Health care coverage has changed dramatically over the past few decades, with more focus on integrated health systems, innovative treatments, and technology. These changes have resulted in cost savings and improved health for many. However, we continue to face challenges in improving outcomes for those with the greatest need.

 Begun more than 50 years ago, Medicaid is designed to serve as a health care safety net for our most vulnerable residents: children, persons with disabilities, and those facing economic hardship. Although Medicaid is a federal entitlement program, it is administered by states with assistance from counties. The federal government sets broad guidelines for Medicaid, and states have the flexibility to expand benefits of eligibility. Unfortunately, many providers are debating whether to continue to serve Medicaid recipients. As some providers elect to serve only patients with private insurance, low-income persons may face health care access issues.

Medicaid Expansion

As originally passed, the Patient Protection and Affordable Care Act of 2010 (ACA), would have required states to extend Medicaid coverage to all persons who earn up to 133% of the federal poverty level (FPL). However, the US Supreme Court ruled that each state should decide whether to expand Medicaid via the ACA. In states that chose not to expand Medicaid (including North Carolina), many low-income adults were left without insurance.

While the federal government agreed to bear many of the initial costs of Medicaid expansion for states that decided to opt in, some of the costs to maintain the program will eventually fall to the states. North Carolina leaders questioned whether our state should bear increasing costs beyond the final year of the ACA implementation deadline. The concern is that there is no guarantee that the federal government will continue to assist states with the ongoing large share of the costs for the program following implementation.

In discussing Medicaid eligibility, readers need to understand several terms related to those facing economic hardship: poor, near poor, and low-income. As defined by the National Center for Children in Poverty, persons are “poor” if they live below the FPL. They are considered “near poor” if their household income is between 100% and 199% of the FPL. The term “low-income” includes both poor and near poor individuals [1].

Health Care Access

A disproportionate number of children are classified as low-income. In 2014, children under the age of 18 years represented 23% of the US population but comprised 32% of all people in poverty. Some 44% of children (31.4 million) live in low-income families, and approximately 1 in 5 children (15.4 million) live in poor families (see Figure 1) [1]. Nationally, the percentage of children living in low-income families has risen from 39% in 2007 to 44% in 2014.
this period, the number of all children has increased by less than 1% [1].

Some factors that impact childhood poverty include parental education, employment, marital status, race/ethnicity, and geographic location. Higher levels of parental education decrease the likelihood that a child will live in a low-income family. Of children whose parents have less than a high school diploma, 86% live in low-income families, and 55% live in poor families. Also, children who live with married parents are much less likely to be low-income than are children who live with a single parent [1].

Lack of access to health care is also a predictor of poverty. A 2015 analysis by the National Bureau of Economic Research found that expanding Medicaid to children had long-term health and economic benefits. As adults, these individuals had higher incomes and thus collected less money from the government in the form of the Earned Income Tax Credit, and women had higher cumulative earnings by age 28 years [2]. Also, these persons were less likely to die prematurely, and they were more likely to attend college [2].

When looking at uninsured individuals, the vast majority (84.5%) are adults, as was true before passage of the ACA. Only 15.5% of uninsured individuals are children age 17 years or younger [3]. Young adults aged 18–34 years constitute the largest portion of the uninsured population. They comprise 38.6% of the total uninsured population and 45.7% of uninsured adults. Almost 20% of uninsured persons are aged 50–64 years [3].

Race and ethnicity are also related to health care coverage. White non-Hispanic persons make up 45.8% of the total uninsured population. Another 13.7% of uninsured persons are non-Hispanic African Americans, and 32.8% are Hispanic individuals [3]. Geography is also important, with almost half (46.5%) of uninsured persons living in the South [3].

