CHAPTER 1
EXECUTIVE SUMMARY

In March 2010, Congress passed national health reform,[a] referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rapidly rising health care costs. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, and places an increased emphasis on quality measurement and reporting. The ACA also has provisions to increase the supply of health professionals and strengthen the health care safety net.[b] The federal legislation also includes provisions aimed at reducing health care expenditures.

The ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs. At the same time, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations. In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and the North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene workgroups to examine the new law and gather stakeholder input to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole.

NCIOM WORKGROUPS

At the request of NCDHHS and NCDOI, the NCIOM convened stakeholders and other interested people to examine the new law and to ensure that the decisions the state makes in implementing the ACA serve 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, North Carolina Department of Health and Human Services,[c] Albert Delia, Acting Secretary, North Carolina Department of Health and Human Services, and G. Wayne Goodwin, JD, Commissioner, North Carolina Department of Insurance. 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, business, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the new act: Health Benefit Exchange; Medicaid; Safety Net; Health Professional Workforce; Prevention; Quality; New

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[a] The ACA is actually a combination of two separate pieces of legislation. The Patient Protection and Affordable Care Act (HR 3590) was signed into law on March 23, 2010. This law was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4872), which was signed into law on March 30, 2010.

[b] A more complete description of the ACA is available in the May/June 2010 issue of the NCMJ. Silberman P, Liao C, Ricketts TC. Understanding health reform: a work in progress. *NC Med J*. 2010;71(3):215-231. http://www.ncmedicaljournal.com/archives/?issue-brief-understanding-health-reform-a-work-in-progress-3733. Accessed January 18, 2011. A review of the steps the state has taken to implement the ACA is available in the March/April 2011 issue of the NCMJ. Silberman P, Cansler LM, Goodwin W, Yorkery B, Alexander-Bratcher K, Schiro S. Implementation of the Affordable Care Act in North Carolina. *NC Med J*. 2011;72(2):156-160. http:// http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf. Accessed February 14, 2012.

[c] Secretary Cansler served as co-chair during his tenure as Secretary of the North Carolina Department of Health and Human Services. Secretary Delia became co-chair when he was appointed as Acting Secretary.

Models of Care; and Fraud, Abuse, and Overutilization. (See Appendix A for a complete list of all Workgroup and Steering Committee members.)

Each workgroup was tasked with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions as well as examining federal funding opportunities in their 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. An interim report was published and is available online at http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf. Altogether, 260 people from across the state were members or steering committee members of one or more of the nine groups. In addition, the meetings were open to the public so that many others have participated in the meetings either in person or online.

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This document is a compilation of reports from each of the health reform workgroups. Each report contains information about the applicable ACA provisions, findings, and recommendations. What follows is a summary of the recommendations from all the workgroups. The complete recommendations can be found in each of the workgroup chapters.

EXPANDING HEALTH CARE ACCESS TO THE UNINSURED

In North Carolina, there were approximately 1.6 million uninsured nonelderly individuals in 2010 (19%).[1] People who are uninsured are more likely to delay care and less likely to receive preventive services, primary care, or chronic care management. As a result, they are more likely to end up in the hospital with preventable health problems and more likely to die prematurely.[2] When the uninsured do seek care, some of the costs of their care are shifted to the insured population.

By 2014 the ACA requires most people to have health insurance or pay a penalty. To meet this requirement, the ACA builds on our current system of employer-sponsored insurance, individual coverage, and public coverage. Large employers (50 or more full-time equivalent employees) are required to offer employees coverage or pay a penalty.[d] Small businesses are not required to offer coverage, but the ACA provides tax credits to some small businesses to help offset some of their premium costs. Many North Carolina families will be eligible for subsidies to help them purchase private coverage, if they do not have access to affordable employer based coverage, cannot qualify for public coverage, and have incomes below 400% of the federal poverty guidelines.[e, f] In addition, the ACA expands Medicaid to cover more low-income adults. In the

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[d] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513.

[e] The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016. Certain individuals are exempt from the mandate, including but not limited to those who are not required to pay taxes because their incomes are less than 100% of the federal poverty line (FPL), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.

first year alone, close to 800,000 uninsured people are expected to gain coverage. Of these, 41% will gain coverage through the private market, and 59% will gain coverage through Medicaid.[3]

Health Benefit Exchange Workgroup

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty. The ACA requires that each state have a Health Benefits Exchange that will offer information to help individuals and small businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own HBE, the federal government will create one to offer coverage to individuals and small groups in the state. The HBE was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The HBE also can help promote competition on the basis of comparative value, price, and quality of care and customer service, and reduce competition based on risk avoidance, risk selection, and market segmentation.

