

RECOMMENDATION 4.3: EXPAND 340B DISCOUNT DRUG PROGRAM ENROLLMENT AMONG ELIGIBLE ORGANIZATIONS
The North Carolina Division of Medical Assistance and Office of Rural Health and Community Care of the Department of Health and Human Services , North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage DSH hospitals, critical access hospitals, sole community hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.

HELPING LINK UNINSURED TO APPROPRIATE INSURANCE COVERAGE

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

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[q] Disproportionate Share Hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients. The state receives an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other health insurance. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than these actual uncompensated costs. HHS Recovery. Disproportionate Share Hospital (DSH). U.S. Department of Health and Human Services website. http://www.hhs.gov/recovery/cms/dsh.html. Accessed April 12, 2012.

[r] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 7101.

[s] 30 FHQCs and FQHC-LAs are eligible to participate in the 340B program. The newest FQHC is not yet listed as participating in the program. This participation may include onsite pharmacies, contracts with local community pharmacies, or a combination of the two methods. Wolf, M. Clinical Programs Manager, North Carolina Community Health Center Association. Oral Communication. January 25, 2012

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

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

RECOMMENDATION 4.4: ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS

a) The Health Benefits Exchange (HBE) should train and certify staff at safety net organizations to serve as patient navigators. In accordance with the ACA, these groups would be required to:
   - **i. Provide public education to raise awareness of qualified health plans (QHPs).**
   - **ii. Distribute fair and impartial information.**
   - **iii. Facilitate enrollment in QHPs.**
   - **iv. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or other appropriate state agency for an enrollee with a grievance, complaint, or question about their health plan.**
   - **v. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.**
   - **vi. Meet standards to avoid conflict of interest.**

b) As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.

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

[u] Entities may include trade, industry and professional associations, commercial fishing, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Association, and other licensed insurance agents and brokers, and other entities that can carry out duties and meet statutory responsibilities.

CARE FOR THOSE THAT REMAIN UNINSURED

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. Most free clinics offer primary care and preventive services and treat both acute and chronic conditions. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.[2] Each free clinic sets its own eligibility guidelines for people who can be served. Services are provided for free to the uninsured with incomes below a certain income threshold and others may be charged on a sliding-fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.[2] There are 79 free clinics across North Carolina. Free clinics provided more than 200,000 patient visits and delivered $167.6 million in free care in 2010.[25]

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

Continued Need for Safety Net Organizations

Safety net organizations are designed to fill gaps in the overall health care system and will still be needed after the full implementation of health reform. Many of the newly insured population will experience barriers to care including provider shortages, transportation, language, and other barriers.[26] The variety of insurance programs and eligibility requirements may cause people to transition between public and private insurance programs as their income changes, which may cause coverage gaps. In addition, we still expect to have more than 700,000 people who are uninsured, even after full implementation of the coverage expansion.

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. Workgroup members recognized the need for safety net organizations to continue to meet, on a periodic basis, to facilitate ongoing collaborations and communication. In the past, a group of safety net organizations met on a periodic basis (called the Safety Net Advisory Council or SNAC) in order to foster

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[v] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10608.

[w] Personal communication. FTCA Free Clinic Program, Health Resources and Services Administration, Bureau of Primary Health Care. January 11, 2012.

communication between the various organizations.[x] The SNAC also serves as the advisory group to help the ORHCC distribute state Community Health Center grant monies.[27] However, this workgroup has not been as active in recent years as it was when it was first created in 2005. Thus, the workgroup recommended that the Safety Net Advisory Council reconvene to identify communities with greatest unmet needs, increase collaboration among safety net organizations, and work together to help monitor and collaborate on future funding opportunities. In addition, the Safety Net Workgroup members recommended that safety net organizations provide data to the NCIOM website [28] to maintain up-to-date information on available safety net resources.

RECOMMENDATION 4.5: RECONVENE THE SAFETY NET ADVISORY COUNCIL

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

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

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[x] A Safety Net Advisory Council (SNAC) was convened in response to the NCIOM Task Force on the Healthcare Safety Net (2005). Initially, this group met quarterly to exchange ideas and advance their common mission to provide free and reduced cost health care services to North Carolina residents.

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CHAPTER 5
HEALTH PROFESSIONAL WORKFORCE

OVERVIEW

In 2014, if the Affordable Care Act (ACA) remains in place, almost 800,000 uninsured North Carolinians will gain insurance coverage.[1] Of these, 41% will gain coverage through the private market either through guaranteed coverage or eligibility in an exchange, and 59% will gain coverage through Medicaid. The increase in the number of North Carolinians with health insurance will increase demand for health care services, particularly primary care.[2] This acceleration of demand will include physical and behavioral health care as well as oral health care. There is evidence that North Carolina does not have enough health practitioners to meet current and future population health needs for all of its population. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. If the ACA is to deliver on its goals of improving population health and quality of care while reducing costs in our state, North Carolina must take steps to ensure there is an adequate workforce.

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

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

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[a] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5201, 5202; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5203, 5204, enacting Sec. 775 of the Public Health Service Act, 42 USC 295f; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5301, 5302, amending Sec. 747 of the Public Health Service Act, 42 USC 293k; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5316, 5508, 5606, 10501.

[b] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5201, 5202, 5306.

[c] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5201, 5202; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5303, enacting Sec. 748 of the Public Health Service Act, 42 USC 293k-2; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5201, 5202; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5304, enacting Sec. 340g-1 of the Public Health Service Act, 42 USC 256g-1.

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

HEALTH WORKFORCE

Increasing access to and the quality of primary care is critical to ensure that North Carolina's health care needs are met. The primary care workforce includes physicians, nurse practitioners, physician assistants, certified nurse midwives, and registered nurses as well as support staff including licensed practical nurses, medical assistants, and others. These practitioners are responsible for providing a wide range of services from preventive care, chronic disease management, and urgent care, to basic psychosocial needs. They are the front door to the health care world and provide continuity of care to patients through ongoing relationships.[3] The primary care workforce is facing large increases in demand due to aging baby boomers becoming eligible for Medicare, expanded insurance coverage through the ACA, and the overall growth in the population.[4]While the primary care workforce is expected to experience the greatest increases in demand, increasing insurance coverage will likely result in significant increases in all types of health care utilization.[5] Over the past decade, North Carolina has expanded its primary care workforce. In 2010, North Carolina had a total of 9,017 primary care physicians, 3,679 nurse practitioners, and 3,625 physician assistants. North Carolina's primary care physician supply was above the national average with 9.2 practitioners per 10,000 population compared to 8.4 nationally. From 1997-2010, North Carolina saw a slight increase in the number of practicing physicians reporting a primary care specialty, from 41% to 43%. At the same time, the percentage of nurse practitioners and physician assistants reporting primary care specialties declined (from 50% to 45% and 45% to 34%, respectively).[6]
While primary care supply is currently strong overall in North Carolina, uneven distribution in rural areas means that many areas of North Carolina qualify as primary care health professional shortage areas (HPSAs). Additionally, it is unlikely that the current primary care workforce and workforce in training in North Carolina will be adequate to handle the large increase in demand for services.

The ACA includes provisions not only to expand access to physical health care, but also behavioral health care, which includes mental health and substance abuse services.[d] The Mental Health Parity and Addiction Equity Act of 2008 was the first federal bill requiring parity for mental and physical health benefits offered by large employers. The ACA further expands access to behavioral health services by requiring behavioral health coverage as part of the essential benefits package.[e] (See Chapter 2 for more discussion of the essential benefits package.) In addition, individual and small group plans offered through the Health Benefit Exchange will be required to cover mental health and substance abuse services in parity with treatment provided for physical health problems.[f] The ACA also includes provisions to encourage integration between physical and behavioral health services and to grow the behavioral health workforce.[g] The behavioral health workforce includes professionally trained (graduate-level) psychiatrists,

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[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5306.
[e] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1302.
[f] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(j).
[g] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5306; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5604, enacting Sec. 520k of the Public Health Service Act, 42 USC 290bb-42.

psychologists, licensed clinical social workers, licensed clinical addition specialists, and psychiatric-mental health nurses as well as bachelor's prepared nurses, technicians, aides, and others with training at or below the bachelor's level.[7] North Carolina's behavioral health workforce is not adequate to address population needs for prevention of and treatment for mental health and addiction disorders.[8]Seventeen counties have no psychiatrists and 24 counties have no psychologist; 82 counties have fewer than one psychiatrist per 10,000 residents and 73 have one or fewer psychologists per 10,000.[9]North Carolina's behavioral health workforce is inadequate to meet existing needs in many parts of the state and will be further strained as large numbers of individuals gain coverage for behavioral health services.

Oral health is an integral component of general health and can significantly affect overall health and well-being.[10]As part of the ACA, all insurance plans that are not grandfathered or self-funded ERISA plans must provide coverage of the essential health benefits. The essential health benefits must provide coverage of pediatric services, including oral and vision care.[h] The ACA does not include provisions to increase adults' access to oral health care. While the ACA does not include provisions requiring dental benefits for adults, it did include provisions aimed at increasing the dental workforce (which have not been funded).[i] North Carolina has fewer dentists per capita than the United States (4.4 per 10,000 vs. 6.0 per 10,000, respectively).[11] This disparity is expected to increase due to a rapidly increasing population and declining retention rates for North Carolina educated dentists.[12] Limitations due to the size of the workforce and the new dental coverage for children is likely to exacerbate existing dental access barriers.

Allied health practitioners make up the largest proportion of the North Carolina health workforce (35%) and account for 44% of job growth in health care over the past decade.[12] Allied health workers are found in primary care, behavioral health, oral health, and other health care fields. Allied health practitioners include, but are not limited to, audiologists, certified medical coders, counselors, dental hygienists, dietitians, medical assistants, medical interpreters, medical office administrators, nurse aides, optometrists, pharmacists, physical therapists, rehabilitation counselors, and speech-language pathologists.[13] Many allied health practitioners work in primary care, with fewer working in behavioral and oral health care. As with other health care professionals, additional allied health professionals will be needed to meet the health care needs of the newly insured.

GROWING THE HEALTH WORKFORCE

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

- Training more North Carolinians in North Carolina schools and institutions by increasing capacity.

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

[i] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5303, enacting Sec. 748 of the Public Health Service Act, 42 USC 293k-2; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5304, enacting Sec. 340G-1 of the Public Health Service Act, 42 USC 256g-1.

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

Training More Health Practitioners

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

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

- New physician assistant programs at Campbell (2011), Elon (planned for 2013), the University of North Carolina at Chapel Hill (UNC-CH) (planned for 2014); expansion of physician assistant programs at Duke University, Methodist University.
- East Carolina University (ECU) opened a School of Dental Medicine in 2011 with a class size of 50. ECU recruits students from North Carolina with an emphasis on students from disadvantaged backgrounds and underserved areas. Students will do their clinical training in community service learning centers in underserved areas around the state.
- The ECU School of Medicine has delayed plans to increase its class size from 80 to 120 students until funding is available. Plans call for students to do their clinical rotations in new satellite clinics located in eastern North Carolina.
- The UNC-CH School of Dentistry has delayed plans to increase its class size from 80 to 100 students in 2012 due to budget constraints.
- The UNC-CH School of Medicine increased the medical class size from 160 to 170 in 2011 and will add another 10 students in 2012. The additional students will receive their clinical education at regional campuses in Charlotte and Asheville. Clinical education for the students enrolled in the Charlotte and Asheville programs will focus on providing primary care to underserved populations. Planned expansion to 230 students is on hold until further funding is available.
- Campbell University plans to open a School of Osteopathic Medicine in the fall of 2013. The program aims to have an average class size of 150. Students will spend their third and fourth years of school training in community hospitals. The program will emphasize primary care, behavioral health, and general surgery with an emphasis on underserved populations.
- Duke University has a new program to increase the number of Adult Nurse Practitioners (ANPs) and Family Nurse Practitioners (FNPs) who enroll full-time and graduate within two years and will accelerate the graduation rate of part-time students in these tracks.

- There have been many other efforts in nursing and allied health over the past five years. The workgroup noted that there were too many efforts to catalogue them all. However, examples of include:
    - The nursing programs at UNC Wilmington, Western Carolina University, ECPI University, East Carolina University, and some of the North Carolina Community College System schools have all significantly expanded enrollment.[j, k]
    - Pitt Community College is leading a regional consortium to develop health information technology training programs.
    - Carolinas College of Health Sciences has created an anesthesia technician certification program at Carolinas College of Health Sciences.
- Additionally there have been some smaller program expansions and various efforts to increase the number of medical, physician assistant, and nursing students interested in entering primary care.

In addition to these efforts, North Carolina has received some ACA grant funds aimed at expanding the health professional workforce. As part of the ACA $253 million in Prevention and Public Health Fund grants were allocated to the Health Resources and Services Administration (HRSA) within the United States Department of Health and Human Services to support workforce grants in FFY 2010.[l] State agencies, academic institutions, and medical centers have applied for grants from HRSA, and these entities were successful in competing for some of the new workforce funding. The following is a summary of ACA grants to increase the health professional workforce awarded to entities in North Carolina as of January 23, 2012.

- *Primary care residency expansion:* The UNC Chapel Hill Department of Pediatrics/UNC Hospitals received a five-year grant of $3.7 million to fund an increase of four residents per year with a focus on training general pediatricians for communities in North Carolina. The program will be done in collaboration with Moses Cone Health System and the UNC pediatrics faculty who are based there. The first four residents 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 four residents per year to six. The expanded residency program will develop a partnership with the New Hanover Community Health Center, a federally qualified health center (FQHC), to serve as a second site for training residents.
- *Expansion of Physician Assistant training.* Duke University School of Medicine's Physician Assistant (PA) Program was awarded a HRSA grant that will provide 34 students $44,000 in tuition support in an innovative longitudinal primary care curriculum. Selected students will do the majority of their clinical training in medically underserved areas of North Carolina, with the goal of practicing in these communities after graduation. In addition, the Methodist University Physician Assistant Program received a

[j] Blain, L. Education Coordinator, North Carolina Board of Nursing. Written (email) communication. March, 13, 2012.

[k] However, there have also been significant decreases in enrollment in many nursing programs due to budgetary cuts at the University of North Carolina at Chapel Hill and James Sprunt and Brunswick Community Colleges. (Blain, L. Education Coordinator, North Carolina Board of Nursing. Written (email) communication. March, 13, 2012.)

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

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.

- *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 North Carolina Foundation for Advanced Health Programs as a subcontractor. With this three-year $2.0 million personal and home care aide training grant, two pilot projects will be developed to enhance the training of between 190-230 personal and home care aides with 60-80 trained via allied health programs in community colleges or high schools and another 120-150 participating in training through home care agencies and adult care homes.
- *Public Health Training Centers*. The University of North Carolina at Chapel Hill received $639,004 to establish the Southeast Public Health Training Center (SPHTC), which is part of the North Carolina Institute for Public Health at the Gillings School of Global Public Health. The SPHTC's focus is on training development, dissemination, maternal and child health, rural public health, leadership, and management.
- *State Health Care Workforce Development Grants*. The North Carolina Department of Commerce received $144,595 to support workforce development planning which was lead by the North Carolina Health Professions Data System at the Cecil B. Sheps Center for Health Services Research.

With the exception of the federal workforce development grant, all of these funds have been limited to incrementally increasing the workforce. While the Workgroup believes such increases are necessary, they are not sufficient to meet the healthcare demands of North Carolina's population. The Workgroup believes that broader changes and investments are necessary to meet the needs of the state and the changing healthcare practice environment. As outlined in this chapter, the Workgroup strongly recommends making additional investments in increasing diversity in the health practitioner workforce, undertaking comprehensive workforce planning, revising existing medical education programs to better meet state needs and the changing healthcare practice environment, and strengthening the state's ability to take advantage of federal workforce recruitment funds.

The Workforce workgroup recognizes that there may be other funding opportunities that could become available sometime in the future to support North Carolina's workforce needs. For example, the ACA includes provisions that authorize, but do not appropriate, funding for other workforce programs, including provisions to increase the number of physical, behavioral, and oral health practitioners through loan and scholarship programs; create medical school rural training programs; develop and implement interdisciplinary medical education; and develop other programs to address current and future workforce needs.[m] Thus, the Workgroup supports

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5201, 5202, 5306, 5316, 5508, 5606, 10501; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5203, 5204, enacting Sec. 775 of the Public Health Service Act, 42 USC 295f; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5301, 5302, amending Sec. 747 of the Public Health Service Act, 42 USC 293k; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5303, enacting Sec. 748 of the Public Health Service Act, 42 USC

the work of organizations that are monitoring federal funding opportunities. These groups should also examine existing funds to determine if the state can take advantage of any opportunity to expand the health care professional workforce and change the way health practitioners are educated. The Workgroup encourages the members and others to continue to work together to develop a coordinated, competitive response when funding opportunities are identified.

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

To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, behavioral, and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. While the current expansions in educational programs will certainly help, they are not likely to meet the full need alone. North Carolina is a net importer of primary care, behavioral health, and oral health practitioners, meaning the state trains fewer health practitioners in these areas than we need for a population of our size and must rely on recruitment of practitioners from other states and countries.[12] Growth in demand in all of these areas, as well as in emerging roles such as health information technology and care coordinators, fuels the increase in demand for a wide range of allied health workers in primary care as well as behavioral and oral health. School's admissions policies, course offerings, training locations, and scholarship opportunities all affect the types of practitioners produced. North Carolina's schools have the means to steer more students into primary care, behavioral and oral health and to increase students' interest and willingness to serve in rural and underserved communities.

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

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

293k-2; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5304, enacting Sec. 340g-1 of the Public Health Service Act, 42 USC 256g-1.

RECOMMENDATION 5.1: NORTH CAROLINA'S HEALTH WORKFORCE SHOULD BE PREPARED TO MEET THE HEALTH NEEDS OF THE POPULATION USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE

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

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

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

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

The Need for a More Diverse Workforce

Patients benefit from receiving care from a diverse workforce that mirrors the population being served. Increasing under-represented minorities' access to careers in the health professions is one of the goals of the ACA.[n] North Carolina's workforce should mirror the population being served—a population that is increasingly diverse. Minority populations make up 32% of North Carolina's population.[14] While some health professions are quite diverse, including primary care physicians and licensed practical nurses (27% and 31% nonwhite and non-Hispanic,

[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5401, amending Sec. 736 of the Public Health Service Act, 42 USC 293; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 5402, 5403; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5404, amending Sec. 821 of the Public Health Service Act, 42 USC 296m.

respectively), most lack diversity. Even among the health professions with more diversity, the racial and ethnic makeup of practitioners does not mirror the makeup of North Carolina's population.[6] Research shows that when patients receive care from a provider of the same race/ethnicity they report higher levels of satisfaction, communication and trust, and are more likely to adhere to care instructions. Given these improvements, research suggests patients would also have better health outcomes when they receive care from a provider of similar demographics.[15] North Carolina's military families and veterans have unique needs and having practitioners with military backgrounds or training in working with military families is essential to being able to care for this population.[16]Language and cultural barriers also pose a significant challenge to ensuring all North Carolinians receive high quality care. Increasing the cultural competency of the health care workforce is one of the goals of the ACA.[o] Multilingual practitioners and practitioners from different cultural backgrounds can help increase the quality of care for North Carolina's diverse population.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[17] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health, and may reduce costs. Although many of North Carolina's health care education programs are working hard to increase the diversity of the practitioner workforce, data show the state has a long way to go.[9] Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the workgroup recommends:

RECOMMENDATION 5.2: SUPPORT AND EXPAND HEALTH PROFESSIONS PROGRAMS TO MORE CLOSELY REFLECT THE COMPOSITION OF THE POPULATION SERVED
The North Carolina Area Health Education Centers Program, North Carolina Community College System, the University of North Carolina University System, private colleges and universities with health professions degree programs, and other interested parties, including the Alliance for Health Professions Diversity, should collaborate to create more intensive programs and coordinate efforts to expand and strengthen existing evidence-based health professions pipeline programs. These educational systems and related programs should strengthen their collective efforts so that underrepresented minority, rural, and other disadvantaged students who are interested in entering health careers can receive continued opportunities for enrichment and support in middle school, high school, college, and health professions schools. These entities should work collaboratively to seek foundation and federal funding to strengthen existing programs, develop new models of educational enrichment, and evaluate the effect of the various programs on the diversity of the health professions in the state. If shown to be effective, the North Carolina General Assembly should provide ongoing program support.

Recruiting and Retaining a Strong Health Care Workforce
North Carolina will not prosper as a whole unless the differences in population health and access to care across the state are addressed. It will take specific incentives and strategies to accomplish

[o] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5307.

this goal. North Carolina should invest more heavily in the health practitioner workforce, particularly in rural and underserved areas of the state.

The federal government provides scholarships or loans to certain types of health care practitioners in return for practicing in a health professional shortage area (HPSA) through the National Health Service Corps (NHSC). In fact, the ACA expands this program—increasing the program by $1.5 billion over five years.[p] NHSC funding can be used to recruit primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, dentists, dental hygienists, psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors into rural and underserved communities that are designated as HPSAs. There are 71 counties or parts of counties that are designated as primary care shortage areas, 54 counties (or parts thereof) that are designated as behavioral health shortage areas, and 78 counties (or parts thereof) that are designated as dental shortage areas.[18] Potential practitioners cannot qualify for NHSC funds to locate in North Carolina communities unless they have first been designated as a HPSA with a high enough designation score. The North Carolina Office of Rural Health and Community Care (ORHCC) plays a critical role in this designation process by working with counties to gather and verify information and submit the application to the federal government. The ORHCC also helps recruit eligible health professionals to practice in HPSAs. In addition to federal funding, there is some state and medical society foundation funding for loan repayment for individuals who commit to practice in a HPSA.

The ORHCC helps eligible health professionals apply for the federal and state loan repayment programs. The federal program only funds health professionals in HPSAs that have been rated to have the greatest need. Currently only 34 of the 71 counties or parts of counties that are designated as primary care shortage areas score high enough for health professionals serving in them to be eligible for NHSC loan repayment. Health professionals serving in HPSAs with lower scores, or who are otherwise not eligible for federal funding, can apply for loan repayment through the ORHCC (which uses state funding). The state provides $1.5 million in recurring funding to the ORHCC to support loan repayment for health professionals. To be competitive with other employers, the ORHCC must be able to recruit and contract health professionals in a timely manner. Potential recruits can be discouraged from practicing in state-funded HPSA positions if they are required to undergo lengthy delays in establishing the loan repayment agreements. Workgroup members were concerned that the Governor's proposal to merge ORHCC with the Division of Public Health (DPH) would create significant delays in the contracting process.[19] Currently, ORHCC contracts take approximately 2-5 weeks to execute contracts[q], whereas DPH takes, on average, six months.[r] The workgroup recommended that if ORHCC is merged into DPH, that they maintain separate contracting authority.

North Carolina, like many other states, is a net importer of primary care, behavioral and oral health practitioners.[12] Thus, we need to rely heavily on our ability to recruit primary care and behavioral and oral health practitioners to practice in North Carolina. Not surprisingly, many

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

[q] Price, John. Director, Office of Rural Health and Community Care. Phone communication March 5, 2010.

[r] Engel, Jeff. Special Assistant to the Secretary, North Carolina Department of Health and Human Services. Oral communication. March 6, 2012.

states are competing to attract health professionals using NHSC funding. North Carolina has benefitted from the recent increases in NHSC funding,[s] which allowed the state to increase the number of NHSC practitioners from 70 to 145. However, North Carolina has fewer NHSC practitioners than it should based on its size.[20] Successful recruitment is affected by the amount of staff time spent understanding the needs of the health professionals and their families as well as the number of eligible HPSA sites in the state. The capacity to recruit and retain health professionals in rural and underserved areas across the state is critical to meet the health needs of North Carolinians. Additionally, increasing the number of practitioners in rural and underserved areas can help improve the local economies and increase an area's attractiveness to businesses. Health care is a knowledge driven industry and the creation of health care jobs brings a high value-add to communities. In 64 North Carolina counties, largely rural or economically depressed, the health care industry is one of the top five employers. Data show that in 2008:

- For every $1 produced by the health care industry an additional $0.89 was generated in the state's economy;
- Every $1 in wages/benefits paid to health care industry employees produced an additional $0.55 in other wages/benefits; and
- For every 1 worker employed in the health care industry, an additional 0.72 workers are employed in the state's work force.[21]

The North Carolina Department of Commerce has recruitment funds that it can use to recruit or support industries "deemed vital to a healthy North Carolina." Yet historically, these funds have not been used to support North Carolina's health care industry, despite its critical role to the success of local economies.[22] Because of the way these programs are designed, it is difficult for individual health care practitioners or small group practices, like the ones typically found in our rural areas, to qualify. Therefore, the Workgroup recommends:

RECOMMENDATION 5.3: STRENGTHEN AND EXPAND THE NORTH CAROLINA OFFICE OF RURAL HEALTH AND COMMUNITY CARE

a) The North Carolina Office of Rural Health and Community Care (ORHCC) should maintain its independent contracting authority, so it has the flexibility to enter into timely contracts with health professionals interested in practicing in underserved areas in the state.

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

i) Provide financial incentives to encourage professionals to remain in practice in health professional shortage areas past their loan repayment obligations.

ii) Recruit veterans with medical training to practice in North Carolina.

iii) Provide enhanced technical assistance to areas to increase the number of communities designated as health professional shortage areas (HPSAs) and to improve the counties' HPSA scores.

