How the Affordable Care Act Will Affect Access to Health Care in North Carolina

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Reforming health care in the United States often focuses on improving access to care by removing financial barriers and bringing practitioners closer to patients. This article reviews the provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) that are intended to improve access and discusses how the ACA will change access to care for Americans.

The central goal of the Patient Protection and Affordable Care Act of 2010 (ACA) is to expand access to health care for Americans. In the actual construction of the legislation, this meant giving people who currently lack health insurance some form of coverage by making health care affordable, through the expansion of Medicaid [1] and the subsidization of insurance costs [2]. However, simply providing insurance coverage does not guarantee access, which depends on a number of additional factors, including the availability, acceptability, coordination, and effectiveness of care [3].

Effective access, or what some experts call "realized access," can only be measured by comparing need with actual utilization [4]. It is essential that there are enough physicians in a community, that patients have transportation or proximity to care, and that patients have the ability to pay for care; however, meeting these conditions does not necessarily mean that people who are ill will get the treatment they need. Effective access also depends on the ability of individuals to negotiate the complex world of program eligibility, to recognize their need for care, to accept their diagnoses, to communicate effectively with caregivers, and to understand their role in the process as patients and citizens. The ACA tries to address all of these things to promote effective access. Nevertheless, affordability of insurance coverage is the fundamental element that supports this comprehensive approach.

The ACA was challenged in court primarily over the structure of health insurance coverage (a key to affordability)—specifically, the requirements that most people must have some type of health insurance coverage or pay a penalty and that the states must expand Medicaid program eligibility to cover more low-income adults. The Supreme Court upheld the coverage provision, but it held that mandatory Medicaid expansion was unconstitutional [5]. In their decision, the justices left in place many of the specific elements that would guide insurance coverage, such as the elimination of preexisting condition clauses that restrict coverage [6], the setting of essential health benefits to allow for informed choices among plans [7], and the requirement that Medicare pay for preventive services [8]. They also left in place those elements of the ACA that would change the way health care systems are organized to care for populations, such as the Medicare Shared Savings Program, with its accountable care organizations (ACOs) [9], and patient-centered medical homes (which are referred to as "health homes" in the ACA) [10].

How changes in insurance coverage will actually affect access is controversial: There are debates over how many individuals will gain coverage and what effect that new coverage will have on demand for services [11]. In North Carolina, we have credible estimates regarding the extent to which elements of the ACA will expand coverage, provided they are implemented. For example, the North Carolina Division of Medical Assistance estimated late last year that if the Medicaid program in North Carolina had been expanded as the ACA had anticipated, 564,000 additional people would have enrolled in Medicaid in 2014, and as many as 624,000 people would have enrolled by 2021 [12]. Other sections of the ACA will also expand coverage by changing the way health insurance is marketed and regulated. The provisions that guide the implementation of the health insurance marketplaces provide for subsidies in the form of premium tax credits or cost-sharing subsidies to help low-income and moderate-income individuals purchase health insurance [2]. The Milliman Group, working under contract to the North Carolina Department of Insurance, estimated that 660,000 people will buy coverage in the individual health insurance marketplace, and another 51,000 people in North Carolina will buy insurance through the small business marketplace (called the SHOP) [12]. Milliman estimated that 300,000 of these 715,000 people are currently uninsured.

Electronically published August 1, 2013.

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N C Med J. 2013;74(4):324-329.
0029-2559/2013/74409

Federally Qualified Health Center Expansion Through the Affordable Care Act

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In crafting the Patient Protection and Affordable Care Act of 2010 (ACA), the Obama administration recognized the need to expand primary care capacity in communities with many low-income and uninsured individuals. One of the key strategies for meeting this need involved the establishment of new Federally Qualified Health Centers (FQHCs) and new sites for existing FQHCs that would target underserved locations across the country. A Community Health Center Fund of $11 billion was established, appropriating $9.5 billion for organizational expansion and $1.5 billion in capital funding. To continue the economic stimulus, the capital funding (to be used for construction and renovation of community health centers) was made available for Federal Fiscal Years (FFYs) 2011 through 2015, and the expansion funding was scheduled for release annually, starting with $1 billion in FFY 2011 and increasing to $3.6 billion in FFY 2015 [1].