Qualified health plans (QHPs) offered through the HBE must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[g] Each state will be required to define its own essential health benefits package (using HHS defined benchmarks) that includes coverage of these services.[4] The ACA also creates a "patient navigator" role to provide information to the public about health plan choices and to help them enroll.

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based HBE. This bill did not pass the Senate in the 2011 Session, but is still eligible for consideration in the 2012 Session. Although the legislature did not pass legislation creating a HBE, it did pass legislation stating its intent to create a HBE within the state, and directing the North Carolina Department of Insurance (NCDOI) and the North Carolina Department of Health and Human Services (NCDHHS) to continue to develop a state-based exchange.[h] If North Carolina is going to operate a state-based HBE in 2014, it must show operational readiness by mid 2013. NCDOI contracted with the NCIOM to continue the work of the HBE workgroup and solicit stakeholder input into some of the HBE policy and design issues. The Health Benefit Exchange Workgroup is the only group that will continue to meet to consider some of the policy options the Health Benefits Exchange Board must consider, if established.

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[f] The constitutionality of the individual mandate along with the Medicaid expansion is being challenged in the United States Supreme Court. The Supreme Court accepted two cases to consider the constitutionality of different provisions of the ACA, *National Federation of Independent Business v. Sebelius*, and *Florida v. Department of Health and Human Services*. The different challenges will be considered in late March. A decision is expected before the close of the Supreme Courts current term in June, 2012. Kaiser Family Foundation. A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law. http://www.kff.org/healthreform/upload/8270-2.pdf. Published January 2012. Accessed February 23, 2012.

[g] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1302(a).

[h] Sec. 49 of NCGA Session Law 2011-391.

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Health Benefits Exchange (HBE). The effective and efficient operation of the HBE will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the HBE. The HBE workgroup and Overall Advisory Committee believe that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government, therefore, the Workgroup recommended:

RECOMMENDATION 2.1: STATE AND FEDERAL HBE OPERATIONAL RESPONSIBILITIES
The North Carolina General Assembly should create a state-based Health Benefits Exchange. The state-based HBE should be responsible for most of the operational aspects of the HBE, including consumer assistance, plan management, eligibility, enrollment, and financial management. However, after the HBE Board is created, the Board should consider whether there are limited functions which the federal government should assume.

The workgroup also explored the issue of whether the HBE should have any discretion to modify QHP participation requirements if necessary to enhance HBE operations. Specifically, the workgroup explored the question of whether the HBE Board should have the authority to: limit the number or type of plan designs, require insurers participating in the HBE to offer all four tiers of health plans, require insurers to meet certain quality standards beyond what is already required in the ACA, or require insurers to meet additional requirements intended to foster innovation. The workgroup also discussed whether the HBE should have the flexibility to give health plans more time to meet the ACA's accreditation standards, and whether the NCGA, NCDOI, or the HBE should establish network adequacy standards, if needed to meet federal requirements. To address these issues, the Workgroup recommended:

RECOMMENDATION 2.2: HBE BOARD AUTHORITY FOR HBE CERTIFICATION
The North Carolina General Assembly should give the Health Benefits Exchange (HBE) Board the authority, beginning in 2014, to standardize terminology, benefit designs, or limit the number of plan offerings if needed to facilitate meaningful choice and promote competition among insurers, but only if the HBE Board determines there is a reasonable level of choice in the HBE market. The HBE Board should also have the authority, beginning in 2016, to require or incentivize insurers to meet state standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services (USDHHS). The HBE Board should give all QHP applicants 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.

RECOMMENDATION 2.3: NCDOI OBJECTIVE NETWORK ADEQUACY STANDARDS
If necessary to meet federal requirements, the North Carolina Department of Insurance should develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the HBE. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

In addition to the network adequacy standards, the ACA requires health plans to contract with essential community providers (ECP) in order to be certified.[i] ECPs are providers that serve predominantly low-income, medically underserved communities. The workgroup members agreed that the HBE Board should monitor this provision to ensure that low-income and other vulnerable populations have access to all services without reasonable delay, and if necessary, further clarify how QHPs can meet this requirement.

RECOMMENDATION 2.4. HBE MONITORING OF ESSENTIAL COMMUNITY PROVIDER PROVISIONS

The HBE 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 HBE 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 HBE.

