

North Carolina Institute of Medicine
2020 Update on Implementation of Recommendations from the
2013 Report on the Impact of the Patient Protection and Affordable Care Act

Introduction

In March 2010, Congress passed the Patient Protection and Affordable Care Act, referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our health care system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rising health care costs. The ACA included provisions that allowed for the expansion of coverage to the uninsured, focused on prevention to improve population health, and placed an emphasis on increased quality measurement and reporting. The ACA also included provisions aimed at increasing the supply of health professionals, strengthening the health care safety net, and reducing health care expenditures.

In 2010, in order to implement the new law, the North Carolina Department of Health and Human Services (NC DHHS) and North Carolina Department of Insurance (NC DOI) asked the North Carolina Institute of Medicine (NCIOM) to convene stakeholders and other interested people to examine the new law to ensure that the decisions the state made in its implementation of the ACA served the best interest of the state as a whole. The effort was led by an Overall Advisory Group, which was chaired by Lanier M. Cansler, CPA, Former Secretary, NC DHHS; Albert Delia, Former Secretary, NC DHHS; and G. Wayne Goodwin, JD, Commissioner, NC DOI. The Overall Advisory Group included an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, and representatives of health care professional organizations, insurers, businesses, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the ACA: Health Benefits Exchange; Medicaid; Safety Net; Health Professional Workforce; Prevention; Quality; New Models of Care; and Fraud, Abuse, and Overutilization.

Each workgroup was tasked with providing advice to the state about the best way to implement ACA provisions as well as examining federal funding opportunities in that topic area. The workgroups were guided by their co-chairs and the steering committee. The workgroups began meeting in August 2010 and met for 12-18 months. Altogether, 260 people from across the state were members or steering committee members of one or more of the groups. In addition, the meetings were open to the public so that many others participated in the meetings either in person or online.

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This document details the progress, or lack thereof, North Carolina has made regarding the recommendations made by the ACA workgroups and Overall Advisory Group. The full 2013 report can be found at https://nciom.org/wp-content/uploads/2020/10/ACA-update_final_10.30.20.pdf.

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Total Recommendations: 44

Fully Implemented: 10

Partially Implemented: 25

Not Implemented: 9

Recommendation 2.1

Not Implemented

State and Federal Exchange Operational Responsibilities

- a) **The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the Exchange Board is created, the Board should consider whether the state, or the federal government, is in the best position to:**
 - i. **Determine eligibility for advance payment of the premium tax credit and cost-sharing subsidies**
 - ii. **Determine whether individuals are exempt from the coverage mandate**
 - iii. **Determine whether employers are offering coverage that meets minimum essential coverage.**
- b) **In making this determination, the Exchange Board should consider the costs of providing these functions through a state-based versus federally facilitated Exchange, which entity would be able to most effectively provide these services, and the impact of the decision on consumer access, consumer protections, and the rest of the North Carolina insurance marketplace.**

The Patient Protection and Affordable Care Act (ACA) gave states the option of creating their own state-run Health Benefits Exchange or allowing the federal government to create one to offer health coverage to individuals in the state. North Carolina's response to this option began with an expressed intention to develop a state-run exchange during the administration of Governor Bev Purdue. However, when Governor Pat McCrory took office in 2013, he announced that the state would instead opt for the federally run Exchange. This choice was codified by Session Law 2013-5, Senate Bill 4^a (referred to as SB4 in this report), which specified the intention to have the federal government operate the Exchange and barred state partnership in the development of the Exchange, and also stated that Medicaid eligibility would not be expanded and could only be achieved through legislation by the North Carolina General Assembly. Because of this, a Health Benefits Exchange Board was never created and the considerations in Recommendation 2.1 were not evaluated by such an entity.

Recommendation 2.2

Not Implemented

Health Benefits Exchange Board Authority for Exchange Certification

- a) **The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority to:**
 - i. **Require insurers offering qualified health plans in the Exchange to standardize terminology, definitions, benefit design or array, or limit the number of plan offerings or types of plan designs if needed to facilitate health**

^a <https://ncleg.net/Sessions/2013/Bills/Senate/PDF/S4v5.pdf>

plan selection or promote meaningful competition among insurers, but only after the Exchange determines that there is a reasonable level of choice in the Exchange market. Any restrictions in benefit design should not limit simple differences in co-pays or limit the use of products that use more cost-effective or high-performing provider networks.

- ii. Require that the insurers offer the bronze and/or the platinum level plan, in addition to the silver and gold level plans, if needed to reduce risk segmentation across insurers, and/or to give consumers and employers greater choice.**
 - iii. Incentivize insurers to meet state set quality standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services (USDHHS).**
 - iv. Incentivize insurers to meet other state standards, such as customer service, participation in health information technology, improved health outcomes, or reduced costs in addition to those required by the ACA or Secretary of the USDHHS.**
- b) The Exchange Board should not have the authority to exclude insurers from participating in the Exchange if they otherwise meet the certification and other ACA requirements.**
 - c) Aside from allowing the Exchange Board to standardize terminology, plan design, or limit the number of different plan designs per level (Sec. a.i. above), the Exchange Board should not impose any other new requirements earlier than 2016. Thereafter, before imposing new requirements on health plans, the Exchange Board should consider the likely impact of those requirements on the overall functioning of the Exchange, the needs of consumers and/or employers purchasing in the Exchange, administrative costs and premiums, consumer choice (including the ability of consumers to compare different health plans), consumer protections, access to essential community providers, quality, coverage of the uninsured and enrollment into the Exchange, participation of health plans in the Exchange, adverse selection into the Exchange and/or among participating plans in the Exchange, and, in consultation with the North Carolina Department of Insurance, the impact of any changes on the health insurance market operating outside the Exchange.**
 - d) The Exchange Board should give insurers applying to become qualified health plans that are not already accredited two years to meet the accreditation standards assuming that the insurer can show that it is making reasonable progress in obtaining accreditation. The Exchange Board can choose to extend this time for extenuating circumstances, for example, if the accreditation agencies are unable to make timely accreditation decisions.**

A Health Benefits Exchange Board was never created due to the General Assembly passage of SB4, and these considerations were not evaluated by such an entity.

Recommendation 2.3

Partially Implemented

Develop Objective Network Adequacy Standards

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

Under the leadership of Commissioner Wayne Goodwin, the North Carolina Department of Insurance (NC DOI) formed a Network Adequacy Working Group in the spring of 2016 to provide advice on adopting the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model. The working group had subgroups with consumer advocates, providers, and health insurers and NC DOI sought public input on their recommendations.^b Commissioner Goodwin was replaced by Commissioner Mike Causey after the 2016 elections and the recommendations of the working group were not implemented.

Recommendation 2.4

Partially Implemented

Monitor Essential Community Provider Provisions

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

The ACA defines essential community providers (ECPs) as those who serve predominantly low-income, medically underserved individuals and requires that qualified health plans offered on the ACA Exchange have sufficient numbers and geographic distribution of these providers.^{c,1} A North Carolina Health Benefits Exchange Board was never created due to the General Assembly passage of SB4, however the NC DOI convened an ECP Workgroup as a subgroup of its

^b The final recommendations of the working group can be found in an online report at <https://ncdoi.com/lh/Documents/NAWG/2016%2012%2022%20Network%20Adequacy%20Recommendations%20from%20Staff%20with%20crosswalk%20and%20introduction%20FINAL.pdf>.

^c CMS identifies six ECP categories: (1) Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" clinics; (2) Ryan White HIV/AIDS Program Providers; (3) Family Planning Providers; (4) Indian Health Providers; (5) Hospitals; and (6) Other ECP Providers including STD clinics, TB clinics, Hemophilia treatment centers, Black Lung clinics and other entities that serve predominately low-income, medically underserved individuals. <https://www.kff.org/other/state-indicator/contract-offering-and-signing-standards-for-essential-community-providers-ecps-in-marketplaces/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Technical Advisory Group (TAG). The goal of the workgroup was to “develop policy options and approaches to meeting ECP requirements for broader TAG consideration. The TAG, in turn, [would] recommend preferred options to the NC DOI, who [would] develop recommendations as applicable to the North Carolina General Assembly.”²

North Carolina now uses the Centers for Medicare & Medicaid Services (CMS) ECP categories and CMS ECP contract signing standards and relies on the CMS Center for Consumer Information and Insurance Oversight for certifying qualified health plan (QHP) compliance with ECP standards. CMS requirements for QHPs include:

- 1) Offering “contracts in good faith,” defined as those that have “terms that a willing, similarly-situated, non-ECP provider would accept or has accepted, to all Indian health providers and at least one ECP in each federally or state-defined ECP category in each county in the service area, where an ECP is available;”¹ and
- 2) Signing “contracts with at least 30% of available ECPs in each plan's service area or if a QHP fails to achieve the 30% standard, provide narrative justification explaining the plan’s efforts to meet the standard, how the plan will provide adequate care to enrollees who might otherwise seek care by ECPs not included in the network, and how the plan will meet the ECP standard in the following year.”¹

Recommendation 2.5

Not Implemented

Ensure Health Benefits Exchange Financial Sustainability

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

iii. Advertising revenues.

iv. Grants from foundations or other philanthropic sources.

A state-based Health Benefits Exchange was never created due to the General Assembly passage of SB4, therefore an Exchange Trust Fund was not created.

Recommendation 2.6

Implemented

Health Benefits Exchange Outreach and Education

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

The work outlined in this recommendation was taken on by the NC Navigators Consortium and Enroll America, along with outreach through the insurers themselves. The NC Navigators Consortium evolved from an initial group of 40 organizations that the NCIOM, NC DOI, and CareShare Health Alliance convened to discuss what would have been the Federal Health Insurance Marketplace in the state.³ This group grew to almost 100 organizations and became known as the “Big Tent.”³ Some members of the Big Tent united to form the North Carolina Navigator Consortium, led by NC Legal Aid.³ The Consortium received a \$1.9 million federal grant for navigation services, the fourth-largest grant in the country. In 2014, the group developed a formal infrastructure called NC Get Covered.³ The Navigator Consortium works to coordinate outreach and enrollment assistance through “free, in-person help to North Carolina consumers seeking to enroll in affordable health insurance plans on HealthCare.gov.”⁴ Along with NC Legal Aid, current members of the Consortium are:⁴

- Access East,
- Capital Care Collaborative,
- Care Ring,
- Council on Aging of Buncombe County,
- Charlotte Center for Legal Advocacy,
- Cumberland HealthNet,
- HealthCare Access,
- HealthNet Gaston,
- MDC,
- Partnership for Community Care, and
- Pisgah Legal Services.