The American Recovery and Reinvestment Act of 2009 (ARRA) established new health centers and sites, and passage of the ACA by Congress allowed the administration to continue funding these centers [2]. One new community health center and one expanded center in North Carolina received ACA funding in 2011 [3]. ARRA also funded nearly all health centers nationally, allowing them to serve additional patients affected by the national economic collapse [4]. This operational funding was continued through the ACA, which added $1.8 million to the base budgets of each of the 26 FQHCs in existence in North Carolina prior to 2010. North Carolina applicants struck out in the first 2 rounds of ACA capital funding, but 4 health centers in the state received a total of $9.2 million in capital funding in the third funding cycle [5]. Funding was used to build 2 new facilities in communities that had previously had none and to replace cramped, aged clinics in 2 other communities.

Prior to the passage of the ACA, the North Carolina Community Health Center Association received a grant from the Kate B. Reynolds Charitable Trust to undertake an 18-month inclusive process that brought together safety-net providers and existing health centers to develop community-level plans and to assist organizations in applying for new start-up funds. North Carolina organizations submitted 30 applications for the initial 2011 round of funding.

The Congressional budget compromise of 2011 cut $600 million per year from the $2.19 billion base health center appropriation [6]. To keep the core level of services in place, the administration chose to "backfill" the budget hole by tapping the Community Health Center Fund. This change resulted in the health center expansion being reduced from $250 million [7] to just $28.8 million [4]. Consequently, only 67 grants were awarded nationwide [4]. In spite of this reduction, North Carolina received 2 New Access Point grants (for 1 new health center and 1 expanded health center) totaling $1.38 million [8], as well as 2 health center planning awards of $80,000 each [9]. In 2012, $128.6 million from the Community Health Center Fund was used to add 219 new health centers nationally from the pool of approved-but-unfunded applications [10]. As a result, North Carolina received 9 new grants (for 4 new community health centers and 5 expanded ones) totaling $5.1 million [10, 11]. Collectively, these 9 projects are expected to serve more than 52,000 new patients in 14 previously unserved counties in the first 2 years.

The second cycle of ACA-funded New Access Point applications closed on April 3, 2013. Eight North Carolina applicants were among those competing for $19 million; only 25 awards were to be granted nationally [12]. Because more than 400 applications were submitted, the administration will likely hold over approved-but-unfunded applications for funding in FFY 2014. There will then be one final round of applications in 2015, with 22 North Carolina counties still contemplating or planning FQHC development. Cuts to the community health center program resulting from the 2013 federal sequester are estimated to range from 4% to 9% and could further deplete support for existing programs and for expansion [13].

The ACA funding design for health centers was built on the premise that a large number of patients who were uninsured in 2010 would begin receiving health care coverage in 2014, either through the Medicaid expansion or through the purchase of a commercial plan in one of the new health insurance marketplaces (formerly called health benefit exchanges). Therefore it was expected that the health centers in existence prior to 2011, as well as those funded afterward, could be sustained with less federal support. The US Supreme Court decision of 2012 upset this assumption by allowing states to opt out of the Medicaid expansion [14]. In March 2013, the North Carolina

As I have noted, however, the potential expansion of insurance coverage is only one aspect of access to care. The ACA includes many additional provisions that promote access in a comprehensive attempt to improve the nation's health. For example, some sections of the ACA aim to help consumers negotiate the system. The ACA encourages the development of ACOs [13], which were originally structured around groups of Medicare beneficiaries and were intended to reward care coordination. ACOs also promote preventive measures that reduce overall costs of care by improving outcomes and preventing costly complications or the emergence of preventable disease. Multiple groups of hospitals, physicians, and suppliers of pharmaceutical and other health care services and products have begun to form ACOs and to develop the systems that will generate these savings and improve health. A large part of this effort involves the use of electronic

General Assembly elected not to participate in the Medicaid expansion and not to partner with the federal government in setting up the state's health insurance marketplaces. Because North Carolina's FQHCs treat a large proportion of uninsured patients—52.1% of patients at the 28 reporting community health centers in North Carolina in 2011 were uninsured [15] compared with 36.4% of patients at the 1,128 community health centers reporting nationally [16]—the state's decision not to expand Medicaid threatens the financial viability of North Carolina's community health centers. In 2016 ACA funding will end, at which time the 2011 budget cuts will have reduced the total national program budget to $1.58 billion.

Foreseeing an increased reliance on commercial payers, community health centers have been preparing to be value-added participants in the transformation of the health care marketplace. Through funding in 2011 from the Blue Cross and Blue Shield of North Carolina Foundation and the North Carolina Office of Rural Health and Community Care, community health centers and other safety-net providers have partnered with Community Care of North Carolina (CCNC) to connect through the North Carolina Health Information Exchange to CCNC's informatics center. CCNC's analytics will allow health centers to provide better, more cost-effective care through a population health approach. Additionally, the majority of FQHCs in North Carolina have banded together to form the Carolina Medical Home Network, a collaborative approach to performance improvement and practice transformation. However, it remains doubtful whether these system changes will be sufficient to overcome the growing number of uninsured individuals and the concurrent loss of federal funding. NCMJ

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Acknowledgment

Potential conflicts of interest. E.B.M. is an employee of the North Carolina Community Health Center Association.