Federal funding necessary to create and operate the HBE is only available through 2014. Thereafter, the HBE must be fully self-sufficient at the state-level. The ACA identifies certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[j] After considering the different financing mechanisms, the Workgroup recommended:

RECOMMENDATION 2.5: HBE FINANCIAL SUSTAINABILITY

The North Carolina General Assembly should establish a HBE 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 HBE Trust Fund to pay for reasonable HBE operations. The North Carolina General Assembly should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the HBE Trust Fund. The North Carolina General Assembly should give the HBE Board the authority to raise other revenues, within parameters established by the General Assembly, if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for the reasonable HBE operations.

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. At the very general level, the HBE and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll.

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[i] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.

[j] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(d)(5).

RECOMMENDATION 2.6. OUTREACH AND EDUCATION
The Health Benefits Exchange (HBE), in conjunction with the North Carolina Department of Insurance (NCDOI), and North Carolina Division of Medical Assistance (DMA) should develop a standardized community outreach and education toolkit and provide workshops so that interested organizations and individuals can disseminate information about public and private insurance options, the HBE 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 ACA also requires that the HBE contract with navigator entities to help people understand their different insurance options and facilitate enrollment into plans. The NCDOI operates a similar program for Medicare recipients, called the Senior Health Insurance Information Program (SHIIP). The HBE should contract with NCDOI to help establish navigator training, certification, and oversight requirements.

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS.
The Health Benefit Exchange (HBE) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator program. The NCDOI, in conjunction with the HBE, should create a standardized training curriculum along with a competency exam to certify individual navigators, and should create strong conflict of interest rules.

The state or HBE can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the HBE. Agents and brokers are in the best position to provide information and advice to small employers as employers need to weigh many factors in deciding whether to offer health insurance coverage and what type of coverage to offer. However, agents and brokers also need training to understand all the new public and private insurance options in order to provide the best information to individuals, small businesses, or their employees. Additionally, the HBE in conjunction with the NCDOI should examine current agent and broker commissions to reduce the financial incentives agents and brokers currently have to steer individuals and businesses to specific insurers.

RECOMMENDATION 2.8. REQUIREMENTS FOR AGENTS AND BROKERS SELLING COVERAGE IN THE HBE
The Health Benefits Exchange Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the HBE. The HBE should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The NCDOI, in conjunction with the HBE, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the HBE, 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.

The ACA creates a "no wrong door" enrollment process. Individuals can apply directly to the HBE, and if eligible for Medicaid or CHIP, enroll directly into those programs. Conversely, people can apply for Medicaid or CHIP first, and if ineligible for public coverage, but eligible for private coverage, can enroll into a QHP in the HBE. Many of the low-income uninsured will first seek information about insurance options through their local department of social services (DSS). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[k] In addition, if the person is determined to be ineligible for Medicaid, he or she must be screened to enroll into a qualified health plan, and, if eligible, must be able to enroll "without delay." [l, m] Thus, the workgroup recommended that DSS workers be trained and certified as navigators so that DSS workers can assist people who are ineligible for Medicaid or CHIP to enroll into a qualified health plan offered through the HBE.

RECOMMENDATION 2.9: "NO WRONG DOOR" ELIGIBILITY AND ENROLLMENT
Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice eligibility workers are cross-trained and certified as navigators 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.

Medicaid Workgroup

The Medicaid Workgroup focused on the new Medicaid expansion, eligibility and enrollment requirements, new benefit mandates or options, and options for home and community-based services. However, Medicaid plays a critical role in almost all aspects of the ACA,and is discussed in other sections throughout the report.

Beginning in 2014, the Affordable Care Act requires that states expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit.[n, o] Children in families with incomes no greater than 200% FPL will continue to be eligible for Medicaid or North Carolina Health Choice (North Carolina's Child Health Insurance Program (CHIP)). Other people will gain coverage through private insurance

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[k] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.908.

[l] Patient Protection and Affordable Care Act, Pub L No. 111-148, §2201, enacting §1943(b)(1)(C) of the Social Security Act, 42 USC 1396w-3(b)(1)(C).

[m] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.1200(g).