[s] The National Health Service Corps received $300 million in ARRA funding in 2009-2011.

iv) **Create state-based area and population health professional shortage areas, if this will assist in recruiting practitioners into HPSAs.**
v) **Create and maintain a database of private and public loan repayment opportunities for health professionals working in North Carolina.**

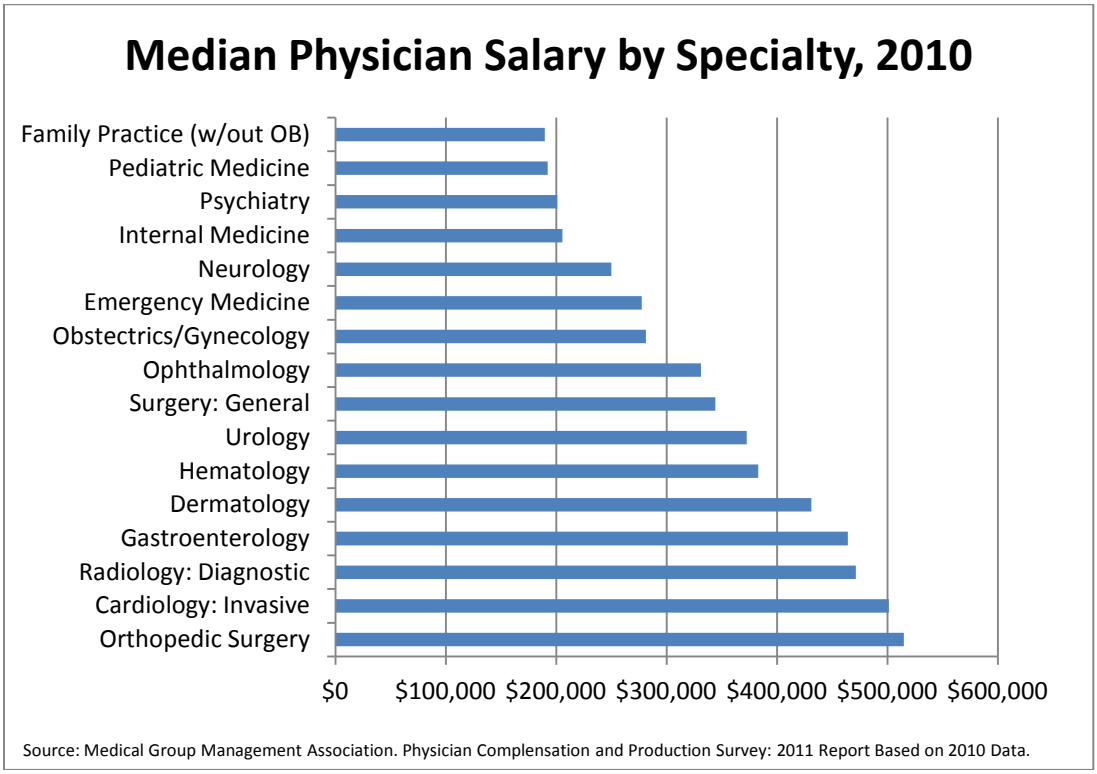
THE IMPACT OF NEW PAYMENT AND DELIVERY MODELS ON THE HEALTH PROFESSIONAL WORKFORCE

One of the chief goals of the ACA is to redesign the health care delivery system to simultaneously meet three objectives: improve population health, enhance patient care, and reduce or control the cost of care. Our current health care delivery and payment system does not achieve these goals.

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

The Workgroup discussed many ways to strengthen the existing primary care, behavioral and oral health workforces. One of the core elements is to make sure that health care practitioners are adequately reimbursed. For example, reimbursement rates for primary care are substantially lower than for specialty care, which affects provider incomes and the willingness of students and trainees to go into primary care.[23,24] This difference in reimbursement rates translates into a large differential between the average salaries for primary care practitioners versus specialists . (See Table 1) Further, a provider's willingness to accept certain insured populations is affected by the payer's reimbursement rates.[25] This can have a profound effect on access to care.

Table 1.
Median Physician Salary by Specialty, 2010



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

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

Medicaid reimbursement rates are of particular concern because traditionally Medicaid reimbursement rates are lower than commercial rates. Low reimbursement rates limit the number of practitioners willing to see patients with Medicaid, particularly dental and behavioral health practitioners.[8,26,27] New proposed federal regulations have been promulgated to create a process for states to use to assure that Medicaid payments "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough practitioners so that care and service are

available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[28] States will be required to monitor access to care and, if needed, take action to ensure adequate access. The Workforce workgroup supports efforts to monitor Medicaid recipient access to care and the requirement that states' take action to ensure access.

The Need for an Integrative Approach to Health Care

The Workgroup believes that our greatest opportunity to improve population health is by providing patient-centered holistic health care including physical, behavioral, and oral health. Patient-centered care requires a shift away from paternalistic care towards a partnership where practitioners work with patients to reach a shared understanding of the problem and course of treatment. In this type of model, patients share in decision-making and responsibility.[29] Research has shown that patient-centered care can reduce primary care charges, the number of diagnostic tests, and referrals—all of which reduce costs and increase the overall efficiency of the system.[30] By taking this approach, the emphasis shifts from treating acute events to providing comprehensive preventive care and treating health problems within a framework focusing on optimizing health over the lifespan. For this shift to occur, the current system must place more emphasis on prevention and primary care.

In integrative health models, all members of the health care team are valued for their contribution to overall health, from primary care practitioners, to oral and behavioral health practitioners, to allied health practitioners such as physical and occupational therapists, nutritionists, health information technologists, and others. In an integrative model, different types of health practitioners work seamlessly together to ensure that the patient gets the right kinds of care, at the right time, from the right person.

New Workforce Models are Needed

While demand for primary care is expected to increase due to the ACA, the primary care physician workforce is shrinking due to declining interest and retiring practitioners. Only 32% of physicians in the United States practice primary care. Fewer than 18% of medical students are expected to practice primary care, and large numbers of primary care physicians are expected to retire in the next decade.[4]Nurse practitioners and physician assistants face similar challenges with increasing specialization away from primary care.[29]

Additionally, as part of the ACA, the types of care covered by health insurance plans are expanding. There are new requirements for covering preventive services,[t] mental health and substance abuse services,[u] women's health services,[v] and others. This expansion in what is covered by most health insurance plans could further increase time demands on primary care practitioners. A study looking at the time demands on primary care physicians showed that 4.6 hours per working day is spent on acute health problems. Comprehensive high-quality management of the 10 most common chronic diseases would require an additional 10.6 hours per

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[t] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, enacting Sec. 2713 of the Public Health Service Act, 42 USC 300gg-13.

[u] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1302(b)(1)(E).

[v] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1001, enacting Sec. 2713(a)(4) of the Public Health Service Act, 42 USC 300gg-13.

day. An additional 7.4 hours a day would be needed if these physicians were to also try to meet the preventive services recommendations for all of their patients. For individual physicians to meet the comprehensive health requirements of their patients, they would need to spend almost 23 hours of every work day providing patient care.[31]Clearly this is not a sustainable model.

In the existing system, patients are not getting all the recommended care, primary care practitioners are often overwhelmed, and new health care practitioners are less interested in going into primary care.[24,32] While more practitioners may be one element of the solution in the long run, a more immediate solution is to explore innovations in the way the current workforce is deployed. The Workgroup believes the best way to solve these problems is to explore alternatives to the traditional care delivery model with its strong emphasis on physician provided care. Models of care that use a variety of health practitioners—physicians, nurse practitioners, physician assistants, and the allied health disciplines—working together as a team to care for patients are needed. In such models, each team member should practice to the full extent of their education and competence. For example, physicians could focus on patients requiring a high level of expertise, nurse practitioners and physician assistants could provide acute and chronic care within the scope of their training, registered nurses could educate patients with chronic conditions to improve self-management, and medical assistants could provide care coordination.[33]

Approaches that encourage delegating tasks from physicians and nurses to other capable, trained practitioners provide opportunities for savings and increased productivity.[34] Expanding the education of current practitioners could allow the current system to expand its capacity without adding additional practitioners. Utilizing all health practitioners at the highest level they are able to contribute within their education will increase the effectiveness and efficiency of the existing workforce. Currently complex federal and state rules about reimbursement and requirements for scope of practice, licensure, and staffing ratios limit the ability of practitioners to implement such models.[3]Therefore, the Workgroup supports the examination of state regulations and licensure board requirements to improve the regulatory environment for all licensed health practitioners. (See Recommendation 8.4 in Chapter 8.)

Current restrictions by payers limit the types of health practitioners that can provide services and the types of services that can be billed. Typically only face-to-face care provided by physicians, nurse practitioners, and physician assistants can be billed.[33] The current fee-for-service model limits the use of team-based care. Innovative payment models such as capitation or bundled payments would give interprofessional teams more discretion to delegate delivery of needed services. (For more discussion of new models of care, see Chapter 8) The use of new payment models is essential if other types of health practitioners, both professional and lay health workers, are to be fully utilized as members of the health care team. Therefore, the Workgroup strongly supports testing of new Medicaid, Medicare, North Carolina Health Choice, and private insurance payment models that would allow for workforce innovations in the provision of care.

Changes in the model of primary care provision could make the existing workforce more productive and care more cost effective, while improving patient experiences and outcomes.[33] The Workgroup strongly supports the rethinking of current practice models to create more effective, productive, and efficient models of health care provision. Research shows that

successful models rely on strong teamwork and incorporate meaningful use of technology.[24] Exactly what these models look like and what the appropriate mix of health care practitioners is cannot be understood without testing out innovative new payment and delivery models. Therefore, the Workgroup supports the work of the New Models of Care Workgroup to foster innovations in the way health care is provided and paid for with the goal of more productively using the existing workforce (see Chapter 8).

THE STATE HAS A VESTED INTEREST IN HEALTH PRACTITIONER WORKFORCE PLANNING

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

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

Health care plays a major role in North Carolina's economy. One out of every eight North Carolinians works in the health care field (12.6% or 487,933 individuals).[21,35]This makes the health care industry one of the largest employment sectors in North Carolina. Only the trade, transportation, and utilities sector employs a larger percentage of the workforce. In most North Carolina communities, health care is one of the largest employers. [21] In 2008, North Carolina's health care industry produced over $46.3 billion in revenue and wages and contributed an additional $41.4 billion in health care goods and services. [21]

As North Carolina looks at areas of growth in the economy, the health care industry, and particularly the health care workforce, offers one area for consistent and continuous job growth.[36]) Even before the ACA, the United States Bureau of Labor Statistics and the North Carolina Employment Security Commission estimated that employment in the health care industry would grow faster than almost any other industry.[35,36] Although the health care industry is one of the bright spots in North Carolina's lagging economy, the state does very little to plan for how to meet the workforce needs of the health care industry.

Although the state does not proactively work to identify health workforce needs, North Carolina does play a major role in the production of the health care workforce by underwriting the cost of education. In 2010-2011, the state spent $508 million to support medical education programs and students in the University of North Carolina system.[w] In addition, the state provided $112 million to the North Carolina Community College System in 2011-2012 to support medical education.[x] In addition to underwriting the education of the health care workforce, the state is also a major consumer of health care as a payer of medical claims for the 2.5 million North Carolinians who have health insurance coverage through Medicaid, North Carolina Health Choice, and the State Health Plan. [3738]This number is expected to increase to approximately 3

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[w] Harb, D. Fiscal Research Division, North Carolina General Assembly. Written (email) communication. February 2, 2012.

[x] Harb, D. Fiscal Research Division, North Carolina General Assembly. Written (email) communication. February 2, 2012.

million with the full implementation of the ACA.[37,39] For these programs to function well, there must be adequate numbers of health practitioners to meet needs.

Limited Workforce Planning is Occurring

The Cecil G. Sheps Center for Health Services Research's Health Professions Data System (HPDS), housed at the University of North Carolina at Chapel Hill, has descriptive data about most of the licensed health professions in the state. The Data System collects data on the supply and distribution of 20 types of licensed health professionals including physicians, nurses, dentists, pharmacists, and psychologists.[9] Data from the Health Professions Data System allow local communities and the state to assess the current workforce.[9] Data from the Health Professions Data System do an excellent job highlighting the geographic variations in the health practitioner workforce. For example, data show that in 2010 there were 9.4 primary care physicians per 10,000 people in North Carolina. Orange and Durham counties had the highest concentrations (33.5 and 24.8 per 10,000 residents respectively) while Tyrell and Gates had the lowest concentrations with less than 1 physician per 10,000 residents. North Carolina has more data on the health care practitioner workforce than most states; however, even this data is limited. For example, the HPDS does not currently collect data on certain licensed behavioral health professionals, including licensed clinical social workers, licensed professional counselors, or licensed clinical addiction specialists, which makes it difficult to examine the adequacy of the existing behavioral health workforce. Further, data are not available to forecast the workforce supply or to assess whether the existing and future workforce can meet the expected sharp increase in demand for services in 2014 and future years.

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

Many Roadblocks to Increasing Health Practitioner Workforce

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

care. [40] Training sites that incorporate new models of care, such as team-based care, are also lacking.

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

RECOMMENDATION 5.5: COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS

a) The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. As part of their work the Center should:

- **i) Identify, collect, and develop data streams to model future health practitioner workforce needs. Potential data need to include:**
  - **A) Population health measures including health status and socio-demographic factors that may influence future health care needs.**
  - **B) Practice level data such as geographic location, types of practitioners employed, types of health insurance accepted, number of patients, services provided, and other capacity information.**
  - **C) Health practitioner workforce data including demographic, practice, and educational characteristics.**
  - **D) Higher education data on the number of students in health education programs as well as tracking information to see where and what students end up practicing.**
- **ii) Use aforementioned data streams to:**
  - **A) Analyze the link between workforce supply, costs, and outcomes.**
  - **B) Identify practitioner shortages by specialty and geographic location.**
  - **C) Identify barriers to expanding the health practitioner workforce in areas of need.**
  - **D) Plan for the state's future workforce needs by identifying priorities for training and education funding.**
  - **E) Report on the diversity of the health professions workforce in the state on an annual basis.**
  - **F) Address barriers that affect entry into the health care workforce or continued practice. As part of this work, the Center should examine:**
    - **(1) State regulations and licensure board requirements to improve the regulatory environment for all licensed health practitioners. This examination should allow all health practitioners to be able to practice to the full extent of their education and competence.**
    - **(2) Public and private insurance payment policies that create barriers to entry and continued practice.**
    - **(3) Barriers to effective team care.**

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

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

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

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CHAPTER 6
PREVENTION

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

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

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

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

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

TOBACCO

Tobacco use is the leading cause of preventable death and disease in North Carolina. Smoking harms nearly every organ of the body and causes many diseases, including coronary heart disease, several types of cancer, acute and chronic respiratory illnesses, and adverse pregnancy

outcomes [2] North Carolina ranks 36th in prevalence of smoking—with 19.8% of the population reporting smoking in 2011—31st in cardiovascular deaths, and 35th in cancer deaths.[1]
Two provisions of the ACA support efforts to reduce tobacco use. First, the ACA prevents states from excluding coverage for tobacco-cessation drugs from their Medicaid programs.[a] Some FDA-approved tobacco-cessation pharmaceuticals are covered by North Carolina's Medicaid Program (Medicaid). However, there are several barriers to access, including:

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

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

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

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

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

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[a] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2502(a), amending §1927(d) of the Social Security Act, 42 USC 1397r-8(d).
[b] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4106.
[c] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4107, amending section 1905 of the Social Security Act, 42 USC 1396d.
[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 4201, 10403.

North Carolina was one of 35 states and communities that received an implementation grant. The state received $7.466 million, the fourth largest award announced. North Carolina plans to fund 10 multi-county collaboratives across the state to address strategies in three core areas: tobacco free living, active living and healthy eating, and use of high impact evidence-based clinical and other preventive services. This funding will be disseminated through one lead health department in each collaborative. The strategies for the tobacco free living core area are:

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

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

RECOMMENDATION 6.1: INCREASE TOBACCO CESSATION IN MEDICAID RECIPIENTS

a) The North Carolina Division of Medical Assistance (DMA) and the North Carolina State Center for Health Statistics should monitor the utilization of tobacco-cessation drugs and the impact on tobacco-related health outcomes.

b) DMA should provide all FDA-approved over-the-counter nicotine replacement therapy (nicotine patch, gum, lozenge) if accessed through the QuitLine or through a physician prescription as part of comprehensive tobacco cessation services.

c) To encourage the provision of counseling and pharmacotherapy to pregnant women for cessation of tobacco use:

i. The North Carolina Area Health Education Centers Program (AHEC), the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Obstetrical and Gynecological Society, and other appropriate groups should partner to provide education to providers on billing options for Medicaid preventive services, particularly for those providers who are not enrolled in the medical home model.

ii. Community Care of North Carolina care managers should educate patients on the availability of these preventive services without copayment.

d) If the state does not take the option to provide all United States Preventive Services Task Force recommended services rated A or B with no cost sharing to Medicaid recipients in return for an increase in reimbursement from the federal government, then the following additional recommendations would provide tobacco cessation support for Medicaid recipients:

i. DMA should reduce out-of-pocket costs for clients for effective cessation therapies.

ii. **DMA should provide access to all FDA-approved tobacco pharmaceuticals without a co-pay for at least two cessation attempts per year.**

PHYSICAL ACTIVITY AND NUTRITION

The percentage of North Carolinians who are obese more than doubled between 1990 (12.9%) and 2011 (28.6%).[1] In 2011, North Carolina ranked 30th in percentage of the population that was obese.[1] As part of the ACA prevention funding, DPH received $3.8 million in Communities Putting Prevention to Work (CPPW) funding. These funds will be used by DPH to implement sustainable evidence- and practice-based approaches to changing policies, systems, and environments contributing to the obesity epidemic in the Appalachian District (including Allegany, Ashe, and Watauga counties) and Pitt County. An additional $272,000 was awarded to support BRFSS data collection in these two communities.

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

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

Through the CPPW and CTG grants, ACA funding has provided additional valuable resources to support North Carolina's efforts to combat rising obesity rates.

MATERNAL AND CHILD HEALTH

Comprehensive, coordinated pre-conception, maternity, and post-partum care is important for improving birth outcomes in North Carolina. The incidence of premature and low-weight births may be reduced through addressing the health of the mother before and during pregnancy. Risk factors for a poor outcome include diabetes, hypertension, tobacco or other substance use, and unsafe living environment. North Carolina ranks 36th in diabetes incidence, 40th in hypertension, and 36th in smoking.[1] These rankings are not specific to the pregnant population, but are indicators of the overall population's health.

Home Visiting

Support is provided through the ACA for pregnant and parenting teens and home visiting programs, as well as requiring reasonable break times for working nursing mothers. The support to pregnant and parenting teens is provided in the form of grants to states, institutions of higher

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

The ACA also provides funding to states to develop and implement maternal, infant, and early childhood evidence-based visitation models targeted at reducing infant and maternal mortality and its related causes. Model goals include improving prenatal, maternal and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.[f] In 2010, the North Carolina infant mortality rate was the lowest in the State's history at 7.0 deaths per 1,000 live births.[3] North Carolina received $5.46 million to implement the North Carolina Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The MIECHV program offers information, risk assessment, and home-based parenting support using evidence-based models in at-risk communities, including sections of Buncombe, Durham, Gaston, Edgecombe, Halifax, Hertford, Northampton, Mitchell, and Yancey counties. [4] Three evidence-based home visiting models are supported: Nurse Family Partnership, Healthy Families America, and an integrated Healthy Families America and Parents As Teachers program. The Nurse Family Partnership provides nurses to educate and support low-income, first-time mothers through the first two years of motherhood. Healthy Families America is a evidence-based home visiting program for families at risk of child abuse or neglect. The program's goals include development of nurturing relationships, promotion of healthy child development and growth, and building the foundation for a strong family. Parents As Teachers provides family education and support to families with young children. This support includes home visits by parent educators, parent group meetings, developmental and health screenings, and linkages to community resources.

Supporting Nursing Mothers at Work

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

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[e] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 10211-10214.

[f] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2951, enacting Sec. 511 of the Social Security Act, 42 USC 711.

[g] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4207, enacting Sec. 7 of the Fair Labor Standards Act, 29 USC 207.

The primary gap identified for North Carolina was the need for education of employers and employees on this provision, including on the definition of reasonable break time and appropriate facilities. The workgroup also identified that the ACA provision for workplace lactation support provides break time and space for hourly employees, which leaves gaps in the law for salaried employees. The break time for hourly employees is unpaid, unless that employer routinely pays for break time. The North Carolina Office of State Personnel policy provides more comprehensive protection for state employees covered by the State Personnel Act, but further action is still required to fill remaining gaps for those state employees not covered by the State Personnel Act, and to provide similar support for non-state employees. Therefore, the Workgroup recommends:

RECOMMENDATION 6.2: SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

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

PREVENTING SEXUALLY TRANSMITTED DISEASES AND UNINTENDED PREGNANCIES

Personal Responsibility and Abstinence Education

Preventing sexually transmitted diseases (STDs) and unintended pregnancies will help improve quality of life, decrease death and disability, and reduce health care costs. North Carolina has been working to reduce cases of STDs and has seen improvements in recent years. In 2010, the reported number of new HIV diagnoses, early syphilis cases, chlamydia cases, and gonorrhea cases declined from the previous year (8.6%, 23.0%, 3.6%, and 4.4% declines respectively) [5]. For the past ten years, the percentage of pregnancies reported to be unintended has remained steady at between 40-45%.[6] [7] However, North Carolina's teen pregnancy rate has declined significantly since 2000 from 44.4 to 26.4 per 1,000 teens ages 15-17 in 2010.[8]

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

[h] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2953, enacting Sec.513 of the Social Security Act, 42 USC 713.

assistance. North Carolina Department of Health and Human Services applied for and received $1.5 million in PREP funds to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections.

In October 2010, the North Carolina Division of Public Instruction (DPI) received $1.5 million in Title V funds for abstinence education as part of implementation of comprehensive sex education pursuant to the "Healthy Youth Act of 2009." The workgroup recognized that the overlap of the goals and audience for these two programs provided an opportunity for collaboration between DPH and DPI. The Workgroup supported collaboration between DPH and DPI on providing this education.

IMPROVING ACCESS TO PREVENTIVE SERVICES

Private Health Insurance

The ACA requires new employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care and screening for infants, children, and adolescents, and additional preventive services for women that are recommended by Health Resources and Services Administration of the United States Department of Health and Human Services[i]. The primary gaps identified by the workgroup were monitoring of health plans to ensure that coverage is provided, education of providers and patients on the covered services, and providing mechanisms in electronic medical record systems to promote the provision of these services.

Medicare

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

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

[j] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4104, amending Section 1833(a)(1) of the Social Security Act, 42 USC 1395l(a)(1).

[k] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4103, amending Section 1861(s)(2) of the Social Security Act, 42 USC 1395x(s)(2).

Medicaid

The ACA provides the option for states to provide similar coverage of preventive services for Medicaid-eligible adults.[1] Beginning in Jan 2013, states may provide Medicaid coverage for all preventive clinical services recommended by the USPSTF and all immunizations recommended by ACIP. States that elect to cover these preventive services and vaccines and provide these services without cost sharing, will receive an increase of one percentage point in their Federal Medical Assistance Percentage (FMAP) rate for these services. The FMAP is used to determine the amount of federal matching funds provided to the state for Medicaid medical expenditures.

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

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

[1] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4106, amending Section 1905(a)(13) of the Social Security Act, 42 USC 1396d(a)(13).

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

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

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

Increasing Child and Adult Immunizations

The ACA authorizes states to purchase adult vaccines under the Centers for Disease Control and Prevention (CDC) contracts and reauthorizes the federal Immunization Program.[m] These contracts for adult vaccines provide savings that range from 23%-69% compared to the private sector cost. This provision also authorizes a demonstration program to improve immunization

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, §4204, amending Section 317 of the Public Health Service Act, 42 USC 247b.

coverage. Under this program, the CDC will provide grants to states to improve immunization coverage of children, adolescents, and adults through implementation of interventions recommended by the Task Force on Community Preventive Services or other evidence-based interventions, such as reminders or recalls for patients or providers, or home visits.

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

RECOMMENDATION 6.3: PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

a) **North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. Thus, North Carolina should provide coverage of all preventive services and immunizations recommended by United States Preventive Services Task Force (USPSTF) (with a rating of A or B) and Advisory Committee on Immunization Practices (ACIP) without cost-sharing.**
b) **The North Carolina Department of Insurance (NCDOI) should continue to monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services rated A or B by the USPSTF; immunizations recommended by ACIP; preventive care and screening for infants, children, and adolescents; and additional preventive services for women that are recommended by the Health Resources and Services Administration (HRSA). Tracking of compliance should include tracking the insurance plan year in which the coverage is required.**
c) **The North Carolina Office of Health Information Technology (NC-HIT) should encourage companies that provide electronic medical record (EMR) systems in North Carolina to provide clinical decision support tools to identify and promote USPSTF and ACIP recommended services targeted to the patient needs.**
d) **NC-HIT, Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC), and the North Carolina Healthcare Quality Alliance should ensure that quality improvement initiatives at the state level include monitoring of utilization of patient-targeted prevention services.**
e) **North Carolina Area Health Education Centers (AHEC), DMA, the North Carolina Medical Society (NCMS), Old North State Medical Society, other health care professional associations, and the North Carolina Division of Social Services should partner to educate providers to ensure that health professionals and caseworkers are aware of, and actively advise their patients and clients to obtain, appropriate clinical preventive services. They also should provide education to providers on billing options to obtain reimbursement from public and private payers for clinical preventive services, particularly for those providers who are not enrolled in the medical home model.**

f) **Providers should be encouraged to educate patients on the value of these preventive services, as well as availability, without copayment or application of deductible, and to appropriately encourage utilization of preventive services.**
g) **AHEC, NCMS, the North Carolina Division of Aging and Adult Services (DAAS), CCNC, the North Carolina Academy of Family Physicians, and the AARP should provide education to primary care physicians on the annual wellness visit benefit for Medicare enrollees.**
h) **Senior's Health Insurance Information Program (SHIIP), AARP, and DAAS should provide education to enrollees on the annual wellness visit benefit.**
i) **AARP, DMA, SHIIP, and the DAAS should engage community leaders to do community outreach for education of the public on the availability and importance of preventive services.**

WORKSITE WELLNESS

Worksite wellness programs can improve the health of North Carolinians by increasing healthy eating and physical activity, decreasing tobacco use, and decreasing stress. By improving the health status of employees, health care costs can be reduced.[9]

The worksite wellness provisions of the ACA allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or prevent disease.[n] Discrimination based on health status is prohibited. However, employers can include requirements that enrollees satisfy health status factors (ie, tobacco cessation or healthy weight) if the financial consequences (reward or penalty) do not exceed 30% of the cost of employee-only coverage (or 30% of family coverage if dependents participate).

