Impacts of the Affordable Care Act for State and Local Health Departments

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Keeneland Conference
Wednesday, April 22, 2015
Session 3C: Impact of the Affordable Care Act
In Crimson Clover at the Hilton Downtown
Lexington
Disclosures

• This presentation was prepared by NORC at the University of Chicago, under contract to the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). The findings and conclusions presented do not necessarily represent the views of ASPE or HHS.
Research Objectives

• Assess scope of impact of Affordable Care Act (ACA) reforms, including expanded insurance coverage and enhanced access to preventive services, on state and local public health programs

• Examine effect of reforms on how individuals seek services and where they are delivered

• Examine anticipated changes to programs and practice resulting from ACA reforms

• Examine role of state and federal support for public health programs
Data Sources

• Case studies with five state health departments and some local health departments (HDs)
  • Interviewed health directors, senior deputies, program directors and staff (immunization, cancer control, others), Medicaid staff, and local HD staff
  • First two states – paired design to explore differences of Medicaid expansion
  • Remaining states – diverse governance structures and geography

• Environmental Scan

• Ongoing consultation with Technical Advisory Group (TAG)
Case Study States

- **Decentralized**
- **Centralized**
- **Mixed**
- **Shared**
<table>
<thead>
<tr>
<th>State</th>
<th>Governance</th>
<th>Expansion Status (Date)*</th>
<th>Region</th>
<th>Pop. Tertile</th>
<th>Unique Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>Centralized</td>
<td>Expanding through waiver (July 2013)</td>
<td>South</td>
<td>Medium</td>
<td>High provision of clinical services</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Mixed</td>
<td>Not expanding (July 2013)</td>
<td>South</td>
<td>Large</td>
<td>High provision of clinical services</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Centralized</td>
<td>Expanding (April 2014)</td>
<td>Southwest</td>
<td>Small</td>
<td>Frontier/rurality, tribal health, border issues</td>
</tr>
<tr>
<td>Maryland</td>
<td>Shared</td>
<td>Expanding (June 2014)</td>
<td>Mid-Atlantic</td>
<td>Medium</td>
<td>Explored LHDs in Western rural counties</td>
</tr>
<tr>
<td>Iowa</td>
<td>Decentralized</td>
<td>Expanding through waiver (June 2014)</td>
<td>Midwest</td>
<td>Medium</td>
<td>99 counties, 101 LHDs, decentralized</td>
</tr>
</tbody>
</table>

*Expansion Status (Date of Site Visit) Data from Kaiser Family Foundation, http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
Initial Findings – Year 1

• Billing for Services
• HHS & State Support for Public Health Programs
  • Changes in client volume
• HD Provision of Clinical Services
• HD Provision of Key Public Health Services
• ACA-Related Opportunities
Billing for Services

• Expanding capacity to bill for services (five states)
• Some services not amenable to billing (e.g., contact tracing, surveillance)
• Reimbursement not sufficient to cover HD costs to deliver services (three states)
• Billing for services changes how HDs do business
  • They establish billing systems, change accounting practice, train public health staff to ask about insurance status, and hire billing staff
“The Department of Health historically didn’t need to think about generating revenue, but we’re feeling that pressure now as a result of the Affordable Care Act. [We are] thinking about funding being cut in the future...[and with] more people insured, there’s an opportunity and we should be maximizing our billing. It’s changing our mindset – we’re becoming more business oriented.”
LHD Billing with Third-Party Payers

Percentage of LHDs

- **Currently Billing and Plan to Increase Billing**
- **Not Currently Billing but Plan to Establish Billing**
- **Currently Billing but No Plans to Increase Billing**
- **Not Currently Billing and No Plans to Establish Billing**

**Source:** National Association of County and City Health Officials (NACCHO) 2014 Forces of Change Survey
LHD Billing for Any Clinical Service

- Private Only
  - 4%
- No Insurers (Do Not Bill)
  - 14%
- Public Only (Medicaid and/or Medicare)
  - 21%
- Public and Private
  - 60%

n=610

Source: National Association of County and City Health Officials (NACCHO) 2014 Forces of Change Survey
HHS & State Support for Public Health Programs

- Concern about ongoing support for public health programs (5 states)
  - HDs seeing reduction in client volume for some public health programs (immunizations, breast and cervical cancer screening)
  - Believe reduction is result of ACA

- Concern that policymakers may not view traditional public health services as essential (5 states)

- States with higher reliance on state funding may be better able to sustain programs if federal cuts occur
Despite expanded insurance…

• Patients may still need to access clinical services at HDs

• Patient need varies by insurance status, geography, and privacy (e.g., seeking anonymous or confidential STD testing or pregnancy services)

• Patients may not have access to care, especially in rural communities

• Many areas have insufficient provider coverage (e.g., for Medicaid recipients)
HD Provision of Key Public Health Services

- By providing clinical services, some HDs maintain capacity for population health activities
  - Especially in rural communities; however, continued delivery of these services may further expand a rural/urban public health divide

- HDs believe maintaining public health activities is important (e.g., immunization, disease surveillance, and screenings)

- Other providers may not cover these activities and some prefer that the HD cover them (rather than providers building their own capacity)
ACA-Related Opportunities

• HD opportunities to contract with providers and health plans, bill for services, and participate in ACOs

• HD challenges:
  • Provide services to hard-to-reach and high-need populations; higher costs make it difficult to compete
  • Often lose money when they contract/bill for services
  • Partnering with ACOs – perception that HDs are not accountable and will not assume risk
  • “While ACO gives kudos to public health, they will not initiate a contract and there has been no planning on how this will be sustained” [beyond grant funding].
Conclusions

• HDs acknowledge that many changes that will result from ACA are still unknown

• HD leaders are concerned that reduced client volume may make it difficult to sustain programs seen as important to maintaining the public health

• Loss of revenue from reduced client volume could have negative effect on HD, including:
  • Ability to maintain robust workforce
  • Ability to provide sufficient surge capacity and emergency response to epidemic, disease outbreak, or public health emergency
Implications and Next Steps

• Explore themes through another five case studies (ASPE funding for FY 2014 study)

• Provide voice to state and local public health leaders’ concerns about ACA effects

• Capture strategies for program planning, sustainability, and adaptation

• Identify opportunities, challenges, and strategic planning efforts that states and localities are implementing to adapt to anticipated challenges