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

[o] The federal poverty levels, established by the federal government, is based on family size. It is usually updated annually based on the changes in the Consumer Price Index. In 2012, the federal poverty levels for a family of one was $11,170; for a family of two ($15,130), family of three ($19,090), and family of four ($23,050). The federal poverty levels increase by $3,960 for each additional family member. United States Department of Health and Human Services. http://aspe.hhs.gov/poverty/12poverty.shtml. Accessed February 14, 2012. Because the federal poverty levels are updated annually, it is likely to be higher by 2014.

offered through the Health Benefit Exchange (HBE). To qualify, a person must be a United States citizen or a lawfully present immigrant who has been in the United States for five years or more. Undocumented immigrants will not qualify for Medicaid coverage. This change in eligibility requirements will be a major expansion to the North Carolina Medicaid program, especially for low-income adults. The North Carolina Division of Medical Assistance estimates that 525,000 individuals will enroll in Medicaid or North Carolina Health Choice in SFY 2014.

Federal regulations prescribe most of the new eligibility and enrollment processes, but left some areas of discretion for the state. The state has many options which could simplify the Medicaid eligibility and enrollment process, therefore, the Workgroup recommended:

RECOMMENDATION 3.1: SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES
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.

Further, it is likely that many individuals will move between these programs as their income fluctuates. Thus, the ACA includes provisions to streamline and coordinate the eligibility and enrollment processes between Medicaid, CHIP, the Basic Health Plan (if the state chooses to implement this option), and the HBE. Educating the public about these new requirements and the various health insurance options and insurance affordability programs is one of these provisions. Therefore, the Workgroup recommended:

RECOMMENDATION 3.2: IMPLEMENT AN EDUCATION AND OUTREACH CAMPAIGN
The North Carolina Division of Medical Assistance (DMA), North Carolina Department of Insurance (DOI), and North Carolina Health Benefit Exchange (HBE) 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.

The workgroup discussed the important role that local Divisions of Social Services (DSS) agencies will continue to play in helping low-income people enroll in the appropriate health insurance coverage. Many people who have received assistance in the past through DSS are likely to continue to seek help there, regardless of whether they are eligible for Medicaid, CHIP, or subsidized coverage through the HBE. Thus, the Workgroup recommended:

RECOMMENDATION 3.3: RETRAIN DSS ELIGIBILITY WORKERS
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. Local Departments of Social Services

should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator in each DSS office.

In addition to expanding Medicaid coverage to more of the uninsured, the ACA gives states a number of options to expand home and community-based services (HCBS) to older adults or people with disabilities. In general, the workgroup was very supportive of the need to expand HCBS while at the same time minimizing new costs to the state. Thus, the workgroup recommended:

RECOMMENDATION 3.4: EXPLORE THE HOME AND COMMUNITY-BASED SERVICES MEDICAID EXPANSION OPTIONS
The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the costs and benefits of options to expand home and community-based services, and should explore options to use existing state dollars to leverage federal Medicaid funding to expand home and community based services. DMA should give priority to support caregivers or otherwise provide services to help the frail elderly or people with disabilities to remain in their homes, and should give priority to those who have been identified as at-risk through the Adult Protective Services system. 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.

Safety Net Workgroup
Many of the people who are expected to gain coverage under the ACA are already receiving some type of medical care from safety net organizations around the state. The safety net is composed of organizations that have a mission or legal obligation to provide health care and other related services to uninsured and underserved populations. Safety net organizations that have traditionally served underserved populations will be critical partners in meeting the health care needs of the newly insured. The ACA recognizes this and includes provisions to increase and strengthen the health care safety net. The Safety Net Workgroup examined these and other sections of the ACA along with the unmet needs of the safety net.

In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers, school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations.

Research shows that many individuals who present in the emergency department have needs that could be met by health care providers outside of the emergency department. The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for underserved patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The Workgroup concurred and recommended:

RECOMMENDATION 4.1: DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT

The North Carolina College of Emergency Physicians (NCCEP) and partners should 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 dental complaints, chronic conditions, and behavioral health issues. NCCEP and partners should seek funding for the emergency care diversion project through federal sources. If adequate funding is not received from the federal sources, the North Carolina General Assembly should fund the emergency care diversion pilot project.

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health".[p] Therefore, the Workgroup recommended:

RECOMMENDATION 4.2: INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS

As part of the hospital and local health department community health assessments, these organizations should include input from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area. 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.

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers. The savings the 340B program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the Workgroup recommends:

RECOMMENDATION 4.3: 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 eligible 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.

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[p] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007(a), enacting Sec. 501(r)(3)(B)(i) of the Internal Revenue Code of 1986, 26 USC 501(r)(3)(B)(i).

