

The Changing Role of Public Health as a Safety Net Provider



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

Disclaimer

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Project Focus

- Assess scope of impact of Affordable Care Act on state and local public health programs.
- Examine how expanded insurance coverage and enhanced benefits may change how individuals seek care and where services are provided.
- Examine potential changes to public health programs as a result of health insurance expansion.

Context

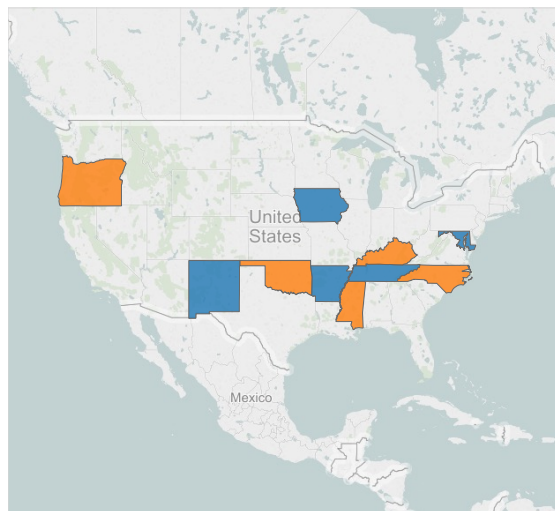
The Patient Protection and Affordable Care Act includes many provisions designed to improve the public's health *via the health care delivery system*.

- What does this mean relative to state and local governmental provision of services such as immunization and cancer screening?
- What does this mean for public health financing?
- What are other impacts/implications for state and local public health programs?

Data Sources

- Case studies with ten state health departments and some local health departments (HDs)
 - Interviewed health directors, senior deputies, program directors and staff, Medicaid staff, and LHD directors
 - First two states – paired design to explore differences of Medicaid expansion
 - Remaining states – diverse governance structures and geography
 - Themes in second project year
- Environmental Scan
- Ongoing consultation with Technical Advisory Group (TAG)

Selected States



■ Year 01
■ Year 02

Comparison of States (Year 1)

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

*Expansion status at date of site visit. Data from Kaiser Family Foundation, <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>

Comparison of States (Year 2)

State	Governance	Expansion Status (Date)*	Region	Pop. Tertile	Unique Features
Kentucky	Shared	Expanded (August 2015)	South	Medium	Leveraging Medicaid expansion for community health
Oregon	Decentralized	Expanded (September 2015)	West	Medium	CCO structure and foundational capabilities
Oklahoma	Mixed	Not expanding (October 2015)	Southwest	Medium	Integrating public health and health care; Tribal health
North Carolina	Decentralized	Not Expanding (January 2016)	South	Large	Provision of direct clinical services in areas with limited access to health care services
Mississippi	Centralized	Not Expanding (March 2016)	South	Medium	Decreasing volume of clinical preventive services

*Expansion status at date of site visit. Data from Kaiser Family Foundation, <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>

Key Findings: Health Departments at the Crossroads

- Health departments may shift clinical services provision to partners post-ACA implementation
 - May allow HDs to increase focus on core public health activities and services (e.g., policy development/support, assessment and surveillance, etc.)
- Instead of providing clinical services, HDs can increase role in building healthier communities and cross-sector collaboration through outreach and education, patient navigation, data collection and surveillance, data sharing and analysis, & policy and systems change

Key Findings: Health Departments at the Crossroads

- HDs may expand provision of clinical preventive services post-ACA implementation
 - Especially in areas with health provider shortages
- ACA may provide opportunities for additional revenue if HDs bill for clinical services
 - Potential challenges with billing include implementing billing systems, contracting with third party payers, and staff reluctance to inquire about insurance status
 - May be dependent on state's decision to expand Medicaid as well as other factors, such as geography and provider coverage

