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Executive Summary

The Affordable Care Act (ACA) creates profound changes in the American healthcare system. The Association of Public Health Laboratories asked researchers at the Milken Institute School of Public Health at the George Washington University to conduct research into the implications of these changes for public health laboratories (PHLs).

This report describes the findings from that research. First, it provides an overview of the Affordable Care Act, with an emphasis on provisions of particular relevance to PHLs, noting the key implications of each provision for APHL and its members. It then describes the quantitative and qualitative findings from a survey of APHL members and structured interviews of PHL directors and other experts in the field. The report is organized into a series of sub-findings that are structured under three main findings, summarized here:

Finding 1
Most PHLs are currently not engaged in, and are often unaware of, healthcare system changes enacted under the ACA. Some PHLs are concerned that coverage expansions under the ACA, along with overall declines in discretionary funds, will decrease the need for clinical testing services at PHLs.

Overall, our survey and interview findings show that, so far, most PHLs have not participated in new healthcare delivery models or other opportunities available under the ACA. Few PHLs report providing services within Accountable Care Organizations or Medicaid health homes, or engaging in local hospitals’ Community Health Needs Assessments or in state projects funded by the Innovation Center at CMS.

However, this lack of participation may be due in part to a lack of knowledge and engagement. Three-quarters of survey respondents stated that they would like more information about one or more provisions of the ACA, including delivery system reforms, preventive service coverage requirements, and Medicaid expansion. Interviewees argued that PHLs need to do a better job of “being at the table” as states and health systems proceed with these developments to identify whether and how PHLs might play a role.

Overall, the new environment created by ACA may challenge the traditional role of PHLs, particularly in providing certain clinical testing services. The findings suggest that increases in insurance coverage under ACA have led to a patient shift away from health department programs, such as STD clinics, and toward private healthcare providers. This, in turn, has led to a decrease in clinical testing services provided by PHLs.
Finding 2

Given the changes in the healthcare system since ACA, public health labs should consider increased fee-for-service testing, including billing public and private health insurers, billing providers, and conducting contract work. PHLs must take into account potential increased competition from private labs as well as logistical and policy barriers to fee-for-service testing.

Against the backdrop of ACA, PHLs are pursuing broader opportunities to gain revenue through fee-for-service testing, including billing insurers, conducting contract work, or directly billing individuals or providers. These efforts preceded the ACA and in many ways were a response to budgetary pressures during the recession and corresponding cuts in federal, state, and local funding. However, interviewees noted that for many PHLs, the capacity to bill various types of payers could be essential for participating in the various types of new delivery models created by ACA.

Most respondents described significant logistical, political, or “cultural” challenges in implementing billing systems. These challenges are compounded by stiff competition from private laboratories in performing some clinical testing services.

Finding 3

PHLs still play numerous crucial roles in the new healthcare system, but they can and must evolve. Survey respondents and interviewees identified examples of how PHLs can seek to broaden their services and maintain or increase revenue to support their key services. In addition, respondents offered recommendations for improved marketing, business models, and return-on-investment analysis to promote PHL viability.

Respondents noted that some PHLs can identify ways to compete effectively for clinical testing, as well as ways in which PHLs can serve functions that private labs cannot. Many also argued that PHLs need to learn how to better “market” their services, including documenting the specific financial or health benefits of the services they provide. These efforts will be difficult but often crucial: survey respondents and interviewees generally agreed that revenue apart from traditional grant funding can be vital for sustaining PHLs’ ability to serve their core public health functions.
Introduction

The Association of Public Health Laboratories asked researchers at the Milken Institute School of Public Health at the George Washington University (GWU) to conduct a project examining the implications of the Affordable Care Act (ACA) and its implementation for public health laboratories (PHLs). This report explores opportunities and challenges faced by PHLs in the context of ACA and other changes in the healthcare landscape. It describes key features of the ACA with particular relevance for PHLs, and presents findings from a national survey of PHLs and a series of semi-structured interviews of APHL members and other key stakeholders.

Overall, we found that ACA creates a complex set of challenges and potential opportunities for PHLs. This work builds on prior studies of PHL funding levels and billing practices to describe how these patterns intersect with PHLs’ ability or inability to engage in reforms under ACA. While these findings were prepared for APHL leadership, we hope that its contents will be useful to specific PHLs as well as they determine how to best adapt in a time of significant change.

Background: Public Health Laboratories and the Affordable Care Act

The Affordable Care Act, enacted in 2010, created a wave of reforms to the U.S. health care system.\(^1\) The changes brought about by the law and related statutes create both opportunities and challenges for all players in the health care arena. This introduction provides a brief overview of some of the main provisions of relevance to public health labs.

Expanded Insurance Coverage and Access: Marketplaces and Medicaid

Ensuring that Americans have access to affordable health care is a primary goal of the ACA. The law requires most Americans to obtain health insurance, a requirement also referred to as the “individual mandate.” This requirement was accompanied by two key expansions in insurance access. First, individuals and small businesses can shop for and purchase insurance plans through state-level exchanges or “marketplaces.” Federal subsidies are available to help make premiums and cost-sharing more affordable for individuals with lower incomes.\(^2\)

In addition, ACA gave states the ability to expand Medicaid programs to cover all adults making up to 138% of the federal poverty level (a decision that the 2012 Supreme Court ruling in \textit{NFIB v. Sebelius} deemed optional).\(^3\) As of August 2014, 27 states plus the District of Columbia were implementing this expansion.\(^4\)

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2. PPACA § 1401.
**Key Implication for PHLs**

Through these and other ACA insurance market reforms, more Americans are now able to get health insurance coverage from the Marketplace or Medicaid, and so the patient populations that health departments serve are more likely than before to have insurance. Some patients may shift to private providers; for those who remain, health departments may be able to bill insurance for services.

**Delivery System Transformation: The Innovation Center, Health Homes and ACOs**

Another major focus of the ACA is realigning the health care system through innovative health care delivery and payment models that incentivize and reward prevention practices. These efforts could potentially offer opportunities for public health labs to conduct clinical testing to promote disease prevention and community health.

One new service delivery model is the Medicaid “health home,” created by the ACA to help states better serve high-risk populations. They are based on the existing model of the “patient-centered medical home,” which has come to mean a model of primary care that is “patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.” Medicaid health homes are providers that give and coordinate care for individuals who have either serious and persistent mental illness, two qualifying chronic conditions, or one chronic condition and risk factors for a second. Health homes must be able to deliver a whole person approach to care, which includes access to preventive and health promotion services.

Also established by the ACA, the CMS Center for Medicare and Medicaid Innovation (Innovation Center) funds innovative health care delivery models that reduce costs while increasing quality of care. One such model, the Accountable Care Organization (ACO), aims to provide comprehensive, coordinated care by creating a network of doctors and hospitals that agree to be accountable for improving the health of their patients. ACO providers share the financial savings they generate from providing efficient medical care, provided they meet certain standards of quality and outcomes (and, in some cases, accept shared risk for any losses). The goal of such a payment structure is to encourage providers to coordinate their services to find more efficient ways to deliver care. ACOs may also employ specific community-based, population-level interventions as a cost-effective way of managing chronic disease, preventing avoidable illness and reducing unnecessary care for the population they serve.

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6 Bruce Merlin Fried et. al., Accountable Care Organizations: Navigating the Legal Landscape of Shared Savings and Coordinated Care, 4 J. HEALTH & LIFE SCI. L. 88, 91, 95 (2010).
7 Patient-Centered Primary Care Collaborative. Defining the Medical Home. Available at: http://www.pcpcc.org/about/medical-home.
9 Fried, supra note 5, at 95.
The Innovation Center also awards grants to states to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation efforts. CMS requires that these State Innovation Model (SIM) grantees specifically address public health concerns. For example, in Oregon, the SIM grant supports coordinated care organizations (“CCOs”), local health entities delivering care to Medicaid beneficiaries in the form of patient-centered care homes that evaluate methods of integrating and coordinating between primary, specialty, mental and behavioral health, and oral health. ACA also authorizes funding for other state-based demonstrations to improve vaccination rates and creates state level grants for the development and evaluation of Medicaid initiatives promoting behavioral change.

Key Implication for PHLs

These ACA delivery and payment reforms could represent opportunities for community-based public health providers to work with the traditional health care system. Public health departments and labs could identify whether their state has developed a Medicaid health home, if any ACOs are operating in the state, or if their state has received a CMS State Innovation Model award. They could then determine if there is an opportunity to engage in providing clinical and preventive services to beneficiaries receiving care through any of these models.

Expanded Coverage of Clinical Preventive Services

The ACA reduces financial barriers to certain preventive services (Section 2713 services) by requiring most insurance plans to cover, without cost-sharing, a comprehensive set of preventive services:

- Services given an A or B rating by the United States Preventive Services Task Force (USPSTF), an independent panel of experts in prevention and evidence-based medicine. These USPSTF rated services include (among others) HIV screening, cholesterol screening, STI screening, and colorectal cancer screening.
- Evidence-informed preventive care and screening guidelines for infants, children, and adolescents recommended by the Health Resources and Services Administration (HRSA).
- Additional preventive care and screening services for women recommended by HRSA, including STI and family planning services.
- Immunizations recommended by the CDC’s Advisory Committee on Immunization Practices (ACIP).

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12 PPACA § 4108, 124 Stat. at 561-64.
13 Most Private employer-based plans, individual and small-group plans, and Medicaid plans for the newly-eligible population must cover all listed preventive services without cost-sharing. PPACA § 1563; PPACA § 2001. In states not expanding Medicaid, people traditionally eligible for Medicaid are not automatically entitled to any of the listed preventive services. Kaiser Commission on Medicaid and the Uninsured, Coverage of Preventive Services for Adults in Medicaid (2012) available at http://kff.org/health-reform/issue-brief/coverage-of-preventive-services-for-adults-in/.
16 PPACA § 1001.
The Prevention and Public Health Fund

The ACA also established the Prevention and Public Health Fund (PPHF) to fund existing and new programs authorized by the Public Health Service Act for “prevention, wellness, and public health activities.” Key programs supported by the Prevention Fund include Community Transformation Grants (CTG) for communities to implement sustainable, community-level programs that prevent chronic disease. In addition, HHS has awarded PPHF funding to help enhance epidemiology and laboratory capacity to detect and respond to infectious disease outbreak through the Epidemiology and Laboratory Capacity for Infectious Disease and the Emerging Infections Program Cooperative Agreements. CDC is expanding public health training in epidemiology, laboratory science, and informatics through the Epidemic Intelligence Service and other training programs. Participants may be placed in state and local health agencies. The National Public Health Improvement Initiative provides support to health departments for goals such as accelerating public health accreditation readiness activities, and Preventive Medicine Training Programs provide funding for graduate or specialized training in public health.

HIT and PHLs

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) provides funding to facilitate the adoption of health information technology, by providing direct reimbursements to clinicians and hospitals as an incentive for adoption. Initial requirements include the ability to transmit data to public health departments including on immunizations and for syndromic surveillance. However, providers are only required to demonstrate this ability to the extent public health departments have the capacity to receive the data. The ability of public health departments to keep up with the HITECH regulations, and with electronic medical records and health information technology in general, is important for their participation in ACA reform.

Key Implication for PHLs

PHLs could determine whether collaborative opportunities are available with local preventive health programs funded by the Prevention and Public Health Fund.

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18 PPHF Report at 3-4.
19 Id. at 21; PPACA § 4304.
20 PPACA § 5314.
21 Ctrs. for Disease Control and Prevention, National Public Health Improvement Initiative http://www.cdc.gov/stltpublichealth/nphii/about.html (last visited Sept. 29, 2014).
Community Health Needs Assessments

The ACA revises the requirements for nonprofit hospitals to maintain their tax status. It strengthens existing requirements for hospitals to conduct a “community health needs assessment” that takes into account the hospital’s entire community, not just the patients it currently serves. The hospital must report on how it will provide a “community benefit” to address the needs it identified in the community health needs assessment, thereby not just providing clinical services but monitoring and improving population health. Moreover, public health officials are required to be part of the process, resulting in a strong partnership between hospitals and community-based organizations.

Key Implication for PHLs

PHLs could both inform community health needs assessment processes at local nonprofit hospitals and take part in “community benefit” monitoring and health improvement activities.

Methodology

To further investigate implications of the ACA for PHLs, GWU researchers conducted an online survey, with the assistance of APHL, as well as structured expert interviews.