The ACA requires that Health Benefits Exchanges (HBE) establish a program to award grants to entities that serve as navigators. The duties of a navigator include public education; distribution of fair and impartial information; facilitation of enrollment in Qualified Health Plans (QHPs); provision of referrals for grievance, complaint, or question about their health plan; and provision of information in a manner that is culturally and linguistically appropriate to the needs of the population being served. In order to receive a grant, an organization must demonstrate that it has, or could readily establish, relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP. In addition, navigators must meet standards to avoid conflicts of interest.

In North Carolina, safety net providers have established relationships with the diverse uninsured population that is traditionally hard to reach. These established relationships provide a unique opportunity for safety net providers to serve as navigators for their patients, thus the Workgroup recommended:

> **RECOMMENDATION 4.4: ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS**
> **The Health Benefits Exchange (HBE) should train and certify staff at safety net organizations to serve as patient navigators as long as these organizations meet the federal requirements for patient navigators. As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.**

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. Workgroup members recognized the need for safety net organizations to continue to meet, on a periodic basis, to facilitate ongoing collaborations and communication. Therefore, the workgroup recommended:

> **RECOMMENDATION 4.5: RECONVENE THE SAFETY NET ADVISORY COUNCIL**
> **The Care Share Health Alliance should reconvene the Safety Net Advisory Council to identify communities with the greatest unmet needs; increase collaboration among safety net agencies; monitor safety net funding opportunities; make a recommendation and plan for integrating safety net tools including the North Carolina Health Care Help website and the county level resources; and serve as a unified voice for the safety net.**

Health Professional Workforce Workgroup

While the ACA includes provisions to increase the number of physical, behavioral, and oral health practitioners to address current and future workforce needs, and authorized new programs to expand the number of health care providers, it does not include new appropriations to fund all of these provisions. Given limited federal funding for workforce initiatives, the Health Professional Workforce Workgroup focused on critical steps that the state could take to ensure an adequate workforce to meet the health care needs of North Carolinians.

The increase in the number of North Carolinians with health insurance will increase demands for health care, particularly primary care[5]). In addition to high demands for physical health care, changes in insurance rules and access to health insurance are expected to increase demands for

other services, particularly behavioral and oral health care. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, and behavioral and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. Furthermore, the provision of health care in the field is changing; therefore, education and training models must also change. Therefore, the Workgroup recommended:

RECOMMENDATION 5.1: EDUCATE HEALTH WORKFORCE USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE
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 work together to create targeted programs and admissions policies to increase the number of students with expressed interested in primary care, behavioral health, and dentistry. AHEC should educate the existing workforce on new core competencies needed by the health care workforce including interdisciplinary team-based care, patient safety, quality initiatives, cultural competency, health information technology, and others.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[6] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health and may reduce costs. Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the workgroup recommended:

RECOMMENDATION 5.2: SUPPORT AND EXPAND HEALTH PRACTITIONER PROGRAMS TO MORE CLOSELY REFLECT THE COMPOSITION OF THE POPULATION SERVED
The North Carolina Area Health Education Centers Program, the 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.

Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. The capacity to recruit and retain health professionals in rural and underserved areas across the state is critical to meet the health needs of North Carolinians. As part of the ACA, the National Health Service Corps (NHSC), a federal program for certain types of health care practitioners who receive loan repayments in return for practicing in a health professional shortage area (HPSA), received $1.5 billion in funding. Many states are competing to attract health professionals using NHSC funding. The North Carolina Office of Rural Health and Community Care (ORHCC) plays a critical role in helping recruit

health professionals and match them with qualified HPSAs. Therefore, the Workgroup recommended:

RECOMMENDATION 5.3: STRENGTHEN AND EXPAND RECRUITMENT OF HEALTH PROFESSIONALS TO UNDERSERVED AREAS OF THE STATE
The North Carolina Office of Rural Health and Community Care (ORHCC) should maintain its independence and flexibility to respond to health workforce needs across the state in a timely manner. In order to support and strengthen the ability of the 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 NC.

In addition to focusing on rural and underserved areas, there is a general need to strengthen the existing primary care, behavioral, and oral health workforces. To recruit more physicians, nurse practitioners, and physician assistants into primary care and to retain the workforce we currently have will require a rebalancing of how practitioners are paid, rewarding those health care professionals who practice in primary care. In order to encourage health care professionals to enter into primary care practices and to retain current practitioners, the workgroup recommended:

RECOMMENDATION 5.4: INCREASE REIMBURSEMENT FOR PRIMARY CARE SERVICES
Public and private payers should enhance their reimbursement to primary care practitioners 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, general internists, psychiatrists as well as nurse practitioners, physician assistants, and certified nurse midwives practicing in primary care.

