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Lessons on preparedness: Ebola in the United States

On July 28, 2014, the Centers for Disease Control and Prevention held its first press briefing about the West African Ebola outbreak, following the infection of two U.S. healthcare workers who were treating patients in a hospital in Monrovia, Liberia. Since the first reported Ebola case in March 2014, the disease has claimed almost 5,000 lives in western Africa, making it the largest Ebola outbreak known to modern medicine.

"I want to underscore that Ebola poses little risk to the U.S. general population," said Stephan Monroe, deputy director of CDC's National Center for Emerging Zoonotic and Infectious Diseases, at the July 2014 briefing. "Nevertheless, because people do travel between West Africa and the U.S., CDC needs to be prepared for the very remote possibility that one of those travelers could get Ebola and return to the U.S. while sick."

On Sept. 29, those preparedness efforts were kicked into overdrive when the first case of Ebola in the U.S. was confirmed at Texas Health Presbyterian Hospital.

"It's a delicate balance between stressing the importance of preparedness and not creating unnecessary fear," said Matthew Merritt, Novant Health emergency preparedness manager. "The reality is the risk of us seeing an Ebola patient is still very low, but the situation in Texas, and now New York, reminded us we can't take that risk lightly."

"Numerous team members have been entirely focused on helping the organization prepare. We have reviewed our plans, equipment, supplies, training and engagement with community health partners," said Tom Zweng, MD, chief medical officer for Novant Health. "Our team members and communities should feel secure knowing we are prepared to provide the right care in a safe environment for all."

Lessons on preparedness: Ebola in the United States continued

The cost of preparation

Across the country, healthcare facilities are vigorously preparing for another patient to walk through their doors. While preparedness is a must, it does not come without cost — even without a single confirmed Ebola patient to treat at the facility.

It is easy to estimate costs related to treating a single Ebola patient. Dan Mendleson, CEO of consulting firm Avalere Health, estimates the final cost of care for Eric Thomas Duncan at Texas Health Presbyterian Hospital may approach \$500,000 once direct and indirect costs are factored into the total. Not only was Duncan in strict isolation, but his treatment included fluid replacement, blood transfusions, a ventilator, dialysis and a host of medications. The facility also employed extra security, disposed of Ebola-contaminated waste in a special manner and provided special equipment to his care team — much of it beyond the scope of daily care.

The most recent estimate by the World Bank suggests the Ebola outbreak could result in an economic drain on the world economy of as much as \$32.6 billion by the end of 2015 if the epidemic spreads further in Africa. There are no estimates, however, on the cost to a healthcare system to prepare: training, testing, personal protection equipment and, of course, unused beds in isolation areas. All this preparedness is a good reminder of the investments made every day by a hospital to be ready for every patient that comes through its doors — no matter the diagnosis.

“Even without a patient, preparation requires tremendous resources,” said Zweng. “We have purchased special personal protection equipment for all of our physician practices, outpatient centers and medical centers. We are training our team and holding meetings with key staff to ensure we are aware and prepared. We are working as a system and testing our processes at the facilities. We look at this as a great exercise in preparation and we are committed to being prepared to provide the best care to a patient in need while protecting our team.”

Following the events in Texas, the CDC has revised its recommendations for handling Ebola patients. With that, preparation efforts by healthcare systems nation-wide must change as well.

“Being prepared is the greatest service we can provide to our communities right now,” said Merritt. “The CDC provides much-needed guidance, but it’s the hospitals that are shouldering most of the burden.”

To learn more about Novant Health’s efforts in Ebola preparedness, visit NovantHealth.org/ebola.

The impact of the Patient Protection and Affordable Care Act: Q&A with Jeff Lindsay, Novant Health chief operating officer

Jeff Lindsay serves as Novant Health's executive vice president and chief operating officer and is responsible for the operational performance and strategic growth of the system. With over 20 years of hospital leadership experience, including serving as the president of three Novant Health facilities, Jeff has a unique insight on the ACA and its impact on healthcare systems nationwide. We've asked him to share his experiences and give us a preview of what the future may bring.

