

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

CHAPTER 3: MEDICAID

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

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

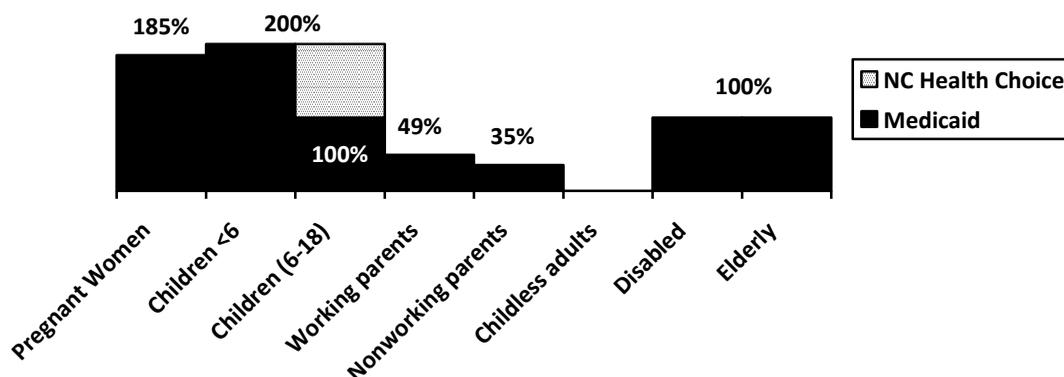
The Medicaid workgroup finished its work before the US Supreme Court decision. It focused on the new Medicaid expansion, eligibility and enrollment requirements, new benefit mandates or options, and options for home and community-based services. Medicaid also plays a critical role in almost all aspects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

COVERAGE EXPANSION

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

The Supreme Court ruling made the Medicaid expansion optional for states. Under the Supreme Court ruling, each state now has the option to expand Medicaid coverage to many low-income adults who are not currently eligible for Medicaid. Currently, to qualify for Medicaid, a person must be a citizen or lawful permanent immigrant in the United States for at least five years and must meet certain categorical, income, and resource requirements. Medicaid is generally limited to children of low-income families, or adults who are either pregnant, have dependent children under age 19 living with them, disabled (under strict Social Security disability standards) or elderly (65 or older). Even if a person meets these categorical eligibility rules, the individual must also have an income below a certain income threshold and have limited resources or assets to qualify. Childless, nonelderly, and nondisabled adults do not currently qualify for Medicaid, regardless of their income. Because of these eligibility restrictions, North Carolina's Medicaid program only covered 30% of all poor adults with incomes up to 100% FPL in 2010-2011.⁴ (Figure 3.1)

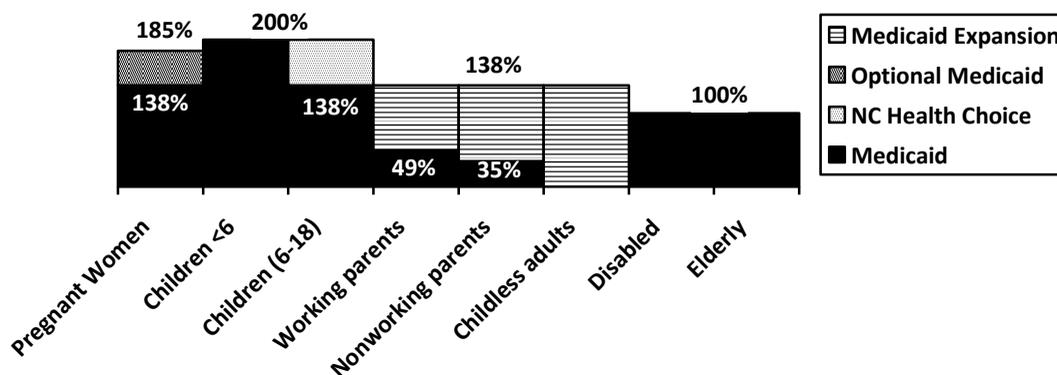
Figure 3.1
North Carolina Medicaid Income Eligibility (2012)



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

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

Figure 3.2
Medicaid Income Eligibility Including Optional Expansion (2014)



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

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

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

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

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

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

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

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

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

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

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

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

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

DMA developed estimates of the number of new people who would gain Medicaid coverage and the costs of providing coverage to these individuals from 2014-2019.¹² DMA prepared separate analyses for the woodwork and the newly eligible individuals. DMA used certain assumptions in developing its enrollment and cost projections:

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

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

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

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

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

- 1) DMA estimated the total service costs for both the woodwork group and the newly eligibles. (See Tables 3.2 and 3.3 and Appendix C.)
- 2) DMA identified the potential cost offsets for each population. For example, both the state and federal government get rebates from pharmaceutical manufacturers.¹⁴ The drug rebates apply to both the woodwork and newly eligible groups. In addition, the ACA includes an enhanced federal match rate for the CHIP program of 23 percentage points in FFY 2016-2019.¹⁵ This will reduce the net new state costs associated with providing coverage to the woodwork population. There are other cost offsets (described more fully below) for the newly eligible population. (See Tables 3.2 and 3.3 and Appendix C.)