Mental Health and Substance Use

Medicaid is the largest source of funding for mental health services in the United States. Untreated mental illness and substance abuse affect overall health care and well-being. A 2014 survey by the Substance Abuse and Mental Health Services Administration found that 27.0 million people aged 12 years or older had used an illicit drug in the past 30 days; this corresponds to about 1 in 10 Americans (10.2%) [4]. The percentage of the population using illicit drugs was higher in 2014 than in any year between 2002 and 2013. More than one-third of young adults aged 18–25 years (37.7%) engaged in binge alcohol drinking in 2014, and about 1 in 10 (10.8%) were heavy alcohol users [4]. Finally, overdose rates from opioid pain relievers are now at an epidemic level nationwide. Nonmedical use of opioid pain relievers costs US health insurers approximately $55 billion annually. Deaths from opioid overdoses tripled between 1990 and 2011, and the death rate from opioid overdoses is now comparable to the death rate from motor vehicle accidents among persons aged 65 years and younger [5].

In 2014, about 1 in 5 adults age 18 years or older had any mental illness in the past year, and 9.8 million adults (4.1%) had a serious mental illness. In 2014, 2.8 million adolescents aged 12–17 years (11.4%) had a major depressive episode in the past year, which was higher than the rates in 2004 and 2012. Those who experienced a major depressive episode in the past year were also more likely to have used illicit drugs during that time (see Figure 2) [4].

Mental illness, often exacerbated by drug and alcohol abuse, affects the entire family. Research has shown that mothers who develop a mood disorder are at increased risk for impaired function across multiple domains including cognitive, social, academic, and physical health. The social domain includes crime, child abuse and neglect, and poverty. These maternal issues can result in parenting problems and interparental conflict, which can impact children [6].

Containing Medicaid Costs

North Carolina has taken several steps to contain Medicaid costs. These include behavioral health reform, capitation of services, establishment of a medical home model, and adjustment of billable fee-for-services rates. However, the state’s Medicaid budget variability and forecasting have historically remained difficult. These issues led to North Carolina’s Medicaid Reform Bill (Session Law
Medicaid patients. These programs support people who programs to meet the needs of special populations of populations. Under the new system, a robust health infor
ports federally qualified health centers, free clinics, and beneficiaries during the transition, plus the proposal sup
Medicaid recipients who are receiving behavioral health services should not see a change in these services for at least 4 years after the managed care companies begin overseeing the physical health component. Over time, Medicaid will begin to include behavioral health services, and recipients should see more focus on integration of physical and behavioral health care.

A New Medicaid Structure

The North Carolina Department of Health and Human Services (DHHS) will still play a role in overseeing the administration of Medicaid, but a new structure will be created. The Medicaid reform bill created a new Division of Health Benefits within DHHS to oversee the implementation of the Medicaid transformation and to enter into contracts with providers. The bill proposes that there will be 6 Medicaid regions across North Carolina, with at least 4 health plans in each region. The new Medicaid system will be implemented after the proposal has been approved by the federal government and the Medicaid health plans are chosen. Eligible residents will be able to select their plan from several that are offered. The proposal also includes the concept of an innovations center to help providers and beneficiaries during the transition, plus the proposal supports federally qualified health centers, free clinics, and public health departments that provide care for vulnerable populations. Under the new system, a robust health information exchange will be created under state control. Finally, a transition reserve will be established as the state moves to full-risk capitation. The state will set the payment rates under the capitation model [7].

North Carolina currently operates 4 Medicaid waiver programs to meet the needs of special populations of Medicaid patients. These programs support people who might otherwise be institutionalized, instead allowing them to receive services in the community. The state anticipates that the existing Medicaid waiver programs will continue to operate alongside the newly proposed system (see Table 1) [8].

Although it improves several parts of the system, the Medicaid proposal also carries some risks. DHHS may struggle to maintain access for Medicaid patients, especially for patients in vulnerable rural areas, as fewer providers accept Medicaid. It is also important to obtain timely data for the new Medicaid system to determine whether it is working as expected; however, this type of data collection has historically been challenging. In addition, many still have concerns about dismantling existing provider networks and establishing new systems of care.

North Carolina faces other challenges such as incorporating cost settlements, which are given when payments do not cover the cost of care. To address this problem, DHHS officials have carefully designed a strategy that includes uncompensated care pools and “bump payments” that can be given to providers who meet certain thresholds and/or make investments. Some providers have also expressed concern that their administrative burden would increase under the new plan.