As COO, what do you hope to accomplish by providing Novant Health communities with quality healthcare in the age of the Patient Protection and Affordable Care Act (PPACA or ACA)?

Long before the ACA was passed into law, Novant Health began transforming the way it delivers care. Rather than wait for change to happen to us, we took a hard look at ourselves and started to make changes in the best interest of our patients and our operations. In our model, healthcare extends far beyond the walls of any hospital or clinic. It is our job to reach out in the communities we serve to inform, educate and provide opportunities for preventive care to patients before they ever enter our facilities. For example, mobile units travel to underserved communities where they provide diabetes and mammography screenings to residents who otherwise may not have received those services. We have teams of care coordinators focused on helping patients manage their chronic conditions more effectively through the relationships we've built with those patients over time. We've expanded access to care through video visits with our primary care physicians. And long before ACA, we've been focused on addressing the affordability problem in healthcare by establishing lower price points for primary and urgent care in our communities so patients have easy access to care for conditions that can be addressed in a more retail-like setting. We didn't make these changes in reaction to the ACA. We made them because of our commitment to make affordable, "easy-for-me" healthcare available when and where our patients need it so they can focus on getting better and staying healthy.

Has Novant Health seen an increase in insured patients since the implementation of the ACA?

Novant Health has not seen an influx of insured patients. In fact, the impact has been neutral to slightly positive. While the exchange efforts were noble — particularly in North Carolina — we have a long way to go to ensure greater access to care for those in the communities we serve. Throughout the Novant Health footprint we still see an enormous number of people seeking care in our hospital emergency rooms whose household incomes are too high to receive Medicaid but too low to pay for their own insurance. This care is expensive, unsustainable and often could have been avoided had the patient received the appropriate preventive care. We continue to advocate for Medicaid expansion across our footprint and to seek new and expanded solutions toward getting these patients insurance coverage and therefore greater access to the appropriate care.

It has been a year since the opening of the health exchanges. Did Novant Health participate in the process to enroll eligible people?

Novant Health takes its commitment to the communities and patients it serves very seriously. Not only is Novant Health dedicated to providing quality, affordable care, but it is dedicated to ensuring its communities are armed with the right information to make informed health decisions. Throughout the enrollment period, Novant Health

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The impact of the Patient Protection and Affordable Care Act: Q&A with Jeff Lindsay, Novant Health chief operating officer continued

took a proactive approach and held information sessions in its communities. We invited the public to learn more about their insurance options and even signed people up for coverage at our events. Over the course of about five months, Novant Health reached out to nearly 160,000 people in its communities through mail, email and educational events. I am proud of our efforts. North Carolina was one of the highest enrollment states in the country, and I believe we played a part in that outcome. Our education events were designed to help simplify an extremely complicated issue and our communities welcomed the information. We plan to hold similar events during the next enrollment period.

What effect do you think the ACA will have in the future?

My hope is that many more individuals have access to quality and affordable healthcare than do today. I also hope that we are significantly closer to a system that creates value by keeping patients healthy, as opposed to the volume-based system of today. We take seriously the imperative to create an environment where people are given the tools necessary to become healthy and where those who are healthy continue to be. I am very proud of what Novant Health is doing in this area. Our patient oriented delivery systems, or PODs, are doing remarkable work around preventable diseases like diabetes as they follow a patient from screening to treatment to follow-up. We are establishing these resources in every community we serve. In specific communities across our footprint, we have organized 100 to 200 physicians and put them in charge of caring for 50,000 to 200,000 patients. Care coordinators work with primary care physicians, specialists, pharmacists, caregivers and the patient to make sure all are working together to make a patient well or manage their illness. We do not receive additional compensation for these services. Instead, we believe the value they provide by enhancing patient care will not only improve the population's health over time, but also improve the financial well-being of the healthcare industry by preventing duplication, confusion and waste. Our goal is to lead that transition so patients in all the communities we serve have access to affordable, accessible healthcare they can count on to be of the highest quality, when and where they need it.