Key Findings

Future Role for HDs in Providing Clinical Services

- Even with insurance expansion, many HDs continue to provide some clinical services
 - Depends on population needs, which varies by insurance status, geography, and privacy concerns (e.g., anonymous/confidential STD testing or pregnancy services), among other reasons
- Insurance coverage does not equate to access to care, as emphasized by HD respondents in rural communities
- Many areas have insufficient numbers of providers, especially for patients with Medicaid coverage
- Some rural HD respondents reported that providing clinical services helps to maintain capacity to support population health activities

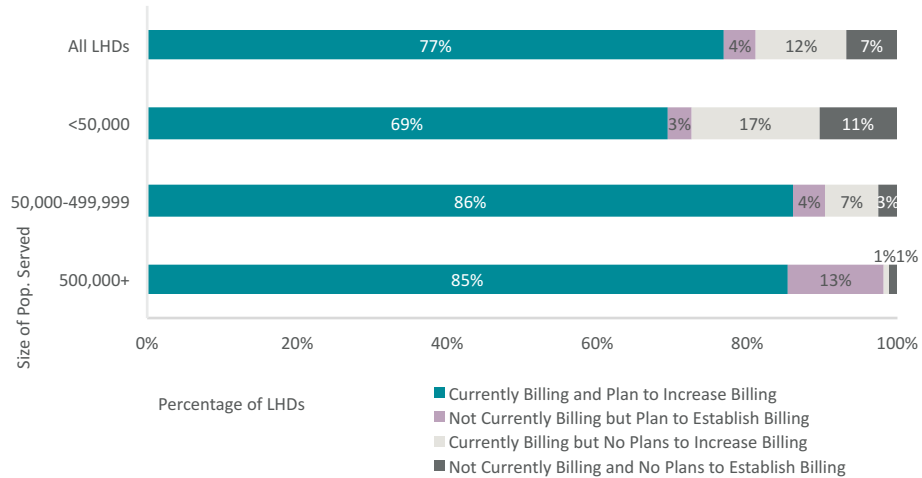
Billing for Services

- Billing and reimbursements likely to be increasingly important for HDs (especially in expansion states?)
- Ability to bill Medicaid and other payers depends on:
 - Knowledge of available programs and resources
 - HD structure
 - Degree to which SHD provides billable services
 - Availability of billing systems

Billing for Services

- Coverage changes under the ACA may impact HDs' provision of clinical preventive services (e.g., vaccinations and screenings)
 - HDs may need to determine patients' insurance status to bill for covered services
 - Billing opportunities may be limited as many key PH activities will never be covered through insurance (e.g., investigations for outbreaks)

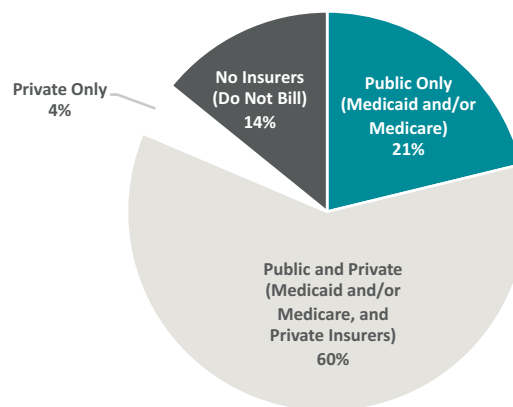
Level of Engagement to Increase or Establish Billing



n=555

Source: National Association of County and City Health Officials (NACCHO) 2014 Forces of Change Survey

Percentage of LHDs that Billed Third-Party Payers for any Clinical Service



n=610

Source: National Association of County and City Health Officials (NACCHO) 2014 Forces of Change Survey

Key Findings

Secondary Impacts

- Concern that differences between HDs in providing clinical preventive services may expand a rural/urban divide
- Concern from several HDs that potential budget cuts will effect HDs' ability to maintain robust workforce to provide sufficient surge capacity and emergency response in the face of an epidemic, disease outbreak, or public health emergency