Legal Aid of North Carolina developed a centralized assister scheduling system and a statewide hotline that helped to link people to local navigators.⁵

Simultaneously, Enroll America^d had a field outreach campaign in North Carolina that served an important role in identifying individuals who were uninsured, raising awareness, and providing messaging about enrollment in the Exchange.⁶ Enroll America staff were able to use the online scheduling system developed by Legal Aid to arrange navigator appointments and remind individuals what documents to bring. Enroll America worked in the state until the program ended in 2017.^{5,7}

The combined efforts of these organizations resulted in North Carolina consistently having one of the highest Exchange enrollments in the country. The first year of enrollment, North Carolina was second only to Florida in surpassing enrollment goals set by CMS.⁵ Along the way, other Big Tent organizations have also coordinated education, outreach, and enrollment activities and CMS has produced many outreach and educational materials that are available online at <https://marketplace.cms.gov/outreach-and-education>.³

Recommendation 2.7 Partially Implemented
**Role, Training, Certification, Oversight, and Compensation of Navigators/In-person
 assisters**

- a) **The Health Benefits Exchange (Exchange) should contract with the North Carolina Department of Insurance (NC DOI) to develop and oversee the navigator/in-person assister program. In the absence of a state-based Exchange, NC DOI should develop and oversee an in-person assister program that meets the same functions.**
 - i. **The NC DOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators or in-person assisters.**
 - ii. **Individual navigators/in-person assisters should be recertified annually. To be recertified, the navigator/in-person assister should be required to:**

^d Enroll America was a national effort that Families USA formed to maximize enrollment in health insurance marketplaces.

- A. Complete continuing education requirements and meet minimum activity thresholds, as specified by the NC DOI, in conjunction with the Exchange.**
 - B. Provide data to the state to ensure the overall functioning of the navigator/in-person assister system. Such data may include, but not be limited to, information on the number of people served and types of services provided.**
 - C. Be connected to a specific navigator/in-person assister administrative entity.**
 - iii. Individual navigators/in-person assisters can be terminated for cause.**
 - iv. Navigator or in-person assister administrative entities should have a designated person who serves as the navigator/in-person assister coordinator. These coordinators must also be certified as navigators/in-person assisters, but will have additional responsibilities and training to serve as coordinator and oversee the work of individual navigators/in-person assisters in their community.**
- b) The Exchange Board (or NC DOI under a partnership model) shall create strong conflict of interest rules for individual navigators/in-person assisters and navigator/in-person assister administrative entities. The conflict of interest rules should:**
 - i. Preclude navigator/in-person assister administrative entities from serving as a coordinating entity if they would derive financial benefit from steering an individual to a particular health plan or health insurer.**
 - ii. Allow employees of primary care safety net organizations (e.g., FQHCs, free clinics, rural health clinics, or health departments) or other individuals to serve as individual navigators/in-person assisters as long as the individuals, and their immediate families, do not receive compensation directly or indirectly from an insurer, and as long as their wages, salary, or job performance is not directly or indirectly based on the health plans which the individual selects. The Exchange Board can allow employees of hospitals or other health care organizations to serve as navigators/in-person assisters in rural or other underserved communities, but only if the Exchange Board certifies that there is insufficient navigator/in-person assister capacity in those communities to meet the needs of individuals seeking navigator/in-person assister assistance. The Exchange should adopt rules, guidance, education, and conflict of interest disclosure requirements, as well as reporting requirements, and should specifically monitor these provider-linked navigators/in-person assisters to ensure that they comply with the ACA’s prohibitions against steering patients to particular plans.**

- c) **If allowed by the federal government, the Exchange Board/NC DOI should use federal funds to help pay for training, continuing education, and certification of individual navigator/in-person assister and navigator/in-person assister administrative entities. In addition, the Exchange should provide small grants to community-based organizations, social services agencies, professional associations, navigator/in-person assister administrative entities, and other appropriate organizations to provide education and outreach about new insurance options to targeted individuals and small employers.**
- d) **The Exchange Board/NC DOI should seek funding from state philanthropic organizations or other sources to help pay small grants to navigator/in-person assister administrative entities to help offset the administrative costs to coordinate and oversee the work of local navigators/in-person assisters.**
 - i. **In 2013, the Exchange/NC DOI should pay each navigator/in-person assister administrative entity a flat rate based on size of the targeted population.**
 - ii. **Thereafter, the navigator/in-person assister grants should be based, in part, on outcomes so that navigator/in-person assister administrative entities are rewarded for doing a good job with education, outreach, and enrollment facilitation.**
 - iii. **The Exchange Board/NCDOI may explore the option of compensating individual navigators/in-person assisters for their services.**

After the passage of SB4 and the state’s move to a federally facilitated Exchange, NC DOI was not involved in developing or directing trainings. The NC Navigator Consortium put together its own training for navigators and assisters in addition to the hours of online training required by CMS. Federal law requires that navigators working in states that are using a federally facilitated Exchange meet several certification and training standards:

- “Obtain certification by the Exchange prior to carrying out any consumer assistance functions or outreach and education activities under § 155.205(d) and (e) or § 155.210;
- Register for and complete a Health and Human Services (HHS)-approved training;
- Following completion of the HHS-approved training described in paragraph (b)(1)(ii) of this section, complete and achieve a passing score on all approved certification examinations prior to carrying out any consumer assistance functions under § 155.205(d) and (e) or § 155.210;
- Obtain continuing education and be certified and/or recertified on at least an annual basis; and
- Be prepared to serve both the individual Exchange and SHOP.”⁸

Navigators in North Carolina operate in accordance with how federally certified navigators in federally facilitated marketplaces operate across the country. Funding for Navigator services

comes from both state and federal sources, as well as philanthropic organizations in North Carolina.

Certified application counselors (CACs), who also help individuals understand their insurance options and typically work for health centers, health care providers, or social service agencies, receive no government funding. The primary differences between CACs and Navigators are that CACs are not required to conduct outreach to consumers and potential conflicts of interest must be disclosed, but do not necessarily bar them from providing services.⁹

Recommendation 2.8 **Partially Implemented**

Requirements for Agents and Brokers Selling Coverage in the Exchange:

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

- iii. **Pay agents and brokers a standard commission for each individual whether enrolling in a nongroup plan or group plan.**
 - iv. **Require insurers to appoint all licensed agents and brokers in good standing who have been certified to offer insurance inside the Exchange as part of the insurers' panel.**
 - v. **Pay agents and brokers a higher per person commission or other compensation to encourage agents and brokers to enroll very small groups (e.g., groups of under 10 employees).**
 - vi. **Pay higher commissions or other compensation to encourage agents and brokers to enroll small businesses that had not offered health insurance in the last six months.**
- c) **If the NC DOI, in conjunction with the Exchange, does not change agent and navigator compensation structure to prevent conflicts of interest or reduce the incentive to steer individuals or businesses to different insurers or plans inside or outside the Exchange, then agents or brokers who place business in the Exchange must disclose to their individual and small business clients if they receive differential commissions from different insurers.**

After SB4 was passed, all work toward a state-based exchange was stopped. However, NC DOI still licenses and regulates producers and can take disciplinary action against insurance companies and agents for violations of North Carolina laws that may occur while selling individual or small-group coverage on or off the federal exchange.

Recommendation 2.9

Not Implemented

“No Wrong Door” Eligibility and Enrollment

- a) **Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice (CHIP) eligibility workers are cross-trained and certified as navigators/in-person assister so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the Health Benefits Exchange (Exchange).**
 - i. **North Carolina Families Accessing Services through Technology (NCFAST) (should design the eligibility and enrollment system to electronically capture data needed for oversight of navigators.**
- b) **If allowed under federal law, the Exchange Board, working with the North Carolina Division of Social Services, North Carolina Division of Medical Assistance, and Social Services Directors Association should create other mechanisms to ensure that people who seek in-person services from local DSS, who are determined to be ineligible for Medicaid or CHIP, can receive immediate assistance from trained navigators/in-person assisters or other trained staff outside of the local DSS offices.**

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

The capacity of local departments of social services (DSS) has not been expanded to assist with the navigation of eligibility for the health insurance Exchange. When the ACA open enrollment period begins, counties receive a large number of applications for individuals that are not eligible for ACA premium subsidies but may be eligible for Medicaid. These applications must be handled within federal processing timelines. This, along with recertifications under Medicaid both at the federal and state levels, contributes to a large volume of work for local DSS offices, whose staff are not cross-trained as Navigators.

Recommendation 3.1

Not Implemented

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.

North Carolina has not expanded Medicaid eligibility in accordance with this recommendation, however, there have been a few attempts to do so. Most recently, the Health Care for Working Families Act (H.B. 655),¹⁰ proposed in the General Assembly in 2019, would have expanded Medicaid eligibility up to 133% of the federal poverty level (FPL) and would have allowed new enrollees to pay a modest premium to receive health coverage through the Medicaid system.¹¹ If passed into law, the bill also would have created work requirements for the newly eligible expansion population.¹¹

Recommendation 3.2

Partially Implemented

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.**

Some progress has been made on revising Medicaid eligibility. Eligibility for Medicaid for Pregnant Women has been expanded to 196%^e of FPL, and includes the unborn child in the family size determination.¹² Regarding the use of self-attestation, the state of North Carolina does not require documentation of date of birth and uses the date entered on application paperwork unless there is a discrepancy between the age entered and other documentation. If such a discrepancy exists, additional verification will be required. To determine income eligibility for ongoing eligibility determinations,¹⁴ NC Medicaid continues to use point in time verification of income but does allow annualized ongoing eligibility for certain applicants. Income for Medicaid eligibility is verified with the North Carolina Department of Revenue, and birth and death data are verified with the State Center for Health Statistics. (Recommendation 3.2(c))

Definitions of allowable “reasonably anticipated changes” have not been included in the eligibility determination process due to statutory limitations on modifications to eligibility criteria. (Recommendation 3.2(a))

^e It is of note that 196% is the MAGI equivalent conversion of the recommended 185% of the federal poverty limit that was in effect prior to the passage of the Affordable Care Act.