Given the health care needs of the population, the role of the health care industry in North Carolina's economy, the amount of money the state invests in educating health care providers, and the state's role in financing the consumption of health care, there is a pressing need for North Carolina to identify workforce priorities and to create policies that ensure there are enough practitioners with the proper training to meet the health care needs of the population. Therefore, the Workgroup recommended:

RECOMMENDATION 5.5: SUPPORT COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS
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. 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.

IMPROVING POPULATION HEALTH

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA includes new funding to invest in prevention, wellness, and public health infrastructure. The ACA includes $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 for a new Prevention and Public Health fund to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina, which ranked 32 of the 50 states in 2011 based on a composite of 23 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[7]

Prevention Workgroup

The Prevention Workgroup focused on provisions of the ACA with immediate implementation requirements, or funding opportunities. These areas of focus included tobacco use, community infrastructure for responding to funding opportunities, maternal and child health, prevention of sexually transmitted disease (STD) and unplanned pregnancies, promotion of healthy lifestyles, worksite wellness, community transformation grants, and improved access to preventive care.

Two provisions of the ACA support efforts to reduce tobacco use including a provision that prevents states from excluding coverage for tobacco-cessation drugs from their Medicaid programs and one that requires states to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use and also prohibits cost-sharing for these services. North Carolina's Medicaid program currently covers some tobacco cessation drugs and is already in compliance with the provision on pregnant women. However, barriers to treatment still exist. Therefore, the Workgroup recommends:

RECOMMENDATION 6.1: INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS

The North Carolina Division of Medical Assistance should provide all FDA approved over-the-counter nicotine replacement therapy without a physician prescription as part of comprehensive tobacco cessation services and work to reduce out-of-pocket costs for such therapies. Primary care providers and Medicaid recipients should be educated about covered tobacco cessation therapies.

The ACA includes a provision that requires employers with 50 or more employees to provide reasonable break time and a private place (other than a bathroom) for an employee to express breast milk for nursing children for one year after the child was born. Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions.

RECOMMENDATION 6.2: SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT

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. Small businesses should be encouraged to provide similar support to working mothers.

The ACA requires new employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for certain preventive services. The state and partners will need to monitor health plans to ensure that coverage is provided, educate providers and patients on the covered services, and provide mechanisms in electronic medical record systems to promote the provision of these services.

RECOMMENDATION 6.3: PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES

North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. The North Carolina Department of Insurance should 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. Electronic medical record systems offered in North Carolina should provide clinical decision support tools to identify and promote prevention services. Outreach should be done to educate providers and individuals about covered preventive services.

The ACA includes provisions that aim to improve population health through benefits provided by employers. The ACA also includes worksite wellness provisions which allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or prevent disease. There is a need for education of employers and employees on these provisions, thus, the Workgroup recommended:

RECOMMENDATION 6.4: PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES

The Center for Healthy North Carolina and the North Carolina Division of Public Health should provide information to businesses on evidenced-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.

The Prevention Workgroup examined funding opportunities available through the ACA and explored strategies to target funding to communities of greatest need. Often the communities with the greatest health needs are those that lack the personnel or infrastructure to apply for grants or to implement new initiatives. Therefore, the Workgroup recommended:

RECOMMENDATION 6.5: 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 develop the infrastructure needed to allow communities of greatest need to respond to prevention-related funding opportunities.

As with other areas of the ACA, many of the provisions that include grant funding opportunities were authorized, but not appropriated. Therefore, the Workgroup recommended:

RECOMMENDATION 6.6: MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS
The state should monitor the federal appropriations process, as well as funding made available as part of the Public Health and Prevention Trust Fund, to identify additional funding of prevention provisions.

IMPROVING THE QUALITY OF CARE

The current health care payment system is structured to reward health professionals and providers based on the volume of services provided rather than based on the quality of care or health outcomes. The ACA begins to change the way that health care professionals and providers are reimbursed to emphasize the quality and value of the services provided.

Quality Workgroup

The ACA includes new provisions aimed at improving the quality of care provided by different types of health care professionals and providers. For example, the ACA requires the Secretary of the United States Department of Health and Human Services to develop quality measures to assess health care outcomes, functional status, transitions of care, consumer decision-making, meaningful use of health information technology, safety, efficiency, equity and health disparities, and patient experience.[q] Health care professionals and providers will be required to report data on these new measures to the Centers for Medicare and Medicaid Services. Ultimately, these data will be made available to the public. In addition, the ACA changes the Medicare (and in some cases, Medicaid) reimbursement structure to reward providers and health care professionals, in part, on the quality of services provided.