The ACA also includes provisions that direct the Centers for Disease Control and Prevention to provide technical assistance to employers to implement and evaluate evidence-based worksite wellness programs.[o] Funding for this provision has not yet been made available. However, there are several ongoing efforts in North Carolina to provide technical assistance to employers interested in implementing worksite wellness efforts. For example, the Division of Public Health, Physical Activity and Nutrition Branch maintains the Work*Well* NC page on the Eat Smart, Move More NC website[10]. The Work*Well* NC page includes toolkits to help businesses develop wellness programs, turnkey programs to encourage healthy behaviors, worksite wellness success story videos from diverse businesses across the state, sample worksite wellness policies, links to worksite wellness services, and guides to implementing wellness program components at the worksites. North Carolina Prevention Partners offers a prevention academy and an evaluation tool for worksites to evaluate their wellness policies, benefits, and environment focused on tobacco, nutrition, and physical activity.[11]

Despite these statewide efforts to work with employers that are interested in implementing worksite wellness initiatives, the workgroup also noted gaps. For example, employers do not all know about the resources that are available, or the potential impact of implementing these programs on improved worker productivity, reduced absenteeism, and reduced health care costs.

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[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 2705, 10408.
[o] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4303, amending Title III of the Public Health Service Act, 42 USC 2801.

The workgroup recommended further employer education about worksite wellness opportunities and requirements, to encourage businesses to adopt a healthy lifestyle culture, and to provide the assistance required for implementation of evidence-based wellness programs with fidelity. Therefore, the Workgroup recommends:

RECOMMENDATION 6.4: PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES

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

b) EatSmartMoveMoreNC should continue to provide information on evidence-based worksite wellness tools and programs through its website [10], including CDC's worksite wellness technical assistance program.

INFRASTRUCTURE

State Infrastructure

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

Develop Local Infrastructure to Respond to Grant Opportunities

The Prevention Workgroup examined funding opportunities available through the ACA and explored strategies to target funding to communities of greatest need. Often the communities with the greatest health needs are those that lack the personnel or infrastructure to apply for grants or to implement new initiatives. State data suggest that some of the smaller, poorer counties have higher *rates* of certain preventable conditions, but urban counties have greater *numbers* of people with the same health problems. Thus, the workgroup discussed the need to target both large and small communities for new prevention activities. The workgroup created an

[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4304, enacting Sec. 2821 of the Public Health Service Act, 42 USC 300hh-31.

infrastructure subcommittee to identify mechanisms to assist communities with limited public health and grant proposal writing infrastructure to respond effectively to prevention funding opportunities that may become available through the ACA or other sources. An additional objective was to provide communities assistance needed to develop the infrastructure to address the HNC2020 objectives.

Two state agencies have missions directly related to the goals of improving the health of North Carolina communities, in part, by assisting with the development of community infrastructure: DPH and the North Carolina Office of Minority Health and Health Disparities (OMHDD). DPH, through the Center for Healthy North Carolina, has been tasked with working with communities to help them develop the infrastructure to reach the HNC2020 objectives. OMHHD works with non-profits in communities on infrastructure development (including capacity building and leadership development) with the goals of improving minority health and reducing health disparities. The subcommittee recognized the importance of community engagement to the success of interventions to improve community health.

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

RECOMMENDATION 6.5: DEVELOP INFRASTRUCTURE TO ALLOW COMMUNITIES OF GREATEST NEED TO RESPOND TO PREVENTION-RELATED FUNDING OPPORTUNITIES. The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should:

a) Encourage partnerships between local health departments and community organizations in responses to funding opportunities.
b) Provide information to these organizations on available resources to assist with identifying funding opportunities, grant writing, evaluation design and implementation, development of leadership capacity, and evidence-based interventions.
c) Cultivate partnerships between communities, community organizations, and academic institutions to provide mutual opportunities for research and service.
d) Provide training to local providers to improve cultural competence, and work to increase cultural diversity in community partnerships and funding opportunity participants.
e) Work with communities to develop communication mechanisms to help communities identify potential collaborators, develop the capacity to produce competitive grant applications, and avoid competition within the same community. Use multiple mechanisms of communicating with community members, recognizing that the availability, ability to utilize, and interest in technology varies widely.

Monitoring Additional Funding Opportunities

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

RECOMMENDATION 6.6: MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS

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

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CHAPTER 7
QUALITY

The Affordable Care Act has many provisions aimed at improving quality and patient safety. This is an important goal for the health of the country and for the health of North Carolinians. In 1999, the Institute of Medicine of the National Academies released its seminal report, *To Err is Human*, which estimated that preventable medical errors led to between 44,000-98,000 deaths per year.[1] A more recent study suggests that adverse events occur in one-third of all hospital admissions.[2] In addition to medical errors which can affect patient safety in and outside of hospitals, there are also studies which show that people, on average, only receive about half of all recommended ambulatory care treatments.[34]

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

Community Care of North Carolina (CCNC)[6] has led to significant improvements in quality of care provided to Medicaid recipients with chronic health problems. When compared to other commercial managed care plans using the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures, CCNC is in the top ten percent for diabetes, asthma, and heart disease. HEDIS is a tool consisting of 75 measures across eight domains of care. It is used by more than 90% of America's health plans to measure and compare performance and to identify areas where improvement is needed.

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

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

However, there is still room for improvement. 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. The analysis suggested that 131,627 more adults with diabetes in North Carolina would have received recommended clinical services to prevent disease complications if North Carolina performed as well as the best state. Similarly, North Carolina would have experienced 23,384 fewer preventable Medicare hospitalizations, saving close to $146 million.

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

OVERVIEW

The ACA includes many provisions aimed at improving the quality of care provided by different types of health care professionals and providers. The legislation also directs the Secretary of the United States Department of Health and Human Services 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.[a] The Secretary was also directed to create a plan to collect these data and make the data available to the public. In addition, the ACA modifies reimbursement methodologies to provide payments to health care professionals and different providers based, in part, on the value of the services provided. The ACA created a new Patient-Centered Outcomes Research Institute to develop research priorities and help fund comparative effectiveness research.[b] 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.[9] 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 includes additional sources to support ongoing funding.

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

ACA PROVISIONS

Quality Measure Reporting

In order to participate in Medicare, certain types of health care providers have been required to report data to CMS on quality of care measures. For example, hospitals already report on patient hospital experiences, surgical process of care, 30-day mortality, use of medical imaging, and

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[a] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3013-3014.
[b] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6301-6302.

complications and deaths for certain conditions. Nursing facilities are inspected at least annually. These data are available to the public.[10] Physicians, while not currently required to report quality data, are provided a financial incentive to do so. The Physician Quality Reporting System collects data on quality measures for covered professional services furnished to Medicare beneficiaries. For 2012, these measures evaluate specific aspects of care for many illnesses, including diabetes mellitus, heart disease, depression, stroke, glaucoma, macular degeneration, perioperative care, osteoporosis, medication reconciliation, preventive care, and respiratory illness. More information on these measures is available on the CMS website.[11] However, data comparing physicians on quality measures is not currently available.

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

The Secretary also is charged with developing a set of quality measures for Medicaid-eligible adults that is similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. States will report these quality measures on a regular basis.[e] The initial set of measures was published in the Federal Register in January 2012.[f] Fifty-one measures were identified in the areas of maternal/reproductive health, overall adult health, complex healthcare needs, and mental health/substance abuse. Funding for the development, testing, and validation of additional measures will be provided through the Medicaid Quality Measurement Program in January 2012. By January 2013, a standardized reporting system will be developed, and voluntary reporting by states will be encouraged. By September 2014, states will be required to submit these measures, and the results of the analysis will be made available to the public.

Medicare's physician feedback program will be expanded to include the development of confidential individualized reports. These reports will compare the per capita utilization of resources and services for an episode of care for physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.[g] By January 2013, the Physician Compare website will provide data to the public on quality and patient experience measures for physicians enrolled in the Medicare program. Under a final rule released in December 2011, Medicare data will also be available to qualified entities to combine with data from other payers and to create public reports on the performance of providers[h]. The workgroup discussion centered on concerns as to how

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

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

[e] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2701, enacting Sec. 1139B of the Social Security Act, 42 USC 1320b-9b.

[f] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 2012: 77(2): 286-291. To be codified at 77 CFR § 286.

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

[h] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 2011;76(235): 76542-76571. To be codified at 42 CFR § 401.

efficiency would be assessed, the need for legal protections for providers who follow evidence-based care, and the need for education of providers and the public on how to use these data. In response to this discussion the workgroup recommends:

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

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

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

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

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

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[i] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2701, enacting Sec. 1139B of the Social Security Act, 42 USC 1320b-9b.

[j] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2701, enacting Sec. 1139B of the Social Security Act, 42 USC 1320b-9b.

Value-Based Purchasing

Another new initiative of the ACA is value-based purchasing, which ties a percentage of Medicare payments to performance based on quality measures. The resulting pay-for-performance mode, a shift from the current pay-for-care-volume mode, will result in savings over time. Value-based purchasing will affect physicians, hospitals, home health, hospice, and skilled nursing facilities.[k] For physicians, Medicare payments under value-based purchasing will be based on risk-adjusted performance data. The performance data will include measures of quality of care that reflect health outcomes, as well as resource use or costs of care. Feedback reports will contain primarily comparisons of performance among similar physicians. The goal is to provide Medicare patients with high quality, efficient care. The proposed rule was published in the July 19, 2011 Federal Register.[l]

In response to the volume of quality reporting and other information for physicians provided by the ACA, the workgroup recommends:

RECOMMENDATION 7.4: EDUCATE PROVIDERS ON ACA ISSUES

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

a) Impact of the use of quality, efficiency, and resource use data by the public and Medicare.[m]
b) Opportunities to provide input into the development of quality measures.[n]
c) Penalties for not reporting quality data, and the advantages of integrating reporting and EHR.[o]
d) Value-based purchasing.[p]
e) Requirement for providers to have a system to improve healthcare quality to allow HBE providers to contract with them.[q]
f) Medical diagnostic equipment requirements.[r]
g) Care coordination and other important follow-up factors to reduce hospital readmissions.

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[k] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3001, 3006; Protection and Affordable Care Act, Pub L No. 111-148, § 10335, amending § 1886(o)(2)(A) of the Social Security Act, 42 USC 1395ww.

[l] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 2011;76(138): 42772-42947. To be codified at 42 CFR §§ 410, 414, 415, 495.

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10331.

[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3003, 3013, 10303.

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

[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3007, amending §1848 of the Social Security Act, 42 USC 1395w-4.

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

[r] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4203, enacting Sec. 510 of the Rehabilitation Act of 1973, 29 USC 794f.

For hospitals, the quality measures used for value-based purchasing are related to common and high-cost conditions, and include efficiency and consumer satisfaction measures. CMS plans to align these measures with the meaningful use standards, so that collection of performance data is a natural part of care delivery. For FY 2011, 45 measures have been adopted that evaluate process of care, mortality and readmission rates, patient safety measures, patient experience of care, and participation in cardiac surgery, stroke care, and nursing sensitive care databases.[s] This payment policy is applicable for discharges occurring on or after 1 Oct 2011 for acute care and long-term care hospitals. In response to the volume of quality reporting and other information for hospitals provided by the ACA, the workgroup recommends:

RECOMMENDATION 7.5 : EDUCATE HOSPITALS ON ACA ISSUES

The North Carolina Hospital Association should provide education to hospitals on the following issues related to ACA:

a) Importance of using the "present on admission indicator" and the meaning and implications of the quartiles.[t]
b) Quality reporting requirements.[u]
c) Value-based purchasing.[v]
d) Importance of having a safety evaluation system to allow HBE provider to contract with hospitals with more than 50 beds.[w]
e) Medical diagnostic equipment requirements.[x]

Quality standards and reporting requirements also are defined for inpatient rehabilitation hospitals, certain cancer hospitals, ambulatory surgery centers,[y] and hospice. Value-based purchasing will be tested for these institutions, and, if implemented, providers who do not successfully participate in the quality reporting program would be subject to a reduction in their annual inflationary payment increase (called the annual market basket payment update).[z] The workgroup also recommends education for other providers of care on the quality issues in the ACA that affect them.

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[s] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.*2011: 76(9): 2454-2491. To be codified at 42 CFR §§ 422, 480.

[t] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 2702, 3008

[u] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3004; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3005, amending Sec. 1866 of the Social Security Act, 42 USC 1395cc; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3014, 10301, 10322; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10305, enacting § 399II(a) of the Public Health Service Act, 42 USC 280-1.

[v] Patient Protection and Affordable Care Act, Pub L No. 111-148, §3001; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10335, enacting § 1886(o)(2)(A) of the Social Security Act, 42 USC 1395ww.

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

[x] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4203, enacting Sec. 510 of the Rehabilitation Act of 1973, 29 USC 794f.

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

[z] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3002, 3004; Patient Protection and Affordable Care Act, Pub L No. 111-148, §3005, amending Sec. 1866 of the Social Security Act, 42 USC 1395cc; Patient Protection and Affordable Care Act, Pub L No. 111-148, §10326.

RECOMMENDATION 7.6: EDUCATE HOME AND HOSPICE CARE PROVIDERS ON ACA ISSUES

The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the ACA value-based purchasing provisions.[aa]

RECOMMENDATION 7.7: EDUCATE FACILITY PERSONNEL ON ACA ISSUES

The North Carolina Division of Health Service Regulation, Association for Home and Hospice Care of North Carolina, and North Carolina Health Care Facilities Association should provide education to their respective constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value based purchasing.[bb]

Public Availability of Quality Data

Data acquired through the quality reporting systems will be made available to the public. Information on quality of care provided by some hospitals and nursing homes is already available to the public. The Hospital Compare[12] and Nursing Home Compare[13] websites allow the public to compare the quality of care provided based on data provided by the institutions on specific measures. The Hospital Compare website measure categories include surgical process of care, mortality rates, use of medical imaging, hospital experience, and patient safety. The Nursing Home Compare website provides information on staffing, quality measures, and fire safety and health inspections.

The ACA expands the types of facilities and providers for which quality data will be publically available. Sections 3004 and 3005 will make quality data from long-term care, inpatient rehabilitation, and PPS-exempt hospitals, and hospices publically available. The Secretary is required to establish a process by which hospitals can review their data prior to posting on the Hospital Compare website.

The Secretary also is required to develop a similar Physician Compare website that will allow Medicare enrollees to compare scientifically sound measures of physician quality and patient experience measures (effective January 2012).[cc] This quality reporting system will cover physicians enrolled in the Medicare programs, as well as other professionals who participate in the Physician Quality Reporting System, such as therapists (physical, occupational, or speech language), audiologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dieticians, and nutrition professionals.

The workgroup felt that physicians and other practitioners would benefit from education to ensure that they were aware of the reporting requirements and the public availability of their data. (See previous recommendations 4 and 5.) Connecting the quality measures to long-term

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[aa] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3006. 10326.

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

[cc] 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).

outcomes will help providers realize the importance of participating in reporting of these measures and using the information meaningfully.

The workgroup also recognized that education for consumer decision-making will be a key element in quality improvement and cost savings through implementation of the ACA. There is currently no group with the breadth to reach all necessary constituents that also has the resources to execute this large undertaking. NCHQA, NC AHEC, CCNC, and the NC HIE will convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.

RECOMMENDATION 7.8: EDUCATE CONSUMERS ON AVAILABILITY AND INTERPRETATION OF PROVIDER QUALITY MEASURES
The North Carolina Healthcare Quality Alliance, North Carolina Area Health Educations program, Community Care of North Carolina and the North Carolina Health Information Exchange should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.

Health Care Acquired Conditions
As a result of the ACA, Medicaid now is prohibited from paying for services related to a health care-acquired condition. A similar policy already exists for Medicare[dd]. The Secretary maintains a list of health care-acquired conditions for Medicaid (effective July 2011).[ee] These conditions must be high cost and/or high volume, and must be reasonably preventable using evidence-based guidelines. For FY2011, the list of hospital-acquired conditions includes retention of a foreign object following surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, manifestations of poor glycemic control, falls, trauma, urinary tract or venous catheter associated infections, and deep vein thrombosis after specific surgeries. Hospitals will not lose reimbursement if the condition was already present when the person was first admitted to the hospital, so education of hospitals on the use of the "present on admission" indicator is important.

Hospitals also will be subject to a Medicare payment penalty starting in FFY2015 if they are in the top 25th percentile of rates of hospital-acquired conditions. The financial penalty would apply to hospital-acquired conditions for certain high-cost and common conditions. This policy also may be applied to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.[ff] The workgroup identified provider education as the primary gap regarding these policies.

Readmission Reduction and Transitions in Care
The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. Specifically,

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[dd] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 2007;72(162): 47379-47482. To be codified at 42 CFR §§ 411, 412, 413, and 489.
[ee] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2702.
[ff] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3008.

hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions: heart attacks, heart failure, and pneumonia. The Secretary has the authority to expand the policy to additional conditions in future years. The Secretary also was directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).[gg]

The goal of this focus on preventable readmissions is to improve quality and efficiency of care by improving transitions in care. Transitions in care refer to movement of patients between health care providers and health care settings, for example, transfer between a nursing home and an emergency department; return to the care of a primary care physician following discharge from a hospital; or multiple providers providing care within a hospital. Problems with transition can occur when information about a patient's care or situation is not communicated adequately to other providers or to the patient. For example, a patient may receive conflicting medication lists on discharge from a hospital due to multiple medication lists stored in the hospital's medical record system, or a follow-up with a primary care physician following discharge from a hospital may not occur due to lack of communication by the patient and hospital regarding the patient's hospitalization. These coordination failures can result in hospital readmissions and/or poor outcomes. North Carolina ranked 18th in the percentage of Medicare 30-day hospital readmissions as a percent of all readmissions in 2006/2007, and 21st in the percent of short-stay nursing home residents with a hospital readmission within 30 days in 2006.[14] The Commonwealth Fund analysis suggests that 5042 fewer hospital readmissions would have occurred among Medicare beneficiaries if North Carolina performed as well as the best state, saving approximately $60,262,008.

The Health Reform Quality Workgroup identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, a shared savings model, information technology support, the forging of relationships between providers of care, and the need to reduce the number of patients transferred from skilled nursing facilities (SNFs) to emergency departments (EDs). The workgroup identified quality initiatives already in place in North Carolina and the provider type and/or transitions between provider types affected by the initiative. This analysis provided the basic information required for the gap analysis, which provided a clear indication of where quality initiatives are needed to improve transitions in care. A subcommittee of the Quality Workgroup, in partnership with a subcommittee of the New Models of Care Workgroup, reviewed models and existing programs that address transitions in care at different points in the health care system, and made recommendations about which models and programs could be used or expanded in North Carolina to reduce preventable readmissions and improve transitions in care (See Appendix C). In order to improve transitions of care, the joint subcommittee recommends:

RECOMMENDATION 7.9: IMPROVING TRANSITIONS OF CARE

a) The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina (CCNC) to improve transition in care, including forging of

[gg] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3025; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10309, amending § 1886(q)(1) of the Social Security Act, 42 USC 1395ww.

relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms for evaluating outcomes. Partner organizations should also work to:

- **i) Improve patient (or responsible family member) discharge education at hospitals, with a focus on the health literacy checklist and teach-back methodology.**
- **ii) Improve discussions of goals of care and education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**
- **iii) Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.**
- **iv) Align existing initiatives that address care transitions at state and local levels.**
- **v) Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.**
- **vi) Encourage collaboration and contracts between hospitals, local management entities, critical access behavioral health agencies, and other community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.**
- **vii) Encourage formal development of medical home models that include the use of non-physician extenders to work with some patients (eg, stable diabetics), with physicians focusing on higher-need patients.**

b) In each community, stakeholder alliances including provider groups, CCNC, home health representatives and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.

c) Individuals should be provided their own personal health records after hospital discharge, pending the availability of a more robust Health Information Exchange.

d) Solutions utilizing transition principles should be applied to all patients regardless of payer.

Hospitalizations and re-hospitalizations of patients in long-term care settings can result in discomfort, secondary injury or illness, and excessive costs. A CMS-funded study in Georgia evaluated the proportion of hospitalizations that were avoidable and the reasons for these hospitalizations. Of the 200 hospitalizations evaluated in this study, 67% were flagged as potentially avoidable. Reasons for these hospitalizations included lack of on-site availability of clinicians, inability to access needed testing or treatment, and difficulty in assessment of acute

changes.[15] A quality improvement study using clinical practice tools and support by advanced-practice nurses resulted in a reduction in the potentially avoidable hospitalizations of 36%.[16] One of the difficulties in implementing the use of advanced practice nurses in long-term care and skilled nursing facilities is reimbursement for their services. These nurses can provide support for transitions from hospital to nursing facilities, provide consistent routine and follow-up care, improve communication with physicians, and, thus, improve the quality and reduce the cost of care of nursing home patients. In order to use advance practice nurses to improve care in skilled nursing facilities, the workgroup recommends;

RECOMMENDATION 7.10: REIMBURSE NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES

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

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CHAPTER 8
NEW MODELS OF CARE

One of the goals of the Affordable Care Act is to reign in escalating health care costs. Over the last ten years, health insurance premiums have increased more than three times the rate of general inflation. The average employer-sponsored premium for single coverage in North Carolina increased 80% between 2000-2001 and 2009-2010 and 85% for family coverage.[1] Nationally, the comparable premiums increased 109% and 115% respectively during the same time period. In contrast, general inflation only increased 24%.[2] Absent major interventions, health care spending is expected to continue to rise faster than other spending in our society.[3]

OVERVIEW

There is more than a three-fold variation in per capita health care spending across the country.[4] Most of the variation in health care spending across the country is due to differences in the types and quantity of services. This variation has not been found to be as related to differences in price of services, severity of health problems, or patient preferences.[5] Further, communities that spend more on health care services do not achieve better health outcomes. In fact, some experts suggest that the amount spent on health care is associated with lower health care quality.[6]

In general, our current fee-for-service (FFS) health care payment system rewards health care providers based on the volume of the services provided, not outcomes or quality.[7] Health care professionals receive payment each time they provide health care services. Payments are not tied to quality or outcomes. In addition, the existing reimbursement structure creates incentives for health care professionals to provide care based on whether a service can be reimbursed. This discourages health care professionals and creates a financial disincentive to provide certain health care services that could have a greater positive impact on an individual's health, but which are not currently reimbursed. The current FFS system also leads to more fragmented care, as health care professionals get paid regardless of whether care is coordinated among different health care professionals.

The NCIOM health reform workgroup recognized that we—as a state and a nation—need to rethink how we pay for and deliver health care services. We cannot continue to pay increasing amounts of our state or nation's wealth on health care services without receiving a commensurate improvement in health care quality and outcomes. The development and implementation of new models of care is essential to face the challenge in improving the value delivered by our health care system. We need to develop new models of care that expand access to and utilization of needed services; incentivize providers to improve quality and individual and community health outcomes; involve patients more directly in their own care; reduce redundant, ineffective, and inefficient utilization (ie, unnecessary utilization); and moderate rising health care costs. In addition, we need to focus more on prevention and improving the health status of the population (ie, improving overall population health) to reduce the need for more costly health care services. This will require a more holistic view of health care, one which recognizes that the health of a population is profoundly influenced by more than the health care services that the population receives. Population health is also influenced by the environment in which individuals' reside, their socioeconomics (including income, education, and housing), personal lifestyle choices, and racial/ethnic disparities.[8]

The workgroup developed a set of principles that should guide the state, as well as other private organizations, as they implement new delivery and finance models. An abbreviated version of the principles is included below. The complete version is included in Appendix D:

1. Individual patients' and their families' needs and preferences should be the central focus of any health system.
2. North Carolina will be best served by developing models that will improve access, quality, and population health, and reduce unnecessary utilization and the rate of increase in health care expenditures. The availability of funding should not drive the development of new models; rather models should be pursued to address North Carolina specific needs.
3. North Carolina should aggressively test new models, building on existing initiatives but continuing to explore other options with the goals of improving health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.
4. North Carolina should continue testing different models of patient-centered interdisciplinary teams that address the health needs of the whole person.
5. Consumers should be given the information, training, and support to be active participants in managing their own health and informed consumers in a redesigned health system.
6. In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals and paraprofessionals to the fullest extent of their education and competency.
7. Models of care should be designed to improve quality, health care outcomes, and health care access for populations that have been traditionally underserved including, but not limited to, low-income populations, the chronically ill, racial and ethnic minorities, and people with disabilities.
8. Data should be collected and analyzed in a manner that allows for the ongoing redesign and improvement of our care delivery systems, and pertinent health care information and performance data should be made available to consumers.
9. Models of care should be thoroughly evaluated in a timely manner to determine if these innovations are leading to the stated goals, and to understand what models work best for different populations in different communities and with different configurations of providers. Any new model tested in the state should be transparent in terms of design, outcomes, and costs.
10. Successful initiatives should be disseminated throughout the state.
11. To the extent possible, the new models of care should involve other payers in addition to Medicaid and Medicare.
12. If savings are realized from the changes in the health care delivery and financing systems, these savings should be reinvested to support additional improvements in access, quality, health care outcomes, and population health and/or be shared with consumers, taxpayers, payers, and providers.

North Carolina is a leader in testing new delivery and payment models, particularly within its Medicaid program. Community Care of North Carolina (CCNC) is a nationally recognized patient-centered medical home model that has helped improve the quality of care and reduce

health care costs provided to Medicaid recipients.[9] This patient-centered medical home model is now being expanded to include some commercially insured populations, Blue Cross Blue Shield of North Carolina enrollees and Medicare recipients (described more fully below). In addition, some of our large insurers and health care systems are also testing new models of care. The ACA provides some opportunities to partner with the federal government to test new models or expand existing models to the Medicare or Medicaid population. However, North Carolina's efforts have not focused solely on opportunities offered through the ACA. Rather, we are seeking to aggressively explore all potential opportunities to expand access to services; improve quality, outcomes ,and population health; reduce unnecessary utilization; and curb the increase in health care cost escalation. This chapter describes some of the new funding opportunities made available under the ACA to test new models of care, as well as some of North Carolina's existing demonstrations, including value-based plan designs and broader population health interventions.