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

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

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

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

Woodwork Population

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

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

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

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

Note: See Appendix C for full cost estimates.

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

Newly Eligibles

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

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

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

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

As noted earlier, the North Carolina Department of Health and Human Services contracted with the REMI to conduct an analysis of the economic impact of the Medicaid expansion on the state. REMI's analysis includes both the impact of the new federal dollars to the state assuming migration of health care workforce into the state (if surrounding states do not expand Medicaid), and without migration. According to REMI, the new federal funds from the Medicaid expansion will generate approximately 25,000 jobs by 2016 (a total of 25,684 if there is migration into the state, or 24,846 without migration). REMI assumed a slight decline in new jobs after 2016, with improved labor productivity and reductions in public jobs as the state redirects internal funding. Thus, total employment declines from the high in 2016 from approximately 26,000 new jobs to a total of closer to 18,000 new jobs by 2021 (20,095 if assuming migration, 17,742 if no migration). Most of the new jobs will be in the private sector. Increases in annual state domestic product (SDP) is expected to range from approximately \$1.7 billion higher (2016) to \$1.3 billion higher (2021). While REMI was not contracted to do a complete analysis of the additional tax revenues that are likely to be generated as a result of the new federal Medicaid funds, REMI did prepare an estimate of the likely new tax revenues—based on historical data on state revenues generated from SDP. Historically, North Carolina generates approximately 4.5% of its SDP in state tax revenues. REMI applied this historical state tax revenue-to-SDP ratio to the increase in SDP generated from the new federal dollars. Based on this analysis, REMI estimated that North Carolina is likely to experience an increase of state taxes ranging from approximately \$17.2 million in SFY 2014 (taking the average of the migration and non-migration estimates), to \$60.7 million in SFY 2021.

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

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

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

Note: See Appendix C for full cost estimates.

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

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

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

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

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

The decision about whether to expand Medicaid coverage has an impact not only on the individuals that may gain coverage, and the state budget, but also on health care providers in the state. The Medicaid expansion will provide a source of reimbursement for the care that many health care providers already provide to the uninsured. In addition, it can help offset some of the other ACA provider payment cuts that were made in anticipation of the Medicaid expansion. For example, the ACA cut Medicaid disproportionate share hospital (DSH) payments. DSH payments have historically been paid to hospitals that serve a high proportion of uninsured and Medicaid patients. In North Carolina, hospitals are scheduled to experience a loss of \$384.5 million in Medicaid DSH payments (2014-2019). The federal government will cut \$13.6 million in 2014, increasing to a \$152.7 million cut in FY 2019.¹⁷

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

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

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

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

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

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

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

RECOMMENDATION 3.1: EXPAND MEDICAID ELIGIBILITY UP TO 138% FPL

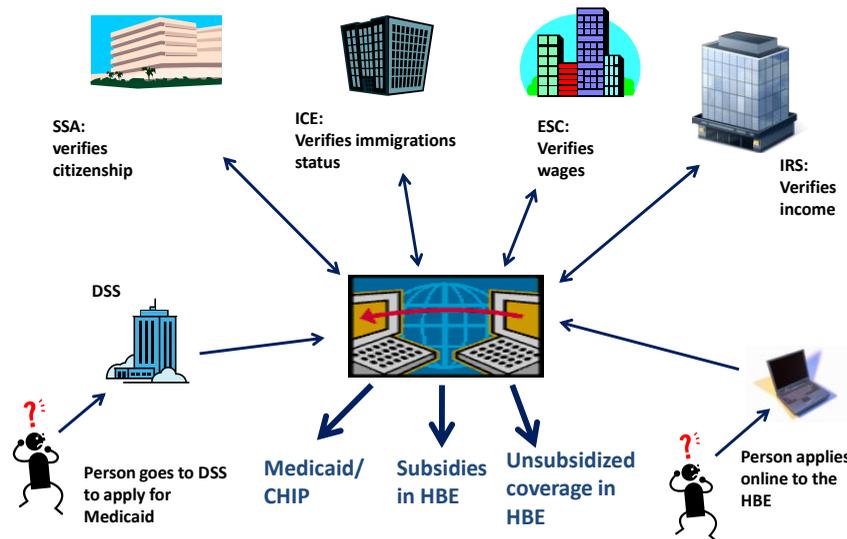
Based on North Carolina Division of Medical Assistance’s projections of the number of people who may gain Medicaid coverage and the costs to the state, and the REMI analysis of jobs created, increase in the state’s gross domestic product, and new tax revenues generated as a result of the expansion, the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

