Whether Health Departments Should Provide Clinical Services After the Implementation of the Affordable Care Act

Glenn M. Landers, ScD, MBA, MHA

I have described a decision support tool that may facilitate local decisions regarding the provision and billing of clinical services. I created a 2 by 2 matrix of health professional shortage and Medicaid expansion availability as of July 2015. I found that health departments in 93% of US counties may still need to provide clinical services despite the institution of the Affordable Care Act. Local context and market conditions should guide health departments' decision to act as safety net providers. (*Am J Public Health.* 2016; 106:271–272. doi:10.2105/AJPH.2015.302949)

Because more individuals have health insurance coverage as a result of the Affordable Care Act, health departments grapple with the question of whether to continue to provide clinical services such as maternal and child health, oral health, and HIV/AIDS treatment and, if so, whether to seek reimbursement from third party payers.[1] In fact, a 2012 Institute of Medicine report states,

> As clinical care provision in a community no longer requires financing by public health departments, public health departments should work with other public and private providers to develop adequate alternative capacity in a community's clinical care delivery.[2(p68)]

The decision to provide clinical services and pursue reimbursement is complex,[3] and that complexity will likely increase as reimbursement moves to new models such as accountable care organizations. Health departments must decide whether it makes sense to provide clinical services on the basis of local context and, if so, whether to seek reimbursement.[4] As of 2013, a minority of local health departments provided clinical services such as maternal and child health, oral health, and HIV/AIDS treatment,[5] although a 2014 report showed that, of those who do, the majority bill some form of third party payment.[6] I tested a simple decision support tool that might be used to facilitate local decision-making.

METHODS

I treated the decision of whether to provide clinical services and seek reimbursement as a supply and demand analysis using a 2 by 2 matrix. When qualitative judgments must be made and visual plotting can aid decision-making, 2 by 2 matrices are particularly useful.[7] I plotted each county health department in 1 of 4 quadrants on the basis of whether the state in which it is located is expanding Medicaid (demand) and the county is a designated primary care health professional shortage area (supply).

I obtained the roster of US counties from the US Census Bureau,[8] health professional shortage area designation data from the Health Resources and Services Administration Bureau of Health Professions,[9] and state

		Medicaid Expansion: No	Medicaid Expansion: Yes
		54% of counties 40% of US population	46% of counties 60% of US population
HPSA	No 14% of counties 10% of US population	**Cell I** No HPSA/no Medicaid expansion Adequate providers No increase in demand from Medicaid members Likely low safety net (11) role 7% of counties 5% of US population	**Cell III** No HPSA/Medicaid expansion Adequate providers Increase in demand from Medicaid members Safety net role potential strongly impacted by presence of other providers 7% of counties 5% of US population
	Yes 86% of counties 90% of US population	**Cell II** HPSA/no Medicaid Expansion Inadequate providers No increase in demand from Medicaid members Potential medium safety net role 47% of counties 35% of US population	**Cell IV** HPSA/Medicaid Expansion Inadequate providers Increase in demand from Medicaid members Potential high safety net role 39% of counties 55% of US population

Note. HPSA = health professional shortage area.

FIGURE 1—HPSA × Medicaid Expansion: United States, July 2015.

ABOUT THE AUTHOR

Glenn M. Landers is with the Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, Atlanta.

Correspondence should be sent to Glenn M. Landers, 55 Park Place, 8th Floor, Atlanta, GA 30303 (e-mail: glanders@gsu.edu).
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Medicaid expansion designations from the Kaiser Family Foundation as of July 2015.[10]

RESULTS

There were 3115 listed counties: 215 (7%) were in cell I (approximately 5% of the US population in 2014), 1461 (47%) were in cell II (35% of the US population), 218 (7%) were in cell III (5% of the US population), and 1221 (39%) were in cell IV (55% of the US population; Figure 1). A map of these counties is included as a supplement to the online version of this article at http://www.ajph.org.

DISCUSSION

According to this analysis, health departments in 93% of counties (cells II, III, IV) may need to consider expanding clinical services, whereas those in the remaining 7% of counties (cell I) may have an adequate supply–demand balance. Health departments in 39% of counties may have the greatest opportunity to seek reimbursement for clinical services because of potential Medicaid expansion revenues and a lack of providers.

Although 86% of counties are designated as health professional shortage areas, few health departments provide clinical services.[1,5] This may indicate the need for additional safety net support for clinical services from providers such as federally qualified health centers and volunteer clinics. The analysis does not account for those who may not be newly eligible for Medicaid, regardless of a state's expansion status, further emphasizing the need to tailor results to local context and conditions. However, the analysis does serve to group health departments in broad categories as a first step in working through the decision-making process. AJPH

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HUMAN PARTICIPANT PROTECTION

No protocol approval was necessary because no human participants were involved in this study.

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