ACA PROVISIONS AND NORTH CAROLINA MODELS

The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and health care expenditures, while improving individual health outcomes and overall population health. To encourage innovations in health care delivery design and payment models, the ACA created the Center for Medicare and Medicaid Innovation (CMI) within the Center for Medicare and Medicaid Services. The stated intent of CMI is "to test innovative payment and service delivery models to reduce program expenditures under … [Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals under such titles."[a] Three of the signature models include patient-centered medical homes, episode of care/patient bundling, and accountable care organizations. However, the ACA also gives CMI, and CMS, more broadly, the authority to test other delivery models in the Medicare, Medicaid, and Child Health Insurance Program (CHIP) programs, including, but not limited to, community-based care transitions, state demonstrations to fully integrate care for Medicare and Medicaid dual eligibles, independence at home, medication therapy management, telehealth or telemonitoring for chronically ill individuals at high risk of hospitalizations, and co-location of primary care and behavioral health.

Private insurers are also exploring similar models to improve quality of care and population health, and to reduce health care costs. Many of the private efforts predate the enactment of the ACA, but the ACA provides additional incentives that will encourage insurers to implement similar initiatives in their commercial products. For example, insurers that offer qualified health plans within the Health Benefit Exchange (HBE) are required to include quality improvement activities.[b] The ACA defines allowable quality improvement strategies to include increased reimbursement or other incentives to improve health outcomes (for example, through quality reporting, case management, care coordination, chronic disease management, medication management, or a medical home model), prevention of hospital readmissions, improvement in patient safety and reduction of medical errors, implementation of wellness and health promotion activities, or reduction in health care disparities.

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[a] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3021(a), 10306, enacting §1115A of the Social Security Act, 42 USC 1315a.

[b] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 1311(c)(1)(E), 1311(g).

These different models, along with some of the similar delivery or payment models being tested in North Carolina are described briefly below. A more complete listing of new models being tested in North Carolina is included in Appendix E.

Patient-centered Medical Homes (PCMH)[c]

PCMH are teams of health care professionals and other ancillary staff who provide comprehensive primary care to patients including preventive, acute, and chronic care management. [10] The care should be patient-centered, actively engaging the patient in their own care and tailoring care to meet the patient's needs and preferences. In addition, PCMHs often include electronic health records and other information support to improve quality of care and patient outcomes. PCMH models sometimes include payment reform, including pay-for-performance or separate payments for care coordination and care management.

CMS and/or CMI have developed several initiatives to promote PCMHs in Medicare and Medicaid. For example, CMI is testing a multi-payer PCMH initiative in 5-7 markets (called the Comprehensive Primary Care Initiative).[11] CMS has a demonstration to support federally qualified health centers in pursuing Level 3 PCMH recognition from the National Committee for Quality Assurance (FQHC Advanced Primary Care Practice demonstration).[12] In addition, the ACA includes funding to encourage every state to develop "health homes" in their Medicaid program.[d] Essentially, "health home" is another name for a type of patient-centered medical home that focuses on care management, care coordination and health promotion, and patient and family support for Medicaid beneficiaries with chronic illnesses. States that agree to the terms of the federal health home requirements are eligible for a 90% federal medical assistance percentage (FMAP) match for certain covered services for eight fiscal quarters after their state plan amendment (SPA) is approved.

Community Care of North Carolina (CCNC) is a nationally recognized, award winning, non-profit, practitioner-led, PCMH model that links more than one million Medicaid recipients (80% of all North Carolina Medicaid recipients), and others in the state, to primary care practices.[9 13 14] CCNC originated over a decade ago as a collaborative effort between the North Carolina Division of Medical Assistance (DMA), the local CCNC networks, and the North Carolina Office of Rural Health and Community Care (NCORHCC). There are 14 autonomous non-profit regional CCNC network entities across North Carolina covering all 100 counties. North Carolina Community Care Network, Inc. (NCCCN) serves as the umbrella coordinating organization for the14 networks. In developing the CCNC model, there was an understanding that many factors affect health, and that networks needed to include more than health care providers to have an impact on the health of the Medicaid population. Thus, each network incorporates primary care providers, federally qualified health centers and other safety net organizations, hospitals, social services agencies, local health departments, and other community resources that work together to provide high quality care and care coordination for the enrolled population. A significant portion

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[c] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2703, amending Title XIX of the Social Security Act, 42 USC 1396a; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021, enacting Sec. 1115A of the Social Security Act, 42 USC §1315a; Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3502, 10321.

[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2703, amending Title XIX of the Social Security Act, 42 USC 1396a.

of the care coordination provided by CCNC is in person, rather than remotely through the telephone.

Each of the CCNC networks have a clinical director, network director, nurse and social worker care managers, pharmacist, psychiatrist, quality improvement coordinator, and informatics system manager. Primary care providers under contract with CCNC receive a per-member-per-month (pmpm) payment from the state to help manage the care provided to their enrolled patients. In addition, the network receives an additional pmpm payment to help pay for care management, disease management, and quality improvement activities; an informatics system that undergirds the quality improvement initiatives; and other resources needed to improve the care provided to the enrollees.

CCNC networks are all involved in clinical improvement initiatives, including specific disease management programs (including diabetes, asthma, congestive heart failure), medication management, chronic care and transitional care programs, and emergency room initiatives. CCNC, working with primary care providers, helps build comprehensive teams that coordinate services to Medicaid and other enrolled patients. Some of the ancillary team members are available at the network level (eg, pharmacists and psychiatrists), and others (eg, nurse and social work care managers) are embedded within the practices—particularly larger practices — and 38 hospitals. The team focuses on care for people with chronic, complex, or other outlier health conditions, working to improve the quality of care provided as well as patient self-management skills.

In addition, CCNC has a new pregnancy home initiative which is intended to improve the quality of maternity care provided to Medicaid recipients. Medicaid currently covers approximately half of the births in the state, including many women who are at risk of poor birth outcomes such as preterm birth or low birth weight. Improving care for this higher risk population can help improve the state's birth outcomes. This is a collaborative effort between CCNC networks, DMA, the Division of Public Health, and local health departments. Participating Medicaid providers will be measured on four performance measures: no elective deliveries before 39 weeks; providing progesterone shots to women at risk of preterm births (17P); reducing the primary c-section rate; and performing standardized initial risk screening of all obstetrical (OB) patients. In addition, the Pregnancy Medical Home provider must coordinate with local public health pregnancy case management to ensure that high-risk patients receive case management. The initial goals of the pregnancy home model are to reduce the rate of low birth weight by 5% in each of the first two years and to achieve a primary c-section rate at or below 20%.

DMA has also submitted a SPA to the Centers for Medicare and Medicaid Services to implement the health home option. Health home services are limited to Medicaid recipients who have two or more chronic conditions, one chronic condition with a risk of a second chronic condition, or one serious and persistent mental illness. Once the SPA is approved by CMS, the state will use the enhanced funding to support comprehensive care management, care coordination (particularly focused on patients with mental health or substance abuse needs), transitional care, individual and family support services, and referrals to community and social supports to qualified Medicaid participants. The care coordination function will be split between CCNC (for patients with more significant medical needs and less acute behavioral health problems), and

Local Management Entities (LMEs) (for patients with more significant behavioral health problems and less acute medical needs).

Although CCNC began as a Medicaid-only initiative, the enrolled population has gradually expanded over time to include additional populations. In 2011, the North Carolina General Assembly expanded CCNC to include North Carolina Health Choice recipients.[e] As of November, 2011, CCNC managed the care of 132,936 North Carolina Health Choice recipients, or 90% of all North Carolina Health Choice enrollees. In addition, as part of the Medicare 646 waiver, CCNC is now managing the care of 53,322 dual eligibles (described more fully below). More recently, CCNC has begun to work with the State Health Plan, Blue Cross and Blue Shield of North Carolina, and some large employers to provide patient-centered medical homes to commercially insured populations. For example, North Carolina was one of the first eight states awarded a demonstration grant through CMI. The demonstration was awarded to test a multi-payer partnership between the North Carolina Division of Medical Assistance, CCNC, Blue Cross Blue Shield of North Carolina, and the State Health Plan in seven rural counties: Ashe, Avery, Bladen, Columbus, Granville, Transylvania, and Watauga. CCNC medical homes currently serve more than 112,000 Medicaid recipients in these seven counties. The new partnership is expected to expand the patients served by CCNC practices to more than 128,000 Medicare beneficiaries and more than 121,000 privately insured or State Health Plan enrollees. Medicare will pay a pmpm payment to participating primary care practices, and BCBSNC and the State Health Plan are also providing financial support for participating primary care practices.

In addition to the multipayer initiative, CCNC is also partnering with several large employers to offer patient-centered medical homes to self-funded populations.[f] This effort, called "First in Health," is a collaboration between CCNC, GlaxoSmithKline (GSK), the State Health Plan, Kerr Drug, SAS, and BCBSNC. Beginning with GSK and the State Health Plan, these self-funded employers are offering their employees the option of joining a CCNC PCMH, with the goal of improving quality of care and reducing costs for their employees, dependents, and retirees.

There are also other initiatives across the state to try to support and expand the availability of patient-centered medical homes. BCBSNC has an initiative—Blue Quality Physicians Program (BQPP)—which provides enhanced funding to primary care practices based on four areas of provider performance: quality of care, patient experience, administrative efficiency, and cost and efficiency of care.[15] The amount of the enhanced payment is based on the physician's performance in these four areas, with more of the assessment weighted towards quality of care measures. Certain performance criteria are mandatory, others are optional. BQPP is an optional program available to physicians in family medicine, internal medicine, pediatrics, OBGYN, or general practice.

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[e] North Carolina Health Choice, North Carolina's CHIP program, is open to children whose family income is below 200% of the federal poverty guidelines but exceeds Medicaid income requirements.

[f] A self-funded company is one that assumes the financial risk of paying for the covered health care costs for its insured employees and dependents. Self-funded companies may have third party insurers administer their plan, but ultimately—the company is responsible for paying the health care bills for covered services. This is in contrast to fully insured groups, where an employer pays a premium to an insurance company to pay for a covered set of services. With fully insured groups, the insurer assumes the financial risk for the costs of health care services utilized by the insured members.

More recently, BCBSNC and UNC Health Care have partnered to create a new delivery model—Carolina Advanced Health in Chapel Hill. Carolina Advanced Health is a health care center that includes a comprehensive team of health care professionals who will work with patients to improve health care outcomes, increase patient satisfaction, and reduce health care costs. The center will focus on caring for patients with chronic illnesses or more complex health problems. This is a unique arrangement between two independent entities, a health system and a private payer, in which both organizations are helping to share in both the costs and savings of the center.

Other private insurers are also supporting innovative payment and care delivery models. For example, WellPath[g] has entered into new agreements with health systems and medical group practices designed to improve the quality and value of services provided and enhance patient outcomes. WellPath believes that health care professionals are in the best position to redesign the health care delivery system to enhance quality, outcomes, and efficiency. As a result, WellPath has focused on designing and implementing collaborative approaches to support redesign efforts to remove barriers and financial disincentives that make it difficult for provider groups to achieve these goals. Some of the key elements include:

- Support for patient-centered medical homes. WellPath has worked with the provider organizations to change provider compensation to support necessary but previously non-revenue producing activities and more closely align with evidence-based quality measures.
- Support for provider-led system redesign by aligning benefit plan design and compensation systems for the purpose of meeting the comprehensive needs of the patient/members and providing increased affordability.
- Comprehensive information sharing between WellPath and the provider organizations to support quality, improved health outcomes, and greater efficiency.

Two of these arrangements will be operational early in 2012 to serve individuals within Medicare Advantage plans, small group and large group employer plans, and individual plans. Approaches for self-funded employers are anticipated to be available later in 2012.

Episode of Care/Patient Bundling[h]

Under this model, a group of health care professionals and providers are paid one bundled payment to pay for all of the services needed by the patient during that episode of care. [7] An episode of care may be based around a discrete medical event (such as treatment for a heart attack), treatment for a chronic health problem over a certain period of time (such as care provided to someone with diabetes over a year), or may be focused on a specific procedure (such as knee or hip replacement). The episode of care payment can be designed to include hospitals, physicians, home health, or other health care providers necessary for the care of a patient for a specific episode of care, or it can be limited to only a subset of this group of health professionals. Episode of care models are intended to encourage greater coordination of care across providers

[g] WellPath is a Coventry health care plan operating in North and South Carolina since 1996.

[h] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3023, 10308(b)(1), enacting Sec. 1866D of the Social Security Act, 42 USC 1395cc-4.

and health care professionals, and to reduce unnecessary utilization. If the provider group saves money under this episode of care payment, the group of providers/professionals could keep the savings. Conversely, if there are complications that require additional expenditures—the group would need to absorb the additional costs. Insurers could develop tiered payment levels, based, in part, on health care outcomes.

CMI is testing four limited episode of care payment models in the Medicare program: acute care hospital stay only; acute care with post-acute care associated with the stay; post-acute care after discharge; or prospective bundled payment that encompasses all the services rendered during inpatient stay by the hospital, physician, and other practitioners.[16] Several North Carolina health care organizations are in discussions with CMS about testing an episode of care payment model in Medicare.

This model is also being tested in the commercial population. Blue Cross and Blue Shield of North Carolina, the State Health Plan, and CaroMont are testing a comprehensive episode of care payment for knee replacement surgery. The episode of care payment will cover preoperative, inpatient stay and post-acute care for up to 180 days after surgery. Payments will be based, in part, on health care outcomes. This initiative began April 2011 and will be evaluated in a year or when there is enough data to make a valid assessment.

Accountable Care Organizations (ACO)[i]

CMI recently released new regulations with different options for Accountable Care Organizations, a Medicare Shared Savings program.[17] Fundamentally, an ACO is a group of providers and health care professionals who agree to be accountable for the quality, cost, and overall care of their assigned Medicare FFS beneficiaries. The performance of the ACO is based on the cost and quality of care provided to the Medicare beneficiaries that are attributed to their ACO. This attribution is "virtual" in that it is based on where the beneficiary chooses to go to receive most of their primary care services. Medicare beneficiaries continue to have complete freedom of choice in health care providers (in or outside the ACO).

The ACO will share in Medicare savings, if it meets program requirements and quality standards, and has achieved savings against a targeted spending threshold. Because of the potential for shared savings, providers have an incentive to better coordinate services, reduce unnecessary health care utilization, and improve quality of care. Under the ACO regulations, there are two options for shared risk and shared savings: a one-sided model (the ACO can share in up to 50% of the savings, but assumes none of the risks if costs exceed the spending target) or a two-sided model (the ACO can share in up to 60% of the savings, but will also share in between 5%-10% of the excess costs if spending exceeds the target). ACOs will be measured against 33 performance measures that capture the patient/care giver experience, care coordination, preventive health services, and services for at-risk populations or the frail elderly.

CMI has also created a number of other ACO models to test other variations of ACOs. For example, CMI has created an Advance Payment ACO model to make it easier for smaller organizations or groups of health professionals to participate in an ACO. The intent is to provide

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[i] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3022, 10307, enacting § 1899 of the Social Security Act, 42 USC 1395jjj.

some up-front capital to smaller ACOs to help them build the infrastructure needed to actively manage their assigned Medicare FFS beneficiaries.[18] CMI also has an ACO model, the Pioneer ACO Model, that is targeted to health care organizations and providers that have more experience coordinating care across different health care settings and who are willing to share risk.[19] Several of the North Carolina health systems are exploring these ACO options.

Prior to the enactment of the ACA, Section 646 of the Medicare Modernization Act created a five-year demonstration program to test models to improve patient safety, effectiveness, efficiency, patient centeredness, and timeliness of care for Medicare recipients. NCCCN was one of two organizations authorized to participate in this demonstration. The NCCCN demonstration program operates in 26 counties across the state: Bertie, Buncombe, Cabarrus, Chatham, Chowan, Edgecombe, Gates, Greene, Hertford, Hoke, Lincoln, Madison, Mecklenburg, Mitchell, Montgomery, Moore, New Hanover, Orange, Pasquotank, Pender, Perquimans, Pitt, Sampson, Stanly, Union, and Yancey. The program assigns dual eligibles and Medicare-only beneficiaries, on a volunteer basis, to a primary care professional, offers care coordination services, enhances the data available to help manage patient care, and includes quality of care performance measures. Under the 646 waiver, NCCCN can share in the savings with CMS if it meets certain quality standards and shows cost savings.

Community-Based Care Transitions [j]

Medicare will start reducing payments to hospitals that have "excess readmissions" for discharges occurring on or after October 1, 2012. Hospitals will be held accountable for a readmission that occurs within 30 days of discharge for heart attack, heart failure, and pneumonia (this list of conditions will expand in FY 2015).[k] CMS has funding to test models to reduce hospital-acquired conditions, improve transitions in care, and reduce preventable hospital readmissions.[20] Improving care transitions and reducing preventable readmissions can help reduce health care costs, as one study showed that approximately one-fifth of Medicare beneficiaries are readmitted within 30 days of discharge, and one-third are readmitted within 90 days.[21]

One of these programs focuses on improving care transitions (in order to reduce preventable hospital readmissions). Hospitals that have high 30-day readmission rates that fall within the top quartile for the state in at least two of the three following conditions: acute myocardial infarction (AMI), heart failure (HF), or pneumonia can serve as lead organizations for this funding. To qualify, the hospital must partner with community-based organizations (CBOs) that provide transition services. CMS identified 16 North Carolina hospitals that can serve as lead organization under this program, including: North Carolina Baptist Hospital, University of North Carolina Hospital, Rutherford Hospital, Lenoir Memorial Hospital, Franklin Regional Hospital, Southeastern Regional Medical Center, Watauga Medical Center, Presbyterian Hospital, Morehead Memorial Hospital, WakeMed, Raleigh Campus, Thomasville Medical Center, Sandhills Regional Medical Center, Lake Norman Regional Medical Center, Martin General Hospital, Nash General Hospital, and Person Memorial Hospital.[22] If a CBO is the applicant, the CBO can partner with other hospitals (even if they are not currently listed as a high readmission hospital). CMS, working in conjunction with the United States Agency on Aging, has also

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

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

funded other care transitions programs, including: The Care Transitions Intervention,[23] The Transitional Care Model,[24] Project BOOST,[25] Re-engineered Discharge,[26] and Transforming Care at the Bedside.[27] CMS will have a rolling application period for the Community Based Care Transition program.

A subcommittee of the New Models of Care workgroup met with a subcommittee of the Quality of Care workgroup to make recommendations on how to improve care transitions. (See Recommendation 7.8 in the Chapter 7 and Appendix C.) Subsequent to this work, the North Carolina Hospital Association has taken the lead in pulling together different stakeholder groups, including representatives of hospitals, CCNC, North Carolina Department of Health and Human Services (NC DHHS), nursing facilities, North Carolina Healthcare Quality Alliance, Carolinas Center for Medical Excellence, home health and hospice, AHEC, aging and disability resource centers, area agencies on aging, foundations, and other community-based organizations to examine strategies to improve care transitions, including the possibility of applying for federal funds to support this effort.

State Demonstrations to Integrate Care for Dual Eligible Individuals[l]

CMI also has funding to test models to improve the care provided to dual eligibles—eg, those individuals who are eligible for both Medicaid and Medicare. The goal of this initiative is to coordinate preventive, primary care, acute, behavioral, and long-term care services for dual eligibles, thereby improving quality and reducing costs. Because of their health needs, dual eligibles are generally among the most expensive of Medicaid and Medicare beneficiaries. Nationally, dual eligibles comprise 15% of the Medicaid population but account for 39% of Medicaid costs and 16% of Medicare beneficiaries using 27% of Medicare costs.[28]

North Carolina is one of 15 states that received planning grant funds to better integrate care for dual eligibles.[29] [30] Between September 2011 and April 2012, NCCCN, DMA, and the North Carolina Division of Aging, will be working with other state and community partners to develop an implementation plan to better integrate care for dual eligibles. The planning grant workgroups will develop a plan to address six issues: medical/health homes and population management, long-term services and supports, transitions across settings and providers, behavioral health integration, payment and delivery system integration, and engaging and educating dual eligibles.

Independence at Home[m]

CMS has the authority to test models that provide primary care services to certain frail Medicare beneficiaries in their homes.[31] To be eligible for services, the Medicare beneficiary must have two or more chronic illnesses, two or more functional dependencies, or have had a non-elective hospital admission within the past 12 months. Primary care services will be provided by a team of practitioners lead by a physician or nurse practitioner. Funding for this demonstration will be made available in 2012.

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[l] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2602; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting § 1115(b)(2)(B)(x) of the Social Security Act, 42 USC 1315a.

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3024, enacting Sec. 1866E of the Social Security Act, 42 USC 1395cc-5.

Duke University Health System and Lincoln Community Health Center have developed a similar initiative, called Just for Us. Care is provided to older adults or people with disabilities age 30 or older who have access to care problems. The care team is comprised of a physician, physician assistant, nurse practitioner, occupational therapist, social worker, community health worker, and phlebotomist. Just for Us is currently serving approximately 350 residents in 14 housing complexes. Duke's evaluation showed that this program reduced emergency room use and inpatient hospital costs, and improved quality of care.[32]

Medication Therapy Management[n]

The ACA includes several provisions which authorize CMI or CMS to create demonstration projects to test medication therapy management for patients who take four or more medications or high-risk medication, or have multiple chronic diseases.

North Carolina has several medication therapy management models. The Health and Wellness Trust Fund (HWTF) launched ChecKMeds in North Carolina in 2007, which reimburses pharmacists to provide medication reviews to Medicare beneficiaries age 65 and older across the state who have a Part D drug plan. When the HWTF was defunded, the ChecKmeds NC was moved to the North Carolina Office of Rural Health and Community Care. The program is funded through June 2012. The North Carolina General Assembly approved the Medication Therapy management pilot which charges CCNC with establishing a pilot that will explore options, including funding options, to continue the ChecKmeds program.

In addition, CCNC also has a medication therapy management component. CCNC has pharmacists embedded in each of the 14 networks. The network pharmacists help provide consultation to primary care professionals when they have questions about medication management. In addition, CCNC has a medication management system that collects medication data from Surescripts, administrative claims, medical records, case managers, patients, and physicians. The data can be accessed by CCNC case managers, pharmacists, and primary care providers. The system helps identify potential adverse events due to drug interactions, as well as addressing poor medication adherence. This enables CCNC care managers and other health care professionals to intervene before adverse events occur.

The State Health Plan also has a medication adherence pilot project.[o] Under this initiative, started in December 2009, all State Health Plan retirees using diabetes or cardiovascular medications were eligible for a reduction in their copayment. Retirees were targeted due to the high prevalence of these diseases among the retiree population and the potential to improve adherence through reduced cost sharing. By October 2011, approximately 26,000 retirees had participated in the program. Medco, the Plan's Pharmacy Benefit Manager, determined that the program saved members more than $1 million in co-payments, and reduced pharmacy costs to the State Health Plan by more than $2.3 million. In addition, the medication adherence rate

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[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3021(a), enacting Sec. 1115A(b)(2)(B)(vii) of the Social Security Act, 42 USC 1315a; Patient Protection and Affordable Care Act, Pub L No. 111-148, §3503, enacting § 935 of the Public Health Service Act, 42 USC 299b-35; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10328.

[o] Barnes, L. Interim Executive Administrator, State Health Plan. Written (email) communication. Dec. 20, 2011.

improved by more than 14% for oral diabetes and cholesterol medications, and by more than 19% for blood pressure medications.

At the local level, Senior PharmAssist has provided medication management to seniors in Durham since 1994. Program evaluation demonstrated a 51% reduction in the rate of any hospitalizations and a 27% reduction in the rate of any emergency department use after two years in medication management.[33]

Telehealth or Telemonitoring for Chronically Ill Individuals at High Risk of Hospitalization[p]
CMI is also authorized to test a number of models that involve the use of telehealth or telemonitoring for individuals with chronic illness, behavioral health problems, or other health conditions. The goal is to help monitor or treat individuals more effectively in the community, in order to reduce unnecessary hospitalizations and improve health outcomes. In addition, telehealth—which links patient data to community practitioners—offers opportunities to expand access to services and increase the quality of care provided to individuals who live in medically underserved communities.

North Carolina has implemented several successful telehealth and telemonitoring initiatives. Roanoke Chowan Community Health Center received funding from the North Carolina Health and Wellness program in 2006 to establish a telemonitoring program for low-income, chronically ill patients with health disparities in northeastern North Carolina. Patients with diabetes, cardiovascular disease, and hypertension are given monitoring equipment, including a scale, blood pressure/pulse monitor, blood glucose monitor, and pulse oximeter to monitor their health on a daily basis. A RN monitors the daily data, and contacts the patients and/or the patient's primary care provider if the readings are abnormal. Over the last six years, this initiative has also received funding through the Kate B. Reynolds Charitable Trust, Health Resources and Services Administration within the United States Department of Health and Human Services, and other state and local foundations. Wake Forest University conducted an evaluation of the program and found a reduction in hospitalization costs of more than $1.2 million for the 64 patients studied. Roanoke Chowan Community Health Center currently provides remote monitoring for people with cardiovascular disease, diabetes, hypertension, and pulmonary disease in 14 counties across the state.[34]

East Carolina University Brody School of Medicine has one of the longest running telemedicine operations in the country. One of ECU's core telemedicine programs is its telepsychiatry program. ECU employs three FTE psychiatrists to provide services to patients in 13 eastern counties (Beaufort, Bertie, Craven, Edgecombe, Gates, Greene, Hertford, Jones, Nash, Northampton, Pamlico, Pitt, Wilson). The ECU psychiatrists provide services to patients through videoconferencing and face-to-face visits, consultation to other clinicians for complicated care, and coordination with the mobile crisis teams covering the 13 counties.

In addition, North Carolina Foundation for Advanced Health Programs (NFAHP) recently completed a congestive heart failure telehealth program funded by The Duke Endowment. This program operated in selected CCNC networks. A CCNC nurse care manager established a

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[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(v), (xvi), (xix) of the Social Security Act, 42 USC 1315a.

relationship with patients before they were discharged from the hospital. The care manager then met with the patients in their homes, and provided telemonitoring equipment as well as ongoing support and education. Evaluation results from the CCNC Informatics Center showed an improvement in the medication adherence rate and a decrease in the inpatient hospital rate. In addition, the total cost per member per month decreased from $2,374 to $1,400—excluding drugs. DMA is pursuing a policy change to cover telemonitoring for patients with congestive heart failure.