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

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

Prior to the passage of the ACA, the North Carolina Department of Health and Human Services (NCDHHS) was in the process of simplifying the Medicaid application and recertification process and streamlining eligibility requirements across all of NCDHHS’s means-tested programs including, but not limited to, the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Temporary Assistance for Needy Families (TANF), and child care subsidies. In addition, NCDHHS was already creating a new electronic eligibility and enrollment system to replace its existing, antiquated system. This new eligibility and enrollment system, NC FAST (North Carolina Families Accessing Services through Technology), will capture and share information across all NCDHHS programs. Because of the new ACA requirements, the timeline for implementing the new Medicaid electronic enrollment system will be expedited so that it will be operational by the fall of 2013.²³ NC FAST will also serve as the eligibility and enrollment engine for Medicaid and NC Health Choice and will coordinate with the Exchange for people who are applying for subsidies through the Exchange. The electronic eligibility and enrollment system must be operational by October 2013, as the Secretary has established an open enrollment period for Medicaid and the Exchange beginning October 1, 2013 and running through March 31, 2014.²⁴

Figure 3.1
Medicaid and Health Benefit Exchange Application and Enrollment System



The federal government issued notices of proposed rulemaking on August 17, 2011 which provided more detail for how the new eligibility and enrollment process will work across the different insurance affordability programs. The final Medicaid eligibility regulations were published on March 23, 2012,²⁵ and the final Exchange eligibility regulations were published on March 27, 2012.²⁶ These regulations are all interconnected, as under the ACA eligibility and enrollment for all the insurance affordability programs need to be coordinated. As family incomes fluctuate, families are likely to move between Medicaid and the Exchange. A study showed that 50% of individuals with incomes below 200% FPL who did not have employer-sponsored insurance would have experienced a change in income necessitating a movement between Medicaid and the Exchange within one year.²⁷ Twenty-four percent would have experienced at least two eligibility changes within a year, and 39% would have experienced at least two changes within two years. Thus, there is a critical need to ensure that eligibility and enrollment is streamlined and coordinated between the different insurance affordability programs.

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

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

- *Determining eligibility for pregnant women.* The ACA gives states the option of continuing to cover pregnant women with incomes up to 185% FPL (existing income eligibility rules) or reducing the income eligibility limits to 138% FPL in 2014. Similarly, the ACA gives states the option of counting the unborn child(ren) as part of the eligibility unit. Thus, a pregnant woman carrying one child would be considered two people for the purpose of determining Medicaid eligibility. Counting the unborn child(ren) in the family unit helps more pregnant women qualify for Medicaid coverage. The workgroup recommended that the state maintain its existing coverage and continue to count the unborn child(ren) in the eligibility unit. North Carolina is trying to reduce infant mortality through the CCNC pregnancy home care management initiative. Through quality initiatives and other program components, the pregnancy managed care initiative should improve birth outcomes and reduce costs associated with poor birth outcomes. The fact that Medicaid covers 72,000 births a year means this initiative can have a profound influence on overall birth outcomes through improving the care that pregnant women receive. North Carolina can positively impact birth outcomes by maintaining existing eligibility coverage.
- *Verification requirements.* In order to determine eligibility for Medicaid, most individuals will only need to demonstrate proof of citizenship or lawful permanent residence, residency, household size, and income.²⁹ The state will obtain most of the verification from secondary data sources (i.e., through administrative data matches with the Social Security Administration, Department of Homeland Security, Internal Revenue Service, or state Employment Security Commission). In addition, applicants will be allowed to provide some information directly. For example, states must allow women to verbally attest to pregnancy status and families to attest to household composition without further written documentation (self-attestation). In addition, applicants must be given the opportunity to review and verify the information provided through the administrative data matches. The agency must use information from the applicant and the administrative data sources unless the two sources of information are not “reasonably compatible.” Reasonably compatible is defined in federal regulations as information that does not vary in a way that is meaningful for eligibility.³⁰ Verification would not be considered reasonably compatible if the data from one source made the person eligible for coverage, but the data from another source did not. For example, if a person loses his or her job, the wage information that the state receives from an administrative data source may not comport with the individual’s attestation about current earnings. In those instances, the state must seek additional information to resolve the discrepancy. This new verification process applies both to the new eligibles and the existing eligibility programs.