Regarding changes to the law, the North Carolina General Assembly continues to prevent the Division of Health Benefits (DHB) (formerly the Division of Medical Assistance) from making changes to eligibility levels and determinations. (Recommendation 3.2(b))

In anticipation of the establishment of the health insurance marketplace, the NC DOI developed a coordination plan to reduce gaps in coverage between the Exchange and Medicaid. When the General Assembly prohibited the creation of a state Health Benefits Exchange through SB4 (see update on Recommendation 2.1), the coordination work ended.¹⁵ Since the state has not yet expanded Medicaid, the Division of Health Benefits (DHB) (formerly the Division of Medical Assistance) has limited ability to facilitate transitions between Medicaid and the federal Marketplace. To develop the necessary flexibilities to identify alternative coverage options or develop alternative eligibility for those with fluctuating income (including those doing seasonal work), NC DOI would need authority to pursue changes and the state would need to move to a state-based exchange—both of which would require legislative intervention. (Recommendation 3.2(d))

Recommendation 3.3 **Partially Implemented**

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 (NC DOI), and North Carolina Health Benefits 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, NC 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, NC 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.**

Anticipating the development of the state Health Benefits Exchange, the NC DOI developed outreach and education plans to educate the public using funding from Exchange grants. That work concluded when the General Assembly prohibited the development of the state exchange and directed the NC DOI to return the grant money. Education and outreach efforts were then picked up by the North Carolina Navigator Consortium with advice and input from the NC DOI. Additional outreach work has been undertaken by NC Medicaid, which has expanded beneficiary resources¹⁶ on its website and recently has included information specifically tailored to the COVID-19 pandemic.¹⁷ Improvements have also been made to the ePASS system to streamline the online application process. Finally, in 2019, Advance Community Health was awarded a Connecting Kids to Coverage Grant to develop programs to increase CHIP enrollment.¹⁸

Recommendation 3.4

Partially Implemented

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.**

Before ACA changes began going into effect in fall of 2013, extensive training programs were conducted with county DSS workers. Since that time, training has continued through a collaborative effort between DHB (formerly the Division of Medical Assistance) and county DSS offices to respond to changes to the Medicaid eligibility processes (See Recommendation 3.4(a)). Initial outreach and education efforts by NC DOI were shuttered when the General Assembly prohibited the development of a state Health Benefits Exchange and effectively shut off education funding from federal Exchange grant sources. These efforts were then picked up by

the North Carolina Navigator Consortium and its partners, and counties that have provided space for navigator work in collaboration with local DSS workers. (Recommendation 3.4(b))

Recommendation 3.5 **Partially Implemented**

Explore the Home and Community-Based Services (HCBS) 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 (Federal Medical Assistance Percentage) 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.**

North Carolina has not yet expanded Medicaid and has not been able to make much progress on this recommendation. Specifically, limitations that the General Assembly has placed on Medicaid eligibility amendments have prevented DHB (formerly the Division of Medical Assistance) from developing new systems that use state money to leverage federal Medicaid funding. Regarding home and community-based services for populations made vulnerable by disability or advanced age, the NC Medicaid Community Alternatives Program for Disabled Adults works in the state to help persons with disabilities remain in their homes and prioritizes services for those receiving respite and adult day care services. (See Recommendation 3.5(a))

According to State Rule: Subchapter 05G .0302, priority for services provided under the Home and Community Care Block Grant for Older Adults will be given to “older adults for whom the need for Adult Protective Services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan.” Prioritized services are adult day care, adult day health care, group respite, home-delivered meals, in-home aide, and/or institutional respite.¹⁹ (Recommendation 3.5(a))

North Carolina is in the process of putting an electronic visit verification system into place to validate assessments for individuals with home and community-based service needs. In October 2018, North Carolina received approval for a § 1115 waiver to develop the Healthy Opportunities Pilot Program. These pilots will deliver social services to Medicaid enrollees after

they have been administered a screening assessment to determine their needs and services and connect those individuals to services through the statewide social services resource platform, NCCARE360. On November 15, 2019, NC DHHS released an RFP for Lead Pilot Entities. In May 2020, after receipt of proposals from potential Lead Pilot Entities across the state, NC DHHS temporarily postponed granting the awards in response to the ongoing COVID-19 public health emergency.²⁰ As of October 2020, no award date has yet been announced.^f (Recommendation 3.5(b))

Recommendation 4.1

Not Implemented

Develop an Emergency Transition of Care Pilot Project

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

No specific emergency transition of care pilot project was ever developed. Work in this area has continued to largely be handled by individual hospitals and the safety-net providers in their communities. Outside of hospitals, free clinics have undertaken efforts to develop contractual agreements with other providers to establish referral pathways to connect uninsured persons who

^f The COVID-19 public health emergency has created new and unprecedented challenges for North Carolinians. In response, NC DHHS has deployed teams of Community Health Workers to underserved communities to ensure that resident needs are identified and social determinants of health-driven supports are provided through the NCCARE360 platform.⁸⁶ This program is anticipated to run through the end of 2020 but may be extended as needed. <https://www.ncdhhs.gov/news/press-releases/ncdhhs-send-community-health-workers-underserved-covid-19-hot-spots> This program builds on other existing community health worker initiatives run by NC DHHS and other stakeholders, which aim to serve as a bridge between medical providers, social service organizations, and individuals with serious illness. This is particularly important in communities that have traditionally been treated unethically or intentionally underserved by the medical community.

present to the ER with safety-net clinics for follow-up care in an effort to establish a medical home.

Although no emergency transition of care pilot project has been developed, regarding dental complaints, specifically, some pilot programs have been developed through the school systems to provide children with routine dental care at school. The North Carolina Healthcare Association (NCHA), through funding provided by the Duke Endowment, provides technical assistance to 18 networks of care that serve uninsured populations in 43 counties to reduce unnecessary visits to the emergency department. These networks of care work to connect low-income, uninsured persons with primary care services to establish a medical home and improve health outcomes.²¹ NCHA has also received funding from NC DHHS to develop the Emergency Department Peer Support Program, a behavioral health pilot program that works to connect patients who present to emergency departments with non-fatal opioid overdoses to ongoing treatment, recovery, and harm reduction services.²²

Recommendation 4.2 **Partially Implemented**
Involve Safety Net Organizations in Community Health Assessments

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

There is still work to be done to better involve safety-net organizations in the assessment of community health needs. Currently, periodic health assessments remain the domain of hospitals and local health departments. However, a few systems have tried to integrate safety-net providers into their assessment procedures. In Eastern North Carolina, the Eastern Health Stewards, a group comprised of providers and community-based organizations, meet regularly to discuss issues such as community health assessments and have streamlined their data collection procedures to become more efficient. The Foundation for Health Leadership & Innovation (FHLI) has also received funding from the Duke Endowment to further align health assessment

procedures and reporting in Eastern North Carolina through the Health ENC program.²³ Additional funding has now been allocated for FHLI to expand its work into the central part of the state. In the Western portions of the state, the Western NC Health Network has also received funding from the Duke Endowment to develop similar processes.²⁴ These initiatives are all founded on the principles of Results Based Accountability™—a data-informed and evidence-based system to plan and evaluate for community interventions.²⁵

Recommendation 4.3 **Partially Implemented**

Expand 340B Discount Drug Program Enrollment among Eligible Organizations

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

The NC DHHS has worked to expand 340B coverage to new populations including incarcerated persons²⁶ and migrant farmworkers.²⁷ Additionally, recent years have seen more Health Centers in North Carolina enrolling in the program and adding pharmacies to their systems. North Carolina Free Clinics are still not eligible to participate in the program. Currently, the program is under review by Congress and the White House, and it is not expected to be expanded. In spite of federal threats, the North Carolina Healthcare Association (NCHA) continues to advocate for the program's continuation and expansion and collaboration with SUNRx, an industry partner with expertise in managing 340B programs designed to expand access to affordable medications, provide financial benefits to hospitals and uninsured patients, and comply with regulations.

Recommendation 4.4 **Partially Implemented**

Allow Safety Net Organizations to Function as Patient Navigators or In-Person Assisters

- a) **The Health Benefits Exchange should train and certify staff at safety net organizations to serve as patient navigators/in-person assisters. In accordance with the ACA, these groups would be required to:**
- i. **Provide public education to raise awareness of qualified health plans (QHPs).**
 - ii. **Distribute fair and impartial information.**
 - iii. **Facilitate enrollment in QHPs.**
 - iv. **Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or other appropriate state agency for an enrollee with a grievance, complaint, or question about their health plan.**

- v. **Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.**
 - vi. **Meet standards to avoid conflict of interest.**
- b) **As staff of safety net organizations, patient navigators/in-person assisters should also educate consumers and patients about appropriate use and location of care.**

When the General Assembly prohibited the development of the North Carolina Health Benefits Exchange (HBE) through SB4 (see update to Recommendation 2.1), much of the public outreach and education work expected from the HBE was shifted to other groups. Since the passage of the ACA, patient navigators and in-person enrollment assisters have largely been trained and deployed by federally funded organizations created for this purpose. In North Carolina, this work has primarily been done by NC Get Covered, although several safety-net organizations across the state were able to get their staff trained to assist. However, in light of recent funding decreases, the NC Navigator Consortium will lead continuing efforts.²⁸ Despite the move to the federal exchange, North Carolina has ranked among the top five states in the country for enrollment performance.²⁹ However, the future of enrollment rates is uncertain due to drastic cuts the Trump Administration has made to funding for navigator services. While safety-net providers do and can continue to provide uninsured patients information about insurance opportunities available to them under the ACA, dedicated navigators are often better-positioned to provide information for patients and consumers.

Recommendation 4.5

Partially Implemented

Reconvene the Safety Net Advisory Council

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

Since the publication of the original ACA Task Force report, some of the work of the Safety Net Advisory Council has continued within the Primary Care Advisory Council (PCAC) facilitated by the Office of Rural Health. The PCAC is currently comprised of representatives from the NC Free and Charitable Clinic Association, the NC Community Health Center Association, the NC School Based Health Alliance, the NC Association of Local Health Directors, the Division of Public Health, and the NC Healthcare Association. The PCAC primarily acts to advise the Office of Rural Health on the administration of Community Health Grants, but also provides more general advice on issues that affect the uninsured provider network such as natural disaster and pandemic funding supports, provider surveys, and telehealth. While the PCAC mission is currently limited to ensuring and supporting primary care services for uninsured persons, collaborative efforts between social and health care providers are developing in anticipation of the state's forthcoming Healthy Opportunities Pilots, which may address many of the components of this recommendation. There is also interest among stakeholders to reconvene the Safety Net Advisory Council as a distinct group from the PCAC to discuss and work toward greater coordination across the health networks in the state. (Recommendation 4.5(a))

The Health Care Help website was never created. (Recommendation 4.5(b))

Recommendation 5.1 **Partially Implemented**

Educate Health Workforce Using New Technologies and Strategies in New Models of Care

a) The North Carolina Community College System (NCCCS), the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties, should:

- i) Create targeted programs and modify admission policies to increase the number of students and residents with expressed interest in primary care, behavioral health, and dentistry, and in serving underserved populations, particularly in rural areas of North Carolina.**
- ii) Incorporate successful new models of interdisciplinary, team-based care into training curricula and ensure that students and residents have the opportunity to practice working together in interdisciplinary teams.**
- iii) Identify new core competencies needed by the health care workforce including patient safety, quality initiatives, cultural competency, health information technology, and others. Develop educational and training curricula to teach these competencies to students and residents.**
- iv) Establish or expand training programs for emerging health workforce roles including community health workers, case managers, client coordinators, patient navigators, and health information technologists.**
- v) Establish or expand training programs in community-based ambulatory patient care centers.**

