

NCIOM Affordable Care Act Task Force – Update on Implementation of Recommendations

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The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. This federal law contained many provisions aimed at expanding health insurance coverage for Americans, controlling the growth of health care costs, and improving the delivery of health care. Many of those provisions required state-level decisions and actions. The North Carolina Department of Health and Human Services (NC DHHS) and North Carolina Department of Insurance (NC DOI) asked the North Carolina Institute of Medicine (NCIOM) to convene stakeholders to examine the law and make recommendations for implementing it to serve the best interest of the state as a whole. This task force included an advisory group and eight workgroups, which met for 12-18 months beginning in August 2010 and published a report with 44 recommendations in January 2013 [1]. To mark the 10-year anniversary of the passage of the ACA, the NCIOM has produced a report on the implementation status of the task force recommendations [2]. The full report will be available at NCIOM.org and here we summarize the work that has been done in North Carolina.

Health Benefits Exchange

The ACA required the development of health insurance Marketplaces in each state, called Health Benefits Exchanges (Exchange), to help people shop for individual coverage. States were given the option of creating their own state-run Exchange or allowing the federal government to create one. The NCIOM task force recommended that the North Carolina General Assembly (NCGA) create a state-based Exchange (*Recommendation 2.1*). At the time of the ACA's passage, Governor Bev Purdue's administration expressed the intention to develop a state-run Exchange. However, when Governor Pat McCrory took office in 2013, he announced that the state would instead opt for the federally run Exchange. This choice was codified by Session Law 2013-5, Senate Bill 4 (SB4), which also barred state partnership in the development of an Exchange [3]. North Carolina also continues to rely on the federal government, through the Centers for Medicare & Medicaid Services (CMS), to monitor the ACA provision that requires health plans to contract with an adequate number of essential community providers that serve people with low incomes or those who are medically underserved (*Recommendation 2.4*).

The task force called on the intended state Exchange, the

NC DOI, and local departments of social services to support the work of helping people learn about and sign up for health insurance (*Recommendations 2.6 - 2.9*). Instead, this activity was successfully taken on by the NC Navigator Consortium and Enroll America. North Carolina has been in the top five states for insurance Marketplace signups from 2014 through 2020, with between 350,00 to 600,000 enrollments per year [4]. In fact, in the first year of enrollment, North Carolina was second only to Florida in meeting enrollment targets set by CMS, enrolling 187% of the set target [5].

Medicaid

The ACA originally required states to expand Medicaid eligibility up to 138% of the federal poverty level, however this requirement was struck down by the Supreme Court in 2012 in *National Federation of Independent Business v. Sebelius*, and the option was left to individual states to implement [6]. The NCIOM task force recommended that North Carolina expand Medicaid eligibility, but the NCGA specifically denied this expansion in SB4 (*Recommendation 3.1*) [3]. However, NC Medicaid has done some work to streamline the eligibility and enrollment process for those who are currently eligible (*Recommendation 3.2*).

Safety Net

Those who did not gain coverage from the ACA's provisions, particularly in light of the absence of Medicaid expansion in North Carolina, may be able to access some medical care from safety net organizations and private providers. As such, the NCIOM task force targeted several recommendations toward improvements in safety net access and quality of care. Subsequently, stakeholders across the state have worked to engage safety net organizations to participate in required hospital and health department community health assessments (*Recommendation 4.2*), expand access to 340B Discount Drug Program coverage to new populations like incarcerated persons and migrant farmworkers (*Recommendation 4.3*), and continue the work of

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the Safety Net Advisory Council within the Primary Care Advisory Council coordinated by the Office of Rural Health (*Recommendation 4.5*).

Health Professional Workforce

With the ACA's promise of increasing the number of people with health insurance, the NCIOM task force made recommendations about how to adequately address the increase in health care usage and related need for a larger health care workforce, particularly in primary care. The University of North Carolina System, the North Carolina Community College System, private colleges and universities, North Carolina Area Health Education Centers (NC AHEC), and other partners have collaborated to develop a variety of programs and strategies to educate new health care providers (*Recommendation 5.1*) and expand the health professional population to more closely reflect the demographics of the population served (*Recommendation 5.2*). This collaboration includes: creation of a more seamless transfer process between community college system schools and state university system schools for nursing students to obtain a bachelor's degree in nursing; recruitment of students from rural and underserved areas, including opportunities for intensive preparatory activities; increase in numbers of residency positions available in rural areas; development of interprofessional collaborative education and practice opportunities; expansion of community health worker curriculum and training; expansion of pipeline programs that reach out to underrepresented, rural, and disadvantaged students in middle and high school.

To improve access to primary and psychiatric care in rural and underserved areas, the Office of Rural Health administers the North Carolina State Loan Repayment Program (*Recommendation 5.3*). This program offers educational loan repayment awards of up to \$50,000 to mental health providers in exchange for a two-year service commitment in a team-based setting that provides comprehensive behavioral health services to rural communities.

