

## Four-years post-ACA: The evolving role of the case manager

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**Adam Zolotor, MD, DrPH**  
**Interim President & CEO**  
**North Carolina Institute of Medicine**



**Patrice Sminkey**  
**Chief Executive Officer**  
**Commission for Case Manager Certification**

## Agenda

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- Welcome and Introductions
- Learning Objectives
- **Patrice Sminkey**, CEO, the Commission
- **Adam Zolotor**, MD, DrPH, Interim President & CEO, North Carolina Institute of Medicine
- Question and Answer Session

## Audience Notes

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- There is no call-in number for today's events. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the links section to the left of your screen. Refresh your screen if slides don't appear to be advancing.
- Please use the "chat" feature on the lower left-hand part of your screen to ask questions throughout the presentations. Questions will be addressed as time permits after both speakers have presented.
- A recording of today's session will be posted within one week to the Commission's website, <http://www.ccmcertification.org>
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

## Learning Objectives Overview

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*After the webinar, participants will be able to:*

- Relate a basic understanding of elements of the Affordable Care that have resulted in an expanded role for case managers: access, population health, quality and cost.
- Relate the connection between value-based payment in the ACA and changes in care delivery, such as efforts to reduce readmissions and the new hospital quality measures coming in 2015.
- Identify the role and function of case managers in team-based care models at the heart of evolving care delivery innovations.

## Introduction

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**Patrice Sminkey**  
**Chief Executive Officer**  
**Commission for Case Manager Certification**

- Webinars
- Certification Workshops
- Issue Briefs
- Speaker's Bureau



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# Health care today: A shifting landscape

The screenshot shows the HealthCare.gov website. At the top left is the logo "HealthCare.gov". To its right are navigation links: "Learn", "Get Insurance", and "Login". A "Español" link is in the top right corner. Below the logo is a dark blue navigation bar with "Individuals & Families", "Small Businesses", and "All Topics" with a dropdown arrow. A search bar with "SEARCH" is on the right. The main content area features a large image of a smiling woman. Overlaid on the left of the image is the text "The Health Insurance Marketplace is Open!" followed by "Enroll now in a plan that covers essential benefits, pre-existing conditions, and more." and "Plus, see if you qualify for lower costs." Below this is a green "APPLY NOW" button. At the bottom of the image area is the text "WANT TO LEARN MORE FIRST?" and a "START HERE" button. The footer is a dark teal bar with five navigation items: "Get covered: A one-page guide", "Find the Marketplace in your state", "Get lower costs on health insurance", "See what Marketplace insurance covers", and "Get help with your application".

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SEARCH

## The Health Insurance Marketplace is Open!

Enroll now in a plan that covers essential benefits, pre-existing conditions, and more.

Plus, see if you qualify for lower costs.