- b) AHEC should develop learning collaboratives and other strategies to educate the existing workforce on new core competencies needed by the health care workforce including patient safety, quality initiatives, cultural competency, health information technology, and others.**
- c) The North Carolina General Assembly should require AHEC to prepare an annual report that includes information detailing progress that has been made, if any, to achieve the goals identified in Recommendations 5.1a, and 5.1b.**
- d) The North Carolina Employment Security Commission, the Commission on Workforce Development in North Carolina, local workforce development boards, and NCCCS should continue to work together to match laid-off and unemployed workers to new health care job and training opportunities.**

The University of North Carolina (UNC) System, the North Carolina Community College System (NCCCS), private colleges and universities, and Area Health Education Centers (AHEC) have collaborated through Registered Nurse (RN) to Bachelor of Science in Nursing (BSN) initiatives. In 2015, the NCCCS and UNC System collaborated to develop the Uniform Articulation Agreement between the UNC RN to BSN Programs and the NCCCS Associate Degree Nursing Programs,³⁰ and in 2018 a Uniform Articulation Agreement was signed between NCCCS Associate Degree Nursing Programs and North Carolina Independent Colleges and Universities RN to BSN programs. Both agreements create a more seamless and rational transfer process for community college nursing students seeking to obtain their bachelor's degree in nursing. In 2020, the University of North Carolina at Greensboro School of Nursing received a \$100,000 grant from Northwest AHEC for an educational mobility grant that will run through June 2021. The grant will fund an RN to BSN cohort in the medically underserved counties of Davidson, Forsyth, Gaston, and Person. Through this grant, nurses will take courses one day per week at community colleges in their counties.³¹ (Recommendation 5.1(a))

The UNC System 2017 – 2022 Strategic Plan included a goal to increase enrollments of and completions by underserved students, including those from rural areas of North Carolina and low-income families.³² Universities throughout the state have developed programs to recruit rural students and serve rural areas of the state. The Brody School of Medicine at East Carolina University intentionally selects students who are more likely to select primary care, and 20.3% of Brody graduates intend to practice family medicine, compared with 8.6% of medical school graduates nationally.³³ (Recommendation 5.1(a))

The East Carolina School of Dental Medicine places all of its fourth-year dental students in eight Community Service Learning Centers (CSLC) in rural and underserved areas throughout the state. In May of their senior year, students spend three nine-week rotations in three different CSLC locations in the state. Students live in the communities they serve and participate in community outreach activities.³⁴ The rotations at CSLC are meant to encourage students to

practice dentistry in rural areas after graduation, and each clinic generates about \$1 million per year in economic impact for the rural communities that they serve.³⁵ (Recommendation 5.1(a))

In 2019, the University of North Carolina at Chapel Hill School of Nursing received a \$6 million grant from the Health Resources and Services Administration (HRSA) that will, in part, fund Nurse Practitioner Residency: Behavioral Health Integration in Rural Primary Care.³⁶ This program partners with the Goshen Medical Center in rural Eastern North Carolina and recruits and trains 70 nurse practitioners to work to the highest level of their scope of practice. The model for the program is nurse-practitioner-led, team-based whole health care that is designed to provide behavioral health access for areas designated as a Health Professional Shortage Area in Mental Health and create a pipeline of nurse practitioners to serve in rural communities after graduation.³⁷(Recommendation 5.1(a))

With the assistance of NC AHEC, public and private colleges and universities have created collaborative activities around interprofessional collaborative education and practice. One example of this interprofessional education is the UNC Health Sciences at Mountain Area Health Education Center (MAHEC), which was established in 2017 and provides interdisciplinary collaboration with UNC Chapel Hill, Western Carolina University, and regional community partners.³⁸ UNC Health Sciences at MAHEC is an academic health center that provides team-based care in a multidisciplinary environment for medical and pharmacy residents and students, family nurse practitioner students, AHEC scholars, and high school students interested in health science careers. UNC Health Sciences at MAHEC seeks to address health care workforce shortages in Western North Carolina by providing access to primary care providers, pharmacists, public health professionals, dentists, and nurses in one setting.³⁹ (Recommendation 5.1(a))

NCCCS requires updates made by individual colleges to meet the requirements of accrediting agencies and workforce demand.⁹ The Healthcare Simulation Technology curriculum program at Wake Technical Community College was approved for implementation starting in the fall of 2018. This curriculum is designed to prepare individuals to teach, remediate, and evaluate health care providers using different forms of health care simulation.⁴⁰ Participants can receive a certificate, diploma, or Associate of Applied Science based on credit hours in the program, and graduates of the program are eligible for employment opportunities at hospitals, public and private educational institutions, emergency medical services agencies, and simulation centers.⁴⁰ (Recommendation 5.1(a))

The North Carolina AHEC Scholars Program began in 2018 and focuses on interprofessional education, behavioral health integration, social determinants of health, cultural competency, practice transformation, and current and emerging health issues.⁴¹ The program is a result of

⁹ Email communication from Lori Byrd, Associate Director Academic Programs - Health Sciences, North Carolina Community College System Office, on July 14, 2020.

partnerships throughout the state, including the NCCCS, all five medical schools, and the NC Alliance for Health Professions' Diversity.⁴² The AHEC Scholars Program provides health professions students, particularly those who are historically underrepresented in the health care workforce and are interested in practicing in rural or underserved urban settings, with a two-year curriculum that focuses on interprofessional education and community-based training.⁴¹ (Recommendation 5.1(a))

Extensive progress has been made on expanding curriculum for Community Health Workers (CHW) and training for community-based ambulatory patient care centers. A NC DHHS report from 2018 recommended that CHW training could be housed in the NCCCS and AHEC.⁴³ The CHW curriculum has been developed for the NCCCS, and it covers the nine core competencies outlined by the NC DHHS recommendations and includes training on NCCARE360.^{44,45} Courses are being taught throughout the NCCCS, including Durham Technical Community College and Catawba Valley Community College. Upon completion of these NCCCS courses, students are eligible to be listed as a North Carolina Certified Community Health Worker.^{44,45} Medical Assisting courses are offered throughout the NCCCS and are designed to train health professionals in ambulatory settings, such as physicians' offices, ambulatory health care facilities, and emergency rooms. Graduates of these programs are eligible to sit for the American Association of Medical Assistants Certification Examination to be awarded the Certified Medical Assistant credential.⁴⁶ (Recommendation 5.1(a))

NCWorks is an online portal for laid-off and unemployed workers to access industry-specific job and training opportunities, including health care.⁴⁷ Over 100 career centers throughout the state provide in-person support and workshops.^{h,48} (Recommendation 5.1(d))

Recommendation 5.2 **Implemented**
**Support and Expand Health Professions Programs to More Closely Reflect the
Composition of the Population Served**

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

^h During the COVID-19 pandemic, state agencies and education entities collaborated to match unemployed workers with health care job and training opportunities. NC DHHS and the East Carolina School of Nursing partnered to match unemployed or underemployed health care workers with long-term care facilities that had urgent staffing needs.⁸⁷

and support in middle school, high school, college, and health professions schools. These entities should work collaboratively to seek foundation and federal funding to strengthen existing programs, develop new models of educational enrichment, and evaluate the effect of the various programs on the diversity of the health professions in the state. If shown to be effective, the North Carolina General Assembly should provide ongoing program support.

Pipeline programs are offered across UNC System schools to expand health professions pipelines for underrepresented minority, rural, and other disadvantaged middle and high school students who are interested in entering health careers.ⁱ NC AHEC facilitates the Passport to Health Careers Program through each AHEC region.⁴⁹ Through this program, students in eighth through twelfth grade can report their health science, community service, and leadership activities to receive a certificate of completion that is recognized by academic institutions.⁵⁰

The NC AHEC Scholars program recruits, trains, and supports students who are enrolled full-time in a health professions degree program. The program focuses their recruitment on underrepresented minority students, first generation students, and students who come from rural or disadvantaged backgrounds.⁵¹ Selected students can receive an annual stipend and commit to a two-year educational program. The program is led by faculty across the state and is comprised of 40 hours of didactic training and 40 hours of experiential learning each year.⁵²

The Medical Education Development (MED) Program at UNC Chapel Hill is a nine-week camp for underrepresented and rural students who are applying or plan to apply to medical or dental school.⁵³ The MED program helps students build their test-taking skills and provides pre-professional counseling, workshops, and orientation to the medical and dental school environment.⁵⁴ Data from the Program on Health Workforce Research and Policy in 2018 showed that 25% of MED graduates practice in rural areas, while only 13% of non-MED graduates do.⁵³

Recommendation 5.3 Partially Implemented

Strengthen and Expand Recruitment of Health Professionals to Underserved Areas of the State

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

- a) Provide financial incentives to encourage professionals to remain in practice in health professional shortage areas past their loan repayment obligations.**
- b) Recruit veterans with medical training to practice in North Carolina.**

ⁱ Email communication from Charlie Hardy, Founding Dean and Professor, College of Health and Human Services, UNC-Wilmington, on July 13, 2020.

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

The Office of Rural Health (ORH) does not receive \$1 million annually from the Department of Commerce. In one of the first editions of the 2019 Appropriations Act, ORH was appropriated \$2 million nonrecurring funds for the 2019 – 2020 fiscal year for the loan repayment program and \$1.15 million for the 2020 – 2021 fiscal year.^j The mini-budgets that were passed did not contain this funding.