Sustainability of Key Public Health Services

- Other entities are unlikely to provide public health services and activities (e.g., immunization, surveillance, and screening)
- HDs reported that many private providers prefer HDs to provide these public health services, rather than building their own capacity to do so

Key Findings

Opportunities for Health Departments

- Contracting with providers and health plans
- Participating in ACOs and CCOs (Iowa, Oregon)
- Redefining the HD's role in prevention and community contributions (Oregon, Mississippi)
- Billing for services (revenue)
- Planning, developing, and implementing CHAs and CHIPs (in coordination with other health care providers such as CCOs, nonprofit hospitals, others)

The Future of Rural Public Health

The Walsh Center
for Rural Health Analysis
NORC AT THE UNIVERSITY OF CHICAGO

Analyzing LHDs by Rurality

NORC
at the UNIVERSITY of CHICAGO

Rural:

Multiple definitions:

- By county
- By Census tract
- By ZIP Code

Multiple grades of “rural”

- “Micropolitan”
- Frontier

Federal government uses 74 definitions of rural,
including 16 primary definitions

Approximately 20% of residents live in rural areas

Defining LHD Rurality by RUCA Code

LHDs coded as “urban”, “micropolitan”, or “rural” based on LHD zip code

Micropolitan

Includes census tracts with towns of between 10,000 – 49,999 population and census tracts tied to these towns through commuting.

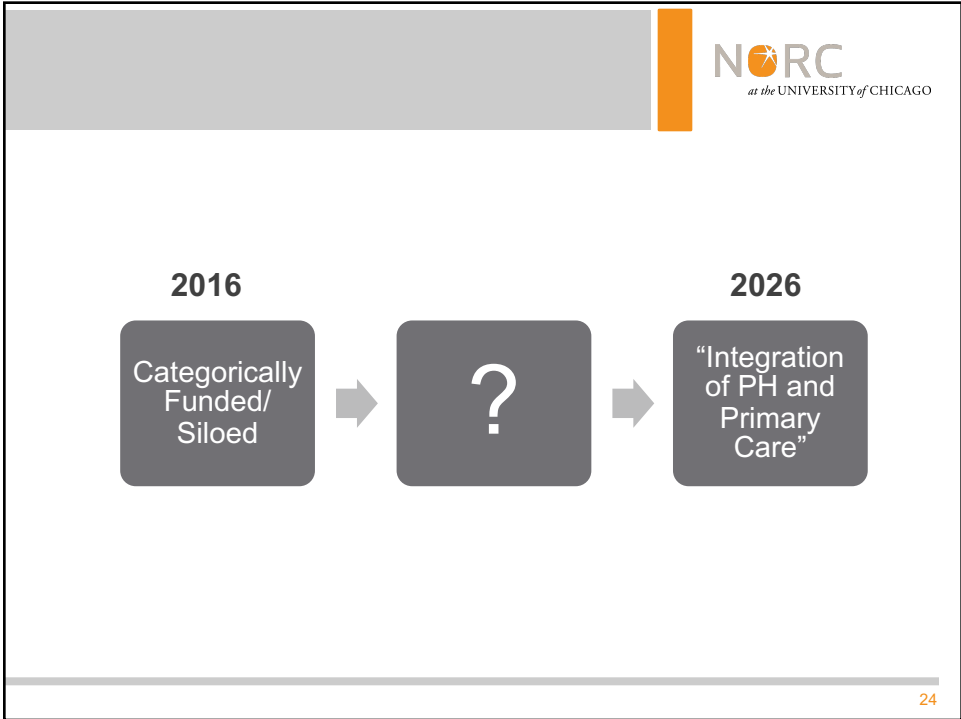
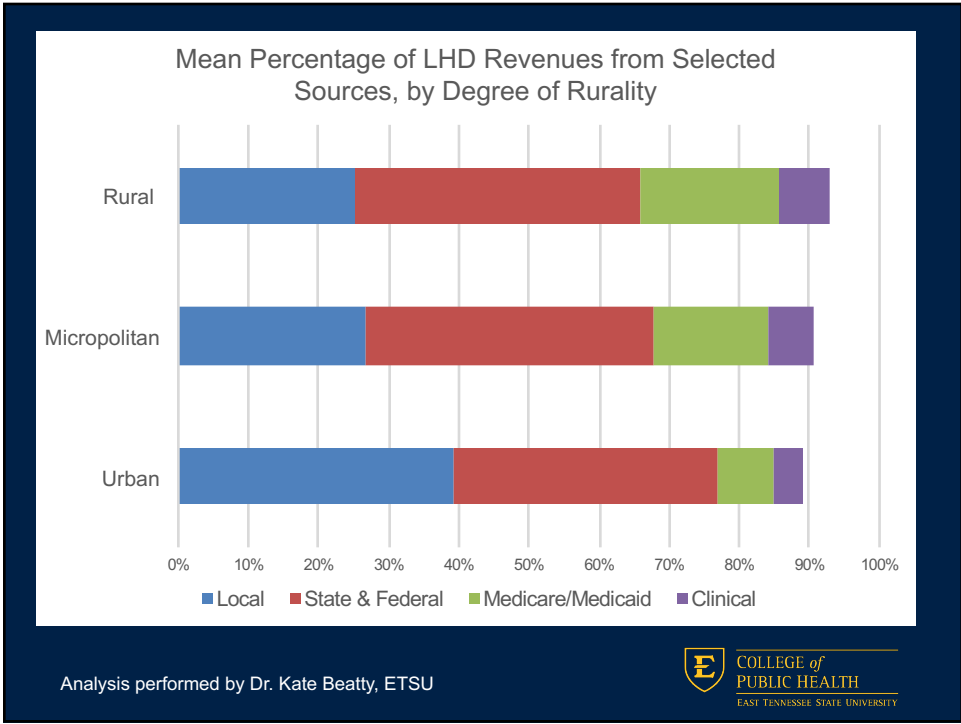
Rural