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Electronically published August 1, 2013.

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N C Med J. 2013;74(4):325-326.
0029-2559/2013/74410

medical records and dedicated care coordinators or patient navigators who can help move patients through the complex health care delivery system. The ACA also includes insurance navigators to help people obtain insurance through the health insurance marketplaces that are being set up in every state [14]. Fundamental to accessing care is simply understanding what is covered by your insurance plan, so the ACA requires every health insurance policy to include a "summary of benefits and coverage" that provides a clear and simple description of coverage [15]. The ACA also provides grants to the states to support consumer assistance programs that can help people when they have problems with their health insurance coverage [16]. There is such a program in the North Carolina Department of Insurance, called Health Insurance Smart NC (www.ncdoi.com/Smart/), which has regional offices in Asheville and New Bern.

Prevention of disease through timely actions, including visits to providers, is another important element of effective access to care. The ACA includes a number of sections (eg, sections 1001, 4001–4004, 4101–4108, 4306, 4402, 10406, and 10408) that mandate expanded coverage of preventive services recommended by the US Preventive Services Task Force. In most instances, insurance policies will have to cover preventive services such as testing to detect diabetes, elevated blood pressure, and elevated cholesterol levels, as well as cancer screenings, such as mammograms and colonoscopies. Policies will also have to cover regular well-baby and well-child visits, from birth to age 21 years. Coverage of routine vaccinations against diseases such as measles, polio, and meningitis will also be required, if these vaccinations are recommended by the Advisory Committee on Immunization Practices.

Taking advantage of this expanded coverage will require coordination and counseling from navigators, patient advocates, or community health workers. These roles are supported either directly or indirectly by the ACA. One such program is a demonstration project to develop training and certification programs for personal or home care aides [17]. North Carolina received a grant under this authority to support a Personal and Home Care Aides State Training Program (PHCAST), which trains qualified personal and home care aides to help address the needs of elderly and/or homebound individuals in areas with a shortage and/or high demand for these services.

The provisions of the ACA that touch on workforce training make up a large portion of the overall legislation. Title V of the ACA covers health care workforce provisions as well as programs specifically earmarked for "improving access to health care services" (Title V, subtitle G). The ACA recognizes that training the right people for the right jobs is a necessary element of access to care. These workforce provisions include programs and grants to increase overall health workforce supply, as well as focused support to expand the number of public health workers, allied health workers, nurses, primary care practitioners, and general surgeons. These programs translate into support for training programs in North Carolina's schools, community colleges, and universities, as well as focused training using the North Carolina Area Health Education Center (AHEC) Program.

Primary care physicians, physician assistants (PAs), nurse practitioners, and other advanced practice nurses—including nurse anesthetists, nurse midwives, and nurse educators—are the clinicians who are most likely to provide first-encounter access to the health care system and to serve as coordinators of care [18]. They are also well accepted by the public and by patients [19]. Fortunately, all of these groups are being supported by ACA funding. More than $5 million has been provided to expand primary care residencies in Chapel Hill and Wilmington through 2015. The PA programs at Duke University and Methodist University also received multi-year grants to support expansion of their training programs. Seven North Carolina nursing schools received grants under the Advanced Education Nursing Traineeships Program funds. This funding is for nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse administrators, nurse educators, public health nurses, and other nurses requiring advance education through eligible institutions. Five North Carolina nursing schools received funding for nurse anesthetist training. These nurses serve in critical roles in smaller (and most often rural) hospitals, where they improve access to inpatient and outpatient surgery. Finally, the North Carolina AHECs are working with the North Carolina Hospital Association to provide focused training in quality assurance for staff members of ACOs, and they are also helping staff members in medical offices to implement electronic medical record systems. Overall, North Carolina programs received more than $12 million to support new or expanded health care workforce training programs under the ACA.