The ORH administers the North Carolina State Loan Repayment Program (SLRP), which offers educational loan repayment awards up to \$50,000.⁵⁵ This program helps mental health providers who provide primary and psychiatric care to people in rural and underserved areas. The awards are granted in exchange for a two-year service commitment in a team-based setting that provides access to comprehensive behavioral health services to rural communities with a Health Professional Shortage Area score of 15 or above. If funding is available, one-year extensions may be requested after completion of the initial two-year service commitment.⁵⁵
(Recommendation 5.3(a))

The ORH has two staff members who conduct Health Professional Shortage Area analyses for the entire state. The ORH works with local communities that request analyses and the federal government to identify shortages in primary care, dental, and mental health providers. The Analytics and Innovations Team at the ORH provides technical assistance for communities and safety net providers seeking to improve access and quality of care for vulnerable populations.⁵¹
(Recommendation 5.3(c))

Recommendation 5.4 Partially Implemented

Increase Reimbursement for Primary Care and Psychiatry Services

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

^j <https://www.ncleg.gov/Sessions/2019/Bills/House/PDF/H966v2.pdf>

In January 2019, NC Medicaid received approval to increase rates for Evaluation and Management procedure codes defined by the Affordable Care Act and paid to primary care physicians, nurse practitioners, and physician assistants. Obstetricians and gynecologists were also included as primary care physicians.⁵⁶

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) has launched two initiatives over the last two years that increase reimbursement for primary care and behavioral health providers.⁵⁷ In 2018, Blue Cross NC and Aledade began their support of physician-led Accountable Care Organizations (ACOs) for primary care physicians. Through the ACOs, physicians are provided with technology and data analytics tools to help improve patients' health care experiences and better understand patients' cost of care, gaps in care, and experiences in the health care system. Primary care practices, general internists, and family physicians are eligible to join the ACO model.⁵⁷ In 2020, Blue Cross NC brought value-based payments to behavioral health providers through Blue Premier Behavioral Health.⁵⁸ In collaboration with Quartet Health, a health care technology company, Blue Cross seeks to reward behavioral health providers with higher payments for achieving quality measures.⁵⁸

Recommendation 5.5

Partially Implemented

Support Comprehensive Workforce Planning and Analysis

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

- D) **Plan for the state’s future workforce needs by identifying priorities for training and education funding.**
- E) **Report on the diversity of the health professions workforce in the state on an annual basis.**
- F) **Address barriers that affect entry into the health care workforce or continued practice. As part of this work, the Center should examine:**
 - (1) **State regulations and licensure board requirements to improve the regulatory environment for all licensed health practitioners. This examination should allow all health practitioners to be able to practice to the full extent of their education and competence.**
 - (2) **Public and private insurance payment policies that create barriers to entry and continued practice.**
 - (3) **Barriers to effective team care.**
- iii) **Report its findings and proposed recommendations on an annual basis to the North Carolina General Assembly, the Governor, the Department of Health and Human Services, and the Department of Commerce.**
- b) **The Center should have an advisory board that includes representatives from the North Carolina Department of Health and Human Services, North Carolina Department of Commerce, North Carolina Office of Rural Health and Community Care, North Carolina Area Health Education Centers program, the North Carolina Community College System, the University of North Carolina General Administration, the five North Carolina academic health centers, private health professional education institutions, relevant professional associations and licensing boards, the Council for Allied Health in North Carolina, the North Carolina Hospital Association, North Carolina Medical Society Foundation, insurers, and nonmedical public members.**
- c) **The North Carolina General Assembly should provide \$550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.**

Sheps Program on Health Workforce Research and Policy, based out of the Cecil G. Sheps Center for Health Services Research, collects health practitioner workforce data including demographic, practice, and educational characteristics through the North Carolina Health Professions Data System (HPDS). NC AHEC and the Office of the Provost at the University of North Carolina at Chapel Hill provide ongoing financial support for the program.⁵⁹ The HPDS does not receive \$550,000 in recurring funding, and the Center for Health Workforce Research and Policy was not created. (Recommendation 5.5(a))

The Sheps Center Program on Health Workforce Research and Policy (Sheps) produces a variety of reports that enable proactive modeling and planning for North Carolina’s future health

workforce needs. They produce a yearly report for physician education programs called “The Progress of Health Professional Schools Increasing the Number of Grads Entering Primary Care”.^k This report addresses the outcomes for graduates of medical schools in the state, such as the number who remain in-state, practice in rural areas, and in primary care five years after graduation. In 2018, Sheps produced a report on state residency program outcomes. Sheps received funding in 2020 to examine the number of North Carolina Graduate Medical Education trainees who remained in-state, rural, and/or in generalist areas of practice five years after graduation. Sheps has completed reporting and tracking for other professions on a one-off basis when funding is available (e.g., nursing education programs), but they are unable to regularly track outcomes for non-physician practitioners. Sheps also produces a report on workforce diversity every 3-4 years. Significant research, publications, and presentations have been created by Sheps staff on state regulations and licensure board requirements to improve the regulatory environment for all licensed health practitioners and barriers to effective team care. (Recommendation 5.5(a))

Recommendation 6.1 **Partially Implemented**

Increase Tobacco Cessation Among Medicaid Recipients

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

^k Email communication from Evan Galloway, Research Associate, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, August 27, 2020.

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

Through the CDC 6|18 project in 2017 – 2018, NC Medicaid and the Department of Public Health developed joint action plans for providing evidence-based tobacco cessation treatment for Medicaid beneficiaries. As a result of that work, the Division of Health Benefits (formerly the Division of Medical Assistance) crafted specific Prepaid Health Plan (PHP) contract requirements that included measurement/reporting of tobacco cessation measures, tobacco cessation quality improvement activities, and requirements for PHPs to support one centralized QuitlineNC as part of the benefit package.¹ (Recommendation 6.1(a))

Tobacco-cessation drugs are a part of the NC Medicaid Preferred Drug List program and are monitored like all medication classes. In addition to covering almost all prescription smoking cessation medications with a script from a prescriber, NC Medicaid allows FDA approved over-the-counter nicotine replacement therapy.^m There is a standing order from the North Carolina Board of Pharmacy that allows registered nurses employed by a North Carolina Local Health Department to dispense over-the-counter nicotine replacement therapy to individuals who use five or more cigarettes per day or one can or pouch or more per week of snuff or chew; voluntarily request nicotine replacement therapy; indicate a readiness to quit smoking or using chew or snuff; have been advised by a medical provider to stop smoking or using chew or snuff; or are requesting Combination Nicotine Replacement Therapy.⁶⁰ These nicotine replacement therapies do not require a prescription to be purchased; however, having a prescription for nicotine replacement therapy may facilitate insurance coverage.⁶⁰ NC Medicaid does not waive co-payments for FDA-approved tobacco pharmaceuticals.ⁿ (Recommendation 6.1(b))

The Pregnancy Medical Home Program Pathway calls for providers to complete a proactive fax referral to QuitlineNC if pregnant patients relay a willingness to quit tobacco use in the next 30 days. For patients who are not ready to quit using tobacco in the next 30 days, providers are encouraged to use counseling techniques, encourage cessation, and collaborate with pregnancy care managers.⁶¹ (Recommendation 6.1(c))

¹ Email communication, Kelly Crosbie, Director, Quality and Population Health, Division of Health Benefits, July 27, 2020.

^m Email communication from Kelly Crosbie, Director, Quality and Population Health, Division of Health Benefits, July 27, 2020.

ⁿ Email communication from Kelly Crosbie, Director, Quality and Population Health, Division of Health Benefits, July 27, 2020.

Support Nursing Mothers in the Work Environment

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

In 2010, the Office of State Human Resources (formerly the Office of State Personnel) implemented lactation support recommendations in order to comply with the Patient Protection and Affordable Care Act.⁶² The new policy requires employers to provide reasonable break time for lactation. The policy was designed to assist agencies in the development of work/life balance initiatives for state employees.⁶² The Office of State Human Resources (OSHR) trained the directors of human resources at state agencies so that the policy was incorporated into agency policies and procedures.^o (Recommendation 6.2(a))

In 2020, the North Carolina Division of Public Health (DPH), North Carolina Breastfeeding Coalition, MomsRising, and Eat Smart, Move More released the *Making It Work* toolkits for employers and lactating mothers working outside of the home.⁶³ *Making It Work: Employers Support Breastfeeding Families* utilizes resources from the Business Case for Breastfeeding and contains ways that employers can accommodate women who work in both non-office and office environments. The toolkit outlines the benefits of breastfeeding and the benefits of supporting lactation policies. (Recommendation 6.2(b))

Through its Essentials for Childhood initiative, a public health oriented framework for child maltreatment prevention, DPH is partnering with the North Carolina Early Childhood Foundation to provide support for Family Forward NC, an innovative program that works directly with businesses of all sizes to increase availability of family-friendly workplace policies, including breastfeeding support for employees and improved paid family leave policies, which in turn are associated with increased frequency and duration of breastfeeding. DPH has provided funding support for the Family Forward NC initiative since 2019. In 2019,

^o Email communication from Lars Nance, General Counsel, NC Office of State Human Resources, September 3, 2020.

the North Carolina Early Childhood Foundation released its *Guide to Family Forward Workplaces*, which includes the Business Case for Breastfeeding framework for supporting women who are breastfeeding.⁶⁴ (Recommendation 6.2(b))

Recommendation 6.3

Partially Implemented

Promote and Monitor Utilization of Preventive Care Services

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

- g) AHEC, NCMS, the North Carolina Division of Aging and Adult Services (DAAS), CCNC, the North Carolina Academy of Family Physicians, and the AARP should provide education to primary care physicians on the annual wellness visit benefit for Medicare enrollees.**
- h) Seniors' Health Insurance Information Program (SHIIP), AARP, and DAAS should provide education to enrollees on the annual wellness visit benefit.**
- i) AARP, DMA, SHIIP, and the DAAS should engage community leaders to do community outreach for education of the public on the availability and importance of preventive services.**

NC Medicaid, through its partnership with Community Care of North Carolina (CCNC), has focused on promoting preventive care for Medicaid beneficiaries for many years.^p NC Medicaid allows for one Adult Preventive Medicine Assessment per year that does not count toward the annual Medicaid visit limit, as NC Medicaid wants to encourage all adults to have this visit.⁶⁵ NC Medicaid has facilitated multiple quality improvement projects aimed at closing preventive care gaps (e.g., childhood immunizations). NC Medicaid has engaged AHEC to provide practice coaching and support, especially to practices that have lower-than-average rates of preventive care.^q (Recommendation 6.3(d))

NC Medicaid tracks preventive care utilization through a series of quality measures. In 2021, DHHS will be transitioning most Medicaid and NC Health Choice populations into fully capitated managed care plans called Prepaid Health Plans (PHPs) to deliver better care, promote health equity, and lower costs.⁶⁶ One of the primary objectives of the state's transition to managed care is to ensure Medicaid beneficiaries are satisfied with their PHP and link them to an Advanced Medical Home (AMH) provider. The AMHs will provide comprehensive primary and preventive care services, including team-based care, population health management, care coordination, and care management for high-risk populations.⁶⁶ (Recommendation 6.3(d))

Several organizations provide education on the importance of preventive services and the annual wellness benefit. AARP NC held several public-facing presentations, particularly in the faith-based community, on annual wellness benefits and overall ACA benefits in 2013 and 2014.^r The AARP blog features many educational articles on open enrollment, annual wellness visits, and how the ACA impacts older adults.⁶⁷⁻⁶⁹ Seniors' Health Insurance Information Program (SHIIP) counselors provide in-depth, objective information, counseling, and assistance to Medicare-eligible individuals, their families and caregivers in the state. SHIIP's primary objective is to educate the public on Original Medicare, Medicare Prescription Drug Plans, Medicare Advantage Plans, Medicare Supplement Plans, long-term care insurance, and employer group health plans. NC DOI contracts with reputable human service agencies (i.e., senior centers, Councils on Aging, Cooperative Extension agencies, etc.) in all 100 counties to serve as SHIIP

^p Email communication from Kelly Crosbie, Director, Quality and Population Health, Division of Health Benefits. July 27, 2020.