Includes census tracts with small towns of fewer than 10,000 population, tracts tied to small towns, and isolated census tracts.

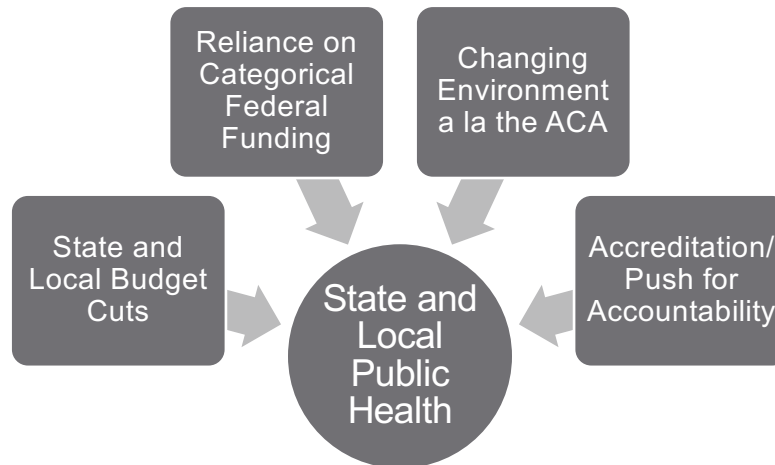
Both “micropolitan” and “rural” categories are considered rural by the Federal Office of Rural Health Policy.