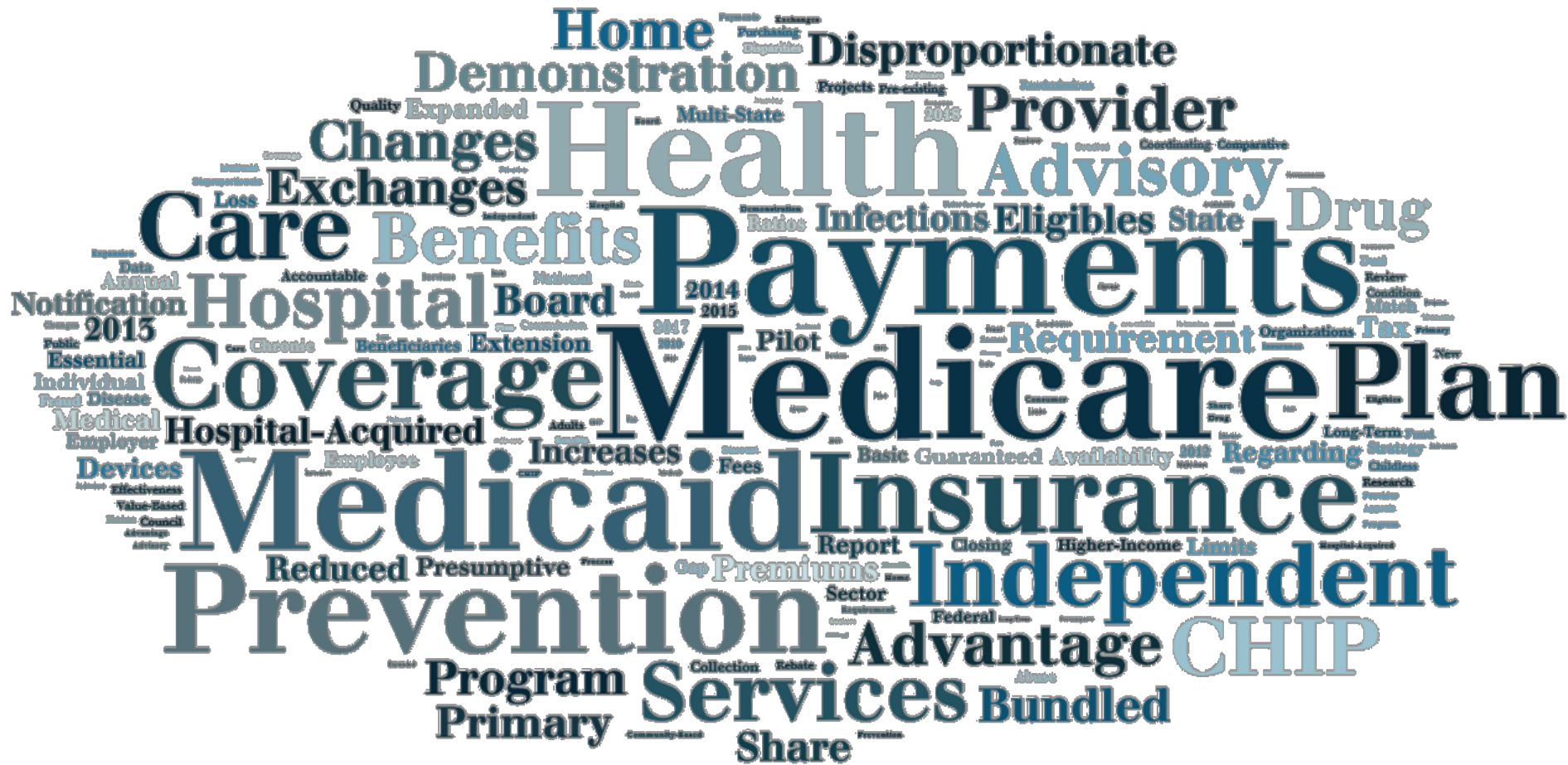
**APPLY NOW**

WANT TO LEARN MORE FIRST? **START HERE**

Get covered: A one-page guide Find the Marketplace in your state Get lower costs on health insurance See what Marketplace insurance covers Get help with your application

# Complexity calls for knowledge

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# Changes? What changes?

## 2010

Review of Health Plan Premium Increases  
Changes in Medicare Provider Rates  
Medicaid and CHIP Payment Advisory Commission  
Comparative Effectiveness Research Prevention and Public Health Fund  
Medicaid Drug Rebate  
Coordinating Care for Dual Eligibles  
Medicaid Coverage for Childless Adults  
Pre-existing Condition Insurance Plan  
New Prevention Council Consumer Website  
Expansion of Drug Discount Program  
Insurance Plan Appeals Process  
Coverage of Preventive Benefits  
Medicaid Community-Based Services

## 2011

Closing the Medicare Drug Coverage Gap  
Medicare Payments for Primary Care  
Medicare Prevention Benefits  
Medicare Premiums for Higher-Income Beneficiaries  
Medicare Advantage Payment Changes  
Medicaid Health Homes  
Chronic Disease Prevention in Medicaid  
National Quality Strategy  
Medicaid Payments for Hospital-Acquired Infections

Medicare Independent Payment Advisory Board  
Medicaid Long-Term Care Services

## 2012

Accountable Care Organizations in Medicare  
Medicare Advantage Plan Payments  
Medicare Independence at Home Demonstration  
Medicare Provider Payment Changes  
Fraud and Abuse Prevention  
Medicaid Bundled Payment Demonstration Projects  
Data Collection to Reduce Health Care Disparities  
Medicare Value-Based Purchasing  
Reduced Medicare Payments for Hospital Readmissions  
Medicare Independence at Home Demonstration

## 2013

State Notification Regarding Exchanges  
Medicare Bundled Payment Pilot Program  
Medicaid Coverage of Preventive Services  
Medicaid Payments for Primary Care  
Tax on Medical Devices  
Extension of CHIP  
Medicare Disproportionate Share Hospital Payments

## 2014

Medicare Independent Payment Advisory Board Report  
Expanded Medicaid Coverage  
Presumptive Eligibility for Medicaid  
Individual Requirement to Have Insurance  
Health Insurance Exchanges  
Guaranteed Availability of Insurance  
No Annual Limits on Coverage  
Essential Health Benefits  
Multi-State Health Plans  
Basic Health Plan  
Medicare Advantage Plan Loss Ratios Fees on Health Insurance Sector  
Medicare Payments for Hospital-Acquired Infections

*Sources: Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), America's Health Insurance Plans, Bloomberg Government, Mercer, Kaiser Family Foundation, U.S. Chamber of Commerce, "Health Policy Brief: Health Reform's Changes in Medicare," Health Affairs, May 20, 2010.*

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# Four-years post-ACA: The evolving role of the case manager

Commission for Case Manager Certification

Adam Zolotor, MD, DrPH

Interim President & CEO, NCIOM

September 30, 2014



# North Carolina Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

*NCGS §90-470*



# Four Key Health Challenges

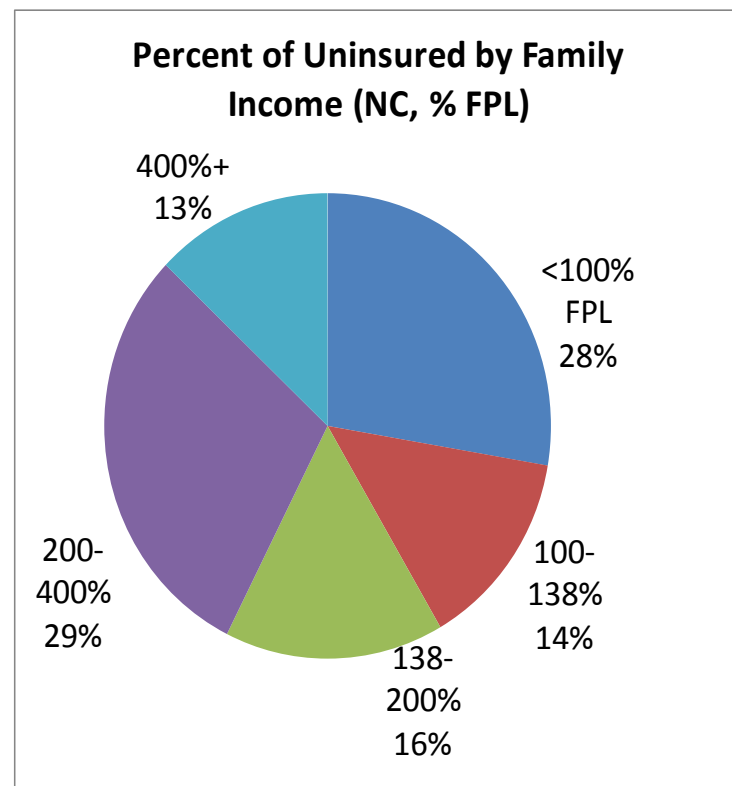
- 1) Coverage and access problems
- 2) Overall population health status
- 3) Quality
- 4) Costs