Co-location of Primary Care and Behavioral Health[q]

The ACA also includes potential grant funding to support co-location of primary care and behavioral health services. These funds could be used to support the provision of behavioral health services in primary care practices, or primary care services within community-based mental health settings. This demonstration grant opportunity was not specific to Medicare or Medicaid.

Although ACA grant funding has not yet been made available for this purpose, North Carolina has been working to expand efforts to integrate behavioral health and primary care services in both primary care practices and in behavioral health settings for many years. In 2006, a coalition of medical and behavioral health organizations, state agencies, and patient advocacy groups created the ICARE partnership to prepare for and pilot integrated practices with primary care, mental health, and substance abuse professionals. [35] This work was supported by Kate B. Reynolds Charitable Trust, The Duke Endowment, and AstraZeneca. In 2007, the North Carolina General Assembly provided support to the NCORHCC to help integrate behavioral health and primary care services in both primary care and specialty mental health offices. NCORHCC continues to support practices in the adoption of best practices for integrated care. In April 2010, DMA began providing funding to CCNC networks to embed a psychiatrist into each network. These psychiatrists support the care coordinators and providers within the CCNC practices.

NCFAHP has provided additional support to help CCNC practices integrate behavioral health and medical services bi-directionally, thus helping behavioral health providers integrate medical screening and chronic disease monitoring, as well as the better know integration of behavioral health into primary care. NCFAHP is home to the North Carolina Center of Excellence for Integrated Care which provides technical assistance, training collaborative, and capacity building for health providers to integrate behavioral and medical care. NCFAHP has a contract with the Office of Rural Health and Community Care for the Center of Excellence to promote integrative care focused on children with special health care needs in selected CCNC-enrolled pediatric practices, family practices, and health departments. [r] The Center of Excellence is also supporting CHIPRA through initiatives targeting autism spectrum disorder, maternal depression, oral health, and childhood obesity. The Center of Excellence is under contract to the Governor's Institute on

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[q] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5604, enacting § 520K of the Public Health Service Act, 42 USC 290bb-42.

[r] North Carolina received a five year Quality demonstration grant, funded through the Child Health Insurance Program Reauthorization Act (CHIPRA). The grant runs from February 2010 through February 2015. The grant has three components: 1) measure and report on quality of care; 2) develop and strengthen the medical home for children, focusing on children with special health needs; and 3) helping establish standards for pediatric electronic health records. The contract to NCFAHP to support integrated care is part of the effort to strengthen pediatric medical homes for children with special health needs.

Alcohol and Substance Abuse to provide technical assistance and training to FQHCs to improve early identification and treatment of patients with substance abuse conditions. In addition, Kate B. Reynolds Charitable Trust has recently provided additional grant support to enable NCFAHP to work with safety net providers and mental health/substance abuse providers in more than 30 counties. All models, including integration, reverse co-location, reverse integration, and co-location, are being tested and implemented.

Value Based Insurance Product Design

Another "new model" that is being tested among private insurers is value based insurance design (VBID). With VBID, insurers encourage enrollees to use services or medications of higher value by reducing or eliminating the out-of-pocket cost sharing (for example, eliminating cost sharing for highly effective medications), or by increasing the cost sharing on services, procedures, or medications that are less useful.[36] VBID products can also be designed to provide financial incentives to enrollees to encourage them to obtain care from high quality, lower-cost health care providers. Unlike a traditional Preferred Provider Organization (PPO) insurance product—which have differential cost-sharing arrangements for in-network and out-of-network providers—value-based insurance products may have multiple tiers of cost sharing. The amount of the cost-sharing may differ depending on the procedure/service and the provider. Thus, a large health care system may be considered a best value provider for open heart surgery, but not for knee or hip replacement. Blue Cross Blue Shield of North Carolina is testing a value-based insurance product design for one large employer group.

Improving Population Health

In addition to the new models that focus on changes in the health care delivery system and payment methodologies, some communities are testing new models focused on improving overall population health. Population health programs include some of the changes in delivery and payment models discussed previously, but also include community-based efforts to address socioeconomic, transportation, literacy, and other broader societal issues that affect population health. The Durham Health Innovation (DHI) is an example of this broader community-focused health intervention. This is a collaboration between Duke Medicine, the health department, and the Durham community that seeks to improve the health status of Durham County residents, focusing on areas in the county that are low-income, more heavily comprised of racial and ethnic minorities, and which have greater health disparities. In 2009, DHI funded 10 planning teams to find ways to reduce death or disabilities from diseases or other health problems prevalent in the community. These teams identified seven strategies that could improve the health and health care delivery in Durham, including: increased health care coordination and eliminating barriers to services and resources; integration of social, medical, and mental health services; expanding health-related services provided in group settings; leveraging information technology; using social hubs (such as places of worship, community centers, salons and barber shops), as sites for clinical and social services and information; increasing local access to nurse practitioners, physician assistants, and certified nurse midwives; and using traditional marketing methods to influence health behaviors.

EVALUATION AND DISSEMINATION OF SUCCESSFUL MODELS

North Carolina has many different pilots or demonstrations under development, both in the public and private sector. The New Models of Care workgroup attempted to catalogue the

different initiatives under development across the state, including basic information about program design, goals, evaluation data (if any), and contact information. To the knowledge of workgroup members, this was the first time that such pilots and demonstrations were catalogued and maintained in one location. The New Models of Care workgroup recommended that funding be provided to NCFAHP to maintain a similar centralized tracking system and update it on an ongoing basis. Rather than "reinvent the wheel," North Carolina public and private payers, health systems, and health care professionals should learn from existing initiatives about what works and what does not. Once NCFAHP identifies successful strategies, it should help disseminate the information across the state and provide technical assistance to health care organizations seeking to replicate similar models.

In addition, NCFAHP could play a role in bringing together different public and private payers, health care systems, and health care providers to identify patient safety, quality of care, and cost drivers affecting the state or particular regions in the state. Public and private payers and health systems have some capacity to analyze their own internal data to identify cost drivers or potential quality concerns for their specific enrollees. However, no group is currently charged with examining these issues for a state as a whole. The workgroup recommended that NCFAHP assume this analytical and facilitative role, and help link potential partners to potential health care delivery or payment models that could address statewide quality and cost concerns. To accomplish these goals, the workgroup recommended:

RECOMMENDATION 8.1: CENTRALIZED TRACKING SYSTEM

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

a) Monitor federal funding opportunities and new regulations identifying new models of care.
b) Identify and/or convene stakeholder groups to examine existing data on costs and utilization, geographic areas of the state that are outliers in terms of costs, quality, or population health measures, and help identify appropriate new payment or delivery models of care to test.
c) Maintain a data base of existing North Carolina demonstrations that test new payment and delivery models of care, whether funded through private or public funds.
d) Collate evaluation data on these demonstrations and, to the extent possible, identify what models work best to address specific problems. The NCFAHP should help identify whether the new payment and delivery models are evidence-based, promising practices, or unsuccessful models.
e) Disseminate information across the state to other health care providers, health systems, insurers, consumer groups, and state policy makers about the success of these initiatives.
f) Provide technical assistance to communities, health care providers, insurers, or others who are interested in replicating a new model of payment or health care

delivery, and encourage groups to involve consumers in the development of new initiatives.

As noted earlier, the workgroup members felt strongly that North Carolina needs to continually examine the way we provide and pay for health care services, to ensure that we are achieving optimal individual and population health outcomes, while providing care in the most efficient manner possible. While we should encourage the development of new models, we must also obtain unbiased data about the effectiveness of these models, whether the models work equally well for different populations, and how well the models work in different health care environments. For example, the CCNC medical home model has been shown to work well among the Medicaid populations, but there is less evidence of the outcomes for the commercially insured population. Similarly, the patient-centered medical home model holds great promise to improve care coordination, quality of care, and patient engagement. However, some populations may not choose to seek care through a comprehensive primary care home, preferring episodic care when they are sick from urgent care or retail clinics.

We can learn both from our successes and our failures. But to do this requires strong, independent evaluations. The evaluations should examine common quality, outcome, and cost metrics, so that different models of care can be compared to one another. We should identify what works, for whom, and in what environment. Further, the evaluation data should be shared publicly among insurers, other health systems, and the public. Thus the work group recommended:

RECOMMENDATION 8.2: EVALUATION OF NEW PAYMENT AND DELIVERY MODELS

a) Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. The evaluation should, to the extent possible, be based on existing nationally recognized metric and should include:
   - **i. Quality of care metric that includes process, appropriateness, and outcome measures**
   - **ii. Patient satisfaction data**
   - **iii. Access to care measures**
   - **iv. Cost information, including changes in per member per month costs over time**
   - **v. The potential to improve population health**
   - **vi. The effect on health disparities**

b) Evaluation data should be made public and shared with other health systems, groups of health care providers, payers, insurers, consumer groups, or communities so that others can learn from these new demonstrations.

c) North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery modvels should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

Several of the NCIOM health reform workgroups noted the need for enhanced data to improve the functioning of the current health care system. State government, public and private payers, health systems, health care professionals, employers, and consumers need information about diagnosis, utilization, costs, and outcomes in order to evaluate new delivery or payment models. The Health Benefits Exchange (HBE) workgroup identified the potential need for diagnosis and utilization data to develop a risk adjustment system that can help stabilize the individual and small group insurance market inside and outside the HBE (See Health Benefits Exchange chapter.) The ACA also requires health care providers (eg, hospitals, nursing facilities) and health care professionals (eg, doctors) to report quality measures to the federal government. However, the Quality workgroup recognized the importance of also collecting and analyzing these data at the state level and making data available to individual health care systems or providers so that we can more rapidly examine state-level data and develop appropriate interventions to improve patient safety and quality. (See Quality of Care chapter.) This is especially important as Medicare moves towards value-based purchasing. As noted previously, Medicare will start reducing payments to hospitals that have "excess readmissions" for discharges occurring on or after October 1, 2012. Hospitals will be held accountable for a readmission that occurs within 30 days of discharge, but hospitals do not always know whether their patients were readmitted if the patients are admitted to another hospital. Hospitals need the data to assess readmission rates and examine cause of readmissions across hospitals. Similarly, the New Models of Care Workgroup recognized the importance of creating a data system that could evaluate quality, costs, and patient experience as we move to test new payment and delivery models.

Several states have created all payer claims data (APCD) systems to help provide the necessary state-level data that can support quality improvement activities, compare disease prevalence or utilization patterns across the state, identify successful cost containment measures, and evaluate health care reform efforts on costs, quality, and access. As of November 2011, nine states had fully functional APCD systems, and five states were in the process of implementing their APCDs.[37] The NC DHHS has created a workgroup to examine the possibility of creating a similar APCD or a confederated data system that can capture data from multiple existing data systems that could be used in North Carolina to examine similar population health, cost, and quality issues across the state.

The New Models of Care workgroup recommended that NC DHHS, in collaboration with the North Carolina Department of Insurance, continue this effort to examine the state's existing data systems, gaps in the existing systems, and different options to address data gaps.

RECOMMENDATION 8.3: DATA TO SUPPORT NEW MODELS OF CARE

a) **The North Carolina Department of Health and Human Services (NC DHHS) should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to develop a plan that examines options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.**

b) **NC DHHS should examine what other states are doing to meet similar data needs and assess the scope, costs, technical requirements, feasibility, impact, and sustainability for different approaches. As part of this study:**
   i. **NC DHHS should examine existing sources of data to determine whether existing systems can provide the necessary data, and, if not, identify the gaps in existing systems.**
   ii. **NC DHHS should examine the feasibility, costs, technical requirements, and sustainability of collecting and/or aggregating different types of data to serve different purposes, including, but not limited to, clinical, operational, population, policy, and evaluation.**
c) **The plan should ensure that:**
   i. **The new data system uses data already collected in the system for other purposes. Such data sources include, but are not limited to: the Health Information Exchange, Community Care of North Carolina Quality Center, Thompson Reuters, and the State Center for Health Statistics.**
   ii. **All providers, payers, and administrators are required to contribute necessary data.**
   iii. **All providers, payers, and administrators have access to their own data, as well as aggregated data for allowable purposes.**
   iv. **The new data system meets strict patient confidentiality and privacy protections in accordance with North Carolina laws.**
d) **NC DHHS should prepare a plan with recommendations, including a timeline and potential financing mechanisms, and report it to North Carolina General Assembly no later than the start of the 2013 session.**

REMOVING BARRIERS TO THE TESTING AND IMPLEMENTATION OF NEW PAYMENT AND DELIVERY MODELS

While public and private health care organizations in our state have sought to take advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. Some of the workgroup's efforts focused on identifying the barriers that prevent North Carolina from more aggressively testing new models that can help reduce health care cost escalation while at the same time improving outcomes. The workgroup recognized that North Carolina will need to more fully utilize all types of health care professionals with the increased demand for health care that is likely to occur as more of the uninsured gain coverage. However, current health professional licensure laws prevent some members of the health care team from practicing to the full extent of their education and competence. The workgroup recommended that we explore options to more effectively utilize all members of the health care team, substituting less highly paid health professionals for more highly paid professionals when this substitution is appropriate and can lead to improved care for lower costs. The workgroup also discussed the challenges in coordinating care across different types of health care providers and systems.

In addition, the workgroup heard concerns about current reimbursement policies that make it difficult for clinicians to offer certain services, even if these services could lead to improved outcomes and lower costs. For example, insurers generally do not reimburse providers for the

time they spend answering patient emails or on telephone calls. As a result, some individuals who could have their concerns appropriately addressed through a quick email or phone call are forced to come into the office for a visit—adding both time and costs to the health care encounter. Some insurers also talked how current state insurance laws make it difficult to create new provider payment models that shift some of the financial risk for a defined population to a health care system or group of health care providers. Additionally, the workgroup heard about barriers some insurers face in developing value-based tiered insurance products, in which insurers can offer lower cost health services to enrollees if they agree to obtain care from higher quality, lower-cost health care providers.

We also heard from provider groups about how multiplicity of different insurer administrative requirements, including provider credentialing, utilization review, and quality initiatives has led to higher administrative costs and reduced clinical time for health care professionals. Further, the workgroup heard examples of how state health professional licensure laws have not kept pace with changes in electronic health records in terms of who is allowed to enter what type of health information into health records. These state regulatory policies can create barriers to effective use of health information systems or the implementation of other innovative system reforms.

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

RECOMMENDATION 8.4: EXAMINING BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS

a) The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models that can improve health outcomes, improve population health, and reduce health care cost escalation. Some of the barriers should include, but not be limited to:

- **i. Health professional licensure restrictions that prevent health professionals from practicing, being held accountable, and receiving payment for care delivered within the full scope of their education, training, and competency.**
- **ii. Insurance laws which impair the development of value-based insurance design or products which shift some of the financial risk to health care professionals or provider groups.**
- **iii. Anticompetitive contractual arrangements which prevent insurers from implementing insurance designs that incentivize use of high-quality, lower cost health care providers or professionals.**
- **iv. Health professional reimbursement issues which reduce the ability of health care professionals from providing evidence-based clinical services that could lead to improved patient outcomes at lower costs.**
- **v. Lack of coordination between public and private payers that create differing and uncoordinated quality and outcome measures for health care professionals.**

vi. **Uncoordinated and costly administrative requirements stemming from multiple payers with differing administrative requirements.**
vii. **Resistance to the adoption of new models of care among insurers, health care providers, professionals, and consumers.**

b) **The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or otherwise prevent effective use of electronic health records.**
c) **The NCIOM Task Force should identify barriers and potential solutions. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.**

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CHAPTER 9
FRAUD, ABUSE, AND OVERUTILIZATION

OVERVIEW OF THE PROBLEM

The ACA includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and 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.

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went into effect in 2010 or 2011. The ACA increases funding to the Healthcare Fraud and Abuse Control Program by $350 million over the next decade. These funds can be used for fraud and abuse control and for the Medicare Integrity Program.[a]

The ACA also includes new or enhanced program requirements for Medicare, Medicaid, and CHIP, including new provider requirements to participate in these programs. States are required to apply these new rules and requirements to Medicaid and CHIP:

- *Provider screening*. States must screen all providers and suppliers of services through Medicaid and CHIP as part of enrollment and re-enrollment in these programs.[b] A period of enhanced oversight is also required for newly enrolled providers and suppliers. Providers and suppliers must disclose any past affiliation with a provider who has had their Medicare, Medicaid, or CHIP payments suspended or has been excluded from participation.[c]

- *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.[d] Similarly, states must exclude providers from participating if they are owned by individuals or entities who have not repaid overpayments, are suspended or excluded from participation in Medicaid, or are affiliated with an individual or entity that has been suspended, excluded, or terminated from participation (effective January 2011).[e, f]

- *Creation of risk categories*. The ACA requires the state Medicaid agency to create limited, moderate, and high risk categories for provider specialty types, and to impose

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

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

[c] DMA already requires providers and suppliers to disclose if they, or any affiliated provider, have had their Medicare, Medicaid or CHIP payments suspended or if they have been excluded from participation. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.

[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6501, amending § 1902(a)(39) of the Social Security Act, 42 USC 1396a(a).

[e] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6502, amending §1902(a) of the Social Security Act, 42 USC 1396a(a).

[f] DMA already excludes providers from participating for these reasons. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.

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. [g] Providers and suppliers of services are also required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid, and CHIP (effective January 1, 2011).[h, i]

- *Expanded data reporting and matching activities to identify fraud and abuse*. States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (effective for data submitted on or after January 1, 2010).[j] For example, states are required to report all final actions including revocation or suspension of licenses, reprimands, probation, dismissal, loss of license, or the right to apply for or renew a license, or other negative action. To ensure that these data elements can be shared with the federal government, state Medicaid information systems must be compatible with the National Correct Coding Initiative (effective March 2011).[k] The federal government will establish a National Health Care Fraud and Abuse Data Collection Program to report all final actions against health care providers, suppliers, and practitioners (effective one year after enactment or when regulations are published, whichever is later).[l]

- *Penalties and federal powers to investigate fraud and abuse are enhanced.* Penalties include those for persons who make false statements when making claims, involuntarily enroll or transfer enrollees, or do not provide timely access to information for audits, investigations, evaluations, or other statutory functions.[m]

- *Overpayments.* The state has an expanded period to recover overpayments (effective March 2010).[n] Individuals who receive overpayments through Medicare, Medicaid, and CHIP are required to report and return the overpayment within 60 days.[o] In addition,

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[g] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6503.
[h] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6402, amending Sec. 1902(a) of the Social Security Act, 42 USC 1396a(a).
[i] DMA already implemented this registration requirement. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.
[j] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6504.
[k] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6507, amending Sec. 1903(r) of the Social Security Act, 42 USC 1396b(r).
[l] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6403.
[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 6402, 6408, 10606.
[n] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6506.
[o] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6402.

states must establish a Recovery Audit Contractor (RAC) program to identify underpayments and overpayments and recoup overpayments under Medicaid. The RAC program is expanded to include Medicare Advantage plans and Medicare Part D (effective December 31, 2010).[p, q]

- *Medicaid payments outside the US*. States are prohibited from providing Medicaid payment for services to entities outside the US (effective January 2011).[r]

- *Home health and suppliers of durable medical equipment (DME).* The ACA includes several new provisions to prevent fraud and abuse in home health and DME. For example, a face-to-face encounter with the recipient is required before home health services can be certified or authorized under Medicare and Medicaid and before payment can be made for DME under Medicare (effective January 1, 2010).[s] 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).[t] The ACA also requires the surety bonds for DME and home health agencies be adjusted by billing volume.[u] Payments to DME suppliers can be withheld for 90 days if there is a significant risk for fraud (effective January 2011).[v] In addition, physicians or eligible professionals who are not enrolled in Medicare are prohibited from ordering home health services or DME for Medicare enrollees (effective July 2010).[w]

- *Provider anti-fraud and abuse compliance programs.* The ACA mandates that providers and suppliers establish anti-fraud and abuse compliance programs.[x] Core program elements and the required implementation date are to be determined by the Secretary.

NORTH CAROLINA RESPONSE

Many requirements of the ACA provisions were already being addressed in North Carolina including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. Specific examples include:

- *Provider enrollment and oversight.* CSC is the agent contracted by NC-DHHS to perform Medicaid provider enrollment, verification, and credentialing (EVC) activities as well as provider file maintenance. HP Enterprise Services is the fiscal agent contracted by DMA

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

q DMA submitted a State Plan Amendment as required, and has a RAC in place. The state is waiting for further guidance on underpayments, but is currently in compliance with the federal requirements to collect overpayments. Larson, T. Chief Clinical Operations Officer, DMA, NCDHHS. Written (email) communication. January 10, 2011.

r Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6505, amending Sec. 1902(a) of the Social Security Act, 42 USC 1396b(a).

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

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

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

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

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

to process claims for Medicaid-enrolled providers.

- *Provider education.* Information on changes to provider requirements and processes is provided through the DMA website through Medicaid Bulletins. Topics include enrollment, audits and post-payment reviews, claim submission, and identification of fraud. Providers also may sign up for email alerts for information that is not covered by the Bulletins.

- *Pre-payment review.* DMA contracts with The Carolinas Center for Medical Excellence (CCME) for pre-payment review of Medicaid claims. The recent audit by CMS indicates that North Carolina is in full compliance for its pre-payment review process.

- *National Provider Identifier.* Providers and suppliers of services in North Carolina are already required to include their National Provider Identifier on all enrollment applications and claims submissions for Medicaid and CHIP.

- *Performance statistics.* The DMA Program Integrity Unit tracks performance statistics on fraud and abuse investigations.

TASK FORCE WORK

The Fraud and Abuse Workgroup conducted a gap analysis, breaking down the requirements of each provision, identifying ongoing efforts to address these requirements; gaps between what is currently underway in North Carolina and the new requirements; and required changes and/or legislation to fully implement the ACA provisions. A copy of the Gap Analysis is available on the NCIOM website.[1] The workgroup used the gap analysis to develop a 19-item legislation concept list representing the guiding principles for legislation. The workgroup also helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the concept list, to draft its recommended fraud and abuse legislation. DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399. The legislation included provisions addressing the following topics:

- Medicaid and Health Choice provider screening
- Criminal history record checks for certain providers
- Payment suspension and audits utilizing extrapolation
- Registration of agents, clearinghouses, and alternative payees
- Prepayment claims review
- Threshold recovery amount
- Provider enrollment criteria
- Change of ownership and successor liability
- Cooperation with investigations and audits
- Appeals by Medicaid providers and applicants
- Procedures for changing medical policy

Although this legislation covers the requirements of most of the ACA Fraud and Abuse provisions, DMA continues to work on rules to address some of the remaining requirements, such as provider compliance programs, fingerprinting as part of provider screening, registration of groups submitting claims on behalf of providers, a face-to-face requirement for certification for home health services, surety bond size adjustment for DME and home health agencies, and withholding of payment for DME suppliers with significant fraud risk. In addition, final federal rules for the RAC program were released in September 2011, so the state now will issue a request-for-proposal (RFP) for a RAC contractor. The state plan amendment has been approved, and an interim contractor is in place, which puts the state in compliance with the RAC program requirement. Two additional provisions regarding submission of Medicaid encounter data (Secs 6402 & 6504) require further information from the Federal government before the State can respond.

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CHAPTER 10
CONCLUSION

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

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

Further, there are still unanswered questions. The ACA directed the Secretary of the United States Department of Health and Human Services to implement many of the provisions of the new law. The Secretary has issued both proposed and final regulations implementing many of the sections of the law, but further guidance on other sections is still pending. Of greater importance, we are awaiting the decision from the United States Supreme Court about the constitutionality of the entire law or specific provisions of the law.

Regardless of how the Supreme Court rules, our current health care system cannot remain as is. Our state and our country are facing serious health system problems that must be addressed. If the ACA is ultimately determined to be unconstitutional—we will still have to address rising health care costs. There will still be pressures to address the health care needs of North Carolina's 1.6 million who lack insurance coverage. We will need to test new payment and delivery models to ensure that we achieve maximum value for our health care dollars. Moreover, we will need to invest more heavily in prevention if we want to have a healthy and productive workforce, reduce the growth in chronic illness, and limit the need for high-cost interventions. The ACA is a starting point, not an ending point. If implemented, it is likely to be amended over time as we understand what works and what needs to be changed.

While the focus of the Health Reform Workgroups was to address new requirements that are part of the ACA, many of the recommendations are applicable even if the ACA, or parts of it, are not upheld. The recommendations from these groups can help the state address concerns about the health practitioner workforce, test new ways to improve quality and reduce health care costs, strengthen the safety net, streamline the eligibility and application process for existing public programs, and increase prevention efforts to improve overall population health.

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APPENDIX B
DESCRIPTION OF SAFETY NET ORGANIZATIONS

This appendix describes many but not all types of safety net organizations in the North Carolina. Those included here participated in the Safety Net Workgroup or were referred to in safety net provisions of the ACA.

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the US Bureau of Primary Health Care under section 330 of the Public Health Services Act.[a] In order to be designated as an FQHC and receive federal funding, FQHCs must meet certain basic criteria. They must be located in a medically underserved area (MUA) or serve a medically underserved population (MUP) based on poverty and population health indicators. FQHCs must provide comprehensive primary and preventive health care services either directly or by contract regardless of a person's ability to pay. They must provide enabling and support services to improve access to health and social services (eg, case management, outreach, transportation, and interpretation and translation). FQHCs must have a community-based board of directors with a majority of board members who are active users of center services. They must have a schedule of fees similar to local health rates and apply a sliding fee scale based on patient income and family size. FHQCs must provide 24-hour/7-day coverage and offer clinic hours outside the typical 9 to 5 work schedule. Finally, they must have a quality assurance program and other program criteria.[1] FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted medications through the 340B federal prescription drug discount program (see 340B program expansion section). FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers.