NACCHO Profile – Small vs. Rural

	Urban n(%)	Micropolitan n(%)	Rural n(%)	Total
<50,000	226 (20.2)	197 (17.6)	698 (62.3)	1,121
50,000–99,999	121 (38.1)	144 (45.3)	53 (16.7)	318
100,000+	427 (84.9)	58 (11.5)	18 (3.6)	503
Total	774	399	769	1942



Drivers of Change in PH



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Drivers of Change – Budget Cuts

- Funding cuts to health departments (HDs) in wake of financial downturn
 - Reduced budgets in all 7 case study HDs participating in NORC PH Financing Study
- Funding shifts result in program reductions, cuts, and layoffs
- Unpredictable funding streams and tight budgets present significant challenges to HDs

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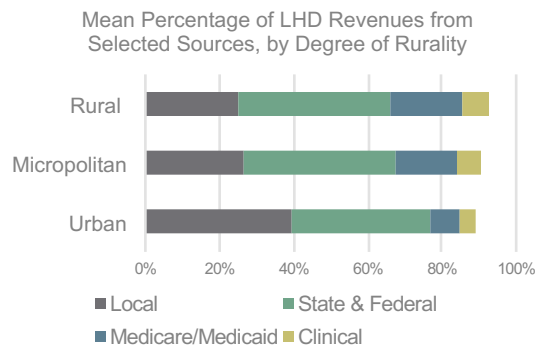
Drivers of Change – Budget Cuts

- No increase in federal funding to make up for decreased state and local funding
- Federal funding has actually decreased, but at slower rate than state decreases, and has thus grown as percentage of total PH revenue
- Trust for America's Health reports significant shortfall in funding for core PH services due to cuts at the federal and state/local levels; reported a 15% loss of the state and local PH workforce between '08 and '11.

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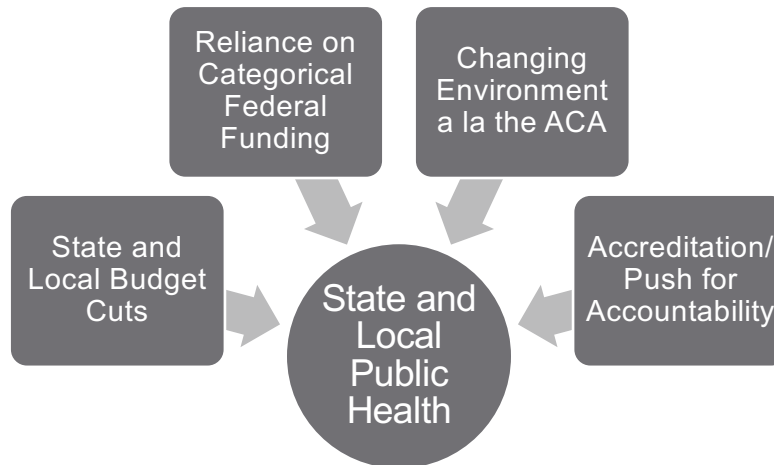
Budget cuts – A Rural Lens

- Rural HDs rely more heavily on state and federal resources as a percentage of overall funds and have less access to local resources.
- Rural HDs have more sensitivity to budget cuts as staff tend to work in multiple program areas, and each program is a “touch point” that helps support others.



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Drivers of Change in PH



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Drivers of Change – Reliance on Federal Funding

- Federal funding is a significant portion of HD revenue
 - Between 57.5 – 74.7% of total revenue in 5 of the case study HDs
 - Third party reimbursement is a small but growing proportion of state funding for PH; fees and fines ranged from .1% to 9.6% of revenue
 - Smaller percentage of revenue from state sources, fees, fines, and other sources
- HDs' largest percentage of federal revenue from USDA, followed by CDC, HRSA, EPA, and DHS.

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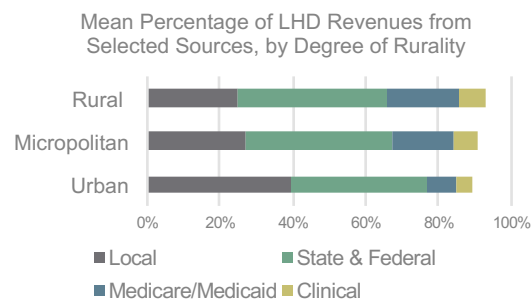
Drivers of Change – Reliance on Federal Funding