# How the ACA Responds to these Challenges

- **1) Coverage and access barriers**
- 2) Overall population health
- 3) Quality
- 4) Costs

# Problem #1 Insurance Coverage and Access to Care

- Approximately 1.5 million nonelderly uninsured in North Carolina in 2011 (19% of the nonelderly population).
- Being uninsured has a profound impact on health and financial wellbeing.



US Census. Current Population Survey (CPS) Annual Social and Economic Supplement. Health Historical Tables. Table HIA-6.

# Coverage Provisions Pre-Supreme Court

- ACA would have required most people to have health insurance coverage or pay a penalty.
  - *Public coverage*: Most low income people with incomes <138% Federal Poverty Levels (FPL) would gain coverage through Medicaid.
  - *Employer-based coverage*: Most other people would continue to get health insurance through their employer.
  - *Individual (non-group) coverage*: Some people would qualify for subsidies to purchase coverage on their own through the Health Insurance Marketplace (formerly called “Exchange”).

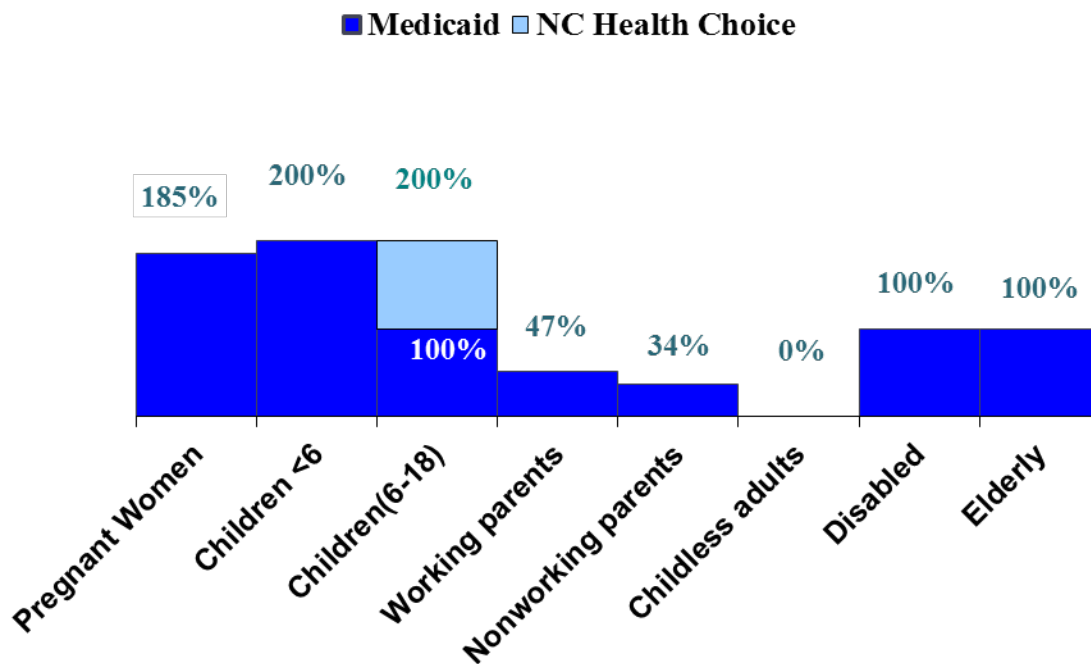


# Supreme Court Challenge to ACA

- Supreme Court, in *National Federation of Independent Businesses vs. Sebelius*:
  - Upheld the constitutionality of the individual mandate (under Congress' taxing authority).
  - Struck down the government's enforcement mechanism for the Medicaid expansion, essentially creating a voluntary Medicaid expansion.
  - Left the rest of the ACA intact.

# Example: Existing NC Medicaid Income Eligibility

(Percent of Federal Poverty Level, 2013)