Online Survey

GW developed a survey (Appendix A) of APHL members to better understand how the Affordable Care Act and other healthcare delivery system changes are impacting PHLs across the country. The survey included questions about how ACA provisions have impacted clinical services provided by PHLs and whether PHLs are participating within delivery system reform models and other initiatives promoted by the ACA. Survey questions also assessed knowledge gaps among PHLs concerning health reform. In addition, included in the survey were a series of questions about how PHL operating budgets have changed since the passage of ACA (2010) and whether budgetary changes have caused PHLs to change their core services. Next, the survey asked respondents to provide information about efforts to pursue fee-for-service billing as a revenue-generating opportunity to support their lab. Finally, questions assessed level of PHL agreement with several statements about the ACA and the future of public health.

We used the Qualtrics survey platform to design our survey with the support of APHL staff. The survey was sent to 95 state, local and territorial PHLs who are members of APHL on July 24, 2014. We sent the survey to APHL members via email, giving each respondent a unique survey link and using email collectors that tracked each respondent’s unique email address. Respondents were able to complete a portion of the survey and return later to finish the rest, but were limited to submitting a single response that could not be edited after their final submission.

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The survey remained open until August 25, 2014, and we made three attempts to reach out to non-responsive PHLs. Appendix B shows survey respondents by State. Once all survey responses were received, we analyzed survey data using Excel. We then combined survey results with our qualitative interview analysis, described below.

**Expert Interviews**

We conducted a series of fourteen interviews: ten with personnel at APHL member laboratories and four with other key stakeholders and experts (Appendix C). We worked with APHL to select an initial list of appropriate interviewees reflecting a range of perspectives concerning PHLs and the ACA. We also asked each interviewee for suggestions of additional APHL members and other key stakeholders to interview. In the end, we interviewed all eight on the initial list supplied by APHL, plus six additional interviewees who were recommended during our interviews.

With input from APHL, we developed a semi-structured interview guide (Appendix D). Using this guide, we asked interviewees a series of questions exploring opportunities and challenges faced by public health laboratories in the context of health reform, ongoing health system delivery changes, and changes in public health spending.

We conducted interviews between May 27, 2014 and July 9, 2014. We recorded and transcribed all interviews. Once all transcripts were received, we combined qualitative interview results with the survey results, described above.
Findings

Our survey and interviews revealed a great deal of uncertainty regarding the implications of the Affordable Care Act for PHLs. Respondent perceptions of the law’s impact were mixed, and in many ways it is difficult to assess the impact of the law independent of other factors, such as overall economic pressures on state and local budgets. However, overall a picture did emerge: since the passage of ACA, PHLs have found themselves operating in a very different healthcare environment. Navigating it will require increased knowledge of ACA and the changing health system, and a clear assessment of whether and how PHLs can participate in those changes while maintaining their core public health roles.

Characteristics of Survey Respondents

A total of 40 state and local public health laboratories completed the survey, for a response rate of 42% (Appendix D):

- Twenty-seven state-level PHLs completed the survey, representing 26 states and one territory. Of these respondents, 26% categorized themselves as “large,” 41% as “medium” and 33% as “small.”
- Thirteen local-level PHLs completed the survey, representing regions in six different states. All local PHLs categorized themselves as “small” in size.

Finding 1
Most PHLs are currently not engaged in, and are often unaware of, healthcare system changes enacted under the ACA. Some PHLs are concerned that coverage expansions under the ACA, along with overall declines in discretionary funds, will decrease the need for clinical testing services at PHLs.

Finding 1.1
Few PHLs are involved in delivery system reform models promoted by ACA (including ACOs, health homes and others).

We asked survey respondents to indicate whether their PHL is involved with one or more health delivery system reforms promoted by the ACA, including ACOs, Medicaid health homes, other patient centered medical homes, state innovation initiatives, or other health delivery system reforms occurring at the state or local level.

The majority of respondents (75%) stated that their lab is not involved in any of these delivery system reforms, and four additional respondents stated that they are unsure whether their lab is participating. Only three respondents reported lab involvement in ACOs; two in Medicaid health homes; one in other patient centered medical home models; one in a state innovation initiative; and four in other health delivery system reforms occurring at the state or local level.24

24 It should be noted that one respondent stated as a reason why their lab was not participating in ACA initiatives is that the lab is strictly a public health environmental lab. For such labs, it may not be appropriate to participate in delivery system reforms. Other respondents may be similarly situated, perhaps explaining some of the reportedly low involvement in delivery system reforms.
In addition, we asked survey respondents to indicate agreement or disagreement with the following statement concerning delivery system reforms and the ACA:

“Delivery system reforms (ACOs, medical homes etc.) provide opportunities for PHLs.”

Results show that most respondents do not believe that there are opportunities for PHLs in delivery system reforms. Most respondents (65%) state neutral feeling about this statement, 25% agree that PHLs have opportunities within delivery system reforms and 11% of respondents disagree or strongly disagree with this statement.

Interviews shed further light on the lack of current PHL involvement in ACA delivery system reforms. While interviewees were aware of some of the delivery system reforms promoted under ACA, most interviewees discussed possible participation by PHLs in ACOs. Several interviewees expressed concern that because PHLs were not included in the early stages of ACO development, it is difficult for them to become integrated into these initiatives today:

- “I think we need to be a part of [ACOs and other delivery system reforms]. And I don’t know who to contact on that or who is organizing that. That was one of the challenges for public health — we weren’t at the table during health reform... If I were allowed to be at the table, I would ask them what needs do you have that we can help fill, and then look at the resources. But to come up with something and not know what an ACO needs... in my opinion it is a waste of time and energy. So I think we need to get all the heads together at the top and say okay where does public health fit, and let us help you. And that hasn’t happened. I don’t know if it ever will happen. Because I don’t even know who’s planning.”
- “I don’t think we explored ACOs because we just didn’t have a critical mass of accountable care organizations that were interested in negotiating with us. But I think that it’s a good thing to explore.”

Other interviewees described the challenges they perceive in being able to compete with private clinical labs given the incentives of the ACO structure. One stated:

- “If you’re an ACO, you’re getting a capitated payment, you’re going to behave like any other sort of quasi-managed care organization. They’re going to look for the cheapest x-rays and the cheapest lab test and the cheapest everything they can... So they aren’t going to send us anything unless the price is really low and/or the service is really good. And so the whole dynamic for the samples that we’ve been receiving from county health departments for communicable disease testing clients forever has fundamentally changed.”
Despite the current lack of PHL involvement with delivery system innovations, several interviewees stated that PHLs should explore the possibility of working with ACOs or other new delivery system models. Several interviewees noted that early involvement in the development of an ACO is critical for an active collaboration. One interviewee sounded a note of caution about the consequence of labs not being part of delivery system reforms:

- “I think the first thing that [PHLs] need to do is to get to the table. And, in some ways, I’ll say that I was fortunate... I was put on the ACO steering committee when I got here...and I started giving presentations to the steering committee saying, ‘Here’s where we could carve out some of our budget, and move upstream and save the ACO money long term.’ So, starting to put dollar signs on that data is where I needed help from the public health community and from the claims people; the health economists that are part of our ACP. First of all I had to be at the table. Public health labs across the country need to get on their ACO board of directors or they need their health administrator or their WIC director or their MCH director or somebody there.”
- “[Y]ou’ve got accountable care organizations contracting with central laboratories that may be in another state and so you set up the potential for a loss of centralization of that information for purposes of disease surveillance follow-up. Some of the decisions are being made more along economic boundaries rather than what’s in the best population health interest of a state or arguably even a region.”

Finding 1.2

Few PHLs report involvement in ACA-funded community prevention initiatives such as Community Health Needs Assessments (CHNAs), Community Transformation Grants, and opportunities at the CMS Innovation Center.

We asked survey respondents to indicate whether their PHL has been involved in community health needs assessments (CHNAs) conducted by non-profit hospitals. No survey respondents reported lab involvement with CHNAs. While all but one of the interviewees was familiar with the CHNA process, only a couple reported involvement with CHNAs. Some expressed the challenge of finding an appropriate role for PHLs in CHNAs.

In addition, we asked survey respondents to indicate whether their PHL has been involved in state innovation models and other system reforms happening at the local level (such as Community Transformation Grants). Among survey respondents, participation in these initiatives is very low. Just one respondent reported involvement in a state innovation model, and four respondents cite participation in other health delivery system reforms occurring at the local level.
While some interviewees noted that they had been involved in the planning for local Community Transformation Grants and CMS Innovation awards, none had directly received funding from these sources to date. In several instances, interviewees had no knowledge about these sources of funding.

- “I didn’t know about community transformation grants. Yeah it’s the first time I’ve heard of it.”
- “My laboratory has not gotten any funding through any of those programs. We’ve not been involved in any of the community transformation grants or any of those other initiatives. I think there’s a potential, but right now that has not been realized. I think [the potential would be in] the biomonitoring and the environmental areas. So to stay tuned on that…”

**Finding 1.3**
Few PHLs are engaging in services geared toward persons with chronic disease, potentially hindering PHL involvement in ACA initiatives focused on chronic disease prevention and cost reduction.

Chronic disease prevention is an important component of ACA reforms. As described in the background section, ACOs and patient centered medical homes work to better coordinate and deliver care for patients with, or who are at risk of developing, multiple chronic diseases. Hospitals engaging in the CHNA planning processes often focus their efforts around addressing chronic disease. Community Transformation Grants have funded state and local agencies, nonprofits and coalitions to implement community-based interventions that often focus on chronic disease prevention.

Our survey and interviews found that few PHLs are engaging in services that help prevent or manage chronic disease. We asked survey respondents what types of clinical lab services they offer under a fee-for-service (FFS) testing model (more information on FFS billing at PHLs can be found in Finding 2).
Figure A shows that where labs are engaging in FFS billing, most are billing for infectious
diseases, and only two labs report engaging in FFS testing for any kind of chronic disease
screenings. While HIV and other infectious diseases can be considered chronic, as described
by participants in our survey and interviews, PHLs are mostly focused on the screening and
identification of these infections, and not on chronic disease management.

PHL’s lack of focus on chronic disease screening is a potential missed opportunity for better
linkages to delivery system reforms. Where ACOs are looking to reduce costs for patients
with chronic disease or where hospitals are pursuing chronic disease prevention within
their CHNAs, these entities may not include PHLs if these labs cannot offer services geared
toward chronic disease prevention and management.

A few interviewees discussed ways that PHLs might offer services related to chronic disease
prevention in the context of delivery system reforms:

- “There is a lot of focus here around strategic planning for chronic diseases. We’re
  still trying to see exactly what our role is with Diabetes, obesity, heart disease, that
  kind of thing. But those lab tests are not typically something that public health labs
do... glucose, glucose tolerance tests, insulin tolerance or heart disease monitors,
those aren’t tests that we have offered and I don’t see us offering them in the future
either. But what we would be interested in looking at is environmental factors that are
impacting chronic disease. That’s where we are trying to steer the conversation. So lung
disease and lung cancer are serious problems. We would be more interested in having a
discussion about radon testing and offering those services the clinical labs don’t offer...
So there are ways we can pull ourselves into the planning and into the solutions by doing
some of that work that really needs to be done.”

- “The other [jurisdiction], they have a huge, huge problem with opioid abuse, and some
years ago their number of opiate deaths surpassed their number of car accident deaths
and that was a real wake-up call; they were very, very concerned. So, their ACO stood up
in 2012, and they immediately did a prevention carve out for forensic testing... They did
that carve-out work for their laboratories to try to get a handle on this huge opiate abuse
problem.”
Finding 1.4
Knowledge gaps concerning ACA provisions may contribute to low PHL involvement in delivery system reforms, CHNAs and other ACA-funded initiatives.

We asked survey respondents to indicate which of five different ACA provisions they would like to learn more about:

![Figure B: Which of the following ACA provisions would you like to learn more about?](image)

As shown in Figure B, over half of respondents indicated they would like to learn more about delivery system reforms. In total, 75% of respondents stated wanting more information about at least one ACA provision, and 50% expressed wanting more information about two or more provisions. These data suggest some potential knowledge gaps among PHLs that may be contributing to lack of participation in ACA-related reforms.

One-quarter of survey respondents marked “I have all the information I need about the ACA.” Interestingly, one respondent who marked this answer had previously stated that he or she was “unsure” whether their PHL was involved in any ACA-related delivery system reforms. Additionally, three respondents marking this answer indicated in a separate question that they were unsure whether their state was expanding Medicaid. This may indicate that knowledge gaps exist even where respondents feel saturated with information about the ACA.
Finding 1.5

Many PHLs believe that with greater insurance coverage under ACA, clinical testing services provided at PHLs will continue to decline.