- Federal PH expenditures often vary based upon emerging needs
 - Example: Pandemic flu funding following H1N1
- Federal PH expenditures are typically categorical in nature, and may not correspond well to local needs
- Federal PH expenditures can get tied up in politics
 - Example: NPHII Funding

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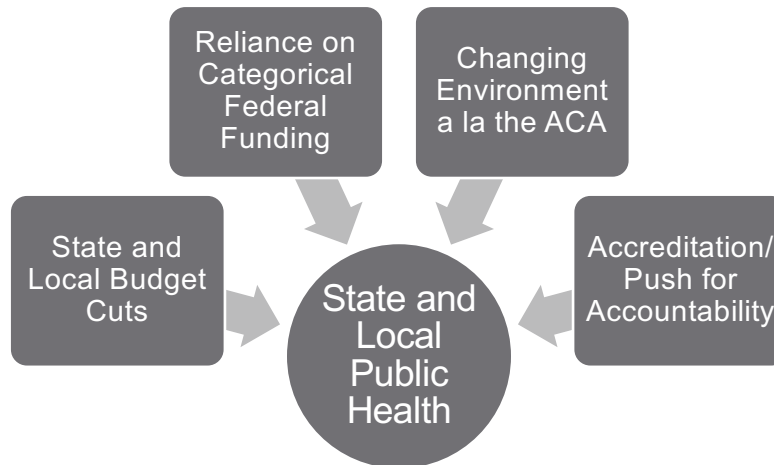
Federal Funding – A Rural Lens

- Rural HDs rely more heavily on federal pass through resources as a percentage of overall funds.
- Fewer local resources, combined with greater reliance on state and federal resources = less flexibility



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Drivers of Change in PH



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Drivers of Change – The Affordable Care Act

- The ACA expands insurance coverage and coverage of clinical preventive services
- The ACA shifts responsibility for some HD services to the provider setting
- As demand for HHS-funded preventive services programs shifts, so may the categorical funding
 - States in NORC's ACA Impacts studies have already reported reduced volume in breast and cervical cancer screening programs and in immunization programs.
 - CDC funds for immunization have already been reduced, and HDs are concerned that other programs may follow.
 - Are resources sufficient to serve a high-need remaining uninsured population?
 - Do LHDs enter the marketplace as a provider? If so, will reimbursement cover the costs?

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Drivers of Change – The Affordable Care Act

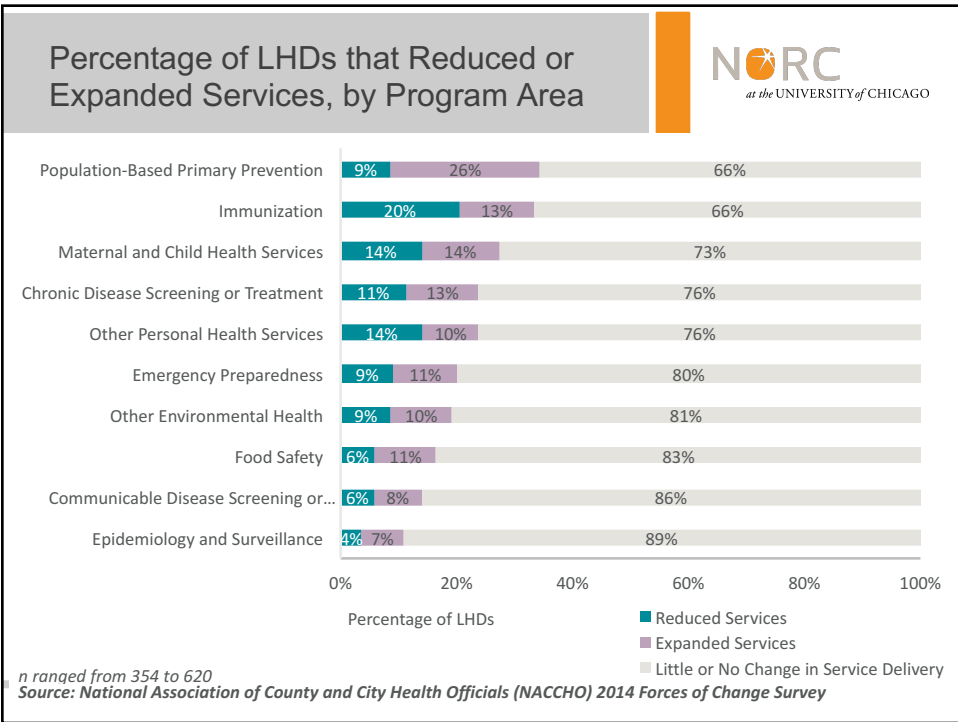
- The ACA may create new opportunities for health departments
 - Expansion of direct services
 - Contracting and billing
 - Care coordination
 - Expansion of population health services
 - ACOs
- Health departments are likely to choose different paths based on geography.
- Does funding for PH shift from CDC to CMS? What are the implications?