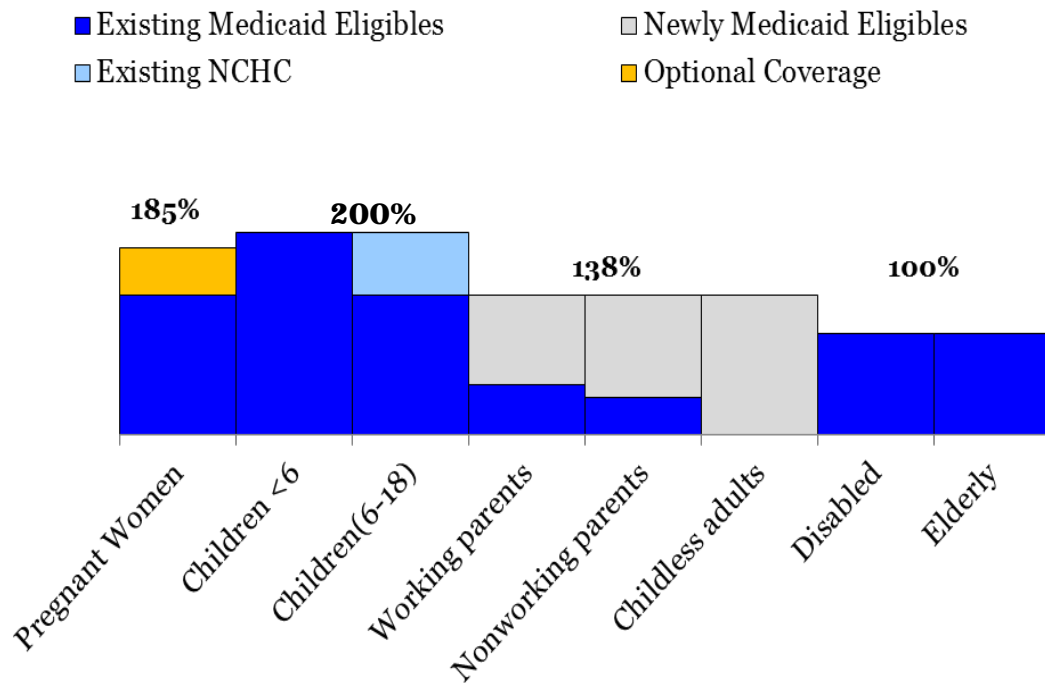


- Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

- Because of categorical restrictions, Medicaid only covers 30% of low-income adults in North Carolina, and 28% of low-income adults in South Carolina

Kaiser Family Foundation. State Health Facts. Calculations for parents based on a family of three. Note: 100% of the federal poverty levels (FPL) (2013) = \$11,490/yr. (1 person), \$15,510 (2 people), \$19,530 (3 people), \$23,550 (4 people)

# NC Medicaid Income Eligibility *if Expanded* (2014)



- *NC Division of Medicaid Assistance estimated Medicaid expansion would provide coverage to approximately 500,000 new eligibles in 2014.*
- *Kaiser Family Foundation estimated 568,000 new eligibles (NC).*

Note: 138% FPL (2013)= \$15,856/yr (1 person), \$21,404 (2 people), \$26,951 (3 people), \$32,499 (4 people).. KFF: The Cost and Coverage Implications of the ACA Medicaid Expansion. Nov. 2012.

# Employer Mandate

- **ACA provisions (postponed until 1/1/2015):**
  - **Employers with 50 or more full-time employees required to offer insurance or pay penalty** (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
  - **Employers with fewer than 50 full-time employees exempt from penalties.** (Sec. 1513(d)(2))

# Individual Mandate

- **Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt.** (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
  - **Penalties: Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment\***
- **Certain groups are exempt from the penalties, including those who would have to spend more than 8% of their income for the lowest cost premium.**

\*Families of three or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).

# Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals to purchase coverage through the Marketplace (formerly called “Exchange”).
- Eligible individuals include those with incomes between 100-400% FPL on a sliding scale basis, *if* not eligible for government coverage or affordable employer-sponsored insurance (Sec. 1401)
- Low income people (<100% FPL) not eligible for subsidies to purchase coverage in the Marketplace.

# Health Insurance Marketplace

- In NC federal government created a Health Insurance Marketplace for individuals. (Sec. 1311, 1321)
- Marketplaces (after a rocky start):
  - Provided standardized information (including quality, costs, and benefits) to help consumers and small businesses choose between qualified health plans.
  - Linked to provider directories.
  - Determined eligibility for the subsidy.
  - Facilitated enrollment for HBE, Medicaid and NC Health Choice through use of insurance “navigators”.

# Essential Benefits Package

- Insurers offered in the nongroup or small group market must offer an essential health benefits package:\* (Sec. 1302)
  - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; maternity care; oral health and vision services for children.
- Most insurance must also cover:\*
  - Well-baby, well-child care for children under age 21 (Sec. 1001)
  - Recommended preventive services and immunizations with no cost-sharing (Sec. 1001, 10406)
  - Mental health and substance abuse parity (Sec. 1311(j))



\* With some exceptions, existing grandfathered plans not required to meet new benefit standards or essential health benefits.