In our survey of PHLs, the majority of respondents (65%) stated that ACA coverage expansions have caused no change in clinical services offered by their PHL. However, 30% of respondents stated that ACA provisions caused a decrease in the volume of clinical services offered within their lab, and 8% of respondents stated that ACA caused a change in the type of clinical services offered. Only one respondent selected more than one response for this question, stating that ACA had caused both a decrease in volume of services and a change in the type of services offered.

Despite the majority reporting no change in services, several respondents stated that they anticipate additional impacts from ACA, and one lab explained that reductions in PHL services had already occurred prior to the ACA due to state policy changes:

- “Many clients now have private insurance, so they are going to their primary care provider and not coming to the health department. The private insurance carriers then have contracts with larger clinical labs and many times will not pay the health department lab. This will impact our services.”
- “Many of these changes were seen before the ACA was in place. The State elected to make decisions about discontinuing clinical testing that reference laboratories currently offer such as STDs, blood lead, etc.”

Themes from the survey were echoed among interviewees. Many predicted that as insurance coverage grows as a result of ACA, reliance on public health clinics will decline, including for clinical testing.

In addition, most survey respondents and interviewees expressed concern about the potential loss of discretionary funds for PHLs. While this is not necessarily an intended result of the ACA, many labs reported declines in service across a number of categories due to decreases in revenue since the passage of ACA in 2010 (Figure D):
“Well it hasn’t happened yet, but we’re all looking at the horizon, and the big question is: if at some point in time everybody is covered by insurance, why will we need any clinical care delivered in a health department or PHL? We’re not there yet, but we’re all wondering: what are the key services that we should plan to continue to deliver if everybody has insurance and they can go to any other practice group in the community as opposed to going to the free clinic at a public health department or lab.”

“As I’ve talked to health departments around the country, the likelihood of budgetary cuts affecting PHLs is great. Budgets are tight, and legislators that don’t fully understand the complexity are likely to say ‘gee, why are we paying for something that’s reimbursable?’ And so I think the change is coming which is in some ways coming not just because of health care reform but because policymakers are looking for ways to save money.”

Only one interviewee predicted that ACA will not likely have a significant impact on her lab’s testing portfolio, largely because its work is primarily around surveillance. Another interviewee opined that decreases in PHL services may not be the case with individuals seeking STD services, explaining that individuals with STDs may still prefer to receive services at a public health clinic due to privacy concerns.

“I don’t think [ACA will cause] a lot of our work to go away, personally, because so much of what we do is really around surveillance and not diagnostic or primary clinical care.”

“There will always be STD patients, whether they’re insured or not, who will seek public health services. What we see a good deal of, interestingly, is patients who are insured, but they don’t want their regular doctor to know they got gonorrhea, so they come to public health. It’s a surprise to me that it’s not one or two or three percent of the patients — it’s a higher number. They may come in as John Doe or Jane Doe, and we may agree not to bill them. But that number is pretty high; people who just don’t want to go to their regular doctor for their STD.”
Finding 2
Given the changes in the healthcare system since ACA, public health labs should consider increased fee-for-service testing, including billing public and private health insurers, billing providers, and conducting contract work. PHLs must take into account potential increased competition from private labs as well as logistical and policy barriers to fee-for-service testing.

Finding 2.1
Some PHLs are looking to increase FFS testing as a means of offsetting lost revenue from other sources.

An additional challenge that ACA coverage expansions appear to cause for some PHLs is a decrease in the need for fee-for-service (FFS) testing at PHLs as private clinical labs are taking up more of the testing volume. This challenge comes at a time when many PHLs are looking to FFS testing as a means of offsetting lost revenue from other sources.

In our survey, we asked respondents to describe any efforts to generate revenue through FFS testing. We defined “fee-for-service testing” to include billing insurers (Medicaid, Medicare, private insurers); contract work as part of cooperative agreements; or direct billing of submitters (hospitals, other providers, agencies or individual patients). In total, 85% of respondents reported engaging in some amount of FFS testing, and one PHL shared its plans to engage in FFS testing by the end of 2014. Only five respondents (13%) report they are not engaging in FFS testing and do not have current plans to do so.

FFS billing revenue makes up an important portion of an operating budget for many survey respondents. In our survey, we asked respondents to describe how their PHL’s total operating budget has changed since passage of the ACA in 2010. Overall, 83% of respondents report a decrease in funding from one or more of the following sources: federal funding, state funding, county/funding, fee-for-service billing, or “other” (which mostly includes private grants or interdepartmental funds). However, only 43% state that their total operating budget has decreased since 2010. This means that for some labs, a decrease in funding from one source of its operating budget was offset by an increase in funding from another source.
For many PHLs responding to the survey, increases in FFS billing make-up for a sizeable portion of revenue lost from other sources. Figure D shows how various sources of funding have changed since 2010. While federal and state funding has dropped significantly in many jurisdictions (65% of PHLs report a decrease in federal funding and 40% report reduced state funding), 43% of labs report an increase in FFS billing. This increase compensates for some of the reductions in federal and state dollars:

![Figure E: Change in Funding Since 2010, by Source](image)

However, not all labs report increases in FFS billing since 2010. As shown in Figure E, 23% of respondents have seen a decrease in FFS billing. Decreases in FFS billing could be due to many factors, but one important factor reported in our survey is ACA-influenced changes. Fifty-six percent of respondents that report a decrease in FFS billing also report a decrease in the volume of clinical services provided by their lab as a result of ACA coverage expansions. One reasonable conclusion is that, in some jurisdictions, ACA coverage expansions that increase access to preventive services and screenings are causing a decrease in the need for FFS testing at PHLs as private clinical labs are taking up more of the testing volume. As one survey respondent explained:

- “While we have recently added Medicaid billing for STI testing, this source of funding will decrease as the impact of ACA continues.”

Two interviewees voiced similar concerns:

- “[A]nother thing to look at is what is now fundable by CMS under health reform? And that’s a double edge sword. If CMS starts funding all the stuff that public health labs do and somebody else is willing to step in because now they’ll get reimbursed for it, I guess you could ask, ‘What’s the need for a public health lab?’”
- “If ACA has fundamentally changed how healthcare is delivered and how testing is delivered, do we have to change the way we deliver public health? Or even how we define public health? It used to be that TB testing was a core public health function, but maybe
that’s not the case anymore. Unfortunately the definition seems to be, is it reimbursable or is it not? So I think enhanced competition will mean that public health is going to end up with all of the testing that either is not profitable or is not reimbursable.”

Finding 2.2
Most survey respondents and interviewees think PHLs should continue to pursue FFS billing despite competition from private labs.

Despite concerns that ACA implementation may be impacting PHL service volume, survey respondents do not advocate that PHLs move away from FFS testing: most survey respondents encouraged PHLs to increase efforts to conduct more FFS testing. We asked respondents to indicate agreement or disagreement with the following statement:

“PHLs should NOT seek to implement more fee-for-service testing.”

Most respondents (68%) disagreed or strongly disagreed with this statement, indicating a belief that PHLs should be engaging in more FFS testing. Nine more respondents (23%) expressed a neutral stance, and only four respondents (10%) either agreed or strongly agreed. Here, most survey respondents report a positive view of FFS testing in the future, and, presumably, a positive view of continuing to offer the types of services that may fall under ACA coverage expansions and cause PHLs to continue to compete with private clinical labs.

Interviewees generally agreed that prioritizing billing or “third-party reimbursement” is important for PHLs. Interviewees generally supported the view that PHLs should only perform services for free when it is necessary for public health purposes and there is no option to bill. The interview responses below summarize the general tenor of conversations with PHLs about continued FFS billing in a post-ACA world:

• “What we’re trying to do in the area of billing is to make ourselves capable of capturing every nickel of available revenue for clients who we’re already testing. Forty-five percent or so of local health department clients are Medicaid eligible. And under the ACA in theory, all the others would be insured by someone, whether they’re seen in a local health department or a community clinic or whatever. If you look a few years down the road, those people all have to buy insurance. And so we need to be ready to bill their insurance.”

• “With the state laboratory...[it begins with] the process of considering what tests have historically been performed for free and which tests could be billable by insurance, either directly by the laboratory itself or by the community-based agencies that were sending in the specimens. We’ve spent a fair amount of time on that, and I think our general assessment was that there was tremendous potential to offset some of the budget cuts we were experiencing by diversifying the funding base for laboratory operations. And that whenever possible, we should only be performing laboratory tests for free if the conditions were such that the billing wasn’t a possibility.”
Even where federal or state funding is available to cover services, many PHLs still see FFS billing, especially of insurers, as a better vehicle for generating revenue. One interviewee described his experience:

- “When I was in [State A], we very often had program managers for women’s health come to us and say “a lot of our clients are Medicaid eligible, why don’t you bill them?” Because of my situation, the program would pay me using federal dollars, Office of Population affairs (CDC dollars) on basically a per capita basis. So, when I left there in 2008, they were paying me $20 for a chlamydia/gonorrhea test, which is the most widely used and highest volume test that public health labs probably use in most cases. And when I came here [to State B], I found that this lab was billing Medicaid $95!...The laboratories that are receiving payments in federal dollars or local dollars invariably are receiving a lot less than they could if they billed Medicaid for a typical reimbursable.”

**Finding 2.3**
Direct billing of providers and contract work remain important sources of revenue.

We asked survey respondents to indicate sources of FFS revenue generation. Of the 34 respondent labs that report currently engaging in FFS billing, many are engaged in direct billing of healthcare providers and consumers/clients, and half generate FFS revenue from contract work as part of cooperative agreements:

![Figure F: Sources of Fee-For-Service Revenue Generation](image)

Interviewees also described the importance of direct billing and contract work, either for newborn testing, infectious disease testing, or regionalized services:

- “Our two biggest items are Gonorrhea and Chlamydia screening. We charge Planned Parenthood and other community providers for the testing.”
- “[W]e also have started doing [Quantaferon] screening, which is an interferon gamma release test to replace skin testing for Tuberculosis...We have the VA, the medical school, and the hospitals sending us blood for [Quantaferons] in lieu of doing skin testing on their employees for their annual or whatever exams that they need to have.”
• “Let me tell you how [newborn screening] works financially. ...The way we have this set up for the other [five] states in our regional program is we have a contract with the state Health Department in each of those states. We provide the full range of services. We have a contract with each of those, and each month we send the state health department a bill for the number of samples that we tested, and they pay us. And then they get paid by the providers in their state by a mixture of direct payment and Medicaid and private insurers and so forth.”

While direct billing of providers and contract work are important sources of FFS revenue, these may not generate a high amount of revenue for PHLs. As one interviewee put it, “We are getting to the point with hospital billing where we are running things more as a business, but it’s not a revenue producing venture I guess.”

Finding 2.4
PHLs are missing opportunities to bill Medicare, Medicaid, and private payers.

Despite the potential for public and private insurers to be a significant source of FFS revenue, our survey and interviews found that PHLs are not currently pursuing it as aggressively as might be needed to offset other declining funding. Survey results showed that while just over half of survey respondents are billing Medicaid/CHIP, fewer PHLs are billing Medicare, Medicaid managed care organizations and private insurers:

Similar to the survey data, more interviewees reported billing Medicaid (5) than Medicare (2) or private insurers (3). Half of jurisdictions interviewed did not report billing insurers at all. Interviewees described their experiences billing, or considering billing, public and private insurers. While one interviewee described a high volume of insurance billing (“I would say 80% of what we do is Medicaid billable... [we bill] all public and private insurances”), most reported very limited billing of Medicaid, Medicare or private health insurers:

• “We have lost a fair amount of STD and other infectious disease testing due to our current inability to bill insurance (including Medicaid).”
• “We do not bill any [private] insurers directly, so one of things we need to do in public health labs is to create systems for billing insurers. If we want to survive, we need to do that.”

Survey and interview data show the desire among PHLs to increase FFS billing of insurers and point to potential missed opportunities for billing Medicaid, Medicare and private insurers. However, these statements need to be considered in context with other information learned from this analysis, namely that ACA implementation may make it more difficult to realistically expand FFS billing. In addition, as described in the next section (Finding 11), whether or not PHLs can increase FFS billing will depend greatly on whether they can overcome several significant billing challenges.

One interviewee gave helpful feedback about some of the advantages of billing insurers rather than providers:

• “[W]e sell the newborn screening collection kits to providers, so they pay up front for the kit and then send us the sample. We don’t charge them for the testing because they’ve already paid for it. That has the advantage of having a zero uncollectable rate. And we charged enough to cover all of the cost of the program, including the lab testing and the other things that I described. But the downside is that if we were set up to bill Medicaid, we’d be receiving a lot more money if we charged for a bundle of newborn screening services. Now it’s doable, and it could be the salvation of the laboratory because we can recover way more from Medicaid than it costs us to do this testing just because of the volume that we have. Our unit cost is amazingly low. So that’s a direction that we could go, but we’re not there now.”