The health insurance exchange: One year later

Healthcare marketplaces, also known as health insurance exchanges, were established by the Patient Protection and Affordable Care Act (PPACA or ACA) and intended to be a significant step toward ensuring more people in the United States have access to health insurance. The ACA created health insurance exchanges to enroll individuals in insurance plans and gave states three options: create their own exchange, partner with the federal government or have their residents participate in the federal exchange. According to the National Conference of State Legislatures, as of October 2014, 36 states have either a full federal exchange or a partnership with the federal exchange. Only 14 states and the District of Columbia have a full state-based exchange.

Although well-documented technical difficulties got the federal exchange off to a rough start, eventually more than 8 million people signed up during the first open enrollment period that ended in April 2014. There is no requirement to purchase coverage on an exchange in order to satisfy the ACA's mandate that everyone must

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The health insurance exchange: One year later continued

have health insurance. However, with few exceptions, in order to take advantage of the income-based premium subsidies included in the law, a consumer needs to buy their coverage through an exchange.

After initially agreeing to create a state-based marketplace, North Carolina ultimately decided against it. North Carolina residents then became eligible for the federal exchange and, despite initial concerns that a lack of state support would discourage enrollment, more than 350,000 residents secured health insurance through this mechanism, making it the nation's fifth highest for enrollees to date.

In Virginia, lawmakers also chose to forgo a state-based exchange. More than 216,000 residents selected insurance on the federal exchange, the 10th highest enrollment in the nation. On Sept. 8, 2014, Gov. Terry McAuliffe released a 10-point plan to further expand health coverage in the commonwealth, estimating it could help about 200,000 additional citizens. The plan includes providing new coverage opportunities for about 25,000 Virginia residents and reaching out to others who have not yet signed up for available coverage. While disappointed in the Virginia General Assembly's reluctance to expand Medicaid, the governor is now aggressively leveraging what resources are available to expand coverage, including the exchange.

South Carolina and Georgia also chose not to create a state exchange. In both states, officials initially accepted federal grant money to explore a state-level exchange. After months of deliberation, state commissions concluded they should encourage the creation of private exchanges instead of a state-run exchange. This made the federal exchange an option for South Carolina and Georgia residents. So far, more than 118,000 residents have enrolled in health insurance through the federal exchange in South Carolina and more than 316,000 have participated in Georgia.

In states that chose not to create an exchange but participate in the federal exchange, additional efforts were necessary to ensure more people were made aware of their options for coverage. Novant Health played a big role in educating patients about their available choices across its four-state footprint.

Novant Health held or participated in 18 education and enrollment events where more than 800 participants learned about their health insurance options. The organization also made significant investments in educating the self-pay and uninsured: answering more than 700 calls and sending more than 158,000 letters and emails informing patients about new enrollment opportunities. Novant Health continues to maintain a microsite focused on the exchanges.

Novant Health believes educating the public is the right thing to do for its communities and patients. The organization takes its role as a trusted advisor seriously and is committed to providing updates and education on the ACA's enrollment options. Being a proactive healthcare partner, Novant Health has already planned additional educational and promotional efforts for the 2015 open enrollment period, which begins in November 2014.

North Carolina Medicaid reform can learn from population health

In an effort to improve health outcomes in the communities it serves, Novant Health has implemented patient oriented delivery systems (PODs) using a “population health” model. This shift from a fee-for-service system to a value-based care system is meant to increase the quality of care while driving costs down. This move from volume to value can provide a meaningful example to North Carolina legislators and administration officials as they work to reform the state’s Medicaid program.

Researchers, practitioners and policymakers in healthcare, public health and other fields increasingly use the phrase “population health.” Although their understanding of this phrase differs, many see population health as a powerful opportunity for healthcare delivery systems, public health agencies, community-based organizations and many other entities to work together to improve health outcomes. By improving healthcare outcomes, costs can be reduced while keeping the population healthier.