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

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

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

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

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

Based on this information, the NCIOM recommends:

RECOMMENDATION 3.2: SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES

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

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

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

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

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

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

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

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

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

Therefore, the NCIOM recommends:

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

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

- iv. Create a unified toll free telephone hotline that is widely advertised to provide information about the new insurance options.**
- b) DMA, DOI, and the Exchange should seek federal, state, and/or private foundation funds to pay for media coverage to educate the public about the new insurance options.**

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

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

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

Therefore, the NCIOM recommends:

RECOMMENDATION 3.4: RETRAIN DEPARTMENT OF SOCIAL SERVICES ELIGIBILITY WORKERS

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

COVERED SERVICES

The ACA mandates that states provide Medicaid coverage for tobacco cessation services for pregnant women (effective October 1, 2010),⁴¹ services provided by free-standing birth centers (effective immediately),⁴² and concurrent coverage for hospice care for children receiving treatment for their illness (effective immediately).⁴³ North Carolina was already in compliance with the tobacco cessation and birth center provisions prior to the passage of the ACA. However, the state did not initially offer concurrent coverage of hospice services for children. However, DMA made a policy change to provide concurrent coverage of hospice services for children effective June 1, 2011.⁴⁴

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

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

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

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

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

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

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

- Balancing Initiative Program.*^{50,51} The goal of the Balancing the Initiative Program is to encourage states to spend at least 50 percent of their long term services and support (LTSS) funds on home and community-based services (HCBS). Under the Balancing Initiative Program, states that spend less than 50 percent of their LTSS on HCBS programs are eligible for an enhanced FMAP on *all* HCBS program spending (including waivers, mandatory home health benefit, optional personal care services, and personal assistance services) in order to reach at least 50% spending by October 1, 2015.⁵² States that choose this option must make the following changes to their long-term services and supports (LTSS) programs to enhance access to HCBS: establish a single point of entry system for all consumers to access LTSS; provide case management services where need is not assessed by the provider or by those financially responsible for the person in receiving LTSS care; and implement a standardized assessment tool for the purpose of eligibility determinations. In addition, states may not restrict eligibility for LTSS more than was in effect as of December 31, 2010. FMAP funds must be used to create new HCBS or expand existing HCBS. North Carolina would be eligible for a 2 percentage point increase in its FMAP through September 30, 2015 based on its current level of spending on HCBS. However, because North Carolina restricted access to personal care services (in response to legislative action and CMS requirements for comparability of service availability across settings of care), North Carolina is not currently eligible for the Balancing Initiative Program.
- Money Follows the Person (MFP).* MFP is a federal and state demonstration project that began before the ACA. It was designed to assist eligible Medicaid recipients to transition out of qualified institutional facilities and into their homes and communities with appropriate supports. MFP also has the long-range objective of expanding the use of HCBS and identifying policy barriers that impact the provision of HCBS. As a result of the ACA, the federal MFP project was extended through 2020, with the final federal funding allocation to be administered in CY 2016. North Carolina has elected to continue its MFP project.

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

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

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

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

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

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

Some of the suggestions included:

- Expanding respite and adult day care services for the frail elderly or others with disabilities currently cared for at home. This expansion could increase the amount of time a person is cared for by family rather than seeking more costly residential services.
- Targeting new HCBS to older adults or people with disabilities who have been identified through the Adult Protective Services system (either as abused or neglected, or at risk of abuse and neglect). This targeting may help reduce state and county expenditures in providing services needed to protect these vulnerable adults from abuse, neglect, or exploitation.