Performed by LHD directly

	Urban	Metropolitan	Rural
Immunizations			
Adult	84.5	96.1	93.0**
Childhood	80.2	96.3	93.3**
Screenings			
HIV/AIDS	60.9	69.4	54.4**
Other STDs	57.6	73.1	62.0**
Tuberculosis	77.1	89.3	87.5**
Cancer	31.3	45.6	33.7**
Cardiovascular disease	25.4	31.8	27.1*
Diabetes	33.1	35.6	31.2
Blood lead	52.7	67.9	62.0**
Maternal and Child Health			
Family planning	38.1	70.5	57.7**
Prenatal care	27.2	27.5	25.6**
EPSDT	21.5	43.1	40.3**
WIC	54.6	72.7	68.4**
Other Health Services			
Comprehensive primary care	9.7	14	7.5**
Mental health services	10.5	13.3	8.5*
Substance abuse services	9.2	8.2	3.9**

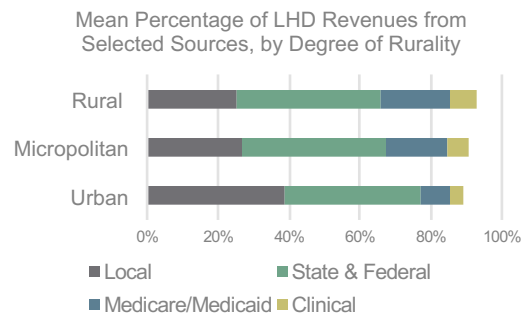
Provided by others in community			
	Urban	Micropolitan	Rural
Immunizations			
Adult	55.5	51.5	50.1
Childhood	59.1	52.6	45.4**
Screenings			
HIV/AIDS	70.1	59.3	54.7**
Other STDs	64.9	56.4	58.1**
Tuberculosis	51.6	53	38.1**
Cancer	85.9	79.6	78.6**
Cardiovascular disease	82.1	88.3	81.1*
Diabetes	78.1	81.2	80.6
Blood lead	64.5	62.5	51.5**
Maternal and Child Health			
Family planning	77.0	65.5	59.4**
Prenatal care	82.1	87.2	67.8**
EPSDT	62.6	62.8	45.8**
WIC	40.6	33.9	29.3**
Other Health Services			
Comprehensive primary care	89.2	90.7	93.0*
Mental health services	90.5	94.7	88.2**
Substance abuse services	90.1	96.7	85.0**