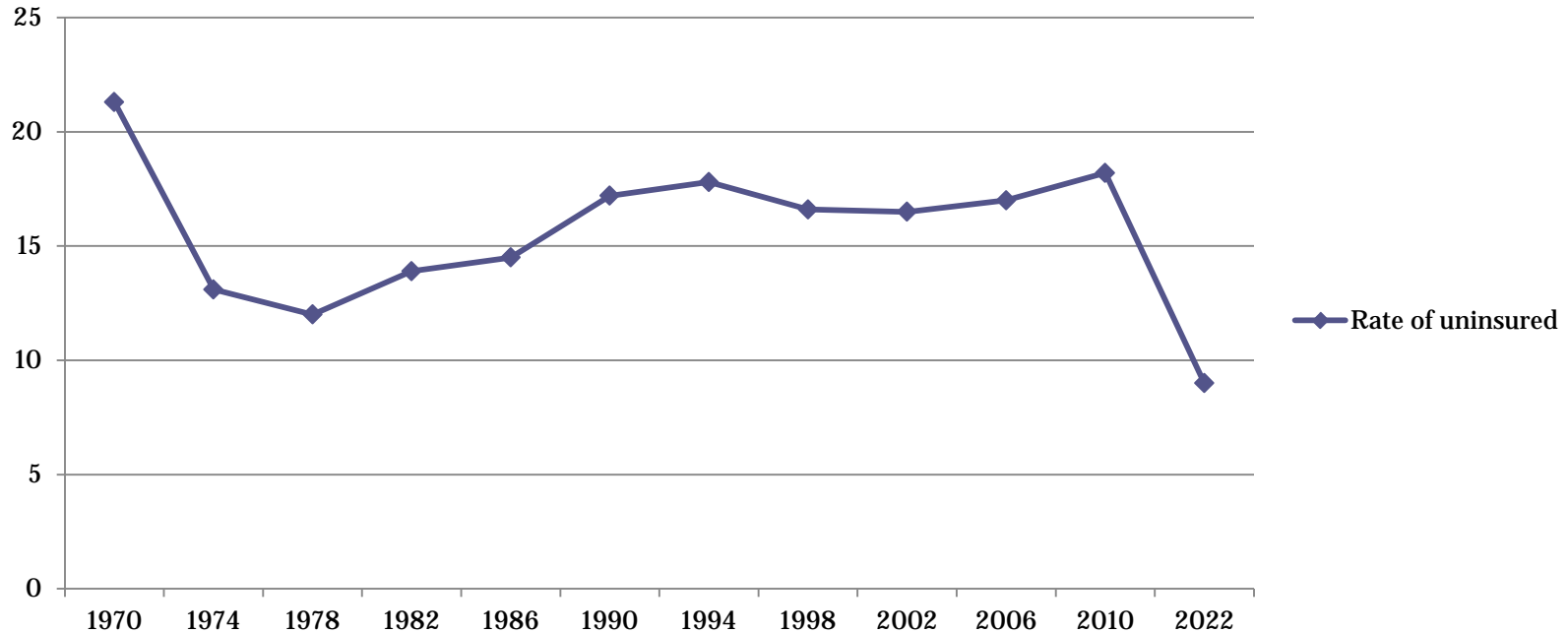
# Other Provisions to Expand Access

- The ACA included funding to:
  - Expand the number of community health centers
  - Expand support for school based health centers
  - Pay for loan forgiveness for health professionals willing to work in underserved areas
- Some new funds available to increase health professional workforce.

# Role of Case Managers in Expanding Access

- Case managers can help uninsured patients know where to go to obtain affordable health insurance
  - Can help link uninsured to the Marketplace, local department of social services, or navigators
- Access is more than insurance coverage
  - Case managers can help link newly insured to medical homes

## Rate of uninsured



[http://www.cdc.gov/nchs/health\\_policy/trends\\_hc\\_1968\\_2011.htm](http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm)

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>

# North Carolina Enrolling More than Most States into Marketplace

- North Carolina has the fifth highest enrollment\* into the marketplace as of March 1, 2014: 357,584 (October 1, 2013-April 19, 2014)
- North Carolina had the 9<sup>th</sup> largest enrollment as percentage of the uninsured and those previously covered by nongroup insurance who were income eligible for coverage in the Marketplace.
  - Third highest for “non-embracing” states
- North Carolinians qualified for \$606 million in health insurance subsidies. (Levitt L, et al. How Much Financial Assistance Are People Receiving Under the Affordable Care Act. Kaiser Family Foundation. March 2014. Issue Brief).



\*Enrollment defined as selecting a health plan. The federal government does not collect data on the number of people who paid the premiums.

# Outreach and Enrollment Assistance Led to Growth in Medicaid

- There was a growth of 68,675 people in Medicaid or NC Health Choice between March 2013 and March 2014.
- In addition, as of April 16, 2014 there were 118,913 MAGI Insurance Affordability applications pending (yet to be processed) so Medicaid enrollment is likely to grow further.

Actual Medicaid and NC Health Choice Enrollment (March 2013, 2014)

	<b>Medicaid</b>	<b>NC Health Choice</b>	<b>Total</b>
March 1, 2013	1,582,046	151,446	1,733,492
March 1, 2014	1,723,050	79,117	1,802,167

# ACA Estimated to Reduce Uninsured

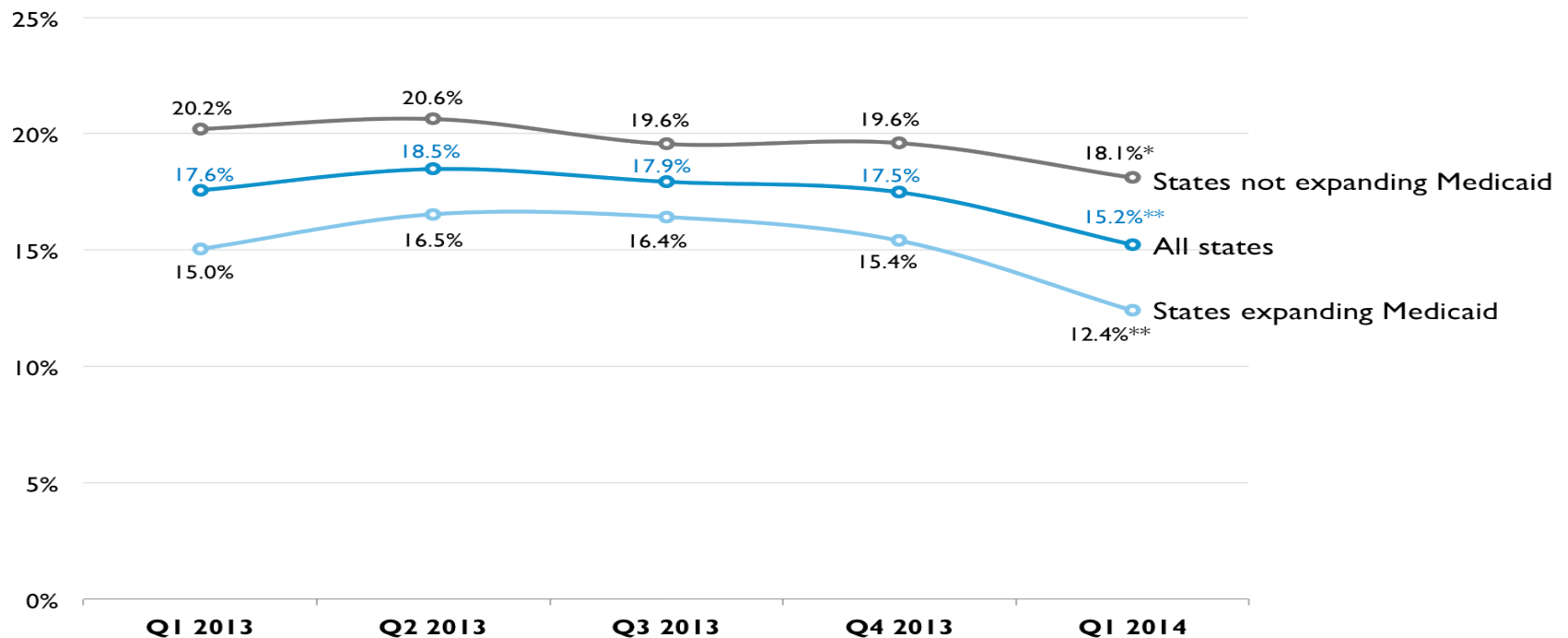
- A RAND study estimated that the numbers of nonelderly uninsured adults declined by 9.3 million between Sept. 2013-March 2014, reducing the uninsured adults from 20.5% to 15.8%
  - Medicaid enrollment increased by 5.9 million.
  - Enrollment in employer sponsored insurance grew by 8.2 million.
  - Enrollment in the Marketplace was 3.9 million (Note: this is lower than the federal estimates, in part because the survey did not capture all the people who applied in March).
  - Less than 1 million people who previously had insurance in the individual market lost their coverage.