In 2011, there were 28 FQHCs in North Carolina delivering care at 150 different sites. There were also three FQHC look-alikes providing services at three clinical sites[b] and a Migrant Voucher program that provides grants and reimbursement for clinical and outreach services. FHQCs provided services to 409,709 patients, 52% of whom were uninsured. Ninety-five percent of North Carolina FHQC patients have incomes below 200% of the federal poverty level (FPL), and nearly 75% of them have Medicaid or no insurance. In addition to serving more low income populations, North Carolina FQHCs also serve patients who are more racially and ethnically diverse than the state population.[2] Compared to other states, North Carolina FHQCs serve a higher proportion of the uninsured (52% NC, 38% US). They also rely more heavily on federal funding and self-pay than FQHCs in other states.[3,4]

FHQCs in North Carolina are cost-saving. The total cost per FQHC patient was $490 in 2010. Medical visits are provided at an average cost of $122 per visit and just $170 per dental visit compared to $569 for a hospital emergency department visit. FQHCs brought $56 million federal

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[a] Health Centers Consolidation Act of 1996, Pub L 104-299, amending Sec. 330 of the Public Health Service Act, 42 USC 254b.

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

dollars into the state of North Carolina. Health centers have been found to improve health outcomes, reduce health disparities, and lower the cost of treating patients with chronic illnesses.[2]

Local Health Departments

Public health departments are local government entities required by state law to provide certain core public health services. These services include communicable disease control, environmental health services, and vital records registration. They are a major source of care to the uninsured, but do not provide comprehensive primary care to all populations.[1]

There are 85 local public health departments in North Carolina. Of those, 79 are single county health departments while 6 multi-county district health departments cover the other 21 counties. All local public health departments provide child and adult immunizations, STD and HIV/AIDS testing and counseling, TB testing, family planning, and case management. Almost all health departments provide child health clinics, prenatal care, and nutrition services. Half of them provide dental services.[5] Health departments in North Carolina are more likely to provide clinical services than health departments in other states.[56] There are 39 local health departments that serve as primary care medical homes and 36 that offer adult primary care services.[c] Local health departments are funded largely through county funds, federal grants or Medicaid and NC Health Choice, and state funds. There is an accreditation process to ensure quality and consistency across the state. As of December 2011, 64 local health departments have been accredited.[7]

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. There is not one specific free clinic model, rather they are designed to meet the health care needs of the low-income uninsured in their local communities. Most free clinics offer primary care services and preventive services. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.[1]

Volunteers are the cornerstone of the free clinic movement. Health care providers and staff volunteer their time to provide services and support to patients. Services are provided for free to the uninsured with incomes below a certain income threshold; others may be charged on a sliding fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.[1]

There are 79 free clinics in communities across North Carolina. Free clinics served approximately 79,500 patients in 2009, 87,000 patients in 2010, and 94,000 patients in 2011. Primary support for free clinics is through voluntary (donated) professional services and supplies, community fund raising, and the Blue Cross and Blue Shield of North Carolina Foundation. The Blue Cross and Blue Shield of North Carolina Foundation provided $18 million

[c] Reed, J. North Carolina Division of Public Health. Written (email) communication. April 19, 2011.

over eight years to expand and support free clinics through the North Carolina Association of Free Clinics.[d8]

Rural Health Clinics

State-funded rural health clinics are nonprofit 501(c)(3) organizations with local boards of directors. They are located in geographic areas that do not have enough primary care resources to meet the needs of their communities. Rural health clinics provide primary care and routine diagnostic and therapeutic care, including basic laboratory services, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental and behavioral health services or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.[1]

There are 86 certified rural health clinics in North Carolina. Of those, 28 rural health service delivery sites receive state funding from the Office of Rural Health and Community Care to help pay for indigent care. The funding is called the Medical Access Plan (MAP) for indigent patients. In order to receive MAP funding, rural health clinics must have a community board, agree to see the uninsured on a sliding scale basis, and be located in either a health professional shortage area (HPSA) or medically underserved area (MUA). The MAP funding is linked to uninsured patients with incomes below 200% FPL. Almost 65% of rural health clinic patients in North Carolina are uninsured.[e]

School-based or School-linked Health Centers

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.[9] A school-based health center is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration. Like other safety net organizations, not all health centers provide each of these services.[1] All centers require parents to sign written consents for their children to receive the full scope of services offered. Centers are monitored by advisory committees to ensure compliance with standards, to evaluate services offered, and to make policy recommendations.[10]

There are 55 school health centers serving 22 counties in North Carolina. Most of these are school-based health centers, several are school-linked health centers, and a few health centers operate from traveling vans or buses to serve several schools. They are sponsored by health care organizations such as hospitals, health departments, universities, community health centers, and other non-profit health care organizations. School health centers are also partially funded by the School Health Center Unit in the Children and Youth Branch of the North Carolina Division of

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[d] The Blue Cross and Blue Shield of North Carolina Foundation funding provides less than $30,000/year on average to free clinics, which is not enough to pay for one-full time administrative staff.

[e] Gilbert R. Primary Care Systems Specialist, Office of Rural Health and Community Care, Department of Health and Human Services. Oral communication. April 12, 2012

Public Health. Like health departments, there is a state credentialing process to provide standards for centers. As of April 2012, 22 school health centers have been credentialed.[f]

Other Safety Net Organizations

There are many other organizations that comprise the primary care safety net. Other communities have created non-profit safety net organizations to serve the needs of the uninsured. Examples include Guilford Child Health,Guilford Adult Health,and Alliance Medical Ministries. These organizations often work in partnership or are supported through local medical societies or hospitals. The North Carolina Medical Society Foundation recruits physicians, physician assistants, and nurse practitioners to underserved areas through the Community Practitioner Program. Participating providers must offer primary care services to uninsured patients on a sliding fee scale. The program is funded by the Blue Cross and Blue Shield of North Carolina Foundation, Kate B. Reynolds Charitable Trust, The Duke Endowment, Golden Leaf Foundation, and other private donations. There are currently 41 private providers participating in the Community Practitioner Program in 30 communities across the state.

Specialty Care Referral Management Networks (Project Access Model)

Specialty care is often difficult for uninsured and underserved populations to access. Project Access organizes private providers and hospitals to expand the health care services that are available to low-income uninsured populations. The services offered vary across communities, but most focus on linking patients to volunteer primary care providers, specialists, and other services that are not available through existing primary care safety net providers. Services are typically provided for free or for a small fee. Project Access is financed primarily through donated services and goods, foundations, and other private funding sources. Safety net organizations and private providers often refer patients to the program in their communities. The Project Access model was developed in Asheville in 1996 and spread to 15 communities across the state.[1]

Care Share Health Alliance

Created in 2009, the Care Share Health Alliance works with state and local partners to facilitate and foster Collaborative Networks that improve the health of underserved people in North Carolina. A Collaborative Network is an entity comprised of multiple local partners who integrate medical, preventative, community, social, and economic resources to achieve collective outcomes through a coordinated system of care. The network has a shared vision and purpose, and priorities, strategies, and objectives are aligned to improve the health of the underserved.

Care Share's statewide technical assistance services help communities improve health by: 1) leveraging new and existing resources; 2) increasing the number of physician volunteers donating care; 3) increasing access to care and other health services; 4) developing common referral networks all providers can use; 5) expanding the continuum of care in local communities; 6) helping networks create efficient systems and become financially stronger; and 7) identifying new grant opportunities for the safety net.[g]

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[f] Garson-Angert, D. School Health Center Program Consultant, Children and Youth Branch, Women and Children's Health Section, NC DHHS, April 12,2012

[g] Chapin, K. Executive Director, Care Share Health Alliance. Written (email) communication. March 1, 2012.

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APPENDIX C
TRANSITIONS OF CARE SUBCOMMITTEE

INTRODUCTION

Effectively managing patients' transitions between settings of care (eg, from hospital to primary care, or from community to nursing home) is one of the most important and most difficult challenges in improving the quality and reducing the cost of health care. The Patient Protection and Affordable Care Act (ACA) includes changes in Medicare payment meant to encourage hospitals to reduce readmissions. However, preventing readmissions and improving the success of transitions between other parts of the health care system will require strategies that bridge the traditional separation of providers across settings.

Under ACA, hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions (heart attacks, heart failure, and pneumonia), and the Secretary of Health and Human Services is given the authority to expand the policy to additional conditions in future years. The Secretary is also directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).[a] The North Carolina Institute of Medicine (NCIOM) Health Reform Quality workgroup identified several gaps in addressing hospital readmissions, and the need to improve information transfer between providers to facilitate transitions in care. The workgroup also identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, a shared savings model, information technology support, the forging of relationships between providers of care, and the need for new models of care within skilled nursing facilities that would reduce the number of patients transferred from skilled nursing facilities to emergency departments by facilitating assessment and care in place.

The ACA also includes many new provisions aimed at testing models to increase quality (without increasing spending), or reduce spending (without reducing quality). The Secretary is charged with evaluating these demonstrations to identify successful initiatives, and then to disseminate these financing and delivery models more widely throughout the country. One provision, Section 3026, appropriates $500 million for hospitals and community-based entities to furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

NCIOM's Quality and New Models of Care workgroups each recommended that a subcommittee discuss priorities and strategies for North Carolina to improve transitions of care in the context of the requirements and opportunities in the ACA.

The New Models of Care workgroup asked its subcommittee to:

- Explore the Transitional Care Model (Naylor)[1], and explore what DMA is implementing to determine if additional changes are needed to follow this evidence-based model.
- Explore the possibility of creating a multipayer demonstration for transition of care.

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

The Quality workgroup asked its subcommittee to:

- Discuss strategies for reducing preventable hospital readmissions, specifically in response to Sec. 3025 of the Affordable Care Act, which will start adjusting hospital payments in 2012 based on potentially preventable readmissions.

A joint subcommittee met on January 19, 2011. This document summarizes the subcommittee discussion and its recommendations for priority steps to improve transitions of care.

SUMMARY OF DISCUSSION

As the starting point for discussing existing transitions of care initiatives in North Carolina and exploring gaps, the subcommittee used a framework of evidence-based components of successful transitions of care compiled by Dr. Sam Cykert. See Table 1 for the subcommittee's working document, with notes on existing initiatives and gaps.

The subcommittee also discussed several cross-cutting issues and questions that affect the implementation of strategies to improve transitions of care. The subcommittee identified key elements to excellent care transitions for hospital discharge, high-risk patients, and outpatient settings, as well as across all care settings.

Key elements of hospital discharge transitions that prevent readmissions include:

1) Effective patient (or caregiver) education on medication management (including medications started, changed, or stopped).
2) Effective patient education on self-management including appropriate factors to monitor (eg, daily weights for CHF, fevers s/p pneumonia, etc.) and "red flags" that suggest a need for immediate care.
3) As part of the educational process, a teach-back approach that confirms patient understanding of these educational elements was highly recommended.
4) Effective selection of high-risk patients for intensified care management. It was acknowledged that CCNC care managers and transition methodologies were well developed and evidence-based though in most counties would not be available for patients covered by other payers, suggesting the need for creative solutions based on local resources (eg, the FirstHealth model[b]).
5) Some form of a personal health record should be provided pending the availability of robust HIE.

Key elements of high risk care management include:

1) Outpatient medication reconciliation with hospital discharge medications – preferably on home visit but at least by telephone visit.
2) Reaffirmation of self-management skills and recognition of red flags.
3) Extended telephone contacts, eg, four or more phone visits over the course of one month

Key elements of outpatient care transitions include:

1) An outpatient visit within 3 to 7 days of hospital discharge; therefore, practices must have a scheduling workflow that accommodates this need for access.

[b] First Health is a mid-sized health system based in Pinehurst, NC that has aggressively sought grant funding for transitions of care pilot programs that include home health and the local CCNC network.

2) Components of the hospital follow-up visit should include:
   a. Reiteration of medication reconciliation and management.
   b. Reinforcement of self-management skills and "red flags."
   c. Appropriate disease specific evaluation.
   d. Review and incorporation of the personal health record into ambulatory records.
   e. Whenever appropriate, discussions concerning palliative care are best initiated with patient in the environs of the medical home.
   f. Systems of shared, after-hours, primary care access should be strongly considered.
   g. Use of non-physician staff to manage care plans for some patients.

Key elements across all care settings include:

1) Emphasis on taking time with patient, maintaining relationships, building trust.

The most effective care model to date for improved transitions, decreased emergency department use, decreased overall hospitalizations, reduced unnecessary utilization, and improved quality of care is an integrated, patient-centered medical home (PCMH) with robust informatic systems, advanced ambulatory access, health literacy appropriate education, a team approach led by primary care, and high intensity care management for well-defined high-risk patients. In these medical homes, the care team is aware of all transitions across the spectrum of care for member patients. These medical homes have core responsibility to ensure that red flag warnings, self-management skills, and the reconciliation of medications and records occur at the level of the medical home. Data regarding the successes in cost efficiency and improved outcomes have been published within the last year by Geisenger Health System, Group Health of Seattle, and the VA Midwest Healthcare Network (VISN 23).[c] Community Care of North Carolina (CCNC) functionality is based on a medical home model with evidence-based transition services and includes NCQA PCMH recognition as one of the major pillars of its multi-payer demonstration pilot project in partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) and the North Carolina State Health Plan. NC Area Health Education Centers (NC AHEC) through its Regional Extension Center (REC) Primary Care Services offers EHR implementation, PCMH Recognition consultation, and workflow redesign tools including a specific "transitions" package.

Given local variation in resources and penetration of enhanced transition programs, members of the subcommittee raised several questions and concerns regarding funding, information, and stakeholders:

Funding

How can money saved by hospital or other providers from improved transitions be shared with the community to help support management and coordination?

Discussion: Hospitals cannot legally pay private practices, although they will be able to share savings if part of a formally constituted Accountable Care Organization. Hospitals may be able to contract with pharmacists in the community to help manage patients and do enhanced medication teaching (that must include medication reconciliation and teach back methodologies).

[c] See Selected Resources section at end of document

Information
What information is most important during a transition given current limitations on electronic and accurate health information exchange?

Discussion: Accurate, complete, single medication list; a hierarchy for resolving conflicts between multiple legitimate documents for a single patient; record of what each provider saw as the next step in patient's care; easy ways to navigate through electronic records (eg, single table of contents for record with direct links). Timeliness of information exchange is crucial. Previous attempts to develop standardized transfer forms have collapsed.

Stakeholders
Who should be at the table in communities when developing transitions of care programs?

Discussion: Home health, hospitals, physicians, public health, free clinics, long-term care, hospice care, Department of Aging/Area Organization on Aging (AOA), MH/DD/SA local management entities (LMEs), Critical Access Behavioral Health Access (CABHA) providers, end users (eg, nurses on duty in nursing homes, medical director that cares for patients), patients and families. All possible local resources should be leveraged to ensure safe and effective transitions.

Specific suggestions for patient and family representatives included LME consumer advisors, Department of Insurance consumer network through outreach work, hospital patient advisory councils, LTC facility residents councils, community advocacy organizations active in a particular community, Spanish speakers via ombudsman in governor's office

RECOMMENDATIONS
The subcommittee's review of existing initiatives highlighted the many programs to improve transitions of care that are in place at integrated health systems, such as CarePartners, CCNC, and FirstHealth.

Therefore, the subcommittee's recommendations address strategies that can be used for patients outside of an integrated system, with a particular focus on transitions for patients leaving the hospital, because of ACA incentives and requirements intended to reduce readmissions.

Recommendations:

- **Improve patient education at hospitals, with a focus on the health literacy checklist and teach-back methodology.**
- **Improve education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**
- **Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.**
- **Personal health records, in the possession of the patient, should be emphasized pending the availability of more robust HIE.**
- **Align existing initiatives that address care transitions at state and local level.**

- **In each community, stakeholder alliances including provider groups, CCNC, home health representatives, mental health providers, and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.**
- **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.**
- **Encourage collaboration and contracts between hospitals, LMEs, CABHAs, and other community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.**
- **Solutions utilizing transition principles should be applied to all patients regardless of payer.**
- **Encourage formal development of Medical Home Models that include the use of non-physician extenders to work with some patients (eg, stable diabetics), with physicians focusing on higher need patients**

SELECTED RESOURCES AND MODELS ON TRANSITIONS OF CARE

Guided Care model developed by Chad Boult, MD, MPH, MBA, and colleagues at Johns Hopkins Bloomberg School of Public Health. Also by Boult: *Guided Care: A New Nurse-Physician Partnership in Chronic Care*. http://www.guidedcare.org/
Care Transitions Program developed by Eric Coleman and colleagues at University of Colorado, Denver, School of Medicine. http://www.caretransitions.org/

Nurses Improving Care for Healthsystem Elders program developed by Mary Naylor,PhD, RN, FAAN, and colleagues at the University of Pennsylvania School of Nursing. http://elearningcenter.nicheprogram.org/login/index.php

Hospital Elder Life Program (HELP) developed by Dr. Sharon K. Inouye and colleagues at the Yale University School of Medicine. http://www.hospitalelderlifeprogram.org/public/public-main.php

Center to Advance Palliative Care. http://www.capc.org/

Hospital to Home National Quality Improvement Initiative . www.h2hquality.org

National Transitions of Care Coalition: NTOCC Compendium. http://www.ntocc.org/Toolbox/default.aspx

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge. Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

”Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting” by David E. Weissman and Diane E. Meier. http://www.capc.org/tools-for-palliative-care-programs/national-guidelines/primary-palliative-care-trigger-criteria-capc-consensus.pdf

“The Ironic Business Case For Chronic Care In The Acute Care Setting” by Albert L. Siu and colleagues. *Health Affairs* January 2009

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge – Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

“The Group Health Medical Home at Year 2: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers” by R. J. Reid and colleagues. *Health Affairs* 2010

“Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial” by K. L. Rice and colleagues. *American Journal of Respiratory and Critical Care Medicine* 2010.

“Value and the Medical Home: Effects of Transformed Primary Care.” R. J. Gilfillan and colleagues. *American Journal of Managed Care* 2010

Table 1
Subcommittee Working Document

Feature	**Evidence-Based Components** (compiled from literature)	**Existing Local Initiatives** (from discussion at 1/19/11 meeting and feedback on draft report)	**Committee Brainstorming – Gaps and Recommendations** (from discussion at 1/19/11 meeting and feedback on draft report)
Inpatient-Outpatient Communication	Direct electronic exchange		
	Record access (EHR or paper)	CarePartners uses Western NC HIE to access hospital records; CCNC has access to Data link (also view only); View only access to hospital records but no ability to download, print, or communicate back; can access records of tertiary care facilities through the local care mgr; car emgrs can ccess different systems but means have to juggle multiple systems; University health system ahs 3rd party view only access for non-affiliated physicians; FirstHealth has access w/in system; will be adding access to home health record by primary care physiciains; HC facilities-receive several conflicting records; tried universal transfer form but couldn't keep ppl at table; discussion w/ UNC of real-time ER record access; electronic prescribing systems allow access to prescription fill history for NC Medicaid, other insurers, sometimes cash coustomers	
	Personal Health Record	CCNC relies a lot on personal health record—delayed access to claims-based info.	
	Secure email system	No real time info exchange for nursing homes other than ad hoc phone calls	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Care Coordination	Identify high risk patients	LME Care Coordinators identify high risk/high cost consumers, coordinate and monitor success of services	
	Engaging Patients	CCNC uses hospital assessment to determine best post-discharge follow-up	Pts more likely to accept home follow-up if physician recommends How to capture patients who initially decline in hospital (multiple contacts)? Importance of low tech activities to build and maintain trust with pateints
	Range of preventable effect		
	Discharge med training	First Health—starts with bedside nurse as part of self-mgt training; pharmacist flags add'l needs for particular education [heart failure, COPD pilot]	Literature shows med adherence is most important in post-MI care
	Self-management training		Literature shows self-management skills most important in CHF patients
	Health literacy—teachback	FirstHealth—assesses depression and health literacy at baseline; uses teachback	
	Sequence of visits		
	In person vs. phone vs. telehealth	FirstHealth has telehealth grant from HRSA; Telehealth ahs been effective in literature for COPD patients; Health center in USH area has telehatlh system--	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Care Coordination	In person vs. phone vs. telehealth	– most complex pts; decrease up to 70% in admissions over 18 mos with 6 months of telehealth; CarePartners has been doing telehealth w/o extra funding; allows them to reduce visits; Challenge to engage some patients to allow visits; Koeble, in Alaska, used webcams to connect pharamacists with patients in remote communities; CCNC care managers conduct home visits with patients after discharge, addressing range of issues including patient education, teaching, coordinating primary care visits, arranging specialist follow-up	
	One coordinator – one patient	A CCNC network pilot was successful with nurse care manager assigned to patient at hospital that followed patient through	
	Practice co-location		
	Timely info to practices		
	Home med reconciliation	FirstHealth does joint home visit with CCNC network; CCNC care manager home visits after discharge may include med rec	For smaller communities and pts not under CCNC—could make arrangements with local pharmacies to help with med rec, but pharmacists can't bill Medicare for those services. (Limited option to bill now under NC Check Meds program); Hospitals could contract with pharmacists (Stark issue w/ paying

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Care Coordination	Home med reconciliation		referring physicians) –want to target the higher risk pateints
	Use of visiting NPs or home health	Home health is already established Medicare benefit for patients who qualify; NPs cost more	How can home health visits be leveraged? (Not all Medicare patients qualify for home health benefit)
	Proactive, prepared care team		Not all care teams and providers alike, but need to be trained and expected to perform necessary functions
Post-Discharge Ambulatory Access	Early outpatient followup	FirstHealth—schedules 7 day follow up appt before patient leaves; facilitates transport, etc. if necessary	
	Components of outpatient visit	UHS—no protocols yet for what happens at the outpt visit	Define essential elements for post-discharge. Create protocols for particular diagnoses for outpt visit after discharge; set protocols could also help with home health taking on larger role.
	After-hours access	UHS setting up after care clinics; Began discussion about how to arrange extra access from private providers; Main challenge has been access to appointments—need to pay for add'l providers UHS has previously looked at partnering w/ Walmart on minute clinics but they are not set up to manage chronically ill; Kaiser has set up after care clinics, staffed by hospitalists for first outpt visit	How to arrange after hours access in communities without academic medical system? Hospitals could engage own employees or hospitalists to ensure post-discharge care and follow ups. Legal challenges to having hospitals incentivize drs to provide extra access

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Post-Discharge Ambulatory Access	Timely transfer of information		Need for timely information discharge summaries from hospital may not be available for 30 days—this makes it difficult to synthesize information for primary care provider. Need for full information—eg, retail, pharmacists can be hesitant to share because of HIPAA concerns
Nursing Home & Assisted Living	Med communication		
	Facility employed NP	Patients from nursing homes go to hospital only with dr order, but dr not on site; often default to hospital visit based on telephone conversation with nurse on site	
	Connection to mental health	Nursing home regs don't allow admission of pts with primary need of mental health; no such restrictions for assisted living	
	Management sequence		
	Outpatient/MD connection		
	Clinical pathways (particularly pneumonia)		

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Palliative Care	Advanced directives/palliative care discussions	Federal requirement to discuss this at admission to nursing home-but decisions are different than at time of event	Too political to include in regulations? Can still be included in protocols used for patients with chronic disease; Needs to be education of providers and patients; currently too linked to hospice care; Ctr. For Palliative Care working on protocols for outpatient care, already have them for inpatient care; Should separate palliative care discussion from hospice image—more emphasis on symptom amelioration; these symptoms bring them back to hospital
	"Good palliative—Geriatric Practice" algorithm		

Addendum:
North Carolina Department of Health and Human Services received funding in 2009 to develop a model(s) to improve the hospital discharge planning process. This will offer individuals information to make good decisions about their lives and post-hospital discharge, while maximizing their opportunities to live in the communities of their choice. This will build upon other initiatives: Community Resource Connections for Aging and Disabilities (CRCs) and Person-centered training. In conjunction with the grant, a Person-Centered Hospital Discharge Planning (PCHDP) Learning Partnership has been established to provide: 1) an inclusive process to develop parameters for common evidence-based benchmarks, critical data elements, and outcomes; 2) establish protocols; and 3) provide resources for local sites. Through a facilitated community engagement process, three local communities are implementing care transition programs designed to meet their community's needs and address issues related to hospital discharge. These communities are Surry, Forsyth, Chatham, and Orange counties. Key partners in this project are Community Care of North Carolina, the Forsyth, Northwest Piedmont, and Chatham-Orange CRCs, and the hospitals serving those communities.

REFERENCES

1. Transitional Care Model (TCM). TCM Overview. http://www.transitionalcare.info/index.html. Accessed April 16, 2012.

APPENDIX D
PRINCIPLES FOR NEW MODELS OF CARE

1. **Person-Centered, Family, and Community Focus.** Individual patients and their families should be at the forefront of any health system. The health of individuals is also strongly influenced by the broader community in which they live. Thus, new models of care should focus on the broader community and should include a strong population health emphasis.

2. **Improve Access, Quality, Health Outcomes, and Population Health and Reduce Costs.** North Carolina will be best served by developing models that will:
    a. Improve health care quality (including outcomes and population health)
    b. Increase access
    c. Reduce costs (ie, reduce absolute health care costs and/or moderate the levels of increase)

    The availability of funding sources should not solely drive the development of new models. Rather, once the key elements have been identified, funding sources should be pursued that will support the new models.

3. **Aggressively Test New Models to Improve Health.** North Carolina has a strong history of innovations that have led to improved access, quality, and patient outcomes with reductions in unnecessary health expenditures. However, there is a clear need for further progress. We need to build on current initiatives, while continuing to explore other options with the goal of further improvements in health care quality and outcomes, population health, improved access, increased efficiencies, and reduced costs.

4. **Patient-Centered Interdisciplinary Teams.** North Carolina should support testing patient-centered interdisciplinary teams that include primary care, dental health professionals, behavioral health professionals, nutritionists, allied health professionals, pharmacists, and lay health advisors. These patient-centered teams should be positioned to address the health needs of the whole person. North Carolina should also support testing models that incorporate additional approaches (eg, health extenders such as lay health advisors or the use of group health visits) to determine if these models improve access, improve quality and health outcomes, and reduce costs.

5. **Involving Consumers More Directly in their Own Care.** North Carolina would be well served to explore options that involve consumers more directly in their own health and empower them to assume a more active role in their own health. Accordingly, consumers should be given the information, training, and support to be active participants in managing their own health and being an informed consumer in a redesigned health system. Any model of care should ensure that consumers are given culturally and linguistically appropriate health education and that information is conveyed in a way that ensures that it is understandable to people with lower health literacy.

