

Implementation of the Patient Protection and Affordable Care Act June 2011

This white paper describes challenges and opportunities faced by local health departments (LHDs) in response to the changing public health and clinical health care environment as the Patient Protection and Affordable Care Act (ACA) is implemented.

The ACA was enacted in March 2010 and makes sweeping changes to the financing of health care for most uninsured Americans. It also recognizes the importance of primary and secondary prevention through clinical preventive services and community prevention efforts.

The ACA:

1) Provides expanded insurance coverage by 2019, through Medicaid and private insurance to 32 million Americans who are currently uninsured, including coverage of essential clinical preventive services with no cost-sharing in new insurance plans and Medicare and an incentive for states to cover these services in Medicaid starting in 2013;

2) Builds the national commitment to prevention through the Prevention and Public Health Fund, providing \$15 billion over ten years in mandatory funding. The Fund provides enhanced support for individual and community-based interventions known to promote healthy behavior, create healthy environments, reduce health disparities and/or reduce the incidence of chronic and infectious diseases;

3) Promotes collaboration between providers of medical care, the public health system, and their partners in the private and public sectors to create healthier communities.

The National Association of County and City Health Officials (NACCHO) has identified key roles that local health departments can and should play to achieve successful implementation of the ACA in communities throughout the United States and to mobilize the 'health in all policies' initiatives of health reform. LHD leaders should be active participants in educating community and state stakeholders about the ACA and engaging partners in new opportunities to improve health.

Implementation responsibilities will develop on the federal, state and local levels and should be coordinated between the three levels. At the federal level, LHD leaders should engage their elected officials in order to ensure continued support of prevention and public health provisions of the ACA. On the state level, State Associations of County and City Health Officials are positioned to conduct health reform review and analysis for LHDs, statewide public health councils, and elected officials.

Opportunities for LHDs

As more people enter the health insurance market, LHDs may serve as facilitators of enrollment for Medicaid, Children's Health Insurance Program (CHIP), and health insurance exchanges. LHDs may pursue a greater role in case management of complex clinical patients.



As use of health information technology (HIT) becomes more widespread by clinical providers, LHDs have the opportunity to maintain and enhance their role as health data and information repository for the community and analyze available data. However, this will require greater adoption of HIT by LHDs than is currently the case. LHDs should adopt electronic health records and work to expand health information exchange between LHDs and health care providers to meet the requirements of the ACA, reduce administrative costs, prevent costly and unnecessary duplications of service, and improve health outcomes. NACCHO has advocated for further support from the federal government, as is currently the case for physician practices and hospitals, to foster further adoption of HIT by LHDs.

Under the ACA, non-profit hospitals are required by the Internal Revenue Service to conduct community health needs assessments. LHDs should pursue collaboration with non-profit hospitals to assist in these assessments.

LHDs need to determine whether a clinical care role continues to make sense for them in their communities and among the services provided by partners and others supported by the ACA. Such determinations should be made in coordination with local or regional stakeholders. LHDs that provide clinical care may need to develop new business models to bill or contract for services, including services to pre-adjudicated detainees.

A need for safety net services for undocumented immigrants will continue to exist. Undocumented immigrants will not receive federally subsidized health care coverage under the ACA. They also will not be eligible for Medicare, nonemergency Medicaid, or CHIP. In addition, the law does not allow undocumented immigrants to purchase coverage in the health insurance exchanges, even if they pay entirely with their own funds, leaving most without a group purchasing option to obtain health care coverage.

An influx of \$11 billion in new mandatory funding was provided through the ACA to federally qualified health centers (FQHC). LHDs may consider applying to become a “public entity” FQHC or pursue partnership opportunities with FQHCs such as co-location of services, referrals, and/or purchase of services. More information about collaboration with FQHCs is available from the National Association of Community Health Centers, including a publication entitled *Partnerships between Federally Qualified Health Centers and Local Health Departments for Engaging in the Development of a Community-Based System of Care*.