But to be successful, the focus cannot solely rely on outcomes. Health outcomes are influenced by social, economic and physical environments, individual capacity and coping skills, human biology, personal health practices, early childhood development and health services. Improving healthcare outcomes requires a team approach and an ability to impact all factors.

These same challenges exist for the Medicaid population. The typical Medicaid recipient is a child from a low-income family or an individual who is elderly, blind or disabled. These groups tend to have many external factors that affect their ability to obtain healthcare and follow a treatment plan. These challenges also make them a more expensive segment of the population to care for.

To cover some of the costs of Medicaid, states are forced to shift money away from needed areas, such as education and transportation. Transportation projects get delayed, and schools become overcrowded and underfunded. At the same time, providers are being paid less than the cost of delivering service and are forced to make up the difference by shifting costs to the commercial market. This cost shifting inevitably results in higher insurance premiums for employers.

North Carolina is one of many states currently struggling with how to reform its Medicaid program. Many agree that North Carolina needs a system that runs efficiently and provides quality care for some of the state’s most vulnerable citizens. How to best deliver that care and provide North Carolina with much needed budget predictability is still the subject of discussion. As North Carolina reforms Medicaid, healthcare providers can be a valuable resource. By managing the health of Medicaid recipients and following a population health approach, the North Carolina Medicaid population can be ensured safe and quality care is delivered efficiently and at a considerable value.

For example, North Carolina patient Sally Smith* tells the story of how population health management can ensure individual patients are given the tools to manage their own conditions. Sally raised a flag in our system when a care coordinator followed up to ensure she understood her treatment plan. In the conversation, the care coordinator learned Sally was not following her treatment plan and she had not even filled a prescription for managing her condition. The reason? She could not afford the drug. Through the population health approach, the team worked with Sally’s doctor, a pharmacist and a local care clinic to adjust her medication

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North Carolina Medicaid reform can learn from population health continued

to a less-expensive, but still effective, drug and also found her financial assistance to pay for the medication. Without this approach, it is likely Sally would have ended up in the emergency room in a crisis — a far more costly alternative to managing her condition.

Population health is evolving at Novant Health. The lessons learned through the organization's efforts could offer valuable information in the Medicaid reform conversation.

**Patient name changed to protect identity. Representative patient example based on true story.*

Medicaid expansion: States struggle to provide coverage

The stated goal of federal healthcare reform was to give more Americans access to affordable, quality health insurance and slow the growth of healthcare spending. When the Patient Protection and Affordable Care Act (PPACA or ACA) was signed into law in 2010, it envisioned accomplishing this in several ways. To start, it would create health insurance exchanges that offer individuals different health insurance options and provide parameters for when employers must provide health insurance for employees.

Other provisions required states to expand Medicaid coverage, dramatically increasing the number of eligible people. The law stipulates the federal government would pay 100 percent of the cost for newly eligible Medicaid beneficiaries for the first few years, eventually lowering the federal government share to 90 percent by 2020. Typically, the federal government pays a much lower share for Medicaid recipients. As of October 2014, 27 states and the District of Columbia have chosen to expand Medicaid.

According to proponents of the law, establishing health insurance exchanges and expanding Medicaid to a much larger population would set the healthcare industry and the communities they serve on a path to a healthier and more financially secure future. With more people covered, there would be greater access to preventive care, fewer expensive emergency room visits and more shared risk on costly medical treatments.

Initial travel down this envisioned path was not smooth. The new controversial law was challenged in the courts for several years, making its way to the U.S. Supreme Court in June 2012. The Supreme Court ultimately upheld nearly all provisions of the law; however, the provision requiring states to expand Medicaid was struck down. When the law went into effect on Jan. 1, 2014, large portions of the population who would have been newly eligible for Medicaid were no longer guaranteed coverage as the law intended.