Finding 2.5
PHLs face significant challenges in implementing, maintaining and expanding FFS billing.

We asked all survey respondents (both those currently engaging in FFS billing and those who are not) to describe challenges their lab has encountered in implementing FFS billing. As shown in Figure G, some of the most frequently cited responses include lack of staff experience with billing and CPT codes (60% of respondents); challenges verifying insurance eligibility (55%) and low reimbursement levels (53%). In addition, 45% of labs cite difficulties setting a fee schedule for clinical lab services because of statutory or regulatory restrictions. Seventy-five percent of labs report challenges in two or more of these areas and 30% report five or more billing challenges.
Interviews with APHL members echo these billing challenges. Interestingly, interviewees did not describe challenges related to the two most frequently cited issues in our survey (lack of staff experience with billing and CPT codes and challenges verifying insurance eligibility of consumers), but interviews were rich with discussion about the other issues listed in Figure G. Included here are a series of representative statements from interviewees about these challenges:

**Low reimbursement levels.** Interviewees described challenges obtaining Medicaid reimbursement, from states reducing the reimbursable amounts and “slow rolling” their reimbursement toward the end of the fiscal year to requiring a lab to bill each coordinated care organization individually rather than the state Medicaid agency. One interviewee explained:

• “The state [Medicaid] component [has] reduced the reimbursables arbitrarily, usually about 10% each year because they were trying to balance their state budget. Even while costs for laboratories to do their operations are rising, they were just arbitrarily cutting it saying, ‘This is what you’re going to get.’ Also, we find that very often, toward the end of the fiscal year, they get slower and slower in reimbursing us. And I’m sure they’re just trying to have their expenses hit targets. We see that all the time. Fortunately, it seems to have leveled as the economy has stabilized and the state’s budget has stabilized. But it’s just arbitrary.”
Difficulties setting fee schedule because of statutory or regulatory restrictions. Many interviewees have their fees/rates set by law or regulation, including county ordinance, state statute, and administrative rules:

- “All of our fees are set in statute. If we want to do a fee change, we have to go to the state legislature to do that. So very, very inflexible.”
- “The other thing I did was [change] the way we set our fees. For decades... [under] our administrative rules...we’ve had a fee schedule that says for Tuberculosis samples we’ll charge this many dollars, and for Gonorrhea samples we’ll charge this many dollars. Every time we wanted to change our fees, we had to go through the entire administrative rule process, which is a mess. We replaced it all with one sentence that says we’re going to charge whatever the Medicaid fee schedule is, and I was able to get that through. And so now our lab charges whatever the Medicaid fee schedule is for every test, and instead of getting 13 dollars and fifty-five cents for a combined Gonorrhea and Chlamydia test, we’re getting fifty-nine dollars for that same test. We have to have a reduced fee option for local health departments and community clinics and so forth. We’ve set that up. Now [we] have this system where we can bill Medicaid clients for a variety of things, and ... we have a way to charge health departments significantly less if they’re having to pay for the testing themselves.”

Two interviewees noted that the public health mindset often is not consistent with a rigid fee system, which contributes to these statutory/regulatory restrictions remaining on the books:

- “This is foreign to public health representatives - at least in my jurisdiction. I don’t know if you would call it an institutional mentality, ‘We’re here to help. We see everybody whether they’re illegal immigrants or whomever. We’re just here to provide good health.’ So there’s that mental change to even asking somebody, ‘Here’s the bill today for $100? What amount can you pay?’ You [need] a lot of training around that. We’ve adopted a sliding scale. We want everybody to pay something.”
- “Many in our county/district health departments feel they are entitled to free lab services. They use a “sliding scale” for payment, based on a patient’s ability to pay. They expect the lab to also use this method.”

A few interviewees noted additional legislative barriers, namely that they do not have authority to bill for certain services in certain contexts:

- “For us to do fee-for-service billing in the infectious disease laboratories would require a legislative change. And that’s where we get into the issue about cost shifting and the political reality of that really not being viable.”
- “Right now I do not have the authority to directly bill Medicaid.”
- “State law says we cannot perform a billable service. We’ve got to get rid of that restriction around the country and basically take the handcuffs off of public health laboratories so they can perform work for reimbursement.”
Inability to retain fee for service revenue generated within the laboratory. Interviewees described a range of ways lab revenue is handled in their jurisdictions, from all funds returning to the state general fund to all reimbursements staying with the lab. One interviewee can, by law, only recover costs and cannot make a profit. Another interviewee noted that even though all the lab’s revenue goes to the state’s general fund, it is still worth billing because the lab then can note that it contributes to the general fund when requesting state money for expenses.

Lack of sufficient funding to cover costs related to developing billing systems/purchasing billing software. Several interviewees explained that electronic health records (EHRs) are a challenge and that the incentives for adopting EHR systems and exchanges are geared towards other parts of the health delivery system (e.g. hospitals and providers) and not towards public health:

- “We don’t really have a robust mechanism for electronic lab reporting. We have an ancient [LEMS] system. There were all these incentives for the information exchanges and for the hospitals and providers — but not for public health. We will be trying to purchase a new system that is HIPAA compliant — it will make it easier for us to do electronic reporting.”
- “The economic recovery and high tech investment efforts were directed more towards hospitals and health systems than it was toward public health laboratories…. We are developing interfaces with those information systems, but I think the labs are more challenged because — and I think this is true for the public sector more generally - [they] have not really [had] a significant role in the development of these systems. Information systems have been more focused on the business transaction side of health systems than they have been on the population health side.”

Insufficient funding to cover costs of contracting out for billing services to a third-party vendor. One interviewee stated that a lack of time was the likely reason for not moving forward with contracting with an entity for their billing; another is now finalizing a contract to bill for all related services:

- [responding to a question about why the lab has not moved forward with contracting out for billing services], “Probably just due to lack of time. We’ve been working with APHL to see if we could address this billing issue as a group of states. We have all the same needs and issues, so we’re trying to see if we could approach it from a lab efficiency perspective to see could we contract as a group with someone to do billing for us.”
- “The catch is that we don’t have the administrative capacity to do billing very well. We’ve never been set up well to do it, and we don’t have an electronic means of billing. We have a data stream for Gonorrhea and Chlamydia that we send to …Wako, Texas, but that’s all they do is Gonorrhea and Chlamydia basically. We’re [now] contracting with a private billing firm. We have the contract just about ready to sign, and they’ll do what they do for all other laboratories. They’ll take a percentage off the top, and they’ll be able to bill for everything that we do that’s billable. They’ll be able to bill not only Medicaid but also private insurers as well.”
Insufficient funding to train/hire staff on billing. Several interviewees expressed the sentiment that increasing FFS billing is next to impossible without additional funding to retain or train staff. As one interviewee put it: “I really don’t see us being able to expand [billing]. I don’t have the people or the people with the right skills to do that.” A few other interviewees described how their pathway to FFS billing has only been possible with dedicated staff that is able to conduct in-house billing.

Privacy considerations. A few interviewees discussed confidentiality issues related to billing, especially in the HIV, STD and family planning context. One interviewee explained that some states like Maryland are working to find ways to send Explanations of Benefits (documents that clients receive when their insurance is billed) to clients who may want their STD or family planning care kept confidential (e.g. minors, those in fear of domestic violence). Two interviewees discussed the shift away from anonymous testing in the HIV context to facilitate billing:

• “On the family planning and STD testing fronts, [there are issues] in terms of revenue streams and ... confidentiality. Maryland passed a bill to address some of the confidentiality concerns related to family planning services. There was concern around explanation of benefits (EOB’s) being sent to the client—particularly in the case of minors or women who were engaged with the Public Health Department and in fear of domestic violence. You wouldn’t want those EOB’s sent home, right? There’s some work being done in Maryland and apparently a bill that had been filed in Massachusetts.”

• “Over the years, we’ve essentially transitioned all of our anonymous testing sites into confidential testing sites. It took some time to understand which of the testing sites could actually do billing. It took some time to think about what the scripts should be for telling patients that people could still request not to use their insurance. So even sorting that out, it’s just the kind of thing that just took time to parse out, and it also took a recognition that it wasn’t one section of the department that could solve the problem.”

• “This year we have decided that: (a) we’re going to bill everybody we can, and (b) we are no longer going to [test] anonymously. So there’s an agreement in my county amongst all the groups, including the non-profits like the HIV alliance. They all said, ‘You know, we’re going to stop this anonymous testing. We have such an STD problem right now, we really need to do good contact investigation and find out who’s having sex with whom and who exposed whom.’ So, that paradigm is shifting too. Public health will still be available for services. But we’re not going to do it anonymously, and we’re not going to do it free.”

Challenges working with other state agencies. In addition, interviewees described several challenges in working with other state agencies when incentives for billing do not align, when a lab is dependent on funding from other agencies’ programs or when there is not sufficient IT infrastructure to communicate electronically.

• “[O]ur laboratory is a separate organizational unit than our HIV Bureau, which does contract with community-based agencies to perform testing and other functions. So those two units needed to coordinate with each other and plan a strategy for how...the new policy [that confidential testing sites would start billing] goes into effect, and what
were the steps that were necessary to make that happen. It was complicated. They were going to have to deal with angry community based sites. [F]iguring those things out, [we needed to] draw up a careful planning process, identify a need for a timeline, centralized decision making, a plan to involve the community agencies, whether they’d be able [to implement it]. We had a consumer advisory board. So all of those components needed to be involved in the plan. And that was simply looking at HIV testing, which one could argue was one of the easier ones to think about in terms of billing.”

• “[Public] health labs rely on funding from other public health programs within the state health departments. Using the example of STDs, those are funds that often flow from other programs whether it’s Family Planning or HIV/AIDS. So within the Health Department, the public health lab directors have to partner internally with the other problematic directors of those resources. And often times, there’s a lot of negotiating, particularly when those pools of funding are shrinking.”

Finding 3

Public health labs still play numerous crucial roles in the new healthcare system, but they can and must evolve. Survey respondents and interviewees identified examples of how PHLs can seek to broaden their services and maintain or increase revenue to support their key services. In addition, respondents offered recommendations for improved marketing, business models, and return-on-investment analysis to promote PHL viability.

Finding 3.1

Most survey respondents and interviewees believe there is a unique role for PHLs to continue providing clinical services.

As shown in Figure I, of PHLs that report declines in clinical services, reference testing, and screening since passage of ACA in 2010 (though not necessarily as a result of ACA), a significant proportion report that private clinical labs have assumed responsibility for the services:

Figure I: Impact of Service Reductions

Private clinical laboratories have assumed responsibility for the service

Service is now provided regionally in conjunction with a PHL in another jurisdiction

Service is no longer being offered in my jurisdiction

Clinical Services

Emergency Preparedness

Outreach

Reference Testing

Screening

Surveillance

Workforce Training

Other
Many interviewees described increased competition from private labs, particularly around clinical testing services:

- “When I came here in 2008, there were two, private laboratories doing business here. Both of those laboratories served the local community and actually supported public health... But then gradually those two labs were bought out by larger private labs. These private labs began putting drawing stations on every street corner; Labcorp successfully out-bid the local lab for a chunk of their business for HMO patients. And pretty soon my customers, many of whom did not have venipuncture capability, would send their patients out the door to the nearest drawing station, and it wasn’t the public health laboratory’s job anymore. So I have had probably a 20% reduction in testing volume just from private laboratory competition... I cannot in any way replicate the blood drawing stations they have.”

- “During the Great Recession, Public Health Laboratories nationwide saw their in-house business, that is clinical services, decrease by anywhere from 15 to 70%. Twenty-five percent of the business and 25% of the laboratory staff, as a general rule, disappeared. So, public health laboratories are basically in a very poor position to maintain their critical mass of staff expertise and provide services. The private labs, of course, are very excellent competitors. And public health laboratories are losing.”

- “I’m not sure we’re going to be able to compete with private labs. I think it will require continued funding from the federal government augmented by at least some state general fund appropriation to do the population based stuff that we need to do.”

Where private labs have taken over a particular service, it can be difficult for PHLs to regain that service. One interviewee explained:

- “It’s a very sore point, but we are out of the newborn screening world and work. It’s been contracted out to a provider. We now have the capability, but we did not have it at the time the state decided to send it out...So we’re looking at the whole situation right now and again, because there are a couple of providers that offered it at a very, very low cost, it doesn’t look like it would be easy for us to get into the game without a subsidy.”