# Federal Enrollment Data

- 8,005,697 enrolled (85% with subsidy)
- 6,724,660 determined to be eligible for Medicaid or CHIP through marketplace
- 5,237,673 Medicaid growth (average monthly enrollment pre/post open enrollment, EXPANSION states only---26 states and DC)
- 812,386 (net growth in non-expansion states)
- Compares Sept 2013 to April 2014 (3 states not reporting).

# Urban Institute Also Shows Decline in Uninsured (Uninsured Adults 18-64)

**Uninsurance Rate for Adults Age 18–64 by State Medicaid Expansion Decision**



Source: Health Reform Monitoring Survey, quarters 1–4 2013 and quarter 1 2014.

Notes: “States expanding Medicaid” indicates those whose expansion took effect before April 1, 2014. These are regression-adjusted estimates based on models that control for potential differences in the demographic, socioeconomic, and geographic characteristics of the HRMS sample across each quarter.

\*/\*\*/ Estimate differs significantly from the quarter 3 2013 uninsurance rate at the 0.05/0.01 levels, using two-tailed tests.

URBAN INSTITUTE





# Four Major Challenges Facing North Carolina

- 1) Coverage and access barriers
- **2) Overall population health**
- 3) Quality
- 4) Costs

# Problem #2: Population Health

- North Carolina ranks 33<sup>rd</sup> the 50 states and DC in population health measures in 2012. (America's Health Rankings, 2012)
  - Determinants of health, including smoking, binge drinking, obesity, poverty, preventable hospitalizations: NC (31).
  - Health outcomes, including diabetes, poor physical and mental health days, cancer and cardiovascular deaths, infant mortality rate, premature deaths: NC (38).

# Affordable Care Act

- **Prevention and Public Health Fund to invest in prevention, wellness, and public health activities**  
(Sec. 4002)
  - **Appropriates \$1 billion in FY 2012 increasing to \$2 billion over time.**
  - **Priority areas for the national public health agenda include health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings).** (Sec. 4001)

# ACA Prevention Grants: NC Example

- North Carolina has received ACA funds to support greater investment in prevention and health promotion. For example:
  - ~\$7.5 million to support multi-faceted interventions for tobacco-free living, active living and healthy eating, and use of evidence-based clinical and other preventive services.
  - ~\$1.8 million to assist pregnant and parenting teens and women in high needs counties.
  - ~\$5.5 million to implement evidence-based maternal, infant, and early childhood home visiting programs.
  - ~\$3.0 million to support personal responsibility education for teens (\$1.5 million to DHHS, \$1.5 million to DPI).

# New Requirements for Charitable Hospitals

- **New requirements for charitable 501(c)(3) hospitals:**  
(Sec. 9007, 10903)
  - **Must conduct a community needs assessment once every three years, and must adopt an implementation strategy to meet the community health needs identified through the assessment.**
  - **In conducting the community health needs assessment, the hospital must take into account input from persons who represent the broad interests of the community, “including those with special knowledge of or expertise in public health.”**
  - **Must report how the hospital is meeting the community needs in its tax reporting.**

# Role of Case Managers

- ACA provisions will encourage hospitals to more actively engage in improving population health
- Case managers play an important role in primary and secondary prevention
  - Helping individuals understand and implement healthy lifestyles
  - Helping individuals manage their chronic illnesses

# Problem #3: Quality

- *To Err is Human* estimated that preventable medical errors in hospitals led to between 44,000-98,000 deaths in 1997. (Institute of Medicine, 1999)
  - More recent study suggests that adverse events occurred in one-third of hospital admissions (Classen DC, Health Affairs, 2011).
- People only receive about half of all recommended ambulatory care treatments. (E. McGlynn, et. al. *NEJM*, 2003; Mangione-Smith, et. al. *NEJM*, 2007)