^q Email communication from Kelly Crosbie, Director, Quality and Population Health, Division of Health Benefits. July 27, 2020

^r Email communication from Audrey Galloway, Associate State Director, AARP. August 18, 2020.

coordinating sites and carry out the mission of SHIIP at the local level. These organizations help coordinate the work of the more than 900 volunteer SHIIP counselors with specific requirements including but not limited to coordinating with the 16 Area Agencies on Aging (AAAs) to provide outreach and education to Medicare beneficiaries on the promotion of wellness benefits and prevention of disease. Local SHIIP sites display Monthly Prevention and Wellness Campaign posters, including information on Medicare's annual wellness visit, in their respective agencies and at all outreach events, and SHIIP developed a Preventive Services flyer for distribution at outreach events and medical provider offices including but not limited to community health centers and county health departments. SHIIP has garnered success in educating Medicare beneficiaries by forming and maintaining partnerships with various agencies and organizations on the federal, state, and local levels.^s (Recommendation 6.3(h))

Recommendation 6.4 **Partially Implemented**
Promote Worksite Wellness Programs in North Carolina Businesses

- a) **The Center for Healthy North Carolina (CHNC) and the North Carolina Division of Public Health should continue to provide information to businesses on evidence-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.**
- b) **Eat Smart, Move More NC (ESMMNC) should continue to provide information on evidence-based worksite wellness tools and programs through its website, including CDC's worksite wellness technical assistance program.**

The Center for Health North Carolina (CHNC) did not reach out directly to any employers due to funding constraints. CHNC was privately funded for Healthy North Carolina 2020 work from 2010-2013. Between 2013 – 2015, the private funding for CHNC focused on implementing evidence-based interventions across the state by working with community coalitions which evolved into the Healthy People, Healthy Carolinas program and is still in place today. CHNC and the Center for Public Health Quality (CPHQ) merged in 2015 to form Population Health Improvement Partners (PHIP).^t (Recommendation 6.4(a))

Eat Smart, Move More NC has encouraged partners across the state to implement Worksite Wellness Programs. The Community and Clinical Connections for Prevention and Health (CCCPH) Branch within the NC Division of Public Health has primarily spearheaded this work since receiving a CDC grant in 2013. Since 2013, CCCPH has impacted 128 worksites through employee wellness programs.⁷⁰ CCCPH continues to maintain *WorkWell* NC which includes the CDC Score Card and many resources for employers.⁷¹ (Recommendation 6.4(b))

^s Email communication from Melinda Munden, Director and Deputy Commissioner SHIIP Division. August 20, 2020.

^t Email communication from Laura Edwards, former director, Center for Healthy North Carolina. August 12, 2020.

Recommendation 6.5**Partially Implemented****Build Capacity of Communities to Respond to Funding Opportunities**

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

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

From 2011 – 2014, the North Carolina Office of Minority Health and Health Disparities (OMHHD) provided grants to continue enhancing the capacity of local health departments to serve clients with Limited English Proficiency through creating new interpreter positions. Grant recipients were provided \$20,900 and expected to match those funds in order to hire a full-time interpreter. Eleven county health departments were selected for the three year grant period.⁷²

The OMHHD currently facilitates the Culturally & Linguistically Appropriate Services (CLAS) Program in order to provide local health departments, community health centers, health professionals, and community-based organizations with training and technical assistance to learn more about cultural competence and help them eliminate cultural and linguistic barriers to quality care.⁷³

Recommendation 6.6**Implemented****Monitor Funding Opportunities for Prevention Provisions**

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

Between 2013 – 2018, the Prevention and Public Health Trust Fund awarded \$222,682,555 to North Carolina recipients for evidence-based activities that focus on prevention, improve health outcomes, and enhance health care quality.^{74,75} Universities, NC DHHS, nonprofits, hospitals, health departments, and corporations received 114 awards over six years. Those awards supported immunization, tobacco prevention, health insurance enrollment support, Alzheimer's Disease prevention and education, heart disease prevention, and many other programs that improve health outcomes and North Carolina public health infrastructure.^{74,75}

Recommendation 7.1

Implemented

Educate Primary and Specialty Care Providers on Quality Measure Reporting

Requirements

The North Carolina Division of Medical Assistance should partner with the Area Health Education Centers program, Community Care of North Carolina, North Carolina Chapter of American College of Physicians, and the North Carolina Academy of Family Physicians to assume responsibility for educating primary care physicians, and with the North Carolina Medical Society to assume responsibility for educating specialty physicians, on the requirement to report adult health quality measures on all Medicaid eligible adults.

NC Medicaid has promoted primary and preventive care and best practices for chronic condition management for individuals enrolled in Medicaid through partnerships with Community Care of North Carolina (CCNC), North Carolina Area Health Education Centers (AHEC), and the North Carolina Academy of Family Physicians (NCAFP). NC Medicaid tracks primary, preventive, and chronic condition management through a variety of publicly reported quality measures. Along with their partners, they have supported multiple quality improvement projects aimed at closing preventive care gaps and promoting best practices. NC Medicaid has engaged both CCNC and AHEC to provide practice coaching and support, especially to practices that have lower-than-average quality scores.

At CCNC, Quality Improvement and Practice Support staff work closely with CCNC-enrolled practices to regularly share quality data for patients enrolled in Medicaid and educate providers on how they can improve quality in their practices. Through its Quality Measurement and Feedback Program, CCNC reported on over 50 quality measures across pediatric and adult populations.

North Carolina's Quality Strategy for Medicaid Managed Care includes provider supports to build on existing infrastructure to support clinical improvements. Advanced Medical Home (AMH) practices that will serve patients enrolled in Medicaid Managed Care in the future will have access to support through stakeholder forums and technical assistance. The forums will "address challenges, share best practices, and discuss implementation of quality improvement

activities aligned with the Quality Strategy.”⁷⁶ Technical assistance will be available at the practice level to support providers as they transition to being an AMH. Prepaid Health Plans will be required to participate in the forums and provide practice-level data to support technical assistance.⁷⁶

Recommendation 7.2

Not Implemented

Explore Centralized Reporting

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

The North Carolina Health Information Exchange Authority (NC HIEA) Advisory Board^u has not formally taken up this topic, however NC Medicaid, the North Carolina Office of Rural Health, and the NC HIEA are partnering for a pilot of common quality measures across payers. This pilot will begin sometime in the near future.

The NCIOM Task Force on Health Care Analytics echoed Recommendation 7.2 in their own recommendations. The task force was convened to develop the set of quality metrics that will be used to drive improvement in population health under North Carolina’s transition to Medicaid managed care. Given the identification by the Task Force of the ongoing need for a robust data collection and data sharing infrastructure, they recommended:

“Ongoing investment in the development of NC Health Connex in order to allow state agencies, public and private payers, and health care providers shared access to quality improvement and performance data. The infrastructure should maintain integration and alignment across electronic health record systems, be aligned as much as possible across payers, allow for flexibility in reporting methods, and meet federal meaningful use standards for interoperability.”⁷⁷

Recommendation 7.3

Not Implemented

Investigate Options for Data Storage

The North Carolina Department of Health and Human Services, working with the North Carolina Health Information Exchange and other stakeholder groups, should examine options to capture federally reported quality data at the state level, including options for capturing the required quality data automatically from electronic health records, and then coordinate submission of data to the appropriate entities. Data should be made

^u The NC HIEA was established by the General Assembly in 2015 to administer the North Carolina Health Information Exchange Network. They operate Nc HealthConnex, the state’s health information exchange. The Advisory Board “provides consultation to NC HIEA on the advancement and operation of NC HealthConnex.” <https://hiea.nc.gov/about-us/about-nc-hiea> and <https://hiea.nc.gov/about-us/advisory-board>

available at the state level for research and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.

This work has not been implemented to date, however the pilot of common quality measures across payers, described in the update for Recommendation 7.2, should support the efforts outlined in Recommendation 7.3.

Recommendation 7.4

Partially Implemented

Educate Providers on ACA Issues

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

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

The Toward Accountable Care Consortium and Initiative (TAC) has made a significant effort to provide education to clinicians on ACA-related quality topics. The TAC began in 2012 and was run through the North Carolina Medical Society (NCMS) Foundation. Forty-two North Carolina organizations joined (see Table 1). The TAC is supported by grant funds and member organization contributions and was in existence for nearly seven years. The TAC developed over 30 toolkits with general and specialty-specific guidelines to help providers interested in forming Accountable Care Organizations (ACOs).^{v,78} In addition, they hosted three ACO summits, wrote a number of feature articles, and hosted several webinars. The North Carolina Accountable Care Organization (NC ACO) Collaborative was founded as part of TAC in 2012. While the TAC is no longer an active program, the NC ACO Collaborative has developed into two groups, the North Carolina Population Health Collaborative and the North Carolina ACO Council, which

^v TAC toolkits are available online at <https://www.ncmedsoc.org/physician-resources/accountable-care/aco-toolkits/>.

remain active today, and are co-hosted by the NCMS and North Carolina Healthcare Association.

Table 1. Toward Accountable Care Consortium and Initiative (TAC) Member Organizations

State Societies/Organizations	County/Regional Medical Societies
Community Care of North Carolina Carolinas Center for Hospice and End of Life Care North Carolina Academy of Physician Assistants North Carolina Association of Local Health Directors North Carolina Community Health Center Association North Carolina Foundation for Advanced Health Programs North Carolina Healthcare Quality Alliance North Carolina Medical Group Managers North Carolina Medical Society	Cleveland County Medical Society Craven-Pamlico-Jones County Medical Society Durham-Orange County Medical Society Mecklenburg County Medical Society Forsyth-Stokes-Davie County Medical Society New Hanover-Pender County Medical Society Pitt County Medical Society Rutherford County Medical Society Western Carolina Medical Society Wake County Medical Society
Specialty Societies	
Carolinas Chapter, American Association of Clinical Endocrinology North Carolina Academy of Family Physicians North Carolina Chapter of American College of Cardiology North Carolina Chapter of the American College of Physicians North Carolina College of Emergency Physicians North Carolina Council on Child and Adolescent Psychiatry North Carolina Dermatology Association North Carolina Neurological Society North Carolina Obstetrical and Gynecological Society North Carolina Orthopaedic Association North Carolina Pediatric Society North Carolina Psychiatric Association	North Carolina Radiologic Society North Carolina Society of Anesthesiologists North Carolina Society of Asthma, Allergy & Clinical Immunology North Carolina Society of Eye Physicians and Surgeons North Carolina Society of Gastroenterology North Carolina Society of Otolaryngology – Head and Neck Surgery North Carolina Oncology Association North Carolina Society of Pathologists North Carolina Society of Plastic Surgeons North Carolina Spine Society North Carolina Urological Association

Specific to the topics mentioned in Recommendation 7.4, the NCMS has provided information on Quality and Resource Use Reports to educate members about the reports, what they show, and how to obtain them. The NCMS and various specialty societies worked with the Physician Consortium for Performance Improvement (PCPI) and individual national specialty societies to encourage physician participation in the development of quality metrics and the NCMS remained a voting member of the PCPI until its dissolution in 2020. The TAC toolkits mentioned above helped to educate the medical community and beyond about value-based arrangements and the NCMS hosted several summits and convened the NC ACO Collaborative to continue the educational opportunities.