Several PHLs described the potential negative impact on PHLs if more clinical testing is sent to private labs. Specifically, interviewees expressed concern about PHLs losing their ability to adequately collect and analyze comprehensive surveillance data, resulting in an inability to track outbreaks. Other interviewees expressed frustration with trying to obtain clinical results from private labs.

- “The implication of fewer services coming to PHLs is the lost epidemiologic surveillance data on high risk populations. We’re not going to be getting all of those people who are most at risk of HIV or Gonorrhea or Chlamydia or whatever if their CCO decides to send their lab testing, their samples, to Tennessee. If they do, we’re not going to know about it.”

- “Recently, my health officer, my boss, the chief of nursing, and myself all gathered at my desk around a single cell phone trying to extract information from a private lab regarding the TB status of a particular patient. We could not get the status from customer service,
and we could not get the status as to why certain testing did or did not happen. That would have never been necessary if my lab was doing the TB work. But the private lab got the TB work, and it became our task to try to extract it from them. The barriers and the impositions are already there, and they probably will grow unless solutions are found. There’s basically a new emerging disease recognized somewhere in the world about every three-six months, and public health laboratories will get the work in those situations. Very often it goes right down to the local labs as being the ones to accurately identify cases in which a huge investment of public health action is needed based on the result of a test for a single patient... So, the outbreaks will get bigger and will occur more frequently because the information that we need is going to be much more difficult to get from the private sector.”

One interviewee, however, was optimistic that outbreak investigation and surveillance would remain in the PHL sphere.

• “We’re always going to have our responsibility for outbreak investigation and surveillance. How that gets funded going forward is a question. I don’t see that moving to the private sector because these laboratory tests are basically imbedded in the broader public health system of surveillance and epidemiology.”

Survey respondents shared this level of optimism about the continued role of PHLs despite new competition from private clinical labs. Almost all (95%) of respondents agreed or strongly agreed that “PHLs provide services that private clinical labs do not or cannot provide.” All interviewees agreed with this statement as well, with some citing the examples of bioterrorism and newborn screening:

• “Any of the tests that are related to the potential for bioterrorism or, the unusual strains of viruses...I think you never want to have any kind of financial barrier to testing in these areas; these areas are too important for public safety and for doing accurate surveillance. “

• “I think you can make the case for why state public health labs are superior to private labs especially with newborn screening. Private labs pop up, they do their jobs, and they get out. Whereas I think there’s a lot more coordination and collaboration that happens with PHLs especially for certain states that serve as an emergency lab for many states. Like Louisiana, for example...there was a lot of long-term follow-up that happened across state lines after hurricane Katrina. Public health really understood how important it was and what needed to happen and really stepped in.”

Two interviewees also noted that PHLs’ ability to collaborate, communicate and share data provide a competitive advantage over private labs:

• “We can generate and find the data that the state programs want. We have in our information system the ability to capture specific data, we call it ‘program specific questions’... And so it incentivizes the state to tell the other providers why they would like their laboratory specimens to come to us because they get a much richer set of data to work from then if they sent it to a private laboratory. For example, what the public
health epidemiologist would very much like to know with sexually transmitted diseases is whether this a married individual. Most lab systems can handle that. They’d like to know whether or not this is a man having sex with a man. There is no other laboratory system that can handle that, ours can. In addition, we can tell them whether or not they’ve been seeing a certain client for X period of time, have they been treated for X period of time, and all of those so called ‘special questions’ that are very relevant for public health purposes. But for the typical laboratory information system, they just don’t collect that… I can’t beat LabCorp and Quest on price, they just have too much volume for us to be able to compete. But I can beat, or I can compete with them on the data that I provide, the customer service that we provide, and the willingness to work with and customize the results. So I don’t have to hit Quest and LabCorp’s price exactly. If I’m within 10 to 20%, the value that we bring to the table is usually enough for people to want to work with us.”

• “Collectively, we need to be making the argument at the national level that there is fundamental value in having an effective public system that aggregates data, looks at trends and outcomes and serves an important surveillance function. That’s the role that public health labs play.”

One interviewee put forward an idea for enhancing PHL services in federal and state contracts by including requirements for data collection:

• “By the way, there are ways for the CDC and the state to say if you can’t provide those other “value adds” [e.g. data collection, surveillance], then you are not eligible or you can be excluded from the contract... If you are coming in as a company with the absolute lowball, but you can’t do those other things that public health wants at the state level then, that’s another way to protect public health; not that we don’t want to compete but we want to compete when it’s a level playing field.”

Finding 3.2
PHLs have many ideas for expanding services and revenue, for example in the areas of newborn screening, quality assurance, infectious disease, and drug testing.

As discussed above, both survey and interview responses indicate a belief that PHLs should continue to pursue FFS billing. We asked interviewees how PHLs could enhance their billing, and many of them had creative ideas about how to modify existing policies and/or expand services in ways that better lend themselves to billing.

A few interviewees cited newborn screening as an area for improvement. One believed its lab was missing out on a stable source of income by not doing newborn screening at all. Another thought that because many PHLs still do the screening regardless of a provider’s ability to pay for the newborn screening “card,” they missed out on funding they could gain from a shift to billing for that testing:

• “No, we do not do newborn screening. ... There are no public health labs to do the approximately 600,000 newborn screens a year that are done here. ... But [other jurisdictions bill for newborn screening]. ... It doesn’t come and go with such things as droughts. The babies always keep on being born. ... [For other jurisdictions] it’s a
stable source of income, and very often [they] used that money to maintain infrastructure when other funds waxed and waned.”

- “I guess it’s possible that the state could do something different with the fee structure for newborn screening. That really has not even come up in discussion. ... I think some of my newborn screening staff would actually be willing to do that [bill for screening services]. I believe there are some states that do the billing. ... There are a lot of out of hospital births, so we do get [newborn screening] requests or cards that come to us directly from parents or ... from doulas or midwives. And sometimes when we request payment, we don’t get the payment. That being said, we still do the testing. And of course the reason is that it needs to be tested regardless of anybody’s ability to pay. ... Do the testing first, and then worry about the payment later. But the non-payment for ... newborn screening is a very, very small proportion. Dealing with collections is really on the hospital end, not on our end. That’s another infrastructure we would have to set up if we went that way [toward billing for newborn screening] or were forced to.”

Other interviewees noted the potential role for PHLs in quality assurance testing, which has a great public health need but historically not a lot of funding:

- “PHLs can have an expanded role with quality assurance. ... What we’ve been able to do is to reach out to these offices and small facilities or hospital labs to say we can help you improve quality. We can train you in how to write a procedure for performing a test — how to set up a quality control program. We’re not your regulators, we’re not your inspectors. You have no reason to worry about asking us any questions because we’re not judging...”

CASE STUDY: A PHL coordinating with clinical partners to provide a population health, incentive-based tobacco cessation program

One interviewee shared an example of “best practices” between a PHL and clinical providers to offer a population-based effort around tobacco cessation for pregnant women. The effort resulted in a return on investment (ROI) of $7.5 for every dollar spent.

“So, in our state of course we have CCOs, Coordinated Care Organizations. As part of the authorizing legislation, they have to focus on prevention, they have to have contracts with the public health department...we’ve put together a consortium of the CCO and public health to look at population level problems. And one of the big problems that we’ve noticed is that we have several primary care doctors saying ‘far too many of my patients smoke.’ And then we have a number of obstetricians in the community saying ‘we have too many pre-term labor cases and premature babies.’ And tobacco use is very clearly associated with pre-term labor and premature delivery, at a huge cost!

“So, that data came up to the board of directors at the CCO, [and we decided to] do a two-pronged investigation. The first prong is to look at the epi data. The second prong is to look at claims data, what is this costing our CCO? Turns out in my five clinics, 32% of moms are smoking in the first trimester. We have far too many women smoking.

“So we put our heads together and we decided what we’re going to come up with a program to pay pregnant moms not to smoke all throughout their pregnancy and for six weeks after they deliver. We estimated that the neonatal cost to our CCO is about eight million dollars a year, and we wanted to decrease that by 10%. So we got money from the CCO, $100,000 a year for two years, to put in place a program that would test moms; so this is laboratory testing of their urine for the nicotine by-product called cotinine. If they’re negative each time, they get money. If they’re negative their whole pregnancy and six months post-partum they get $200. So we added it all up, we started this program about a year ago. And, we’re looking at a return on investment of about seven and a half. For every dollar spent, we save seven and a half....”
you. We have no authority over you. We’re your lab partners, and we can help you improve your office practice. They’ve been very receptive to that.”

• “Eventually maybe hospitals or insurers would pay for [quality assurance services], maybe. ... Here’s an example around flu. State public health labs do a lot of flu testing. We’re not doing flu testing to diagnose people with flu. We’re doing flu testing to figure out what’s out there, like is it [H1N1]? What’s changing? Surveillance — again it’s surveillance for flu. So what are we relying on then? We’re relying on that front line of those physician offices or emergency rooms running those rapid flu tests, and we’re relying on them working. We’re relying on them doing the test correctly. So that has been our interest early on, to say we need to help make sure they are doing these things right. How are these rapid tests really working? How are they storing them? Who’s doing them? It really kind of was self-serving the beginning knowing that it’s important to us that those rapid tests are done. Because if it’s not done correctly and they get a wrong result, then we may miss something that’s not referred to us for follow-up testing or for something that we might have wanted to know about. ... We have been able to get small amounts of money from APHL and from CDC to do some of these programs, so we’ve been successful just getting small training grants from them. But we have not charged. I think we could in the future look to doing that. Maybe this was just helping to demonstrate the value in this service that we could offer to them because they’ve been receptive to it. ... I would like to see them use us as a resource in the future to say, ‘We have a test that’s failing,’ or ‘I think we have a problem’ that they may be willing to pick a phone up and call someone just to talk through trouble shooting something. If they don’t have a lot of experience, we could help them with that.”

Interviewees noted possible new business opportunities including biomonitoring and funding for special initiatives to improve health and reduce costs, among others.

• “The growing area that I see is what I would call biomonitoring. Looking at chemicals in the blood and either monitoring for good things or bad things like sodium. We have a lot of capability and capacity to monitor all kinds of different chemicals. We collaborate on a variety of different studies where we have, for example, looked at mercury in newborn screening bloodspots. And we have found some surprisingly high levels in the blood of newborns. So we’re going back and doing some additional studies to try to educate women in terms of the risks of fish consumption. Now these are research studies that are funded by the federal government but I could envision some of these being done as part of an ACO as well. You have to get the right mix of issues that they want to address or reduce, but I see that as a big opportunity.”

• “I love what [Oregon] did with the tobacco cessation project where they’re getting money from one of the CCO’s to try to reduce smoking in pregnant women. And their laboratory is going to be doing nicotine testing as part of that. So I think there are some opportunities, but it has to be tied very specifically to some prevention outcome. Someone said at the APHL meeting that to the ACOs, a lab is a lab is a lab. So if you’re just doing the primary diagnostic testing, they’re not going to see the value unless you can tie it to something else. And that’s where I think the strategy should be. I think we have to view and market where we would add value to an ACO.”
• “There’s one of two ways for it to happen [talking about how labs get revenue from CCOs for upstream public health initiatives]. Either your ACO, CCO or whomever does a carve-out and provides grant type funding for this work. Or, you find a way to bill for it. So you bill Medicaid.”

Several interviewees discussed how changing circumstances impact an ability or willingness to bill. One interviewee noted that policies to not charge for certain communicable disease testing in order to eliminate financial barriers when there may be larger public health need present a challenge, but that interviewee also felt that greater health insurance coverage due to the ACA may lessen the need of such policies. A couple of interviewees used the example of a transition from HIV anonymous testing sites (no information from which to bill) to confidential testing cites (collect enough information to bill) as an example of this dynamic:

• “At least in our state, we have a written agreement with the state health department that on a number of the reportable diseases, like rabies for example, we would provide that testing at no charge to the individuals submitting a specimen. The purpose has historically been that you didn’t want to create a financial barrier for any individual coming in and being tested for a communicable disease and [to] prevent outbreaks by removing one barrier for people being tested for something that might cause an outbreak. With the Affordable Care Act’s movement toward arguably universal coverage or certainly wider coverage, the need for that kind of policy at the state laboratory or the state health department certainly comes into question to the extent that there is a way to have those tests paid for that would not be burdensome on the individual. Then I think laboratories need to change their policy regarding billing and uncompetitive testing.”