If approved by CMS, North Carolina will join the majority of other states in relying on managed care for delivery of comprehensive Medicaid services. This change should result in more budget predictability. One of the federal requirements of the waiver is that it be as budget neutral as possible [9].

North Carolina’s Medicaid program has historically provided optional services that other states’ programs do not. Many of these services benefit adults in the aged, blind, and disabled eligibility category. In 2011, nearly two-thirds of Medicaid expenditures benefitted elderly individuals and those with disabilities, even though they made up less than one-fourth of the program’s enrollees [10]. Advocates note that paying for optional Medicaid services up front can sometimes prevent more costly expenditures later on, such as emergency room visits and higher levels of care.

Conclusion

Programs that serve the whole patient are long overdue, particularly for individuals in vulnerable populations. The proposed reform must incentivize providers to serve populations they have not been rewarded for serving in the past, and it must yield more comprehensive care by integrating mental health and physical health. The proposed reform could also help address social determinants of health and reduce health inequities in rural regions and underserved communities. The proposal addresses ways to provide services to children and families in the child welfare system, which will ensure that both foster children and their parents can receive services needed to promote family stability and well-being.
Medicaid can benefit local economies in addition to increasing access to health care services for our most vulnerable citizens. By doing so, it not only improves health and quality of life, but it also reduces the amount of uncompensated care that must be borne by states and local economies. The Urban Institute estimated that states and localities spent $20 billion on uncompensated care in 2013, in addition to almost $33 billion from the federal government [11].

As North Carolina moves toward a more efficient means of delivering health care, I hope the long-term impact on vulnerable populations will be a high priority. A short-term focus on cost containment alone may result in greater costs in the long term if health care needs are not adequately met [11].

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### Table 1. North Carolina’s Current Medicaid Waivers

| Name of waiver | Covered services | Beneficiaries | Impact of upcoming Medicaid transformation |
|----------------|------------------|---------------|-------------------------------------------|
| Community Alternatives Program for Disabled Adults (CAP/DA) | Provides adult day health services, institutional respite services, personal care aides, assistive technology, community transition services, home accessibility and adaptations, meal preparation and delivery, noninstitutional respite services, participant goods and services, personal emergency response services, specialized medical equipment and supplies, training and education, and consultative services. | Available to individuals aged 65 years or older and individuals with disabilities aged 18–64 years. | The waiver will continue to exist. Regular State Plan services and waiver services should still be provided through the new plan groups. |
| CAP Choice | Provides adult day health services, institutional respite services, personal assistants, care advisors, financial management services, consumer-directed goods and services, home modifications and mobility aids, preparation and delivery of meals, in-home respite services, telephone alert services, and supplies. This waiver offers the option for family members to be the paid caregiver for their loved ones. | Available to individuals aged 65 years and older and individuals with disabilities aged 18–64 years. | The waiver will continue to exist. Regular State Plan services and waiver services should still be provided through the new plan groups. |
| Community Alternatives Program for Children (CAP/C) | Provides in-home respite care, personal care, case management, care advisors, financial management services, nursing services, caregiver training and education, community transition funding, home modifications, institutional respite, motor vehicle modifications, palliative care, personal assistants, and supplies. | Available to medically fragile individuals aged 0–20 years. | The waiver will continue to exist. Regular State Plan services and waiver services should still be provided through the new plan groups. |
| NC Innovations | Provides community navigator services, community networking, day supports, personal care services, residential supports, family caregiver respite services, supported employment, financial support services, assistive technology, community transition services, crisis services, home modifications, in-home intensive supports, in-home skill building, individual goods and services, natural supports education, specialized consultation services for family caregivers, and vehicle modifications. | Available for individuals with intellectual or developmental disabilities. | The Innovations Waiver will continue to be administered through the LME/MCOs. Individuals may be required to enroll with the 1115 PHPs for medical services and providers. |

Note. LME/MCO, local management entity/managed care organization; PHP, prepaid health plans.

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