NC AHEC and CCNC partnered on a project funded by the Agency for Healthcare Research and Quality called NC IMPaCT that works on care transitions and decreasing hospital readmissions through a Regional Leadership Collaborative and Primary Care Transitions Planning Collaborative. These two infrastructure elements did the following:

- Regional Leadership Collaborative – “designed to enhance quality improvement capacity as well as partnerships among leaders and staff in regional areas. North Carolina IMPaCT leaders formed teams in each region with local AHEC and CCNC personnel, and brought in national experts to help facilitate learning. Each regional team selected and implemented projects by applying quality improvement techniques from the regional leadership collaborative curriculum.”⁷⁹
- Primary Care Transitions Planning Collaborative – “applied the quality improvement infrastructure to improve care processes that occur when a patient is discharged from a hospital setting. To date, most efforts to reduce hospital readmissions have been hospital-focused, but primary care practices also have a key role in preventing avoidable readmissions. From April 2012 to September 2013, nine North Carolina primary care practices participated in a Web-based learning collaborative focused on improving care transitions. The practices developed and tested processes that would help them provide timely visits following a hospitalization and communicate and coordinate an ongoing care plan, with the ultimate goal of reducing avoidable hospital readmissions and emergency department visits.”⁷⁹

The NC IMPaCT model has been disseminated to partners in Idaho, Maryland, Montana, and West Virginia.

Recommendation 7.5 Implemented

Educate Hospitals on ACA Issues

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

- a) **Importance of using the “present on admission indicator” and the meaning and implications of the quartiles.**
- b) **Quality reporting requirements.**
- c) **Value-based purchasing.**
- d) **Importance of having a safety evaluation system to allow Health Benefits Exchange providers to contract with hospitals with more than 50 beds.**
- e) **Medical diagnostic equipment requirements.**

Since the passage of the ACA, the North Carolina Healthcare Association (NCHA; formerly the North Carolina Hospital Association) has conducted routine education sessions, conferences, and webinars with members regarding significant aspects of the Act. ACA guidance was regularly shared at annual Summer and Winter meetings, annual Trustee Institutes, quarterly and monthly webinars, and via affinity group meetings and conferences designed for specific hospital association members, such as the Critical Access Hospital Forum, the annual Small and Rural Hospital Conference, and regional membership meetings. In addition, NCHA operated and managed two Centers of Excellence, the North Carolina Center for Hospital Quality and the North Carolina Center for Rural Health, which provided custom education and technical

assistance programs related to hospital quality and patient safety, value-based purchasing, and engagement with ACA exchanges and beneficiaries. The Centers coordinated with NCHA members to encourage participation in quality reporting systems, to engage NCHA members in the quality improvement and reporting initiatives designed by the CMS Innovation Center (Hospital Engagement Networks), and to spread best practices and innovations that improve quality and safety performance.

NCHA's Center for Hospital Quality successfully applied for and received a multi-year federal grant through the CMS Innovation Center to develop a two-state Hospital Engagement Network (HEN) in partnership with the Virginia Hospital Association. The HEN developed guidance, data reporting systems, and technical assistance to improve hospital performance in specific safety and quality improvement initiatives developed by CMS and federal DHHS in response to the ACA provisions. More than 95% of NC and VA hospitals actively participated in the HEN, allowing for collaborative performance across all of the HEN domains and measures. NCHA's Quality Center also successfully deployed a formal Patient Safety Organization (PSO) to engage North Carolina hospitals, health systems, and patient safety officers in performance improvement systems, data reporting, and measurable performance improvement in quality and patient safety domains.

NCHA's Center for Rural Health partnered with NCHA's Quality Center to drive small and rural hospital participation in the improvement activities of the HEN. The Center for Rural Health also partnered with the North Carolina Office of Rural Health to feature quality and patient safety guidance, training resources and programs, and measurable improvement collaboratives within the structure of the Critical Access Hospital (CAH) Forum. A major aim of the CAH Forum was to improve rural hospital performance in clinical domains specified by CMS's value-based purchasing program. Also, NCHA's Center for Rural Health received a grant from The Kate B. Reynolds Charitable Trust to create and promote an ACA toolbox and resource compendium, specifically designed for rural hospitals. The online toolkit provided resources for ACA compliance, community-based ACA recruitment and enrollment, and value-based purchasing developments and guidance.

Recommendation 7.6 **Partially Implemented**

Educate Home and Hospice Care Providers on ACA Issues

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

The Association for Home and Hospice Care of North Carolina (AHHC of NC) has provided some educational opportunities for its members on value-based purchasing. Neither organization

has provided education to home or hospice care providers on quality reporting requirements or pay for performance.

Recommendation 7.7 **Implemented**

Educate Facility Personnel on ACA Issues

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

AHHC of NC and the North Carolina Health Care Facilities Association (NCHCFA) have both offered education on the implications of value-based purchasing. NCHCFA has offered dozens of hours of this education over several years, including with new Medicare initiatives, Medicaid managed care, and commercial insurance changes. NCHCFA also provides updates, as needed, related to these topics annually at their Convention and Summer Meeting, including as recently as their 2020 Summer Meeting.

The North Carolina Division of Health Service Regulation (DHSR) has noted that Recommendation 7.7 is not aligned with its licensing and regulatory oversight of health care facilities. DHSR's licensing and regulatory oversight is focused on the health, safety, and well-being of individuals receiving care in a health care facility and does not include the financial operations of a facility such as payment models like value-based purchasing.

Recommendation 7.8 **Not Implemented**

Educate Consumers on Availability and Interpretation of Provider Quality Measures

The North Carolina Healthcare Quality Alliance, North Carolina Area Health Education Centers program, Community Care of North Carolina, and the North Carolina Health Information Exchange should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.

The organizations identified in Recommendation 7.8 do not report efforts to educate consumers on interpretation of provider quality measures.

Recommendation 7.9 **Implemented**

Improve Transitions of Care

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

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

- i) Improve patient (or responsible family member) discharge education at hospitals, with a focus on the health literacy checklist and teach-back methodology.
 - ii) Improve discussions of goals of care and education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.
 - iii) Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.
 - iv) Align existing initiatives that address care transitions at state and local levels.
 - v) Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other health care providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.
 - vi) Encourage collaboration and contracts between hospitals, local management entities/managed care organizations, critical access behavioral health agencies, and other community providers (e.g., pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.
 - vii) Encourage formal development of medical home models that include the use of non-physician extenders to work with some patients (e.g., stable diabetics), with physicians focusing on higher-need patients.
- b) In each community, stakeholder alliances including provider groups, CCNC, home health representatives, and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.
- c) Individuals should be provided their own personal health records after hospital discharge, pending the availability of a more robust Health Information Exchange.
- d) Solutions utilizing transition principles should be applied to all patients regardless of payer.

CCNC published a report in June 2014 titled “Recommendations for Transitions of Care in North Carolina.”^w This work, funded by the North Carolina Office of Rural Health and Community Care and North Carolina Healthcare Quality Alliance (NCHQA), reported on new findings about transitional care and recommended four priority steps to improve quality and efficiency of transitional care in the state:

1. “Promote systems that identify patients with multiple chronic conditions (MCC) and provide robust care management support following hospital discharge.
2. Promote systems that include home visits with medication reconciliation for MCC patients after discharge, with prioritization of patients at highest risk of readmission and those whose prescription fill history indicates no or little prior medication use for chronic disease care.
3. Promote systems that ensure the highest-risk MCC patients receive an outpatient follow-up visit to a health care provider within seven days of discharge.
4. Promote measurement of readmission rates on a per beneficiary basis and not a per admission basis.”⁸⁰

As reported in its analysis, CCNC began implementing these recommendations in its own care processes, in addition to working with NCHQA to promote the findings to other populations and payers in the state.

The NC AHEC and CCNC NC IMPaCT project (described in update for Recommendation 7.4) works on care transitions and decreasing hospital readmissions through a Regional Leadership Collaborative and Primary Care Transitions Planning Collaborative.

Also, in 2014, CCNC created and implemented the Transitional Care Impactability ScoreTM. This score combines risk-adjusted Medicaid claims data with CCNC’s experience providing care management interventions to assign each beneficiary a score (0-1,000) that represents the expected cost savings over the next six months for hospitalized patients who receive transitional care management immediately following discharge. Care managers use the score to prioritize patients identified on thrice-daily Admission, Discharge and Transfer (ADT) reports provided in partnership with the NCHA to provide transitional care management services following hospital discharge. These services include home visits, medication reconciliation, patient education, and timely follow-up with primary care providers. CCNC reports that transitional care has led to a 27% reduction in inpatient admissions and 48% reduction in potentially preventable readmissions, with \$128 million in savings in 2017 for CCNC beneficiaries compared to the unenrolled population.⁸¹

^w The CCNC report, “Recommendations for Transitions of Care in North Carolina,” is available online at https://nchqa.org/documents/NCHQA_Transitions_of_Care_Final_Report.pdf.

Although the NC HIEA and the HIEA Advisory Board have not been involved in any formal stakeholder groups related to care transitions, representatives from the NC HIEA have met individually with organizations named in Recommendation 7.9 to identify common goals to improve transitions of care in North Carolina. To that end, the state’s health information exchange – NC HealthConnex – launched an event notification service called NC*Notify in 2018. This service is provided at no cost to full NC HealthConnex participating provider organizations to support improved care coordination.

Based on admission, discharge, and transfer data received from more than 100 participating hospitals plus encounter data from more than 6,000 ambulatory care settings, the NC*Notify real-time event notifications provide care teams with valuable information that spans geography and care settings and support state and federal efforts to focus on patient-centered care. Subscribers include hospitals, primary care physicians in clinically integrated networks or accountable care organizations, behavioral health provider organizations, payers, and local management entities/managed care organizations.

NC HealthConnex is also working to improve patient access to their personal health records after hospital discharge. The NC HealthConnex clinical portal allows providers to download a PDF of the patient’s consolidated record stored in the HIE. In addition, the HIEA Advisory Board is working to implement new guidelines from CMS published in March 2020 that require patient information to be more readily shared^x and will be coming up with recommendations on opportunities to support NC HealthConnex participants in the implementation of the rules. NC*Notify already supports the new CMS rule requiring hospitals to notify community providers upon patient request on admission and discharge.