The Quality workgroup recognized the importance of educating health care professionals and providers about these changes, so that these groups can understand and be prepared to meet the new Medicare reporting and quality standards. In addition, consumers need to understand how to interpret the quality comparison data when they become available. Thus, the Workgroup made many recommendations about the need for education, including:

RECOMMENDATION 7.1: EDUCATE PRIMARY AND SPECIALTY CARE PROVIDERS ON QUALITY MEASURE REPORTING REQUIREMENTS
The Division of Medical Assistance (DMA) and partners should educate primary care and specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults.

RECOMMENDATION 7.4: EDUCATE PROVIDERS ON ACA ISSUES
The North Carolina Area Health Education Centers and partners should educate physicians on new ACA requirements and provisions aimed at improving quality.

RECOMMENDATION 7.5: EDUCATE HOSPITALS ON ACA ISSUES
The North Carolina Hospital Association should provide education to hospitals on new ACA requirements and provisions aimed at improving quality of care in hospitals.

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[q] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3013-3014.

RECOMMENDATION 7.6: 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.

RECOMMENDATION 7.7: EDUCATE FACILITY PERSONNEL ON ACA ISSUES
The North Carolina Division of Health Service Regulation and partners should educate their constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value-based purchasing.

RECOMMENDATION 7.8: EDUCATE CONSUMERS ON AVAILABILITY AND INTERPRETATION OF PROVIDER QUALITY MEASURES
The North Carolina Healthcare Quality Alliance and partners 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.

A concern addressed by the workgroup was the impact on providers of multiple requests or demands for quality indicator data, since the state and federal governments, and private insurers, will be requesting data. Further reduction in the reporting burden could be achieved through alignment of the state quality measure requirements (eg, CCNC, DMA) with the federal measures. To reduce this reporting burden on providers and ensure that the state has access to information to drive state for state level quality improvement initiatives, the workgroup recommended:

RECOMMENDATION 7.2: 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.

RECOMMENDATION 7.3: 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 data automatically from electronic health records and then coordinate submission of data to the appropriate entities. Data should be made 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.

The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. The goal of this focus is to improve quality and efficiency of care by improving transitions in care. Transitions in care refer to movement of patients between health care providers and health care settings. Problems with transition can occur when information about a patient's care or situation is not communicated adequately to other providers or to the patient. A subcommittee of the Quality

Workgroup, in partnership with a subcommittee of the New Models of Care Workgroup, reviewed models and existing programs that address transitions in care at different points in the health care system, and made recommendations about which models and programs could be used or expanded in North Carolina to reduce preventable readmissions and improve transitions in care. In order to improve transitions of care, the joint subcommittee recommended:

RECOMMENDATION 7.9: IMPROVE TRANSITIONS OF CARE
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 to evaluate outcomes. Solutions utilizing transition principles should be applied to all patients regardless of payer.

RECOMMENDATION 7.10: 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.

COST CONTAINMENT
The United States spends more on health care that any other developed nation (17% of the gross domestic product, or $7,960 per capita in 2009). Spending on health care is rising far more rapidly than other costs in our society. The ACA attempts to reign in health care costs by encouraging the development of new models of care that promote better patient outcomes and reduces unnecessary utilization, reducing payments to certain providers, streamlining administrative costs, and reducing fraud and abuse.

New Models of Care Workgroup
The New Models of Care Workgroup recognized that the development and implementation of new models of care is essential to improve the value delivered by our health care system. The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and health care expenditures, while improving individual health outcomes and overall population health. The ACA gives the Center for Medicare and Medicaid Services authority to test new models of care that expand access to needed services; incentivize providers to improve quality and individual and community health outcomes; involve patients more directly in their own care; reduce redundant, ineffective and inefficient utilization; and moderate rising health care costs.

North Carolina has many different pilots or demonstrations under development, both in the public and private sector, including, but not limited, to multipayer patient-centered medical homes, new payment models, value-based insurance designs, and broader population health interventions. The New Models of Care workgroup attempted to catalogue the different

initiatives under development across the state, but there is a need for such work to continue. Therefore, the Workgroup recommended:

RECOMMENDATION 8.1: 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.