LHDs should pursue relationships with groups forming Accountable Care Organizations. Opportunities exist within the ACO regulation for LHD involvement in health needs evaluations. NACCHO has recommended that the proposed regulation require ACOs to partner with health departments for this purpose and that ACOs consult with health departments to ensure that their providers and their patients are aware of the full range of community resources that are available. NACCHO has also recommended that ACOs should be required to consult with their health departments to identify the public-health-related clinical guidelines that they should be using with their ACO patients and with their other patients.

In order to document the importance of prevention, LHDs should develop information on the return on investment of population-based public health, notwithstanding the challenge of showing change in health status within a short timeframe.

There are a number of new partnership opportunities for LHDs facilitated by the implementation of the ACA. Some of the potential partnerships are listed below:

- Convene partnerships for population-based prevention, including the engagement of new partners in policy development for communities.
- Transition clinical services to community partners such as FQHCs and focus LHD resources on population-based functions.

- Convene and coordinate population health and health information technology activities among community partners including health care providers and community-based organizations etc.

There are important roles where LHDs can provide leadership and expertise, including the following:

- Promoting a framework for understanding and measuring health inequities in order to impact both the medical and social determinants of health
- Oversee the planning, development and implementation of health care reform locally
- Evaluate changes in the health environment, on a local and regional basis
- Monitor health status of vulnerable populations, including uninsured and immigrant communities, and gaps in health insurance coverage
- Work with individual States to apply for grant opportunities that align with state and local priorities and leverage the work of community and local stakeholders
- Educate community residents and community-based organizations about the choices available under the ACA

Challenges for LHDs

The implementation of the ACA may also present challenges to LHDs already facing ongoing budget challenges.

Communities can expect an influx of new patients to health care systems with inadequate reimbursement or resources, particularly primary care providers, to care for them. Some states, because of political considerations or budget challenges, lack the willingness or capacity to work towards implementation of the ACA. Some community members as well as health care providers may disagree with the passage of the ACA and be resistant to its implementation.

Both in health care and community settings, there is also persistent confusion between prevention and secondary prevention in the medical model with population-based prevention and the social determinants of health. LHDs will need to continue to conduct education about primary prevention activities.

Local and state policymakers may erroneously assume that because of the passage of the ACA, public health services are now unnecessary or can be cut back even further. There may be attempts to duplicate local health department services as other entities assume greater roles in prevention and primary care. Policymakers may lack understanding of the unique roles, accountabilities and authorities of government public health departments.

The Prevention and Public Health Fund has come under attack in Congress, with the House of Representatives repealing the Fund in April 2011. However, as long as the Fund remains available it is an important resource for prevention and public health. The vulnerability of the Fund requires constant vigilance and continued efforts to assure that policy makers and the public understand the importance and benefits of health promotion and disease prevention and mitigation and the role(s) of the LHDs in such initiatives

The governmental public health system has been weakened by years of cuts, which may make it easier for other agencies, with little or no history of offering public health services, to argue they need to fill the gaps. The constant vigilance and continued assurance efforts will be needed to avoid a costly attempt to recreate what already exists.

As some local health departments move away from clinical care, either by choice or because of budget cuts, the clinical public health workforce will need training for new roles in prevention-related activities.

In conclusion, the passage of the Patient Protection and Affordable Care Act presents a variety of opportunities and challenges to local health departments. The ACA recognizes for the first time in a major federal law the importance of investing in prevention and public health and the need to bolster the work of state and local health departments as part of that investment. However, the implementation of the law and changes to the health care system present challenges that will require local health departments to be flexible and examine the services they provide with attention to the particular needs of their population and the environment they face locally. As the ACA is implemented, LHDs will continue to face a shifting environment and need to be able to adjust to the changed health care system.

NACCHO has developed a number of resources to help LHDs navigate the changed landscape as health reform is implemented. These resources, along with links to tools and resources from other organizations, can be found at: <http://www.naccho.org/advocacy/healthreform/index.cfm>