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

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

Thus, the NCIOM recommends:

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

- a) The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the amount of new federal funding it would receive through the enhanced FMAP rate versus the costs of expanding Medicaid through the Community First Choice option.**
 - i. DMA should explore options to use existing state dollars to leverage federal Medicaid dollars.**
 - ii. DMA should give priority in new HCBS to respite and adult day care services for the frail elderly or people with disabilities services to help them remain at home. DMA should also give priority to older adults or people with disabilities who have been identified as at-risk through the Adult Protective Services system.**
- b) DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.**

REFERENCES AND NOTES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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- 23 North Carolina will need to be able to integrate Medicaid and CHIP eligibility with the web portal offered through the Exchange. NCDHHS already has a multi-year project to simplify and automate the eligibility verification and application processes of 13 income-related programs (NC FAST). When implemented, NC FAST should not only lead to improved customer and beneficiary service, but also to improved efficiencies. To comply with ACA's timeline of 2014 interoperable eligibility programs for public and private health coverage, NCDHHS has had to revamp its NC FAST timeline and scheduled implementation for the Medicaid eligibility module. Some of the costs of planning such changes are being recognized in the Exchange Planning Grant awarded through NCDOL. In addition, the federal portion of the development and ongoing operational cost of this Medicaid/CHIP component of NC FAST will rise from 50% to 90%.
- 24 United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475. 45 CFR §§155.410.
- 25 Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217.
- 26 United States Department of Health and Human Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(59):18310-18475.
- 27 Sommers BD, Rosenbaum S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Aff.* 2011;30(2):228-236.
- 28 Department of the Treasury. Internal Revenue Service. Health Insurance Premium Tax Credit. Notice of proposed rulemaking and notice of public hearing. *Fed Register* 76(159):50931-50949.
- 29 If an individual is not eligible for Medicaid under the new coverage groups (e.g., 138% FPL), then the person can apply for Medicaid under another category. In those instances, the individual may have to demonstrate proof of other eligibility requirements, such as disability status, resources, or outstanding medical bills.
- 30 Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217 42 CFR § 435.952(c).
- 31 Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR § 435.403.
- 32 The United States Supreme Court held, in *Shapiro v. Thompson*, 394 US 618 (1969), that a durational residency requirement which denied welfare benefits to low-income people unless they resided in the state for at least one year was unconstitutional. The court held that such residency requirements denied individuals' equal protection of the law, and violated their right of interstate travel.
- 33 Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR §435.603(h)(3).
- 34 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2201, amending § 1943(b)(1)(F) of Title XIX of the Social Security Act, 42 USC 1397aa et seq.
- 35 Department of Health and Human Services. Centers for Medicare & Medicaid Services. Final Rule, Interim Final Rule. *Fed Regist.* 77(57):17144-17217. 42 CFR § 435.908.
- 36 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(i).
- 37 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2202(a), amending Sec. 1902(a)(47) of the Social Security Act, 42 USC 1396a(a)(47).
- 38 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2001(a)(4)(B) amending Section 1920 of the Social Security Act, 42 USC 1396r-1(e).
- 39 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2202.
- 40 There are currently DSS workers in 99 of the county DSS offices who are certified as Senior Health Insurance Information Program (SHIIP) counselors. These counselors receive training and certification through the North Carolina Department of Insurance (See Chapter 2 [Health Benefits Exchange Chapter] for more information about the SHIIP program).
- 41 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4107.
- 42 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2301.
- 43 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2302, amending Sec. 340B of the Public Health Service Act, 42 USC 256b.
- 44 Larson, T. Chief Clinical Operations Officer, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication. January 10, 2011.
- 45 Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2303.

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- ⁴⁶ Patient Protection and Affordable Care Act, Pub L No. 111-148, §2703, as enacting § 1945 of Title XIX of the Social Security Act, 42 USC 1396a et. seq.
- ⁴⁷ DMA currently operates three HCBS waiver programs: CAP-DA (Community Alternatives Program for Disabled Adults), CAP-MR/DD (Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities), and CAP-C (Community Alternatives Program for Children with complex medical needs).
- ⁴⁸ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 2401, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, 1205.
- ⁴⁹ The Federal Medical Assistance Percentage, or FMAP, is the percentage of the Medicaid costs that are paid by the federal government for allowable health care services and supplies. In FFY 2013, the underlying North Carolina FMAP rate was 65.51%. Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2012 through September 30, 2013. *Fed Regist.* 2011;76(230):74061-74063.
- ⁵⁰ Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10202.
- ⁵¹ United States Government Accountability Office (GAO). Report to Congressional Requesters. Medicaid: States’ Plans to Pursue New and Revised Options for Home- Community-Based Services. <http://gao.gov/assets/600/591560.pdf>. Published 2012. Accessed January 2, 2013.
- ⁵² Kaiser Family Foundation. Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law. <http://www.kff.org/healthreform/upload/8079.pdf>. Published 2010. Accessed January 2, 2013.
- ⁵³ National Institute of Mental Health. United States Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health; 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>. Published 1999. Accessed September 22, 2010.
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