North Carolina needs to continually examine the way we provide and pay for health care services, to ensure that models being used are achieving optimal individual and population health outcomes, while providing care in the most efficient manner possible. Strong, independent evaluations that examine common quality, outcome, and cost metric—so that different models of care can be compared to one another—are needed to identify what works, for whom, and in what environment. Further, evaluation data should be shared publicly among insurers, other health systems, and the public. Thus the work group recommended:

RECOMMENDATION 8.2: EVALUATION OF NEW PAYMENT AND DELIVERY MODELS
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. Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that others can learn from these new demonstrations. 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.

Several of the NCIOM health reform workgroups noted the need for enhanced data to improve the functioning of the current health care system. State government, public and private payers, health systems, health care professionals, employers and consumers need information about diagnosis, utilization, costs, and outcomes in order to evaluate new delivery or payment models. To ensure that necessary data is captured in a way that allows for such evaluation, the Workgroup recommended:

RECOMMENDATION 8.3: CAPTURE DATA TO SUPPORT NEW MODELS OF CARE
The North Carolina Department of Health and Human Services should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to identify 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. The plan with recommendations, including a timeline and potential financing mechanisms, should be reported to North Carolina General Assembly no later than the start of the 2013 session.

While public and private health care organizations in North Carolina have sought to take advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. A broader group of stakeholders need to be involved in discussions to address potential barriers as well as solutions to overcome those barriers, including licensure boards, the North Carolina Department of Insurance, health professional associations, and health care systems. Thus, the workgroup recommended:

RECOMMENDATION 8.4: EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS
The 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. The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or the otherwise effectively use of electronic health records. 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.

Fraud and Abuse Workgroup
The Affordable Care Act (ACA) includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs).

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went in to effect in 2010 or 2011. Many requirements of the ACA provisions were already being addressed in North Carolina, including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. To fulfill other requirements, the state will need to implement new enforcement procedures.

The Fraud and Abuse Workgroup broke down the requirements of each ACA fraud and abuse provision, then identified ongoing efforts to address these requirements, the gaps between what is currently underway in North Carolina and the new requirements, and required changes and/or legislation to fully implement the ACA provisions. The workgroup also helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the concept list, to draft its recommended fraud and abuse legislation. DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399.

CONCLUSION

North Carolina currently faces significant health challenges, including the growing numbers of uninsured, poor overall population health, rising health care costs, and the need to increase

access to care and improve quality. The Affordable Care Act begins to address some of these problems. If implemented, the numbers of uninsured will decline. Greater emphasis will be placed on improving overall population health and the quality of health care services. Further, the ACA includes provisions aimed at lowering the rate of increase in health care expenditures.

The ACA does not address—or solve—all of the state's health care problems. For example, while the ACA includes provisions to expand the health professional workforce, the Act included little new funding. Thus there is likely to be workforce shortages to address the pent-up demand for health services in 2014 when many of the uninsured gain coverage. The ACA includes new provisions to change the way we deliver and pay for health care with the goal of improving quality and health outcomes while reducing escalating health care costs but, as of yet, most of these efforts are untested.

Further, there are still unanswered questions. The ACA directed the Secretary of the United States Department of Health and Human Services to implement many of the provisions of the new law. The Secretary has issued both proposed and final regulations implementing many of the sections of the law, but further guidance on other sections is still pending. Of greater importance, we are awaiting the decision from the United States Supreme Court about the constitutionality of the entire law, or specific provisions of the law.

Regardless of how the Supreme Court rules, our current health care system cannot remain as is. Our state and our country are facing serious health system problems that must be addressed. If the ACA is ultimately determined to be unconstitutional—we will still have to address rising health care costs. There will still be pressures to address the health care needs of North Carolina's 1.6 million who lack insurance coverage. We will need to test new payment and delivery models to ensure that we achieve maximum value for our health care dollars. Moreover, we will need to invest more heavily in prevention if we want to have a healthy and productive workforce, reduce the growth in chronic illness, and limit the need for high-cost interventions. The ACA is a starting point, not an ending point. If implemented, it is likely to be amended over time as we understand what works and what needs to be changed.

While the focus of the Health Reform Workgroups was to address new requirements that are part of the ACA, many of the recommendations are applicable even if the ACA, or parts of it, are not upheld. The recommendations from these groups can help the state address concerns about the health practitioner workforce, test new ways to improve quality and reduce health care costs, strengthen the safety net, streamline the eligibility and application process for existing public programs, and increase prevention efforts to improve overall population health.

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