Further work is still needed to address the task force's recommendation to expand and support comprehensive workforce planning and analysis (*Recommendation 5.5*).

Prevention

The ACA set new standards and allocated funds for the purpose of prevention, wellness, and public health infrastructure. One of the national prevention priorities was tobacco use, and NC Medicaid now covers almost all prescription smoking cessation medications with a prescription and allows Food and Drug Administration-approved over-the-counter nicotine replacement therapy (*Recommendation 6.1*). Since 2019, the North Carolina Division of Public Health (DPH) has provided financial support to Family Forward NC, a program implemented by the North Carolina Early Childhood Foundation that partners with businesses of all sizes to provide support in implementing family friendly workplace

policies, including breastfeeding support and paid family leave. NC Medicaid also allows for one Adult Preventive Medicine Assessment per year that does not count toward the annual Medicaid visit limit (*Recommendation 6.3*). DPH implemented the Communities Putting Prevention to Work (CPPW) program using grant funds through the ACA's Prevention and Public Health Fund (PPHF). CPPW programs that increase opportunities for healthy eating and active living have been implemented in work sites (*Recommendation 6.4*), health care organizations, and schools. The PPHF also supports the Preventive Health and Health Services Block Grant, which funds local health department programming to address the social drivers of health, including physical activity and injury/violence prevention, with a focus on health equity.

Quality

The ACA included a variety of provisions aimed at improving quality and patient safety. These included new quality measures and reporting requirements related to adults eligible for Medicaid and providers of hospice and long-term care. NC Medicaid tracks primary and preventive care data and works with Community Care of North Carolina (CCNC) and NC AHEC to provide practice coaching and support (*Recommendation 7.1*). Health profession trade organizations in the state have worked to educate providers and staff on ACA-related quality topics, particularly through the North Carolina Accountable Care Organization (ACO) Collaborative and the North Carolina Healthcare Association (*Recommendations 7.4, 7.5, & 7.7*). The North Carolina Health Care Facilities Association and the Association for Home and Hospice Care of North Carolina have hosted trainings on value-based purchasing provisions of the ACA.

The ACA's quality improvement provisions also include a focus on preventing hospital readmissions, especially through improved communications and processes as patients transition from one health care setting to another. The task force recommendation to improve care transitions was implemented through multiple CCNC initiatives, including development of a new Transitional Care Impactability Score that helps identify individuals enrolled in Medicaid who would benefit most from transitional care management following hospital discharge (*Recommendation 7.9*). NC AHEC and CCNC partnered to create NC IMPaCT, which includes two collaboratives aimed at improving care transitions and decreasing hospital readmissions (*Recommendation 7.4*). This successful model has been disseminated to at least five other states [7]. Also, North Carolina's health information exchange—NC HealthConnex—provides an event notification service called NC*Notify that gives providers notifications to support care coordination. Additionally, to support care transitions from hospitals to nursing facilities and provide follow-up care, nurse practitioners are now paid to provide these services in skilled nursing facilities (*Recommendation 7.10*).

New Models of Care

The ACA provided opportunities to partner with the federal government to test new models or expand existing models of care with a goal of reigning in escalating health care costs. The North Carolina Medical Society (NCMS) worked for several years to monitor federal funding opportunities that involved physician practices through CMS and the newly formed Center for Medicare and Medicaid Innovation (CMMI) (*Recommendation 8.1*). Programs funded through CMS and CMMI are subject to independent and publicly reported evaluations (*Recommendation 8.2*). It remains challenging to track demonstrations of new payment and delivery models of care funded both privately and publicly, as well as any associated evaluations. NCMS has worked with NC DOI to review regulations that might be barriers to testing new payment and delivery models in the state. As a result, Next Generation ACOs that allow providers to take on a higher level of risk and reward [8] and CMS ACOs that took on downside risk are exempt from NC DOI regulation.

The NCIOM and NC DHHS examined options for capturing health care data through an all-payers claims database (APCD) that would improve patient safety and population health and reduce trends in health care expenditures (*Recommendation 8.3*). The APCD task force, convened in 2016-2017, made eight recommendations for developing this type of system in North Carolina, but they have not yet been implemented [9].

Conclusion

In the years since the ACA was passed and the NCIOM task force made recommendations about its implementation, North Carolina has seen a mixture of successes, ongoing work, and some missed opportunities. Navigators help North Carolina have one of the highest rates of Exchange sign-ups of any state. State university and community college systems are working to improve the diversity and distribution of our future health care workforce. NC HealthConnex continues to expand capabilities of health care data to improve quality of care for patients. Yet, one of the greatest opportunities that the ACA has offered states to increase access to care is the

ability to expand Medicaid eligibility. North Carolina has yet to do so. The NCIOM task force on the Affordable Care Act, and many other NCIOM task forces since then, call on the NCGA to implement this policy change that would improve the health of thousands of North Carolinians. NCMJ

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