Analysis performed by Dr. Kate Beatty, ETSU

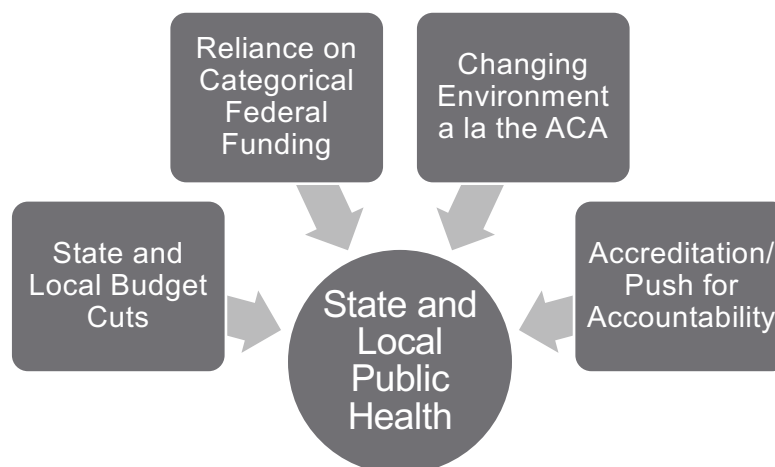


ACA Impacts – A Rural Lens

- Rural HDs rely more heavily on clinical services as a source of revenue.
- Does this position rural HDs better, or put rural HDs in competition with other providers?
- Are rural HDs prepared to operate under this new “business model”?
 - Assume risk?
 - Compete on price?
- What are the implications of rural and urban HDs choosing different paths?



Drivers of Change in PH

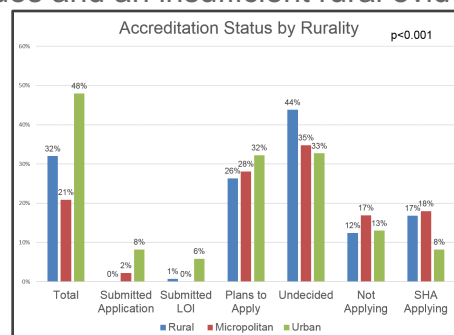


Drivers of Change – Accreditation & Accountability

- Key goal of accreditation is to provide a standard set of measures upon which HDs will be evaluated; that is, to help bring consistency to the field.
- Clinical services are not considered as documentation of PHAB standards and measures.
- Concurrent with PHAB, federal agencies are demanding more accountability for limited PH resources – “outcomes” is the new buzz word.

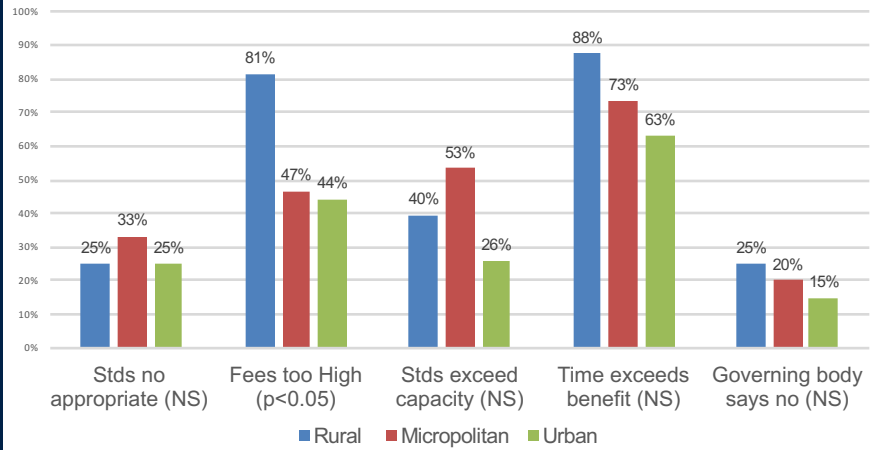
Accreditation & Accountability – A Rural Lens

- What does accreditation mean for rural HDs given that they are more heavily engaged in clinical services?
- In general, will rural HDs apply for accreditation?
- What does accountability mean for rural HDs given small numbers issues and an insufficient rural evidence base?



Analysis performed by Dr. Kate Beatty, ETSU

Why has your LHD decided NOT to apply for accreditation? (Select all that apply)



Analysis performed by Dr. Kate Beatty, ETSU



Discussion

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