• “We did an analysis of the kind of tests that were done in the laboratory, and we did a little bit of an analysis of why are we getting them. For example, for many years it’s been HIV and the analysis of anonymous testing sites. If you have anonymous testing sites where you’re analyzing samples that need a laboratory, then you obviously need the state laboratory to be the testing location. And most of those testing sites had the ability to request insurance information but hadn’t always done it because it was cumbersome and they started initially as anonymous testing sites.”

• “Part of the problem has been the nature of the disease for the role of the public health laboratory. In some instances we found the reason the laboratory was involved in doing those tests was based upon conditions that didn’t exist any longer. We allotted HIV anonymous testing sites where the sites wouldn’t even record their names. So they certainly weren’t going to record their insurance. But, what had happened over the years was we’ve essentially transitioned all of our anonymous testing sites into confidential testing sites...so the reasons for not billing don’t exist anymore.”

Interviewees also discussed how to pursue billing for services that used to be covered with federal or state funding. For example:

• “[The infertility prevention project] program is gone. The national level — they eliminated it. They did sort of augment it by using other STI money to support the laboratory testing component. But what that meant was we’re getting a lot of samples on paper forms
from local health departments that are from Medicaid billable clients staying in local health departments. But they weren’t part of the IPP project. They didn’t meet the strict criteria. So we’ve been just doing those tests without billing anybody for anything. We’ve been absorbing that cost as best we could, and we still are. The reason is we have not yet been able to simply capture those data and turn them over to a billing vendor. ... [A]s soon as we make internal changes that allow us to efficiently capture data and generate bills electronically, then we will have a big expansion ... in the stuff that we bill for.”

• “We just introduced last year blood/lead testing for children. It was something that we offered in the past. We had an opening because parents didn’t want to take their children for a venipuncture blood collection. But they would tolerate a finger stick. So we set up the finger stick blood collection, and after a lapse of probably 15, 20 years began a blood/lead testing program again. We’re constantly looking for ways to serve the public’s health with analytical testing.”

Other interviewees discussed ways to broaden their testing portfolio by focusing on new areas that might enhance FFS billing. For example, water quality testing, drug testing, working with local law enforcement, food testing, and radiological testing:

• “Public health laboratories ... are looking at broadening their testing portfolio. Things like, well we’re having a drought here, so water quality testing is becoming a big deal. Local public health laboratories are doing a lot more of that and charging for it in a fee-for-service manner.”

• “We do drug testing. Our clientele ranges from individual providers to school children, to drug courts, to people who are on probation. The only ones that don’t pay their own bill are those referred through drug courts or mental health courts. Everybody else pays for their own. ... It’s been a success — a little overwhelming success. It really exploded. So we are sticking with it.”

• “I also believe that there is a big opportunity for public health laboratories with law enforcement, and by that I mean either the local sheriff or the state enforcement agencies. They will want, and they need to have a local arm that they can count on to deal with their specimens. For all kinds of reasons they’re reluctant to hand those over to the federal government. That’s part of our survival strategy.”

• “What areas do we want to expand in my mind? Food testing will continue to strengthen and grow, and there is not a lot of competition for that. Another area we really want to expand here is radiological testing. Those are the two areas we’re looking to expand that we won’t have to compete with clinical labs for...”

Despite these numerous ideas for increasing FFS billing, most interviewees also felt that PHLs could not pursue these strategies without first addressing some significant billing challenges and without strategies for better competing with private clinical labs. These issues are described in detail above in Findings 9 and 10.
Finding 3.3
PHLs should better market PHL services, update business models, and document return on investment for PHL services.

Documenting Return on Investment. Most interviewees stated that they have not specifically measured the financial return on investment of PHL services. Some interviewees asserted that such an analysis would be difficult due to the nature of public health services and/or a lack of resources to invest in cost-benefit analyses:

• “We don’t have anything approaching the resources to do cost benefit or return on investment analysis. That’s just not in the equation. We don’t have the money to hire anybody to do it. … [W]e do the best we can. I think the epidemiologists and the people who are running the programs have a pretty good concept of return on investment, but it’s not very precise.”

• “At our Department of Health, we have started implementing more accountability. It’s not ROI per se, but for our funding proposals, now we’re doing what’s called “turn the curve” proposals. If, for example, obesity is sky rocketing and there’s something that we could do to try to not just eliminate obesity but change the shape of that curve. You can say, ‘Well things are pretty good now, but we’ve had to cut half of our staff. So we think this is what’s going to happen.’ We can project the curve. Again they’re not ROI studies per se, but they are trying to capture what we do and how it it feeds into our state’s ultimate goal that citizens are healthy.”

However, several interviewees pointed to recent disease outbreaks and suggested using these as a platform for talking more generally about the contributions and value of a PHL. For example:

• “We have been fortunate if you want to think of it that way. … We’ve had a couple of events that have happened in our state that have brought a lot of attention to what we do and the value it brings. In 2012, there was a Hepatitis-C outbreak here, and it was caused by a person diverting drugs in a local hospital. Thirty-two patients who were in a cardiac catheterization lab acquired Hepatitis-C from this person who was diverting drugs. It ended up being a national outbreak. So if there was anyone in our state who didn’t really understand our purpose or value — there was so much publicity around this event and so much relied on laboratory data — people do understand now. That’s really what we need to do, calculate return on investment or quantify the ability to prevent something from happening.”

• “Things are not going in the right direction. Transmitted diseases are on the rise. And certain population groups are doubling and tripling. Gonorrhea is on the rise, syphilis is on the rise, and HIV. There are many cases where battles are being lost with HIV. We have huge outbreaks. Measles is at its highest level in a decade right now. Mumps outbreaks. And part of that is education is needed about the value of immunizations. So … we have a role. I think it’s an anonymous saying that the surest way to bring back a disease is to end the funding to control it.”
**Updating PHL Business Models.** Two interviewees mentioned the importance of updating PHLs’ business models:

- “We are working with a private sector organization to bring in very complete information systems to allow us to better determine our costs, our trends, our profits, and where are we losing money, so that we can be far more sophisticated in our business processes than we’ve ever been before. Public health labs have generally — because we do receive some unrestricted funds from the state — been relatively unsophisticated at our cost accounting processes. At least right now, we can’t afford to be unsophisticated in our cost accounting. ... Our primary strategy right now is to fix the information problem that precludes us from really understanding what all of our costs are. It may mean that we need to look at changing our business model to incorporate other kinds of activities that we’re not involved with now.”

- “What should be our relationship with an institution that does a lot of National Institutes of Health research? Public health labs are not ideally suited to NIH type research. We’re more applied or maybe translational. We have just completed a contract to bring on a PhD epidemiologist. He’s an NIH researcher type and will help us look at how we are doing our information acquisition. How we are dealing with our laboratory practices so that they can be more accessible to NIH or the more discovery-type researcher, not just clinical researchers. At the very least, we can be offsetting some of our capital costs or capital requirements by diversifying our — I’ll call it — our product line.”

**Need for PHLs to Better Market Services.** Part of the solution to enhancing service volume and FFS testing is to market services. All interviewees emphasized the need to proactively market their services better to private providers, private clinical labs, and others. Two interviewees discussed their activities in this area, including hiring new marketing staff specifically for this purpose. A few statements illustrate these conversations:

- “We tend to deal more with people in the clinical laboratories and the healthcare facilities themselves. It becomes a continuing responsibility of ours to reach out to [healthcare facilities] and to enhance customer service. One of the things that we did achieve with the appropriations increases last year was to bring on a marketing rep for our state laboratory. Somebody who is coming from another healthcare institution where they’ve done this before. They are joining us to essentially do the care and feeding of the people that would be our customers. That’s something that I don’t know many laboratories do, but we clearly see it as a need here to ensure that our business needs are met through person to person hands on customer services.”

- “We have marketers that work for the public health laboratory. Most people would call those ‘sales people.’ But we actually have people who go out to either the private clients or to the quasi-public entities, or to ACOs, and say to them, “Look, these are the services that the state public health laboratory provides. And here’s what they can do for you.’ Those are not lab people. They might have been lab people in a former life. They truly are a sales force, and they actually present our case. You can have a great product, but if you don’t have anybody selling it, you’re not going to make any sales.”
Conclusion: The Affordable Care Act and the Future of Public Health Labs

“Public health labs are going to have to adapt. Our role is going to fundamentally change and not necessarily for the worse.”

As our findings illustrate, PHL officials hold a range of views about what the future holds. But a majority of survey respondents — 60% — agreed that ACA implementation either has or will shift priorities for PHLs. Some believe that ACA will lead to diminished roles for PHLs in performing clinical testing services; others that it will create opportunities. Some are pessimistic about PHLs’ ability to continue to serve their core public health functions, while others believe that new sources of revenue could strengthen PHLs’ bottom line and stability.

Of course, part of this variation likely stems from variation among PHLs. As prior surveys have found and ours echoed, PHLs are all in very different situations, depending on the type of lab, its history, the economic state of its jurisdiction, its leadership, and other factors. Ultimately, some labs may choose to broaden their activities and their revenue base, while others might continue or return to core public health functions, such as surveillance, research, or functioning as a reference lab.

Regardless of this variation, we believe based on this research that it is imperative for all PHLs to pause and take a careful look at what ACA and other health system changes really mean for them. Four years into implementation, many PHLs still have a limited understanding of ACA’s provisions and how they change healthcare. These changes may help, hurt, or have no impact on any given PHL, but regardless, they form part of the context in which PHLs function.

Therefore, determining what next steps to take to adapt to the changing healthcare landscape will require broader understanding of ACA and other changes. For some labs, simply understanding how ACA is being implemented in their state could help shape discussions of financial stability and the PHLs’ role moving forward. For others, particularly those that believe they may have a role to play in health system reforms, the appropriate next step might be identifying ways to claim a more active “place at the table” in both state and federal discussions.

Experts we interviewed agreed that APHL has an important role to play in helping PHLs navigate the landscape of ACA implementation. Several interviewees urged APHL to “elevate the conversation” about the impact of health reform, including the impact on surveillance data. One noted that free webinars are an extremely useful training tool that CDC used to offer and that could help APHL’s membership. Another noted that some PHLs are working with PHL to see if barriers to billing can be discussed, and potentially addressed, on a collaborative basis across states.

Ultimately, PHLs have no choice but to evolve with the healthcare system. Individually and with APHL’s support, well-informed and engaged PHLs will be best situated to weather the changes.
Appendix A: Survey Questionnaire

AFFORDABLE CARE ACT AND PUBLIC HEALTH LABORATORIES SURVEY

Conducted by the APHL on behalf of the Milken Institute School of Public Health at the George Washington University

July 2014
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Introduction

Thank you for taking the time to complete this survey.

With generous support from the Association of Public Health Laboratories, the Milken Institute School of Public Health at the George Washington University (GWU) is developing a report that explores opportunities and challenges faced by public health laboratories in the context of the Affordable Care Act, ongoing health system delivery changes, and public health spending reforms. Through this survey, we want to better understand how system-level changes impact your ability to serve the public, where opportunities may lie, and where challenges are present. You will be asked questions about laboratory funding, revenue, fee-for-service testing, and the Affordable Care Act.

We will be collecting survey responses until August 25, 2014.

Public Health Laboratories and the Affordable Care Act

The Affordable Care Act (ACA) was passed by Congress in 2010. This section of the survey focuses on the Affordable Care Act and its relevance to public health labs.

1. ACA provisions expand insurance coverage to many previously uninsured or underinsured Americans. How has the increase in insurance coverage impacted your public health laboratory (PHL)? Please check all that apply.

   □ Increased the volume of clinical services provided
   □ Decreased the volume of clinical services provided
   □ Caused a change in the type of clinical services offered
   □ No change

1a. Please describe any changes in the type of services or volume of services provided by your laboratory as a result of ACA insurance coverage expansions:
2. ACA provisions promote several novel health delivery system models. Has your laboratory been involved in any of the following since ACA became law in 2010? Please check all that apply.