# Improving Quality of Care

- **The ACA directs the HHS Secretary to establish national strategy to improve health care quality.**  
(Sec. 3011, 3012)
  - **Funding to CMS to develop quality measures** (Authorizes \$75M for each FY 2010-2014; Sec. 3013-3014)
  - **Plan for the collection and public reporting of quality data** (Sec. 3015, 10305, 10331)
  - **Move towards value-based purchasing**
  - **Funding to support comparative effectiveness research**
  - **Funding for new models of care that change reimbursement to reward quality and health outcomes**



# Hospital Value-Based Payments: Examples

- Hospitals are no longer paid for treatment of “hospital acquired conditions”
- Hospitals with excess readmissions (risk-adjusted 30-day readmission rates) are receiving lower Medicare payments (Sec. 3025)
  - Initially, CMS will track readmissions for pneumonia, heart failure, and heart attacks. Additional health conditions will be added (2015).
  - In NC, 59 hospitals will be subject to a penalty (average reduction in DRG payments: 0.25%) (2013).

# Community-Based Care Transition Program

- **ACA created a community based care transition program. Grants awarded to:**
  - **NC: Northwest Triad Care Transitions Program, Access East Community-Based Transition Partnership, Access Care**
- **Program focuses on care for high-risk Medicare beneficiaries with multiple chronic conditions (i.e., cognitive impairment, depression, multiple readmissions, or other chronic disease/risk factor determined by the Secretary). (Sec. 3026)**

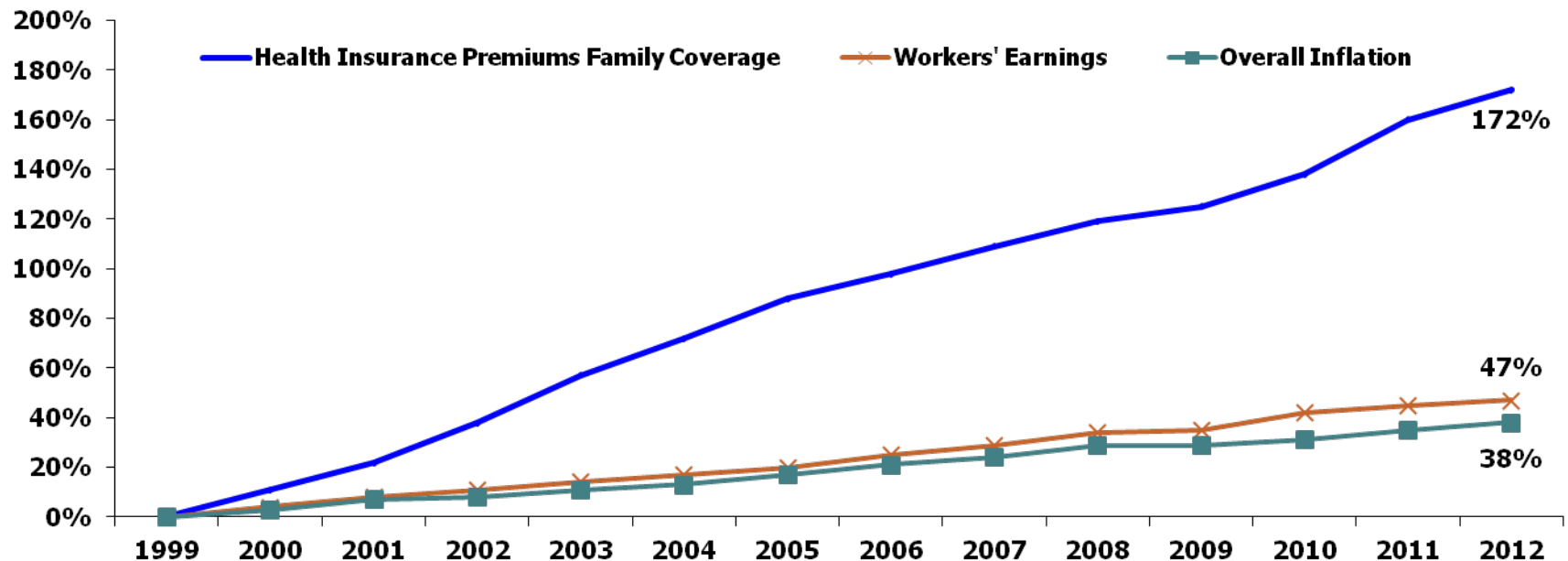
# Hospital Value-Based Purchasing (VBP) Program

- Beginning in 2013, hospitals will have their Medicare payments increased or reduced depending on how well they perform on certain quality measures.
- In 2015, VBP includes 19 measures including:
  - Process of care measures (20% weighting)
  - Patient experience with care (30%)
  - Outcome measures (30%)
  - Efficiency (20%)

# Problem #4: Costs

- US spending on health care rising far more rapidly than other costs in our society.
  - US spends more on health care than any other industrialized nation.
  - Health care costs rising about 3 times the rate of inflation.