6. **Utilize Health Professionals and Paraprofessionals to their Fullest.** In order to improve the capacity of our health care system to be able to serve all the newly insured, we need to consider new models that will utilize health professionals and paraprofessionals to the fullest extent of their training.

7. **Protect Vulnerable Patients and Safety Net Providers Serving Large Proportions of Vulnerable Populations.** Models of care should be designed to improve quality, health care outcomes, and health care access for populations that have been traditionally underserved including, but not limited to, low-income populations, the chronically ill, racial and ethnic minorities, and people with disabilities. New models should be specifically evaluated to determine the impact of redesigned delivery or payment methodologies on these vulnerable populations as well as on safety net providers serving large proportions of vulnerable populations.

8. **Transparency and Data.** Data should be collected in a manner that allows for the ongoing redesign and improvement of our care delivery systems including data collected at the individual, provider, and community levels. The data collection tools, evaluation methods, and results should be available to consumers.

9. **Evaluation and Monitoring.** Models of care should be thoroughly evaluated to determine if these innovations are leading to the stated goals (increased access, better quality and health outcomes, improved population health, increased efficiencies, and/or reductions in health care costs). It is important to understand what models work best for different populations in different communities and with different configurations of providers.

10. **Use Existing Frameworks to Encourage and Enhance Dissemination of New Innovations**. Successful initiatives should be disseminated throughout the state using existing dissemination infrastructures. Any new model tested in the state should be transparent in terms of design, outcomes, and costs.

11. **Multi-payer, Multi-provider.** To the extent possible, the new models of care should involve other payers in addition to Medicaid and Medicare. Multi-payer, multi-provider initiatives that involve public and private providers and community-based organizations have a greater possibility of improving quality, access to care, health outcomes, and population health while reducing health care costs.

12. **Reinvest Savings.** If savings are realized from the changes in the health care delivery and financing systems, these savings should be reinvested to support additional improvements in access, quality, health care outcomes, and population health and/or shared with consumers, taxpayers, payers, and providers.

APPENDIX E
NEW MODELS OF CARE IN NORTH CAROLINA

The ACA includes funding to test new models of delivering and financing health services, with the goal of improving quality and patient outcomes and reducing the costs of health services. The ACA included $5 million in FFY 2010, and $10 billion for FFY 2011-2019 to develop and evaluate new delivery and payment models through the new Centers for Medicare and Medicaid Innovation (Innovation Center), within the Center for Medicare and Medicaid Services (CMS).[a] All Innovation Center demonstrations are specific to Medicare, Medicaid, and CHIP. However, the ACA also includes other innovations that could be supported and/or tested with broader populations.

The following includes a short description of some of the new innovations that may be tested as part of the ACA. They are grouped into 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.*[b]
  A health home is a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. Health home services include comprehensive care management, care coordination and health promotion, transitional care, patient and family support, and referrals to community and social services. Note: This is a state option specific to Medicaid, not a demonstration program. States that agree to the terms are eligible for an enhanced federal match (90%) for payments to health homes for eight fiscal year (FY) quarters beginning once they have an approved state plan amendment. Eligible individuals include Medicaid enrollees with two chronic conditions, one chronic

[a] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021, enacting Sec. 1115A of the Social Security Act, 42 USC 1315a.

[b] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2703, enacting Sec. 1945 of the Social Security Act, 42 USC 1396w-4.

condition with a risk of a second chronic condition, or one serious and persistent mental illness.

- *Primary care payment and practice reform.*[c]
  This Innovation Center demonstration is intended to test broad payment and practice reform in primary care including patient-centered medical homes for high-need individuals, women, and models that transition primary care practices away from fee-for-service (FFS) to more comprehensive payment or salary-based payment.

- *Optimal use of health professional credentials.*[d]
  This Innovation Center demonstration is intended to promote greater efficiencies and timely access to outpatient services through models that do not require a physician or other health professional to provide services or be involved in establishing the plan of care. Services must be provided by a health professional who has the authority to furnish the service under existing state law.

- *Community-based interdisciplinary, interprofessional health teams to support patient-centered medical homes.*[e]
  The health teams established by this section must be from a state, state-designated, or tribal entity and must establish a plan for financial stability after three years. This demonstration is not specific to Medicare or Medicaid, but entities must agree to provide services to Medicaid eligibles with chronic conditions. Health teams shall create contractual agreements with primary care providers to support services; collaborate with providers and area resources to coordinate prevention efforts, disease management, and transitions of care; and implement and maintain health information technology to facilitate coordination of care. Providers shall provide care plans for each patient, provide health teams with access to patient medical records, and meet regularly with the health teams to ensure integration of care.

North Carolina Initiatives

- *Community Care of North Carolina (CCNC).*
  North Carolina is nationally known for the work it has done through CCNC in creating patient-centered medical homes for the Medicaid population. CCNC has led to improved health outcomes and reduced health care costs, particularly as costs relate to patients with chronic or complex health problems. The program is funded through DMA, within NCDHHS, and the North Carolina Foundation for Advanced Health Programs, Inc. CCNC is a community-based approach that involves primary care providers, federally qualified health centers, and other safety net organizations, hospitals, social services, local health departments, and other community resources that work together to provide care coordination and high quality care for the enrolled population. There are 14 regional community health networks across North Carolina providing services to more than 1.2 million Medicaid and NC Health Choice beneficiaries. Providers in the network are responsible for delivering,

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[c] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(i) of the Social Security Act, 42 USC 1315a.

[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(xvii) of the Social Security Act, 42 USC 1315a.

[e] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3502, 10321.

coordinating, and managing the care of enrollees and receive a per-member-per-month (PMPM) payment from the state. CCNC also offers clinical improvement initiatives including specific disease management programs (eg, diabetes disease management), medication management programs, chronic care and transitional care programs, and emergency room initiatives. CCNC has been expanded to include a more comprehensive team-based approach, embedding care managers, pharmacists, psychiatrists or other behavioral health professionals, and nutritionists in the networks and in some of the larger patient practices. The team focuses on care for people with chronic or complex health conditions, working to improve the quality of care provided as well as patient self-management skills.[1]

Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org; Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, NCCCN, dlevis@n3cn.org.

- *CCNC Pregnancy Home.*
  CCNC's Pregnancy Home initiative aims to improve the quality of perinatal care by increasing healthy birth outcomes and thereby reducing Medicaid expenditures. The initiative is modeled after CCNC's primary care case management program. The goal is to reduce the low birth weight rate by 5% per year in the first two years and to achieve a primary c-section rate at or below 20%. Medicaid providers who choose to become a Pregnancy Medical Home must ensure there are no elective deliveries before 39 weeks, administer progesterone ("17P" project) to reduce premature births, decrease primary cesarean section rates, perform a standardized high-risk screening on all initial visits, integrate care with the pregnancy care manager from the local health department, and agree to open chart audits. All qualified Medicaid providers that provide prenatal care are eligible to become a Pregnancy Medical Home. Participating providers receive incentives such as exemption from prior approval for obstetric ultrasounds, a $50 incentive for each risk screening form, a $150 incentive for each post-partum visit, and an increased reimbursement rate for a vaginal delivery.

  Women who are determined to be at risk of poor birth outcome, specifically preterm birth (based on the screening), will be assigned a pregnancy care manager from the local health department. Priority patients include those with a history of preterm birth or low birth weight, chronic disease that might complicate the pregnancy, multifetal gestation, fetal complications, tobacco use, substance abuse, unsafe living environment, unanticipated hospital utilization, two or more missed prenatal visits without rescheduling, or when a provider requests care management assessment.

  Contact: Kate Berrien, RN, BSN, MS, Pregnancy Home Project Coordinator, North Carolina Community Care Networks, Inc., kberrien@n3cn.org.

- *North Carolina Community Care Networks, Inc. (NCCCN) 646 Demonstration.*
  Section 646 of the Medicare Modernization Act (MMA) created a five-year demonstration program to improve safety, effectiveness, efficiency, patient-centeredness, and timeliness of care for Medicare enrollees. NCCCN is one of two organizations currently receiving funding

to test new models to achieve these goals. Eight of the 14 networks in NCCCN are participating in the demonstration, which began on January 1, 2010, and will end on May 31, 2014. NCCCN builds on CCNC's patient-centered medical home model by including dual-eligibles and Medicare-only beneficiaries. The program assigns beneficiaries to a primary care physician, provides community-based care coordination services, expands case management information systems, and uses a performance measurement and an incentive program to encourage improvements in care and reductions in cost.[23]

The program is being implemented in 26 counties: Bertie, Buncombe, Cabarrus, Chatham, Chowan, Edgecombe, Gates, Greene, Hertford, Hoke, Lincoln, Madison, Mecklenburg, Mitchell, Montgomery, Moore, New Hanover, Orange, Pasquotank, Pender, Perquimans, Pitt, Sampson, Stanly, Union, and Yancey.[4]

Contact: Angela Floyd, NCCCN, afloyd@n3cn.org.

- *CHIPRA Grant Demonstrations.*
  These grants were awarded to establish and evaluate a national quality system for children's health care that encompasses care provided through the Medicaid program and the Children's Health Insurance Program (CHIP). This grant is funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The CHIPRA statute mandates the experimentation and evaluation of several promising ideas to improve the quality of children's health care.[f] North Carolina was one of 18 states that received CHIPRA grant funds.

  North Carolina's CHIPRA grant is focused on three primary areas. The first is a statewide initiative to collect and report pediatric quality measures to CMS and to report these measures on a quarterly basis to the networks and practices to drive quality improvement. CMS has identified 24 measures. To date, the practices are reporting on 13 of the 24 measures and have plans to report on 23 of the 24 measures by the end of 2012. In addition, the state has voluntarily added five measures which it is collecting. As part of this statewide initiative, CCNC is working with DMA to develop and distribute an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) report card at the network and practice level which will report on rates of well-child (EPSDT) screens for children under age 21, as well as developmental, autism, vision, and hearing screens, Body Mass Index (BMI) measurement, and lead testing. CCNC has also hired 14 part-time Quality Improvement specialists through this grant. They are housed in the 14 CCNC networks to support primary care practices throughout the state. The second component is focused in seven of the 14 CCNC networks. It is focused on strengthening the medical home for children, particularly for children and youth with special needs. This initiative began in 11 practices, and is providing learning collaboratives to help practices with community linkages and referrals, maternal depression screening, child and adolescent mental health risk factors and screenings, and developmental and autism screenings for children birth through age five. This work is supported through the NC Center for Excellence for Integrated Care and four full-time QI specialists. Finally, the third component focuses on developing and evaluating a

[f] Warren, S. Project Director, Community Care of North Carolina. Written (email) communication. December 2, 2011.

pediatric electronic health record model. Rather than work with a specific vendor to develop a software package, North Carolina's initiative is focusing on evaluating a set of best practice standards for effectiveness and improving quality child health care. Any EHR vendor can participate, and those that do will be more competitive, as national certification for meaningful use will be based on the model that North Carolina is helping develop.

Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *North Carolina's Health Home State Plan Amendment.*
  The ACA gives states the option of creating "health homes" for Medicaid recipients with chronic health problems and receiving enhanced FMAP rates for eight fiscal quarters. DMA has submitted its SPA to CMS and is awaiting approval. North Carolina's health home will strengthen the coordination between primary care providers and those who are meeting the needs of people with mental health or substance use disorders, or those with intellectual and developmental disabilities.

  Contact: Debbie Pittard, Debbie.pittard@dhhs.nc.gov

- *BCBSNC and UNC-CH Medical Home.*
  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.[5]

  Contact: Don Bradley, MD, Senior Vice President and Chief Medical Officer, BCBSNC, don.bradley@bcbsnc.com.

- *State Health Plan Maternity Case Management Incentive Program.*
  The State Health Plan implemented a two-year maternity care incentive pilot program to incentivize pregnant women to engage in care management in the first trimester. Women will receive telephone nurse support and education to support healthy birth outcomes and identify high-risk conditions. Active participants will have their hospital inpatient copayment waived at time of delivery. The goal is to decrease pregnancy-related complications, preterm deliveries, low birth weight babies, and neonatal intensive care unit admissions.

  Contact: Anne Rogers, RN, BSN, MPH, Director of Integrated Health Management, State Health Plan, Anne.Rogers@shpnc.org.

- *WellPath Models to Improve Quality and Value.*
  WellPath has entered into new agreements with health systems and medical group practices designed to improve the quality and value of services provided and enhance patient outcomes. WellPath believes that health care professionals are in the best position to redesign the health care delivery system to enhance quality, outcomes, and efficiency. As a result, WellPath has focused on designing and implementing collaborative approaches to support redesign efforts to remove barriers and financial disincentives that make it difficult for provider groups to achieve these goals. Some of the key elements include:

  - Support for patient-centered medical homes. For example, WellPath has worked with the provider organizations to change provider compensation to support necessary but previously non-revenue producing activities and to more closely align with evidence-based quality measures.
  - Support for provider-led system redesign by aligning benefit plan design and compensation systems for the purpose of meeting the comprehensive needs of the patient/members and providing increased affordability.
  - Comprehensive information sharing between WellPath and the provider organizations to support quality, improved health outcomes, and greater efficiency.

  Two of these arrangements will be operational early in 2012 to serve individuals within Medicare Advantage plans, small group and large group employer plans, and individual plans. Approaches for self-funded employers are anticipated to be available later in 2012.

  Contact: Peter Chauncey, FACHE, Executive Vice President and Chief Operating Officer, WellPath, A Coventry Health Care Plan. PWChauncey@cvty.com.

- *North Carolina Health Care Facilities Association's "Journey to National Best" demonstration of the effectiveness of nurse practitioners in skilled nursing care facilities*.
  One of the initial efforts as part of the *Journey to National Best* (described more fully in Nursing Home Culture Change), supported by NC DHHS, has been a carefully evaluated demonstration of the utility and effectiveness of nurse practitioners in skilled nursing care facilities. This project, implemented in a single facility in North Wilkesboro, NC, showed the impact of an on-site nurse practitioner, as evidenced by lower rates of re-hospitalization, lower medication errors, and higher levels of patient satisfaction. Efforts are underway to negotiate with federal Medicare fiduciary agents and DMA to work out procedures for payment for these services (as has been the case with NPs in primary care) when the NP is an employee of the nursing facility, but supervised by multiple physicians responsible for individual patient care. Although some North Carolina nursing homes already employ nurse practitioners and have reported similar results, widespread adoption of this innovation awaits resolution of these payment arrangements with Title 18 and 19 authorities.[g]

[g] Souza, C. President, North Carolina Health Care Facilities Association. Written (email) communication. February 16, 2011.

- In addition, FutureCareNC, the nonprofit research and educational foundation of the North Carolina Health Care Facilities Association, is sponsoring an oral hygiene demonstration in partnership with a multi-disciplinary team from UNC-Chapel Hill for participating facilities in 2010 and 2011. This project focuses on oral care procedures to improve oral and nutritional outcomes as well as training for promoting oral care with resistive individuals. Dedicated oral health aides have been trained to provide routine, daily oral health care for patients unable to provide these services for themselves. Projects employing similar approaches in other states have demonstrated both improved hygiene and health outcomes, as well as increased dietary intake and positive self-esteem of patients. Early results from the North Carolina demonstration projects have shown similar results.

  Contact: Craig Souza, President, North Carolina Health Care Facilities Association (NCHCFA), craigs@nchcfa.org.

TRANSITIONS OF CARE

Description of ACA Provisions

- *Community-based care transitions program.*[h]
  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 focuses on high risk traditional fee-for-service Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions. This demonstration began on January 1, 2011.

North Carolina Initiatives

- *NCCCN's 646 Demonstration.*
  NCCCN, a community-based organization, coordinates patient care among providers, including hospitals, to improve overall quality of care for Medicare beneficiaries and dual-eligibles. One performance measure for quality involves transition of care. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[4]

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Description of ACA Provisions

- *Medicaid global payment system demonstration project.*[i]
  The Secretary, in conjunction with the newly established Innovation Center, shall establish the Medicaid Global Payment System Demonstration Project. This project, to be tested in no more than five states, will adjust state payments to an eligible safety net hospital from fee-for-service to monthly capitated payments for years FY2010 through FY2012. The

[h] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3026.
[i] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2705.

Innovation Center will test and evaluate patient outcomes and costs resulting from this model. Funds for this project have been authorized but not appropriated.

- *Pediatric ACO demonstration in Medicaid*.[j]
  Allows pediatric medical providers that meet specified requirements to be recognized as an accountable care organization (ACO) for purposes of receiving incentive payments. This demonstration is specifically for Medicaid and CHIP and lasts from January 1, 2012 to December 31, 2016. Money has been authorized but not appropriated.

- *Medicare shared savings program*.[k]
  Establishes a shared-savings program for Medicare providers no later than January 12, 2012. Providers meeting eligibility requirements determined by the Secretary can coordinate care for Medicare beneficiaries through an ACO. ACOs that meet quality requirements set by the Secretary can receive these capitation payments. ACOs are required to report measurement data as determined by the Secretary. This section was amended to allow for other methods of making payments such as partial capitation models.

North Carolina Initiatives

- *NCCCN 646 Demonstration.*
  The 646 Demonstration is a shared-savings ACO program, which offers the potential to share savings with CCNC networks. If NCCCN is able to show improved health outcomes and lower health care costs, then it can share in the savings with CMS. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.[3]

- *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.
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- *Forsyth Medical Group Physician Group Practice Demonstration.*
  Forsyth Medical Group, located in Winston-Salem, was one of 10 sites selected for the CMS Physician Group Practice demonstration for Medicare beneficiaries. The five-year demonstration began in 2005. The demonstration was designed to improve coordination of Medicare hospital, physician, and outpatient services; promote quality and cost effectiveness; and reward physicians for positive patient outcomes. Providers receive incentive payments based on Physician Quality Reporting Initiative (PQRI) measures in diabetes, congestive heart failure, coronary artery disease, and preventive care. Each practice was allowed to design its own care programs in order to meet the quality measures.

  Forsyth Medical Group developed the COMPASS Disease Management Program and the

[j] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2706.
[k] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3022, 10307, enacting Sec. 1899 of the Social Security Act, 42 USC 1395jjj.

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.[61]

Currently, the CMS is allowing ACOs to apply for participation in this demonstration until the Medicaid Shared Savings Program begins on January 1, 2012.[m]

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- *PACE Model.*
  The Program of All-Inclusive Care for the Elderly (PACE) model is designed to care for the frail elderly who want to receive long-term care services in their own community instead of in a nursing home. Patients receive adult day-center services and in-home services such as transportation, nutrition counseling, social services, case management, primary care, specialized therapies, and nursing care through the program. To receive PACE benefits, an individual must be 55 years of age or older, eligible for Medicaid under the state's criteria for nursing facility level of care, reside in a PACE-approved area, and be safely served in the community. Medicaid pays PACE a monthly fee for each recipient, allowing PACE to provide all services patients need without the limitations of fee-for-service systems. Medicare covers some of the costs for dual eligibles in addition to the Medicaid payments. Only nonprofit and public entities can have PACE models. All programs are monitored on an ongoing basis by the state and CMS to ensure compliance.

  There are currently two PACE models in North Carolina: Elderhaus, Inc. in Wilmington and Piedmont Health SeniorCare in Burlington, PACE of the Triad, Greensboro, and LIFE (Living Independently For Seniors) at St. Joseph of the Pines in Fayetteville, and PACE at Home in Newton. Other PACE models are in development in Durham, Hickory, Statesville, Greenville, and Asheville.

  In general, PACE models in North Carolina have seen a majority of patients improve or maintain performance in activities of daily living and cognitive functions.[n]

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[l] Holland, N. Senior Director, Clinical Excellence, Novant Medical Group. Written (email) communication. February 9, 2011.

[m] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3022.

[n] Barton, J. RN, DHHS, North Carolina Division of Medical Assistance. Oral communication. January 9, 2012.

Contact: Jennifer Barton, RN, North Carolina Division of Medical Assistance, jennifer.barton@dhhs.nc.gov.

ALL-PAYER PAYMENT REFORM

Description of ACA Provisions

- *Allowing states to test and evaluate systems of all-payer payment reform.*[o]
  States can test and evaluate payment reform systems for the medical care of all residents in the state including dual eligibles. This demonstration is a part of the new Innovation Center.

North Carolina Initiatives

- *North Carolina Multi-payer Demonstration in seven rural counties.*
  North Carolina was one of the first eight states awarded a demonstration grant under the new Innovation Center. The demonstration is to test a multi-payer partnership between NC DHHS, CCNC, BCBSNC, and the State Health Plan. The demonstration will allow individuals in seven rural North Carolina counties (Ashe, Avery, Bladen, Columbus, Granville, Transylvania and Watauga) who are enrolled in Medicare, BCBS, or the State Health Plan to enroll in Community Care networks. Community Care medical homes in these seven counties currently serve over 112,000 Medicaid beneficiaries. The program is expected to expand the number of patients served to over 128,000 Medicare beneficiaries and over 121,000 privately insured or State Health Plan recipients.[7] Medicare will support this initiative by paying per member per month payments to primary care practices and CCNC networks to pay for care management and quality improvement activities.

  Contact: Torlen Wade, Executive Officer, NCCCN, Inc., twade@n3cn.org.

CO-LOCATION MODELS

Description of ACA Provisions

- *Co-location of primary and specialty care in community-based mental and behavioral health settings.*[p]
  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.

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[o] Patient Protection and Affordable Care Act, Pub L No. 111-148, §3021(a), enacting Sec. 1115A(b)(2)(B)(xi) of the Social Security Act, 42 USC §1315a.

[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, §5604, enacting §520K of the Public Health Service Act, 42 USC 290bb-42.

North Carolina Initiatives

- *CCNC Co-Location Pilot Program.*
  CCNC's co-location of mental health and primary care pilot program targets practices with high Medicaid enrollment (2,000 or more). The program aims to build practice infrastructure, increase the number of primary care providers who use evidence-based screening tools to identify patients with mental health needs, and increase the number of mental health patients with access to primary care services. Twelve CCNC networks participate in the program. Early evaluations show the program has improved functioning and increased screenings for Medicaid beneficiaries. Significant cost savings have also been identified due to early intervention for behavioral health problems. Medicare and DMA have created new coding to help sustain and expand this model.[q]

  Contact: Torlen Wade, Executive Director, NCCCN, Inc., twade@n3cn.org.

- *Foundation for Advanced Health Program's Center of Excellence for Integrated Care.*
  The North Carolina Foundation for Advanced Health Programs (NCFAHP) was initially funded by the North Carolina Health and Wellness Trust Fund and DMA to create a Center of Excellence for Integrated Care. The work is now supported by other contracts and foundations, including funding from the federal CHIPRA Quality demonstration grant, Kate B. Reynolds Charitable Trust, and a contract with the Governor's Institute on Substance Abuse. The Center works to improve patient outcomes through integrating mental health, substance abuse services, and primary medical care. It provides trainings, learning collaboratives, and technical assistance to primary care and behavioral health providers, health departments, Local Management Entities (LMEs), and Critcal Access Behavioral Health Agencies (CABHA) to help them implement integrated care models to better serve patients with underlying medical problems, mental health conditions, substance abuse disorders, and/or certain intellectual or developmental disabilities. The Center currently has funding to support integrative practices in primary care and mental health and substance abuse settings in seven of the 14 CCNC networks, including 27 primary care practices. The Center provides training, technical assistance, and learning collaboratives around integrated care processes; brief intervention and referral into treatment for substance abuse disorder, depression, and other forms of mental illness; identification and support for children with autism spectrum disorder; maternal depression; and childhood obesity.

  Contact: Regina S. Dickens, Program Director, NC Center of Excellence for Integrated Care, regina.dickens@ncfahp.org; Maggie Sauer, President and CEO, North Carolina Foundation for Advanced Health Programs, Maggie.sauer@ncfahp.org.

[q] Wade, T. Executive Director, NCCCN, Inc. Written (email) communication. January 31, 2011.

COORDINATION OF DUAL ELIGIBLES

Description of ACA Provisions

- *Integrated care for dual eligibles.*[r]
  States are allowed to test and evaluate fully integrated care for dual eligible individuals, including management and oversight of all funds with respect to these individuals. This demonstration is a part of the Innovation Center.

North Carolina Initiatives

- *NCCCN 646 Demonstration (Medicare Shared Savings Program).*
  The 646 Demonstration is a five-year program that coordinates care for Medicare/Medicaid dual eligibles. For more details on the 646 Demonstration, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *CCNC Medicaid Payment for dual eligibles.*
  Medicaid pays CCNC a per-member-per-month payment for all dual eligibles. An increased PMPM payment is given to primary care providers and CCNC for all aged, blind, and disabled beneficiaries, including dual eligibles. This increase was to fund behavioral health integration, embedded care managers in large hospitals and practices, and network privacy and security officers. A portion of the payments are given to NCCCN to fund centralized clinical leadership and the Informatics Center.[s,t] For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *PACE Pilots.*
  When an individual enrolled in PACE is eligible for both Medicaid and Medicare, then both Medicaid and Medicare provide PACE with monthly capitation payments.[8] 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.*[u]
  This demonstration, which is a part of the Innovation Center, provides medication therapy management (MTM) by licensed pharmacists to treat chronic disease while improving quality and reducing cost. Targeted individuals include those taking four or more

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[r] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(x) of the Social Security Act, 42 USC 1315a.

[s] Collins, C. Deputy Director, NCORHCC; Assistant Director, Division of Medical Assistance-Managed Care, NCDHHS. Written (email) communication. February 3, 2011.

[t] Levis Hewson, D. Director of Clinical Programs and Quality Improvement, NCCCN. Written (email) communication. February 4, 2011.

[u] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(vii) of the Social Security Act, 42 USC 1315a.

medications, taking any high-risk medications, having two or more chronic diseases, or having had a transition of care.

- *Medication management for people with multiple medications and/or chronic diseases*.[v] This demonstration is similar to the one above but it is not specific to Medicare or Medicaid. The HHS Secretary shall establish grants or contracts to provide medication management for people with four or more medications, high-risk medications, and/or chronic diseases to improve quality of care and reduce overall costs. The demonstration will be funded by Section 931 of the Public Health Service Act (PHSA), which authorizes $75 million for FY2010-2014.