- Accountable Care Organizations (ACOs)
- Community Health Needs Assessments conducted by non-profit hospitals
- Medicaid health homes
- Other patient centered medical home models
- Other state/local health delivery system reforms
- State Innovation Models
  - Unsure
  - None of the above

2a. Please provide additional details about your laboratory's involvement in delivery system reforms:

3. Which of the following ACA provisions would you like to learn more about? Please check all that apply.

- Delivery system reforms, such as accountable care organizations and Medicaid health homes
- Medicaid expansions
- New community health needs assessment and community benefit requirements for nonprofit hospitals
- Private insurance expansions (including "exchanges")
- New preventive service coverage requirements
- Other - please specify: ____________________
  - I have all the information I need about the ACA

4. Has your state expanded Medicaid under the ACA?

  - Yes
  - No
  - An expansion is planned in my state, but not yet in place
  - Unsure

5. Please indicate whether you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</thead>
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<tr>
<td>ACA has decreased, or will decrease, the need for PHLs generally</td>
<td>o</td>
<td>o</td>
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<tr>
<td>ACA implementation has shifted, or will shift, priorities for PHLs</td>
<td>o</td>
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<tr>
<td>ACA implementation reduces the ability of PHLs to serve core functions (e.g. surveillance, emergency preparedness, etc.)</td>
<td>o</td>
<td>o</td>
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<td>o</td>
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<tr>
<td>ACA provisions cause, or will cause, an increase in clinical services conducted by PHLs</td>
<td>o</td>
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<tr>
<td>ACA will have no impact on PHLs</td>
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<td>There are good opportunities for PHLs under the ACA</td>
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6. Please share any other views/concerns/opinions/questions about the ACA’s impact on PHLs:

**Laboratory Funding Sources**

This section asks you to briefly describe how your PHL’s total operating budget has changed since passage of the ACA, and how this has impacted its services.

7. **How has your total operating budget changed since 2010?**
   - ○ It has decreased *(please go to question 7a)*
   - ○ No change *(please go to question 8)*
   - ○ It has increased *(please go to question 7b)*

7a. **By how much has it decreased?**
   - ○ >50%
   - ○ 25-50%
   - ○ 10-25%
   - ○ <10%

7b. **By how much has it increased?**
   - ○ >50%
   - ○ 25-50%
   - ○ 10-25%
   - ○ <10%

8. **How has the amount of funding from the following sources changed for your laboratory since 2010?**

<table>
<thead>
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<th>Source</th>
<th>Increased</th>
<th>Decreased</th>
<th>Stayed about the same</th>
<th>Not applicable</th>
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<td>County/local funding</td>
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<tr>
<td>Federal funding</td>
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<tr>
<td>Fee-for-service billing</td>
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<tr>
<td>State funding</td>
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<tr>
<td>Other</td>
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8a. **Please specify your other sources of funding:**

*If you reported a decrease for ANY of the funding sources please answer questions 9-12. Please go to question 12 if you did not report a decrease for any of the funding sources.*
9. Has the decrease in funding reduced any of the following services? Please check all that apply.

- □ Clinical services
- □ Emergency preparedness
- □ Outreach
- □ Reference testing
- □ Screening
- □ Surveillance
- □ Workforce training
- □ Other - please specify: ______________________
- ○ None of the above

10. What has been the impact?

<table>
<thead>
<tr>
<th>Private clinical laboratories have assumed responsibility for the service</th>
<th>Service is now provided regionally in conjunction with a PHL in another jurisdiction</th>
<th>Service is no longer being offered in my jurisdiction</th>
<th>Other</th>
<th>No impact on service</th>
<th>I don’t know</th>
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<tbody>
<tr>
<td>Clinical services</td>
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<td>Screening</td>
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<td>Other</td>
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11. Please share any additional details about the impact of reductions in your services:

12. Please share any additional comments about changes in your laboratory’s funding since 2010:

Public Health Laboratories and Fee-for-Service Billing

In some jurisdictions, state, local or federal funding for public health laboratories has decreased. Some public health laboratories have pursued revenue-generating opportunities to support their work. This section asks respondents to describe any efforts to generate revenue through fee-for-service testing.

As used in this section, “fee-for-service testing” means billing insurers (Medicaid, Medicare, private insurers); contract work as part of cooperative agreements; or direct billing of submitters (hospitals, other providers, agencies or individual patients).
13. **Does your lab currently receive payment for fee-for-service testing?** Examples could include billing insurers (Medicaid, Medicare, private insurers); contract work as part of cooperative agreements; or direct billing of submitters (hospitals, other providers, agencies or individual patients).

- Yes, my lab currently engages in fee-for-service testing (*Please go to questions 14-17, and to question 23*)
- My lab has plans to engage in fee-for-service testing by the end of 2014 (*Please go to questions 18-21, and to question 22*)
- No, my lab does not engage in fee-for-service testing (*Please go to question 22*)

14. **For which of the following clinical laboratory services are you engaged in fee-for-service testing?** *Please check all that apply.*

- Chronic disease screening
- HIV screening
- Newborn screening
- STD screening
- TB screening
- Other infectious disease
- Other clinical preventive screening services - please specify:________________
- None of the above

15. **Please indicate the sources of fee-for-service revenue generation.** *Please check all that apply.*

- Contract work as part of cooperative agreements
- Direct billing of FQHCs
- Direct billing of hospitals
- Direct billing of individual consumers/clients
- Direct billing of other health-care providers
- Medicaid/CHIP
- Medicaid managed care organizations
- Medicare
- Private insurers
- Other - please specify:____________________
16. Has your laboratory encountered any of the following? Please check all that apply.

☐ Challenges verifying insurance eligibility of consumers
☐ Difficulties setting fee schedule because of statutory or regulatory restrictions
☐ Inability to retain fee-for-service revenue generated within my laboratory (revenue goes to health department or to state general fund)
☐ Insufficient funding to cover costs of contracting out billing services to a third party vendor
☐ Insufficient funding to train/hire staff on billing
☐ Lack of staff experience with billing and CPT codes
☐ Lack of sufficient funding to cover costs related to developing billing systems/purchasing billing software
☐ Low reimbursement levels
☐ Privacy considerations
☐ State law prohibits charging for services
☐ Other - please specify: ______________________
☐ None of the above

17. Does your laboratory contract with a third party billing company to bill Medicare, Medicaid or private insurers?

☐ Yes
☐ No

18. As your lab begins to implement fee-for-service testing, please indicate which clinical services you plan to conduct under a fee-for-service model. Please check all that apply.

☐ Chronic disease screening
☐ HIV screening
☐ Newborn screening
☐ STD screening
☐ TB screening
☐ Other infectious disease
☐ Other clinical preventive screening services - please specify: ______________________
☐ None of the above
19. **Please indicate planned sources of fee-for-service revenue generation. Please check all that apply.**

- [ ] Contract work as part of cooperative agreements
- [ ] Direct billing of FQHCs
- [ ] Direct billing of hospitals
- [ ] Direct billing of individual consumers/clients
- [ ] Direct billing of other health-care providers
- [ ] Medicaid/CHIP
- [ ] Medicaid Managed Care Organizations
- [ ] Medicare
- [ ] Private insurers
- [ ] Other - please specify: ______________________
- [ ] Unknown

20. **Has your laboratory encountered any of the following? Please check all that apply.**

- [ ] Challenges verifying insurance eligibility of consumers
- [ ] Difficulties setting fee schedule because of statutory or regulatory restrictions
- [ ] Inability to retain fee-for-service revenue generated within my laboratory (revenue goes to health department or to state general fund)
- [ ] Insufficient funding to cover costs of contracting out billing services to a third party vendor
- [ ] Insufficient funding to train/hire staff on billing
- [ ] Lack of staff experience with billing and CPT codes
- [ ] Lack of sufficient funding to cover costs related to developing billing systems/purchasing billing software
- [ ] Low reimbursement levels
- [ ] Privacy considerations
- [ ] State law prohibits charging for services
- [ ] Other - please specify: ______________________
- [ ] None of the above

21. **Is your laboratory planning to contract with a third party billing company to bill Medicare, Medicaid or private insurers?**

- [ ] Yes
- [ ] No
22. Please indicate the reasons for not engaging in fee-for-service testing. Please check all that apply.

- Challenges verifying insurance eligibility of consumers
- Difficulties setting fee schedule because of statutory or regulatory restrictions
- Inability to retain fee-for-service revenue generated within my laboratory (revenue goes to health department or to state general fund)
- Insufficient funding to cover costs of contracting out billing services to a third party vendor
- Insufficient funding to train/hire staff on billing
- Lack of staff experience with billing and CPT codes
- Lack of sufficient funding to cover costs related to developing billing systems/purchasing billing software
- Low reimbursement levels
- Privacy considerations
- State law prohibits charging for services
- Other - please specify:_____________________
  - None of the above
  - My laboratory does not perform services appropriate under a fee-for-service structure

23. Please indicate whether you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<tr>
<td>Delivery system reforms (ACOs, medical homes etc.) provide opportunities for PHLs</td>
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<td>Implementation of the ACA has caused a decrease in PHL services</td>
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<td>PHLs are currently at risk of losing the infrastructure to provide certain core services to the public (e.g. surveillance, emergency preparedness etc.)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PHLs provide services that private clinical labs do not or cannot provide</td>
<td>0</td>
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<tr>
<td>PHLs should NOT seek to implement more fee-for-service testing</td>
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<td>0</td>
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24. Please provide any other comments you have about fee-for-service testing offered by PHLs.

Thank you for completing this survey. Your answers will provide critical insight into the opportunities and challenges faced by public health laboratories in the context of health reform, ongoing health system delivery changes, and public health spending reforms. We really appreciate you taking the time to support our project.

If you would like more information about this project, please contact:

Mary-Beth Malcarney
Assistant Research Professor
The Milken Institute School of Public Health at the George Washington University
mbharty@gwu.edu
### Appendix B: Survey Respondents by State

<table>
<thead>
<tr>
<th>Director Name</th>
<th>State</th>
<th>TYPE</th>
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<tbody>
<tr>
<td>Bernd Jilly</td>
<td>AK</td>
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<tr>
<td>Victor Waddell</td>
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</tr>
<tr>
<td>James Beebe</td>
<td>CA</td>
<td>Local PHL</td>
</tr>
<tr>
<td>Musau Wakabongo</td>
<td>CA</td>
<td>Local PHL</td>
</tr>
<tr>
<td>Denise Lopez</td>
<td>CA</td>
<td>Local PHL</td>
</tr>
<tr>
<td>Akin Babatola</td>
<td>CA</td>
<td>Local PHL</td>
</tr>
<tr>
<td>Laura Gillim-Ross</td>
<td>CO</td>
<td>State PHL</td>
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<tr>
<td>Sergio Huerta</td>
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<td>State PHL</td>
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<tr>
<td>Elizabeth Franko</td>
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<tr>
<td>Josephine O'Mallan</td>
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<td>A. Christian Whelen</td>
<td>HI</td>
<td>State PHL</td>
</tr>
<tr>
<td>Christopher Atchison</td>
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<td>State PHL</td>
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<td>Bernard (Tom) Johnson</td>
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<td>Bonny Van</td>
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<td>Judith Lovchik</td>
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<td>State PHL</td>
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<tr>
<td>Robert Myers</td>
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<tr>
<td>Aaron Hoogenboom</td>
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<td>Tamara Theisen</td>
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<td>Joanne Bartkus</td>
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<td>Ron Paul</td>
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<td>Peter Iwen</td>
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<td>Onesia Bishop</td>
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<td>Patricia Armour</td>
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<tr>
<td>Rosemarie Gearhart</td>
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<tr>
<td>Michael Skeels</td>
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<td>Ewa King</td>
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<tr>
<td>Jerry Hofer</td>
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<td>Richard Steece</td>
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<td>Jennifer Chewens</td>
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<tr>
<td>Donna Rosson</td>
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<tr>
<td>Janine Yost</td>
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<tr>
<td>Robyn Atkinson-Dunn</td>
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<tr>
<td>Deborah Severson</td>
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<tr>
<td>Romesh Gautom</td>
<td>WA</td>
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<td>Paul Swenson</td>
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<tr>
<td>Charles Brokopp</td>
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<tr>
<td>Sharon Cibrik</td>
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## Appendix C: List of Stakeholder Interviewees

### APHL Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Atchison, MPA</td>
<td>Director, State Hygienic Laboratory at the University of Iowa</td>
</tr>
<tr>
<td>Joanne Bartkus, PhD</td>
<td>Director, Minnesota Public Health Laboratory Division</td>
</tr>
<tr>
<td>Christine Bean, PhD, MBA, MT(ASCP)</td>
<td>Laboratory Director, New Hampshire Public Health Laboratories</td>
</tr>
<tr>
<td>James Beebe, PhD D(ABMM)</td>
<td>Director, San Luis Obispo County Public Health Laboratory</td>
</tr>
<tr>
<td>Dr. Steven Hinrichs</td>
<td>Director, Nebraska Public Health Laboratory</td>
</tr>
<tr>
<td>Paul Kimsey, PhD</td>
<td>Director, California Department of Public Health Laboratories</td>
</tr>
<tr>
<td>Patrick Luedtke, MD, MPH</td>
<td>Senior Public Health Officer, Lane County Department of Health and Human Services (Eugene Oregon)</td>
</tr>
<tr>
<td>Bonnie Rubin, MBA, MHA, CLS</td>
<td>Associate Director for Planning and Development at the State Hygienic Laboratory at the University of Iowa</td>
</tr>
<tr>
<td>Michael Skeels, PhD, MPH</td>
<td>Director, Oregon State Public Health Laboratory</td>
</tr>
<tr>
<td>Tammy Thiesen, BS, MT(ASCP)</td>
<td>Laboratory Director, Saginaw County Dept. of Public Health (Michigan)</td>
</tr>
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</table>

### Non-APHL Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monica Valdes Lupi</td>
<td>Chief, Health Systems Transformation, ASTHO</td>
</tr>
<tr>
<td>John Auerbach, MBA</td>
<td>Northeastern University, Distinguished Professor of Practice and Director of the Institute on Urban Health Research Former Commissioner, Massachusetts Department of Public Health (2007- 2012)</td>
</tr>
<tr>
<td>José Montero, MD, MHCDS</td>
<td>Director of the Division of Public Health Services (DPHS) at the New Hampshire Department of Health and Human Services</td>
</tr>
<tr>
<td>Joe Damore</td>
<td>Vice President of Engagement and Delivery Premier, Inc.</td>
</tr>
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Appendix D: Semi-Structured Interview Guide

Description of Project Background

APHL has asked GWU to develop a report that explores opportunities and challenges faced by public health laboratories in the context of health reform, ongoing health system delivery changes, and changes in public health spending. As part of our research, we are interviewing several APHL members and other key stakeholders to better understand how health reform and other health system changes affect public health labs.