# US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings



Source: KFF. Employee Health Benefits Survey. Chartpack. 2012. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

# Reducing Rate of Increase in Health Care Spending: ACA

- No “magic bullets” to reduce rising health care costs
- ACA includes new opportunities to test new models of care delivery and payment models in Medicare and Medicaid to improve quality, health and reduce unnecessary health care expenditures
- Once new models are shown to work in different communities and with different delivery systems, Secretary of HHS has the authority to implement broadly in other communities

# Affordable Care Act

- New models of care will reward health professionals and health care systems for:
  - 1) Improving population health
  - 2) Improving health care quality and health outcomes
  - 3) Reducing health care costs
- Some of the new models include patient-centered medical homes, bundled payments and accountable care organizations

# Elements of a Patient-Centered Medical Home

- 1) Primary care that is comprehensive, and covers preventive, acute and chronic care across the lifespan and incorporates a team of health professionals
- 2) Patient-centered—actively engaging patients in their own care management and tailoring care to meet the needs and preferences of the patients
- 3) Incorporating electronic health records and information support (such as patient registries, point-of-care decision support, population management) to improve quality of care and patient outcomes
- 4) Payment reform including fee-for-service, pay-for-performance, and separate payments for care coordination and care management



# Episode of Care (Bundled Payment) Models

- **Key elements of episode of care models**
  - 1) Single, bundled episode of care payment made to group of providers to cover all services needed by patient during episode
  - 2) Group of providers could include hospitals, physicians, home health, nursing homes, involved in patients care for that episode
  - 3) Amount of payment would vary based on patients diagnoses and other factors, but no increase in payments for adverse events
  - 4) Amount of payment would be prospectively defined, but would include retrospective adjustment based on risk-adjusted outcomes
  - 5) Patients would receive incentive to use high-quality, lower-cost providers and to adhere to treatment protocols

# ACO: Overview

- An ACO is an organization of eligible providers and supplies who are accountable for the quality, cost, and overall care of the an assigned group of enrollees (e.g., Medicare beneficiaries).
- ACOs can share Medicare savings with the federal government IF:
  - The ACO complies with all the ACO requirements, AND
  - The ACO meets quality standards, AND
  - The ACO has measured savings below a calculated threshold
- Three CMS models: Shared Savings Program, Advance Payment Model (for rural), Pioneer ACO Model

# New Payment/Delivery Models: North Carolina Selected Examples

- **Multi-payer Advanced Primary Care Initiative: CCNC**
- **Accountable Care Organizations:**
  - **Advance Payment: Coastal Carolina (New Bern)**
  - **Shared Savings: ACC of Caldwell County; ACC of Eastern North Carolina; Cornerstone Health Care, Triad Healthcare, Physicians HealthCare Collaborative**
  - **Pediatric Accountable Care Collaborative: CCNC**
- **Bundled Payments:**
  - **Blue Ridge Healthcare System (Morganton, Valdese), Duke Hospital (Durham), First Health Moore Regional (Pinehurst), Amedisys Home Health (Fayetteville, Louisburg, Chapel Hill)**

# New Payment/Delivery Models: South Carolina Selected Examples

- **FQHC Primary Care Initiative:**
  - New Horizon, Beaufort-Jasper-Hampton Comprehensive Health Services, Jefferson Medical Office, Lugoff Medical Office
- **Bundled Payments:**
  - Providence Hospital (Columbia)
  - Amedisys Home Health (Georgetown, North Charleston, Camden, Myrtle Beach, Charleston, Conway, Bluffton, Hilton Head)
- **Strong Start for Mothers and Newborns**
  - Medical University of South Carolina
- **Innovation initiatives:**
  - Eau Claire Cooperative Health Centers
  - South Carolina Research Foundation

# Role of Case Managers

- New payment models (capitation, shared savings) will encourage hospitals and health systems to examine more cost effective ways to provide care
- Case managers (including nurses, social workers, and other caregivers) are critical to successful transitions
  - Help education patients about their treatment plan and medications
  - Help people with chronic illnesses manage their health problems
  - Help link patients to other providers (“warm handoffs”)
  - Provide care to patients in their home

# ACA: Outstanding Challenges

- The ACA presents many new challenges to the state.
  - The poorest people will lack insurance coverage and they will be ineligible for subsidies
  - We may not have enough trained navigators or volunteers to help people enroll
  - May not be sufficient provider supply in 2014 to handle health care needs of newly insured, and will continue to be maldistribution issues
  - Some providers and higher income individuals will pay more in taxes
  - We do not yet have the “magic bullet” that will ensure better quality and reduced health care costs

# ACA: New Opportunities

- **However, ACA offers many opportunities, including:**
  - **Expanding coverage to more of the uninsured.**
  - **Makes health insurance coverage more affordable to many (although some people may have to pay more for coverage).**
  - **Helping improve overall population health and expands coverage of preventive services.**
  - **Greater emphasis on quality of care.**
  - **Potential to reduce longer term cost escalation.**

# Question and Answer Session

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## **Commission for Case Manager Certification**

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# Thank you!

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- Please fill out the survey after today's session
- Those who signed up for Continuing Education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at [www.ccmcertification.org](http://www.ccmcertification.org)



# NCIOM Health Reform Resources

- Implementation of the Affordable Care Act in North Carolina. <http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>
- Implementation of the Affordable Care Act in North Carolina. *NCMJ*, May/June 2011;72(2):155-159. <http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf>
- What Does Health Reform Mean for North Carolina? *NCMJ*, May/June 2010;71:3 <http://www.ncmedicaljournal.com/archives/?what-does-health-reform-mean-for-north-carolina>
- NCIOM: North Carolina data on the uninsured <http://www.nciom.org/nc-health-data/uninsured-snapshots/>
- Other resources on health reform are available at: <http://www.nciom.org/task-forces-and-projects/?aca-info>

# National Health Reform Resources

- **Patient Protection and Affordable Care Act.  
Consolidated Bill Text**  
<http://docs.house.gov/energycommerce/ppacacon.pdf>
- **U.S. Health Reform website**  
[www.healthcare.gov](http://www.healthcare.gov)
- **National Federation of Independent Business v. Sebelius**  
<http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>
- **Congressional Budget Office. Selected CBO Publications  
Related to Health Care Legislation, 2009-2010.**  
<http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>
- **Kaiser Family Foundation**  
<http://healthreform.kff.org/>