North Carolina Initiatives

- *Health and Wellness Trust Fund's ChecKmeds NC***.**
  The ChecKmeds NC program, launched in 2007, uses a network of nearly 500 retail and community pharmacists to provide medication reviews to Medicare beneficiaries 65 and older who have a Medicare-approved drug plan. The program targets drug effectiveness, safety, adherence, and cost-effectiveness. Pharmacists under contract with the third party administrator ,Outcomes Pharmaceutical Health Care, provide patient education and coordinate patient care among multiple providers. Some of the pharmacists also provide assistance with how to maximize Medicare-approved drug benefits; however, ChecKmeds does not reimburse for this service. When the Health and Wellness Trust Fund lost its funding, the ChecKmeds NC program was moved to the North Carolina Office of Rural Health and Community Care. The program is funded through mid-2012.[w]

  Contact: Ginny Klarman, Community Development Specialist, North Carolina Office of Rural Health and Community Care, ginny.klarman@dhhs.nc.gov.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home uses the Medication Reconciliation PLUS process to coordinate care among multiple providers. This process collects patient data from administrative claims, medical records, case managers, patients, and physicians. The data is then put into a virtual database, which can be accessed by CCNC case managers, pharmacists, and primary care physicians. The system is used to identify potential adverse events due to drug interactions as well as poor medication adherence.

  CCNC has been collecting information on the number and type of medication-related problems that are identified during the Medication Reconciliation PLUS program. The 18-month results through October 2011 indicate that CCNC staff identified 19,022 medication-related problems in 6,927 patients.[x] On average, there were 2.7 problems found per patient reviewed, including patients not taking their prescribed discharge medication (23% of problems identified); poor adherence to medications for chronic conditions (18%); or

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[v] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3503, amending §935 of the Public Health Service Act, 42 USC 299b-35; Protection and Affordable Care Act, Pub L No. 111-148, § 10328.

[w] Upchurch, G. Executive Director, Senior PharmAssist. Written (email) communication. November 23, 2011.

[x] Williams, N. Vice President, E-Prescribing Project Manager, CCNC. Written (email) communication. November 28, 2011.

problems with the medication dose/frequency or duration (19%). Of these problems, 6% were deemed urgent (potentially leading to imminent hospitalization). Identifying these potential events allows the patient's providers to intervene before the events occur. This intervention reduces hospitalizations and re-hospitalizations.[y]

Contact: Troy Trygstad, PharmD, MBA, PhD, Director, Network Pharmacist Program, CCNC, troy@t2email.com.

- *North Carolina State Health Plan Medication Adherence Pilot Project***.**
  The State Health Plan also has a medication adherence pilot project.[z] Under this initiative, started in December 2009, all State Health Plan retirees using diabetes or cardiovascular medications were eligible for a reduction in their copayment. Retirees were targeted due to the high prevalence of these diseases among the retiree population and the potential to improve adherence through reduced cost sharing. By October 2011, approximately 26,000 retirees had participated in the program. Medco, the Plan's Pharmacy Benefit Manager, determined that the program saved members more than $1 million in co-payments, and reduced pharmacy costs to the State Health Plan by more than $2.3 million. In addition, the medication adherence rate improved by more than 14% for oral diabetes and cholesterol medications, and by more than 19% for blood pressure medications.

  Contact: Sally Morton, PharmD, Clinical Pharmacist, State Health Plan. Sally.Morton@shpnc.org.

- *Senior PharmAssist.*
  The mission of Senior PharmAssist is to "promote healthier living for Durham seniors by helping them obtain and better manage needed medications, and by providing health education, Medicare insurance counseling, community referral and advocacy."[9] The nonprofit program is funded primarily through private donations, with some small government contracts and earned income. This program assists seniors in Durham with medication management, medication access, and tailored health education and community referral that helps seniors remain in their homes. In addition, Senior PharmAssist helps Medicare beneficiaries select appropriate Medicare health and prescription drug plans as Durham County's Senior Health Insurance Information Program (SHIIP) coordinating site.

  The program is evaluated based on medication adherence, health services utilization, functional capability, and satisfaction. Data is collected every six months. After two years, the evaluations have shown a 51% reduction in the rate of any hospitalizations and a 27% reduction in the rate of any emergency department use.[10]

  Senior PharmAssist conducted an evaluation of their SHIIP counseling assistance with stand-alone Part D plan selection for 2010 benefits. Two-thirds of the seniors needed to switch drug plans for a mean savings of $522 (median of $343).[11] The 2011 findings were very similar and have been accepted for publication. These savings do not yet reflect the staff's

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[y] Trygstad, T. Director, Network Pharmacist Program, NCCCN. Written (email) communication. January 25, 2011.

[z] Barnes, L. Interim Executive Administrator, State Health Plan. Written (email) communication. Dec. 20, 2011.

recommendations for generic or therapeutic substitutions, clinical interventions, or referrals for other subsidies that could help reduce health care or pharmacy costs.

Currently, the program is working to expand its services further through providers in Durham, North Carolina, with a focus on decreasing hospital readmissions for Medicare beneficiaries. Senior PharmAssist has helped other communities begin similar programs and has a newly revised implementation guide. The program is also currently contemplating applying for grants related to the ACA.

Contact: Gina Upchurch, RPh, MPH, Executive Director, Senior PharmAssist, gina@seniorpharmassist.org.

GERIATRIC CARE

Description of ACA Provisions

- *Geriatric assessments and care plans.*[aa]
  This Innovation Center 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.

- *Independence at Home Demonstration Program.*[bb]
  This demonstration will test a payment-incentive service delivery model with eligible home-based primary care teams who serve eligible Medicare beneficiaries. No more than 10,000 beneficiaries will be served by the demonstration. The Secretary will determine quality and performance standards that the project teams must meet. Payments will be based on a target-spending standard based on the amount the Secretary estimates will be saved annually through the program. Incentive payments will be made to project teams if actual annual expenditures are less than the estimated spending target set by the Secretary. Five million dollars for each fiscal year 2010 through 2015 was appropriated for the demonstration. The demonstration is scheduled to begin no later than January 1, 2012. Agreements with practice teams will last no more than three years.

North Carolina Initiatives

- *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

[aa] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(iii) of the Social Security Act, 42 USC 1315a.

[bb] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3024, 10308(b)(2), enacting Sec. 1866E of the Social Security Act, 42 USC 1395cc-5.

phlebotomist. JFU currently serves 350 residents in 14 housing complexes.[12cc] 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.[13]

Contact: Frederick S. Johnson, MBA. Assistant Professor, Deputy Director, Division of Community Health, Department of Community and Family Medicine, Duke University Medical Center, johns427@mc.duke.edu.

- *CCNC home visits.*
  As part of CCNC's care-management program, care managers visit patients' homes to provide medication reconciliation, falls prevention assessments, chronic care assessments, home environment assessments, and/or patient education. Patients are given a severity screening and those categorized as "high risk" are given priority for home visitation. Outcome measures of the program include hospital admissions, readmissions, emergency department visits, and follow-up appointments with primary care providers. Home visits are covered in the PMPM payment to CCNC.[dd]

  Contact: Denise Levis Hewson, RN, MSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

TELEHEALTH/TELEMONITORING AND HEALTH INFORMATION TECHNOLOGY

Description of ACA Provisions.

- *Supporting care coordination of chronically-ill individuals with health information technology*.[ee]
  The Innovation Center is authorized to test care coordination for chronically-ill individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

- *Facilitate inpatient care of hospitalized individuals*.[ff]
  The Innovation Center is also authorized to test the use of electronic monitoring by specialists based at integrated health systems to improve services to patients at local community hospitals.

- *Using telehealth services in medically underserved areas and facilities of the Indian Health Service*.[gg]

[cc] Johnson, F.S. Deputy Director, Division of Community Health, Department of Community and Family Medicine, Duke University Medical Center. Written (email) communication. February 4, 2011.

[dd] Denise Levis Hewson, Director of Clinical Programs and Quality Improvement, NCCCN. Written (email) communication. February 4, 2011.

[ee] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(v) of the Social Security Act, 42 USC 1315a.

[ff] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3021(a), enacting Sec. 1115A(b)(2)(B)(xvi) of the Social Security Act, 42 USC 1315a.

[gg] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3021(a), 10306(2)(B), enacting Sec. 1115A(b)(2)(B)(xix) of the Social Security Act, 42 USC 1315a.

Another potential initiative of the Innovation Center will be to use telehealth to treat behavioral health issues and stroke and to improve the capacity of non-medical providers to provide health services for people with chronic complex conditions.

North Carolina Initiatives

- *Roanoke-Chowan Telehealth Network Grant.*
  Roanoke-Chowan Community Health Center received a grant from the North Carolina Health and Wellness Trust Fund in 2006 to establish a daily remote monitoring and chronic care management program. Phase I of the program began in September 2006 and targeted high risk patients with diabetes, cardiovascular disease (CVD), and hypertension. Patients are given monitoring equipment, including a scale, blood pressure/pulse monitor, blood glucose monitor, and a pulse oximeter to monitor their health status daily. Data from these devices, along with other information about a patient's health status and functioning, is sent via a phone line or Internet daily to a secure server. RCCHC RNs monitor data daily, contact the patient via phone and conduct a nursing assessment and education for any patient with abnormal readings. When the RN determines a potential need for a change in medical regimen, the RN informs the patient's primary care provider via the electronic health record (EHR). This program allows health professionals to intervene early if a patient's health begins to trend downward. An external evaluation showed a statistically significant reduction in hospital charges for patients who participated in this initiative. Patients in the program demonstrated a statistically significant reduction in diastolic blood pressure and have learned better self-management skills. During 2007-2009, additional funding was obtained by Kate B. Reynolds Charitable Trust, the Obici Foundation, Pitt County Foundation, and Roanoke Chowan Community Benefit to expand RCCHC's remote monitoring program and implement post-discharge remote monitoring and chronic care management for diabetes patients at Roanoke Chowan Hospital. Funding received by East Carolina School of Cardiology implemented remote monitoring for RCCHC/ECU cardiac patients and funding received by Piedmont Health Services implemented remote monitoring for CVD patients.

  North Carolina Health and Wellness Trust Fund Phase II Health Disparities funding, received in July 2009, is targeting Medicaid and dual eligible patients with CVD in five additional Community Health Centers (Bertie Rural Health, Greene County Health Services, Kinston Community Health, Commwell Community Health and Cabarrus Community Health Center). In September 2010, RCCHC received a three-year HRSA Telehealth Network Grant and has expanded or will expand the pilot to North Carolina community health centers (First Choice Community Health Center, Piedmont Health Services, Robeson Community Health Center, Wake Health Systems), a rural hospital (Chowan Hospital), and Pitt County Memorial Hospital East Carolina Heart Institute. RCCHC is currently monitoring and managing patients in 14 North Carolina counties from Ahoskie.[hh]

  Contacts: Kim Schwartz, MA, CEO, Roanoke-Chowan Community Health Center, kschwartz@pcmh.com; Bonnie Britton, MSN, RNC, Telehealth Administrator, University Health Systems of Eastern Carolina. Bonnie.Britton@uhseast.com.

[hh] Schwartz, K. CEO, Roanoke-Chowan Community Health Center. Written (email) communication. January 31, 2011.

- *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.[ii]

  Contact: Sy Saeed, MD, MS, DFAPA, MAC*Psych*, Professor and Chairman, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University, Chief of Psychiatry, Pitt County Memorial Hospital, saeeds@ecu.edu.

- *Duke Telepsychiatry.*
  For the past six years, the Durham Child Development and Behavioral Health Clinic in the Department of Pediatrics, formerly the Community Guidance Clinic, has had a telepsychiatry program for children with Axis I diagnoses in three Durham public schools. Child psychiatry fellows offer on-site mental health services and staff enrichment each Tuesday morning in order to continue a child's education in a public school in a therapeutic environment. A maximum of 48 students are served through the program, 24 students from K-5th grade and 24 from 6th-12th grade. Duke faculty supervise the visits and provide consultation via telepsychiatry to each school while the fellows are with the children, teachers, counselors, case managers, and family members. The Department of Pediatrics charges Durham Public Schools for each hour the fellows are on site, billing semiannually. New grant funding has allowed Duke to begin a consultation service to two pediatric clinics through Southern Regional AHEC.

  Contact: Richard E. D'Alli, MD, Med, ScM, Associate Professor of Psychiatry and Behavioral Sciences, Associate Professor of Pediatrics, Department of Pediatrics, Duke University Medical Center, dalli003@mc.duke.edu

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[ii] Saeed, S. MAC*Psych*, Professor and Chairman, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University; Chief of Psychiatry, Pitt County Memorial Hospital. Written (email) communication. January 18, 2011.

- *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.[jj]

  Contact: Susan Yaggy, President and CEO, North Carolina Foundation for Advanced Health Programs, susan.yaggy@ncfahp.org.

- *CHIPRA Grant Demonstrations.*
  North Carolina's grant initiative was designed to test the use of new and existing measures of quality for children; provider-based models to improve the delivery of care; and demonstrate the impact of model pediatric EHRs (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.[kk]

  For more details on the CHIPRA Grant Demonstrations, please see North Carolina initiatives under Patient-centered Medical Homes.

  Contact: Stacy Warren, Project Coordinator-CHIPRA, stacy.warren@dhhs.nc.gov.

- *Beacon Grant.*
  The Southern Piedmont Community Care Plan (SPCCP) in Concord was one of 15 communities awarded over $15 million to model a demonstration in HIT. The grant is a part of the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Three counties (Cabarrus, Rowan and Stanly) are participating in the grant and make up the Southern Piedmont Beacon Community. SPCCP will use the grant to improve community-level care coordination in high-risk populations such as diabetics, asthmatics, patients with congestive heart failure, and patients going through transitions to medical homes. Objectives

[jj] Yaggy, S. President and CEO, North Carolina Foundation for Advanced Health Programs. Written (email) communication, February 1, 2011.
[kk] Collins, C. Deputy Director, NCORHCC, Assistant Director, Division of Medical Assistance-Managed Care, NCDHHS. Written (email) communication. January 19, 2011.

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.[14] 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.[15]

Contact: Cindy Oakes, RN, BSN, Director, Southern Piedmont Community Care Plan, cindy.oakes@carolinashealthcare.org.

- *CCNC Pharmacy Management Initiative: The Pharmacy Home Project.*
  The Pharmacy Home will be expanding to include additional data and capabilities and will be expanded for use by all users of the Health Information Exchange (HIE), including providers who are not part of the CCNC system. North Carolina was just awarded an additional $1.7 million for the HIE to build a system to manage medication information from the HIE and other sources. This system will be built by CCNC on the Pharmacy Home model. The project will be piloted in 10 North Carolina counties: Ashe, Avery, Bladen, Cabarrus, Columbus, Granville, Rowan, Stanly, Transylvania and Watauga. All North Carolina counties will have access to the system by late 2012.[ll]

  For more details on CCNC's Pharmacy Home Project, please see North Carolina initiatives under Medication Management.

  Contact: Troy Trygstad, PharmD, MBA, PhD, Director, Network Pharmacist Program, CCNC, troy@t2email.com.

SHARED DECISION-MAKING

Description of ACA Provisions

- *Program to facilitate shared decision-making.*[mm]
  The ACA authorizes a demonstration to facilitate collaboration between patients, caregivers, or authorized representative and clinicians. A contracted entity will create standards for decision aids—educational tools to help patients, caregivers, and providers understand treatment options and make informed medical care decisions. Grants will be provided to organizations to develop and implement decision aids that meet standards, facilitate informed decision-making, present up-to-date information, explain any lack in clinical evidence for a treatment, and address decision-making across all age groups. The provision also provides grants to develop Shared Decision-Making Resource Centers. These centers will provide

[ll] Walker Kasper, E. Project Manager, North Carolina Healthcare Quality Alliance. Written (email) communication. February 7, 2011.

[mm] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3506, amending S936 of the Public Health Service Act, 42 USC 299b-36.

technical assistance to providers and develop and share best practices. This demonstration is not specific to Medicare or Medicaid and went into effect immediately. Money has been authorized for FY2010 and each subsequent fiscal year thereafter.

North Carolina Initiatives

- *CCNC Care Management.*
  Case Managers with CCNC coordinate care between patients and providers. A majority of patients can be taught by a case manager how to manage their own conditions and only need one or two follow-ups. However, patients that need more intensive case-management receive regular services. For more details on CCNC, please see North Carolina initiatives under Patient-Centered Medical Homes.

- *CCNC Palliative Care Initiative.*
  CCNC is proposing a new initiative to train care managers in palliative/end-of-life care to improve health care quality and resource utilization. The initiative aims to teach care managers clinical skills in care planning, cultural competency, and about important documentation tools in end-of-life planning (eg, power of attorney and DNR). The initiative will also create access to palliative care services through information resources, toolkits for care managers, and toolkits for primary care providers. Eight faculty members will develop the curriculum and toolkit for the training sessions. The one-day sessions will include patient communication, care planning, symptom distress screening, and palliative care services.[nn]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

- *Stanford Self-Management Model.*
  The Division of Aging and Adult Services, within the NC DHHS, collaborated with CCNC to bring Stanford University's Chronic Disease Self Management Program to North Carolina. The program is offered through local Area Agencies on Aging and aims to educate patients with chronic conditions on living a healthy life. Participants in the program meet with two certified trainers once a week for six weeks. The curriculum includes exercise and nutrition, medication usage, stress management, communicating with health care providers, emotional health, problem solving, and supporting others. The evidence-based program helps patients feel better and decreases hospitalizations and emergency room use.[oo]

  Contact: Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, CCNC, dlevis@n3cn.org.

[nn] Wade, T. Executive Director, NCCCN, Inc. Written (email) communication. January 31, 2011.
[oo] Wade, T. Executive Director, NCCCN, Inc. Written (email) communication. January 31, 2011.

MALPRACTICE REFORM

Description of ACA Provisions

- *Medical Malpractice*.[pp]
  The HHS Secretary is authorized to award $500,000 in demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. This demonstration is not specific to Medicare or Medicaid and is effective for a five-year fiscal period beginning FY 2011.

North Carolina Initiatives

- *NCORHCC and Access II Care system of near miss reporting and improvement tracking in primary care.*
  The North Carolina Office of Rural Health and Community Care (NCORHCC) and Access II Care (a CCNC Network) received a federal grant of $297,710 to conduct a preliminary study to determine the feasibility of creating a near miss reporting and improvement tracking system in an ambulatory practice network. The near miss reporting and tracking system will be introduced into six diverse practices. The initiative has three components: 1) a standardized orientation for each practice; 2) reporting and collection of near-miss reports from each practice for six months, and 3) ongoing educational and quality improvement efforts aimed at understanding and learning from the near-miss events including ongoing staff prompts and reminders to use the system. Research aspects of the study include: a) evaluation of the implementation of the system in the six study practices; b) analysis of the types of near-miss events reported including their correlates and the validity of seriousness ratings; and c) evaluation of patient and provider reported behaviors regarding the influence of near-miss disclosure. As a result of this preliminary study, the research team expects to gain a better understanding about how to implement a near-miss reporting system in primary care settings; how practices respond to near-miss event reporting (eg, which types of events may be most amenable to improvement); how increased recognition of near-miss events relates to provider awareness and attitudes toward patient safety and practice change; and how provider disclosure might influence patient behavior in terms of seeking legal advice.[qq]

  Contact: Steven Crane, MD, Assistant Director, Division of Family Medicine, Mountain Area Health Education Center (MAHEC), steve.crane@pardeehospital.org.

NURSING HOME DEMONSTRATIONS

Description of ACA Provisions.

- *Nursing Home Culture Change*.[rr]
  The ACA authorized two three-year demonstration projects by March 2011 to develop best

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[pp] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6801; Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10607, enacting § 399V-4 of the Public Health Service Act, 42 USC 280g-15.

[qq] Collins, C. Deputy Director, NCORHCC; Assistant Director, Division of Medical Assistance-Managed Care, NCDHHS; Written (email) communication, January 19, 2011.

[rr] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 6114.

practice models for culture change and use of information technology to improve resident care. This demonstration is not specific to Medicare or Medicaid. Funds have been authorized but not appropriated.

North Carolina Initiatives

- *NC NOVA.*
  The North Carolina New Organizational Vision Award (NC NOVA) was created under a Better Jobs, Better Care grant from the Robert Wood Johnson Foundation and The Atlantic Philanthropies to the North Carolina Foundation for Advanced Health Programs. NC NOVA was expanded to be a statewide program effective January 1, 2007, and program activities were integrated into the Department of Health and Human Services. NC NOVA is a voluntary, incentive-based special state licensure program. Any licensed nursing facility, adult care home, or home care agency whose operating license is in good standing may apply for the NC NOVA special licensure designation. NC NOVA encompasses a comprehensive set of workplace interventions to address the retention and recruitment of direct care workers and the quality of care they provide. The criteria for NC NOVA designation apply equitably across nursing homes, adult care homes, and home care agencies. The four domains of NC NOVA include: 1) supportive workplace, which covers six elements: orientation, peer mentoring, coaching supervision, management support, worker empowerment, reward and recognition; 2) training; 3) balanced workloads; and 4) career development. An applicant must demonstrate on paper and in practice, that it meets the established criteria for each domain.

  NC NOVA's determination process is separate from the state's regulatory review and licensure process and is conducted by an independent review organization. The NC NOVA special license is issued by the state.

  Staff turnover data from all three care settings, nursing home nurse aide wage data, and nursing home occupancy data are used to compare those organizations with NC NOVA to those who do not have the NC NOVA designation as a means to evaluate program impact. Although early in the analysis, NC NOVA designees tend to show a positive impact.[ss]

  Contact: Jan Moxley, Office of Long-Term Services and Supports, DHHS, jan.moxley@dhhs.nc.gov.

- *North Carolina Coalition for Long-Term Care Enhancement (NCCLTCE).*
  The NCCLTCE, formerly the North Carolina Eden Coalition, offers enhancement grants to nursing homes to support environmental and cultural changes through new health care innovations. The grants are funded by civil money penalty funds through the North Carolina Division of Health Service Regulation. Changes must improve the quality of life for residents of Medicare/Medicaid certified and Medicaid-only certified long-term care nursing facilities with a history of deficiencies.

[ss] Moxley, J. Office of Long-Term Services and Supports, DHHS. Written (email) communication. February 2, 2011.

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- *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.[16]

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- *North Carolina Health Care Facilities Association's "Journey to National Best"***.**
  Started in 2005, the *Journey to National Best* is North Carolina Health Care Facilities Association's effort to transition skilled nursing homes into facilities of the future. The Journey's goal is to develop strategies to exceed the demands and expectations of long-term health care consumers and families. To strengthen and transform North Carolina nursing homes, NCHCFA focuses on the issues that are relevant to the lives of residents and the staff who care for them, and works to assure the highest level of health care relevant to the needs of the growing population needing this level of care. The program's mission is a collaborative effort between consumers, policy makers, stakeholders, and providers.

  With a grant from The Duke Endowment, FutureCare of North Carolina, the nonprofit research and educational foundation sponsored by the Association, conducted a two-year project "Enhancing the Skills of Nursing Practice in North Carolina Long-Term Care Facilities," 2008-2010. In this project, FutureCareNC launched one of the first projects of its kind in the nation, employing a patient care simulator (PCS) mannequin and a nurse educator in 34 participating nursing homes in North Carolina for 3-5 days per facility. All nursing personnel (at every level: NA, LPN, RN) working in each facility were exposed to clinical modules simulating common patient care situations among older adults. Through these hands-on learning experiences, nursing home staff were exposed to the very best of both nursing education as well as the latest technologies for learning. Emphasis in these sessions was on observational and reporting skills, especially those essential to effective clinical teamwork and individual nursing staff self-efficacy. The experience gained in this initial FutureCareNC project led to a new initiative to use the same technology and approach in addressing the leading categories of medication errors in nursing homes.

For more details on *Journey to National Best*, please see North Carolina initiatives under Patient-Centered Medical Homes.

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OTHER NORTH CAROLINA NEW MODELS

Value Based Insurance Product Design

Another "new model" that is being tested among private insurers is value based insurance design (VBID). With VBID, insurers encourage enrollees to use services or medications of higher value by reducing or eliminating the out-of-pocket cost sharing (for example, eliminating cost sharing for highly effective medications) or by increasing the cost sharing on services, procedures, or medications that are less useful.[17] VBID products can also be designed to provide financial incentives to enrollees to encourage them to obtain care from high quality, lower-cost health care providers. Unlike traditional Preferred Provider Organization (PPO) insurance products—which have differential cost-sharing arrangements for in-network and out-of-network providers—value based insurance products may have multiple tiers of cost sharing. The amount of the cost sharing may differ depending on the procedure/service and the provider. Thus, a large health care system may be considered a best value provider for open heart surgery, but not for knee or hip replacement. Blue Cross Blue Shield of North Carolina is testing a value-based insurance product design for one large employer group.

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Improving Population Health

In addition to the new models that focus on changes in the health care delivery system and payment methodologies, some communities are testing new models focused on improving overall population health. Population health programs include some of the changes in delivery and payment models discussed previously, but also include community-based efforts to address socioeconomics, transportation, literacy, and other broader societal issues that affect population health. The Durham Health Innovation (DHI) is an example of this broader community-focused health intervention. This is a collaboration between Duke Medicine, Durham County Health Department, Durham Center (Local Management Entity), Durham County Department of Social Services, Durham Public Schools, Durham Housing Authority, Durham Parks and Recreation, City of Durham, Lincoln Community Health Center, and numerous other community agencies and faith-based organizations that are working together to improve the health status of Durham County residents. In 2009, DHI funded 10 planning teams to find ways to reduce death or disabilities from diseases or other health problems prevalent in the community. The planning group selected seven neighborhoods as their pilot sites, focusing on areas in the county that are low-income, more heavily comprised of racial and ethnic minorities, and which have greater health problems. DHI involved the targeted communities in selecting priority interventions. Based on this feedback, DHI decided to develop a neighborhood health navigators program to help link

community residents with existing health and social services programs; involve community agencies in providing health information; and engage community organizations, faith-based organizations, neighborhood and community leaders, business owners, and community members to ensure healthy foods in schools and neighborhoods and safe places to exercise. DHI is funded through an institutional commitment of $1 million from Duke University, support from the Clinical and Translational Science Awards which are funded by the National Institutes of Health, and in-kind contributions from numerous community organizations.[18]

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