These workforce programs anticipate the expansion of demand that is likely to occur when health insurance coverage is increased. To understand the possible impact of this expansion, it is useful to review Massachusetts' experience with rapid and wide expansion of health insurance coverage [20]. One of the positive effects of that expansion was that more adults reported having a "usual source of care"—that is, a practitioner they see regularly, so that they no longer need to make use of the emergency department for regular care. These effects, and others, were achieved in a system that anticipated a rapid increase in demand and a potential shortage of available practitioners. There were indicators of a potential for a lack of access to practitioners in Massachusetts as health reform was being implemented, and there is evidence that some strain has been put on the system: In 2010, 17.9% of adults in Massachusetts reported being told by a physician or physician practice that no new patients, or no patients with a specific insurance type, were being accepted; there were also reports of longer waiting times for appointments [20]. The expansion of coverage in North Carolina may produce similar stresses if the use of services, especially primary care services, by new enrollees reaches levels that match the current level of health care utilization by higher-income, employed, insured adults and their families.

Whether physician supply will be able to keep up with increased demand is the subject of some debate. Petterson and colleagues have predicted a nationwide need for nearly 52,000 additional primary care physicians by 2025, primarily because the population is growing but also because of the aging of the population and the demand stimulated by the ACA [21]. Others have suggested that the proper deployment of teams, nurse practitioners, PAs, and other nonphysician health care providers can meet the increase in demand [22]. The Petterson study suggests that, if national trends hold in North Carolina, the state might face a shortage of more than 1,500 primary care physicians by 2025. A

more detailed state-by-state analysis published in 2011 by Hofer and colleagues anticipated that North Carolina would have an increase in need of between 150 and 240 primary care physicians by 2019, solely due to immediate insurance expansion [23]. This estimate was based on the assumption that many people would gain coverage as part of the Medicaid expansion; in North Carolina, however, this expansion is likely to be delayed, if it is implemented at all.

Certain provisions of the ACA, especially those that promote the use of patient-centered medical homes, are intended to change the health care delivery system to more appropriately care for patients while potentially reducing demand for some services, thus freeing up physicians to provide more appropriate care. These provisions are likely to affect the actual demand for services in such a way as to reduce the need for physicians while increasing the need for care coordinators, navigators, and other workers who will be necessary in a more complex system of care. The need for a "new" workforce has been recognized in North Carolina, and training programs—from postgraduate residencies to community college short courses—are being organized to meet that need [24]. The North Carolina Institute of Medicine recommended that training programs and employers work together to increase the number of workers who have the core competencies that support interdisciplinary team-based care: competency in patient safety, an understanding of quality initiatives, cultural competency, the ability to use health information technology, and familiarity with the other necessary elements of a reformed and more effective health care delivery system [12]. These roles may be played by existing professionals, including nurses, or the roles may be combined into new occupational classifications such as patient navigator or care coordination specialist.

The safety-net structure in North Carolina is supported by local, state, and federal funds as well as through the provision of charity care by hospitals and other providers. However, the core of the safety net for primary care consists of Federally Qualified Health Centers (FQHCs). The ACA emphasizes the role of FQHCs in meeting the demand for care from newly insured individuals and in working with people who may have difficulty understanding the system and how to make use of available resources. Funding for operations and capital expansion of those centers is an important part of the ACA [25], both because Congress recognized that insurance coverage was not going to be extended to the entire population and because these centers make special adaptations to accommodate low-income individuals and those who face other barriers to access. North Carolina has its own network of rural health clinics, community health centers, free clinics, and public health clinics, as well as a Medicaid program (Community Care of North Carolina) that emphasizes coordinated care and meets the special needs of low-income patients and clients. This network—which is supported by teaching institutions, the North Carolina AHEC Program, hospitals, and independent practitioners—has created an effective safety net across the state.

In addition, FQHCs are now eligible to host the graduate medical training of primary care physicians in a context that emphasizes care coordination and team-based care. The Mountain AHEC in Asheville has already been funded and accredited to operate one of the "Teaching Health Center Graduate Medical Education Programs" authorized by the ACA [26]. This represents a milestone in the development of a health care system focused on complete access; although such centers have, from their inception, hosted students of all types, they are now seen as the locus where best practices for enhancing access can be actualized as well as taught [27]. The program in western North Carolina is likely to be the first of several that will be established in the state.

The ACA appropriately emphasizes the development of human resources as a necessary step toward increasing access to health care services. Developing the health care workforce to meet the changing needs of patients and populations is one of the obvious ways to improve overall health status, and North Carolina has taken advantage of the opportunities the ACA offers in this area. Fortunately for the state, some of the necessary groundbreaking has already been done. We have a primary care network that is focused on Medicaid beneficiaries but also provides substantial "halo" effects for other patient populations; a set of practice acts that can accommodate some, but not necessarily all, of the skills and capacities of a wide range of clinical practitioners; and education and training institutions supported by a robust AHEC system. NCMJ

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Acknowledgment

Potential conflicts of interest. T.C.R. has no relevant conflicts of interest.

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