Under the ruling, the federal government could not force states to expand Medicaid; each state had the right to make that decision. While states that expanded Medicaid were eligible to receive millions in federal dollars for the newly covered, opponents of the law voiced serious concerns about the federal government following through on its commitment to pay the vast majority of costs associated with this population. As a result, 23 states have declined expansion, including North Carolina, Virginia, South Carolina and Georgia.

These state decisions not to expand Medicaid have left many in a "coverage gap," where an individual's income is high enough to prevent Medicaid eligibility but also low enough to make private, individual coverage

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Medicaid expansion: States struggle to provide coverage continued

unaffordable. Those in the coverage gap do not have health insurance but still require medical care, often turning to emergency rooms for even the most minor (but significantly more expensive) treatments.

The decision not to expand comes at a price, according to a recent Urban Institute study. For every \$1 a state invests in Medicaid expansion, \$13.41 would flow into the state over a 10-year period (2013 to 2022). In North Carolina, this means \$39.6 billion in lost federal dollars. In Virginia, the commonwealth loses \$15.8 billion, and in South Carolina, \$14.7 billion stays in federal coffers. The Urban Institute study concludes these lost dollars translate to weaker economic activity and lost opportunities for job growth.

Not-for-profit health systems, including Novant Health, are committed to providing high-quality care to any and all seeking treatment, regardless of a patient's ability to pay. For those unable to afford healthcare, the hospital covers the cost, resulting in tens of millions of dollars in charity care each year. While Novant Health believes this is the right thing to do for its patients and communities, over time, uncompensated care challenges hospital budgets. A hospital is most sustainable when most of its patients are covered by some type of insurance plan.

With millions in federal dollars still available and states continuing to struggle to pay for many programs, additional states should seek partnerships to make sure as many people as possible have insurance coverage. And though sometimes controversial, a financially beneficial option continues to be Medicaid expansion. Expansion does not have to be a one-size-fits-all approach, however. Many expansion states have taken creative approaches that better fit their population and approach to Medicaid coverage.

Most of these alternatives emphasize a partnership between enrollees and the state. Officials say this approach is important — both to ensure citizens have health coverage and to emphasize personal responsibility and choice. In Michigan, for example, the Healthy Michigan program expands Medicaid coverage by sharing healthcare costs between the state and beneficiaries through state-provided health savings accounts that can be used for paying part of a patient's medical care. Total annual cost sharing cannot exceed 5 percent of the beneficiary's annual income, and cost sharing can be reduced if individuals participate in certain healthy behaviors and preventive care measures. Beneficiaries with incomes above 100 percent of the federal poverty line also make premium contributions not to exceed 2 percent of an individual's annual income.

States that have not expanded Medicaid are at various stages in their discussions. In North Carolina, decision makers are considering ways to reform the Medicaid system as a whole to make current costs more predictable. Novant Health is hopeful that, once reform has taken place, a discussion on Medicaid expansion can begin in earnest.

Regardless of the approach, providing comprehensive coverage and giving most people access to quality healthcare should remain the top priority, as hospitals and health systems continue to adapt to the changing healthcare environment.

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Novant Health experts are available for more information on these and other topics.

Please contact [Caryn Klebba](#) to arrange a conversation.

About Novant Health

Novant Health is a four-state integrated network of physician clinics, outpatient centers and hospitals that delivers a seamless and convenient healthcare experience to our communities. The Novant Health network consists of more than 1,200 physicians and 26,000 employees who make healthcare remarkable at nearly 500 locations, including 14 medical centers and hundreds of outpatient facilities and physician clinics. Headquartered in Winston-Salem, N.C., Novant Health is committed to making healthcare remarkable for patients and communities, serving more than four million patients annually. In 2013, Novant Health provided more than \$566 million in community benefit including charity care and services. Novant Health is one of the top 25 integrated health systems in the United States and was named a top 50 “Best Places for Diverse & Women Managers to Work” by Diversity MBA Magazine.

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