With your permission, we would like to record our conversation today. We will be using transcribed interviews to enhance the accuracy of our research; these recordings will not be used publically. With your permission, we may use information from our interviews for our report; we will not release any specific information publically without confirming with you first.

We very much appreciate your time today and support of APHL in this project. Before we get started, do you have any questions?

Background Questions

(1) Please describe your current position and work related to public health labs.

(2) Briefly describe how the public health laboratory system in your state is organized and funded.

Fiscal Strains & PHL Infrastructure

We’d like to start with some questions to help us understand your lab’s current budgetary context.

(1) Has your lab experienced budget cuts in the last ten years?

(2) Have you had to reduce services in any way? If yes, how have you or the jurisdiction compensated for those reductions?

(3) Has your lab considered or adopted new/alternative models for providing testing services, such as sharing testing services with PHLs in other jurisdictions; merging PHLs with environmental or other types of public-sector laboratories; contracting for testing services?

• If yes: what are the benefits/challenges of adopting these new approaches?

(4) Given fiscal constraints, have any PHLs in your state/region had to close?

• If so, what is the impact of these closures on laboratory capacity in the state/region? What strategies are decision-makers undertaking to ensure continued provision of quality laboratory services?
(5) Have budget issues impacted the ability of laboratories in your state/region to respond to emergencies or conduct essential surveillance? Have they affected your ability to purchase capital equipment, maintain supplies and upgrade technology infrastructure?

- If PHLs in your state/region have seen reduced funding for screening services, how has this reduction impacted ability to cover other operational costs?
- Describe your ability to sustain public investment in PHL core functions that are not impacted by ACA (e.g. testing services provided for epidemiologic purposes, outbreak detection, and food safety).

(6) If your lab has received Public Health Emergency Preparedness and Epidemiology and Laboratory Capacity Grants, how have cuts these programs impacted PHLs in your state/region?

(7) Describe efforts, if any, to document return on investment of PHL services.

**PHL Testing & ACA Preventive Service Coverage Requirements**

(1) Health reform now requires insurers to cover a broad range of preventive screening and laboratory services. Have you seen this affect the pattern of services that you provide?

(2) If yes, how?
- Have clients shifted from you to private labs?
- If you’re newly billing insurers for these and other services, have you faced any privacy issues?
- How have ACA changes impacted your ability to serve the uninsured?

**Billing/Insurance**

(1) Please give an overview of how lab services are generally financed in your state/region.
- Prior to the passage of health reform (March 2010), what were your primary revenue sources by percentage (approximate)? Has this changed in the past four years?

(2) Describe whether you are engaging in billing services. Do you bill Medicare? Medicaid? Private insurance?

(3) If you are billing, what obstacles have you faced? (e.g. costs related to developing billing systems, difficulty determining fee setting procedures, challenges verifying insurance eligibility, interaction with state laws, low reimbursement levels, privacy considerations, diversion of payments away from the PHL to state’s general fund, lack of staff experience with billing and CPT codes etc.)
- What is your current balance of reimbursed vs non-reimbursed services? Has this changed as a result of health reform?
- Are you considering expanding fee-for-service testing? If so, what is planned?
- Do you have any other plans to change or diversify revenue streams?
(4) Other than billing insurers, do labs in your state/region obtain reimbursement from other sources? (other state agencies, hospitals etc.)

(5) Are labs in your state contracting with health insurers to be part of provider networks? Have you faced any barriers?

(6) Have you found that you or other PHLs in your state/region have had to find new ways to “compete” with, or distinguish services from, private sector labs?

(7) Are there any other ways in which health reform implementation led PHLs in your state/region to change or think about changing the way that lab services are financed?

**Delivery System Reforms**

(1) Are PHLs in your state participating in patient centered medical home (PCMH) models and/or accountable care organizations (ACOs) (or do PHLs have plans to participate in the future)?
   - Describe ways that ACOs/PCMHs have successfully engaged with the public health system in your region.
   - Describe opportunities/challenges for PHLs to participate in ACOs/PCMHs.
   - Have you adopted/are you considering adopting strategies to provide specialized services to ACOs/PCMHs?

(2) Are labs in your state participating in community transformation grants / state innovation models (or do they have plans to participate in the future)? Describe opportunities/challenges for PHLs to participate in these types of delivery system reforms.

(3) Are labs in your state participating in community health needs assessments (or do they have plans to participate in the future)?

(4) Have you been engaged in any efforts to integrate PHL services into primary care? [examples?].

**Other questions**

(1) What are priorities for your lab in the foreseeable future?

(2) Apart from funding, what kind of TA could CDC or AHPL be providing to better support your work? (technical advice, training etc.)

(3) Do you know of good “case study” examples of cities/states/regions where PHLs are succeeding in adapting under health reform?

(4) Is there anyone else you’d recommend we interview?
Appendix E: Other Supporting Statements

Finding 1

(1.1)
• “The counties here have not been at the table with ACOs. I’ve heard from a number of people that public health really was not at the table in California, and so now we are playing catch up a little bit. That’s happening very independently at the local level which is where it would have to be just because of our political structure.”
• “I’m not aware that ACOs as corporate entities are reaching out to our laboratory. We’ve got a number of local labs that are very clinically oriented so they may have some relationship with the local hospital. I don’t think they’ve reached out to us.”

(1.2)
• “We have been involved here from the perspective of what services could the laboratory offer if they were looking at community transformation grants... We’ve been involved in planning and hope to be involved when things come to fruition.”
• “I don’t know much about these programs. And to my knowledge we’ve not received any of those dollars.”

(1.3)
• Most people in public health don’t think about ‘oh, we’re part of the Triple Aim.’ Well, it’s very clear that the only way that our clinical entities are going to achieve the Triple Aim is if public health is involved. And thinking of ourselves as owning the middle aim of the Triple Aim — it’s where we need to be...We all need to be thinking of population level health and what it is that we can do. So, if we look at the big causes of death, you know, tobacco and obesity are number one and two of preventable causes of death, and alcohol is third. There’s plenty of opportunities in the lab world to get involved in those chronic conditions. We have to be creative; we have to forge new relationships. We have to be at the table when these topics are being discussed and when the money is being parcelled out. That’s the first step and a lot of people aren’t doing this. But we need to.”
• “They have had a variety of providers in the community concerned about the obesity epidemic in kids. And they decided in their CCO to carve out money from their global budget to do prevention work around obesity in kids in schools. And that includes a diabetic program. The PHLs are doing some of the testing for hemoglobin A1Cs and blood sugar and they’re doing the calibration and the preventive maintenance on those machines, for a fee. And they get that money from the CCO.”

(1.4)
• “We are seeing a continuing decline in clinical tests. The actual impact of the ACA vs. other reasons, e.g. technology is not well understood.”
• “Patients/clients formerly seen in local PH departments are now seen in private sector clinics, which are part of [accountable care organizations (ACOs)] and have a provider panel, including labs other than our own. Samples are starting to go to the ACO’s contract lab, so we may see more decline.”
• “For example, since sexually transmitted diseases will now be provided under preventive
services, the public health arena is no longer motivated, and unfortunately is no longer receiving federal dollars to do that work. Now as a taxpayer I get it, and it’s great that the government isn’t having to pay for services that should be covered by the insurance plan. But that sort of change will have a huge impact on public health laboratories, and it could essentially eliminate 50% or so of their revenue in the next couple of years.”

Finding 2

(2.3)
• “We bill hospitals directly for the testing that we perform for them, and then they bill the patient’s insurance.”
• “In newborn screening, it’s entirely fee-for-service, and we do not bill directly. [W]e sell the newborn screening cards. [O]ur newborn screening fee is about a hundred and fifty dollars, which covers the fifty-five, I’m not sure, fifty-six tests that we do. We sell the cards directly to the hospital, so they’re basically like cash. The hospitals will order a pile of those cards, and then when we get a card, [we] know [the tests have] already been paid for. And then the hospital bills the patient, the parents presumably.

(2.4)
• “We bill Medicaid, but we’ve not been as comprehensive in the past as I think we need to be. Part of it comes from the nature of [how] the public health lab has historically seen itself, and we’re just talking on the disease control side. On the environmental side I think we’ve traditionally billed individuals, and it’s generally not covered by any kind of insurance.”
• “We don’t really do front line patient testing that’s billable under Medicaid. Medicaid [in our state] does not fund reference testing.”
• “We’re a state expanding Medicaid, so more and more people are eligible. We needed to do it [move to billing Medicaid] sooner rather than later.”

Finding 3

(3.2)
• “Our so-called additional value added is that not only will we get new data back on your case, but we’ll also satisfy the state that you’re a good data provider. We’ll also transport that specimen to the public health laboratory for you.”
• “I would also point you to examples going on in Minnesota. There was the recent Health Affairs post on the “totally accountable community care organizations (TACCOs).” TACCO’s are a way of expanding beyond just the patient which is often the reference point for the ACO and looking at broader indicators of population health in the communities.”
• “You know, we don’t do drug abuse testing here, but we could. We don’t do testing to verify that people have stopped smoking, but we could. We don’t know what new environmental events may take place. Technology may allow us to do testing that we didn’t do before. So we will just continue to stay tuned...”
• “ROI is a difficult question because the lab is so far removed from the outcome. One area that’s obvious is food borne illness. If you detect food borne illness early, then you prevent people from getting sick, and there’s cost savings somewhere. The CDC did a study to look at what the cost savings would be, and it has not seen the light of day. It’s been years since they’ve actually had the data and it hasn’t come out. With newborn screening, the argument in the past was that you’re identifying these disorders and saving money. That’s actually one of the reasons it’s done on a population basis. But because we use screening for so many disorders now and the cost has gone up, we’re not sure that we can say there are cost savings.”

• “We really need to position ourselves. We need to take advantage of where we have unique data of value, and where we have an infrastructure in place that can make a difference. And we need to market that value. [For example,] we’re the ones who found out twelve months ago that gonorrhea rates were off the charts. And there might be a provider or two out in the community saying, ‘Gosh, I’ve seen quite a few gonorrhea patients. I wonder what’s going on’ But we’re the ones who are able to say, “Hey, these numbers are historically very high. And here’s where they’ve been for the last five years.” Not only that, we’re able to do some other testing for antibiotic resistance. We’re able to do some select testing of high-risk groups. We’re able to ascertain who’s highest risk because again, that data is reportable to us and we can tell who’s getting gonorrhea by age group, by sex choice and then share that data.”

• “One thing that’s very much on my mind is that we have to repetitively visit our customers to make them aware of our services. It just requires somebody to be out in the field to make people aware.”

• “You know, we are a pretty withdrawn group. We’re not very outgoing, and it’s a real struggle for us to go and touch and talk to the public. But you’ve got to do it. We’ve got to get out there. And if we can’t do it, then we need to hire somebody else who can do it on our behalf. Marketing is key.”
The Association of Public Health Laboratories (APHL) is a national nonprofit whose mission is to shape national and global health outcomes by promoting the value and contributions of public health laboratories and continuously improving the public health laboratory system and practice.