Recommendation 7.10 **Implemented**

Reimburse Nurse Practitioners in Skilled Nursing Facilities

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

The Division of Health Benefits (DHB) (formerly the Division of Medical Assistance) now provides reimbursement for nurse practitioners working in skilled nursing facilities.^y

^x CMS published the Interoperability and Patient Access final rule (CMS-9115-F) in March 2020. A fact sheet describing the new policies can be found at <https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet>.

^y In light of the COVID-19 public health emergency, the department is also working to temporarily extend reimbursement opportunities to nurse practitioners for telehealth services provided to patients in skilled nursing facilities for the duration of the pandemic state of emergency. <https://medicaid.ncdhhs.gov/blog/2020/06/25/special-bulletin-covid-19-103-telehealth-and-virtual-patient-communications-clinical>

Develop a Centralized New Models of Care Tracking System

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

- a) Monitor federal funding opportunities and new regulations identifying new models of care.
- b) Identify and/or convene stakeholder groups to examine existing data on costs and utilization; geographic areas of the state that are outliers in terms of costs, quality, or population health measures; and help identify appropriate new payment or delivery models of care to test.
- c) Maintain a database of existing North Carolina demonstrations that test new payment and delivery models of care, whether funded through private or public funds.
- d) Collate evaluation data on these demonstrations and, to the extent possible, identify what models work best to address specific problems. The NCFAHP should help identify whether the new payment and delivery models are evidence-based, promising practices, or unsuccessful models.
- e) Disseminate information across the state to other health care providers, health systems, insurers, consumer groups, and state policymakers about the success of these initiatives.
- f) Provide technical assistance to communities, health care providers, insurers, or others who are interested in replicating a new model of payment or health care delivery, and encourage groups to involve consumers in the development of new initiatives.

The Foundation for Health Leadership and Innovation (FHLI) (formerly the North Carolina Foundation for Advanced Health Programs) portfolio of work does not include tracking of new models of payment and delivery reform in North Carolina. However, the North Carolina Medical Society (NCMS) has done some of the work outlined in this recommendation as part of the Toward Accountable Care Consortium and Initiative (TAC) (described in update for Recommendation 7.4), of which FHLI was a member along with over 30 other state and national specialty and county medical societies. The TAC developed over 30 toolkits with general and specialty-specific guidelines to help providers interested in forming Accountable Care Organizations (ACOs).^{z,78} The TAC was also instrumental in forming the NC ACO Collaborative (now NC ACO Council) for existing ACOs in the state and the NC Population

^z TAC toolkits are available online at <https://www.nemedsoc.org/physician-resources/accountable-care/aco-toolkits/>.

Health Collaborative, which provides opportunities for emerging and existing ACOs to exchange ideas and solutions.

NCMS monitored federal funding opportunities through CMS and the Center for Medicare & Medicaid Innovation (CMMI) that involved physician practices. These opportunities included work on Medicare Shared Savings Program (MSSP) ACOs^{aa}, Next Generation ACOs^{bb}, the ACO Investment Model (AIM)^{cc}, ESRD Seamless Care Organizations (ESCOs)^{dd}, and bundled payments^{ee}. NCMS also attempted to track demonstrations in the state that were testing new payment and delivery models of care funded both privately and publicly. These efforts revealed that private contracts through commercial payors were challenging to track.

Through the work of the TAC, NCMS recruited five potential AIM ACOs, two of which had a large enough panel of patients to proceed, and one of those received AIM funding. Although AIM funding has ended, that ACO continues today (Tar River ACO—Boice-Willis Clinic, Rocky Mount, NC).

Recommendation 8.2

Partially Implemented

Evaluate New Payment and Delivery Models

- a) Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. The evaluation should, to the extent possible, be based on existing nationally recognized metrics and should include:**
 - i. Quality of care metric that includes process, appropriateness, and outcome measures**

^{aa} Through MSSP ACOs, providers and suppliers create an Accountable Care Organization that agrees “to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.” <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about>

^{bb} Next Generation ACOs are a model that allows “ACOs that are experienced in coordinating care for populations of patients.... to assume higher levels of financial risk and reward than are available under the MSSP. The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.” <https://innovation.cms.gov/innovation-models/next-generation-aco-model>

^{cc} AIM allows for testing of “pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.” <https://innovation.cms.gov/innovation-models/aco-investment-model>

^{dd} ESCOs join together dialysis clinics, nephrologists and other providers “to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries.” <https://innovation.cms.gov/innovation-models/comprehensive-esrd-care>

^{ee} “The Bundled Payments for Care Improvement (BPCI) initiative was comprised of four broadly defined models of care, which linked payments for the multiple services beneficiaries received during an episode of care. Under the initiative, organizations entered into payment arrangements that included financial and performance accountability for episodes of care.” <https://innovation.cms.gov/innovation-models/bundled-payments>

- ii. Patient satisfaction data
 - iii. Access to care measures
 - iv. Cost information, including changes in per member per month costs over time
 - v. The potential to improve population health
 - vi. The effect on health disparities
- b) Evaluation data should be made public and shared with other health systems, groups of health care providers, payers, insurers, consumer groups, or communities so that others can learn from these new demonstrations.
 - c) North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

Many new payment and delivery models tested in North Carolina over the past several years have been part of the CMMI Health Care Innovation Award projects. All CMMI projects are subject to an independent evaluation that includes analysis of “quality, access to care, health care cost and utilization patterns, supplemental expenditures, beneficiary experience, population health,” and other metrics that may be impacted by the payment model being tested. Results of these evaluations are available to the public.⁸²

Information on evaluations conducted for privately funded payment and delivery models is less widely available. Groups like the Primary Care Collaborative, a not-for-profit membership organization focused on primary care and patient-centered medical homes, have a searchable database of outcomes for some models, such as those tested by Humana and CCNC, as well as multi-payer models.⁸³

Recommendation 8.3

Implemented

Capture Data to Support New Models of Care

- a) The North Carolina Department of Health and Human Services (NCDHHS) should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to develop a plan that examines options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.
- b) NC DHHS should examine what other states are doing to meet similar data needs and assess the scope, costs, technical requirements, feasibility, impact, and sustainability for different approaches. As part of this study:

- i. **NC DHHS should examine existing sources of data to determine whether existing systems can provide the necessary data, and, if not, identify the gaps in existing systems.**
- ii. **NC DHHS should examine the feasibility, costs, technical requirements, and sustainability of collecting and/or aggregating different types of data to serve different purposes, including, but not limited to, clinical, operational, population, policy, and evaluation.**
- c) **The plan should ensure that:**
 - i. **The new data system uses data already collected in the system for other purposes. Such data sources include, but are not limited to: the Health Information Exchange, Community Care of North Carolina Quality Center, Thompson Reuters, and the State Center for Health Statistics.**
 - ii. **All providers, payers, and administrators are required to contribute necessary data.**
 - iii. **All providers, payers, and administrators have access to their own data, as well as aggregated data for allowable purposes.**
 - iv. **The new data system meets strict patient confidentiality and privacy protections in accordance with North Carolina laws.**
- d) **NC DHHS should prepare a plan with recommendations, including a timeline and potential financing mechanisms, and report it to North Carolina General Assembly.**

In 2016-2017, the NCIOM, in partnership with NC DHHS, convened the Task Force on All-Payer Claims Database (APCD) to examine and plan for many of the details outlined in Recommendation 8.3. An APCD collects health claims data from multiple payers into one central database. The APCD task force had the overarching goal of creating a set of recommendations for improving the sharing, dissemination, and use of health care claims data in North Carolina. They did this by “study[ing] the use case of an APCD for North Carolina, examin[ing] alternatives to a state-based APCD, and evaluat[ing] options for implementing an APCD in North Carolina, including an assessment of legislative interest, governance, and finance. The task force also examined the 22 states with an active APCD [at the time] or an APCD under development to inform the discussion and identify best practices for implementation.”⁸⁴ The task force made a total of eight actionable recommendations:

1. The North Carolina General Assembly (NCGA) should establish an APCD.
2. The NCGA should create an APCD governing board that would be responsible for making recommendations on the organizational home, regulations, funding, and other details.
3. The NCGA should require payers with 1,000 or more covered North Carolinians to contribute claims data to the APCD.
4. The NCGA should appropriate recurring funding for the APCD and explore other funding sources with the APCD governing board.

5. The APCD should be designed in conjunction with other sources of health and human services data and existing data systems.
6. The APCD should collect and manage identified data in accordance with federal and state law.
7. The APCD should collect all claims data and incorporate data on uninsured patients, if feasible.
8. The APCD should adapt a standard data model, if feasible.⁸⁴

Recommendation 8.4

Partially Implemented

Examine Barriers that Prevent Testing of New Payment and Delivery Models

- a) **The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models that can improve health outcomes, improve population health, and reduce health care cost escalation. Some of the barriers should include, but not be limited to:**
 - i. **Health professional licensure restrictions that prevent health professionals from practicing, being held accountable, and receiving payment for care delivered within the full scope of their education, training, and competency.**
 - ii. **Insurance laws which impair the development of value-based insurance design or products which shift some of the financial risk to health care professionals or provider groups.**
 - iii. **Anticompetitive contractual arrangements which prevent insurers from implementing insurance designs that incentivize use of high-quality, lower-cost health care providers or professionals.**
 - iv. **Health professional reimbursement issues which reduce the ability of health care professionals from providing evidence-based clinical services that could lead to improved patient outcomes at lower costs.**
 - v. **Lack of coordination between public and private payers that create differing and uncoordinated quality and outcome measures for health care professionals.**
 - vi. **Uncoordinated and costly administrative requirements stemming from multiple payers with differing administrative requirements.**
 - vii. **Resistance to the adoption of new models of care among insurers, health care providers, professionals, and consumers.**
- b) **The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or otherwise prevent effective use of electronic health records.**
- c) **The NCIOM Task Force should identify barriers and potential solutions. The NCIOM should present the potential recommendations to the North Carolina**

General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.

The NCIOM has not convened a task force to address the barriers described in this recommendation. After the North Carolina General Assembly passed Session Law 2013-5, Senate Bill 4^{ff} stating that the state would not be involved in developing a state-run health benefits exchange and would not be expanding Medicaid eligibility, much of the work around implementing and evaluating the ACA provisions became decentralized.

The NCMS took up some of this work, including obtaining a change in Chapter 58-3-7 to ensure that Next Generation ACOs and CMS ACOs that took on downside risk would be exempt from NC DOI regulation. NCMS and NC DOI reviewed NC DOI rules on anticompetitive contractual agreements that may impact new payment arrangements. Some issues were identified; however, no statutory changes have been made.

^{ff} <https://ncleg.net/Sessions/2013/Bills/Senate/PDF/S4v5.pdf>

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