The Affordable Care Act and Health Care Market Reforms:   
**IMPLICATIONS FOR PUBLIC HEALTH LABORATORIES**

An Iowa Assessment

July 2012

The State Hygienic Laboratory at the University of Iowa



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**FUNDING FOR THIS PROJECT WAS PROVIDED THROUGH AN INNOVATION GRANT FROM THE ASSOCIATION OF PUBLIC HEALTH LABORATORIES.**

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# Acknowledgements

This project seeks to explore relevant issues for public health laboratories related to the provisions in the Patient Protection and Affordable Care Act (ACA) with the resulting information provided to the Association of Public Health Laboratories, state and local public health laboratories, and other interested stakeholders.

This work was made possible through an Innovation Grant from the Association of Public Health Laboratories (APHL).

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The State Hygienic Laboratory wishes to extend special thanks to State Public Policy Group for assistance with this project and to those who participated in the discussions across the state:

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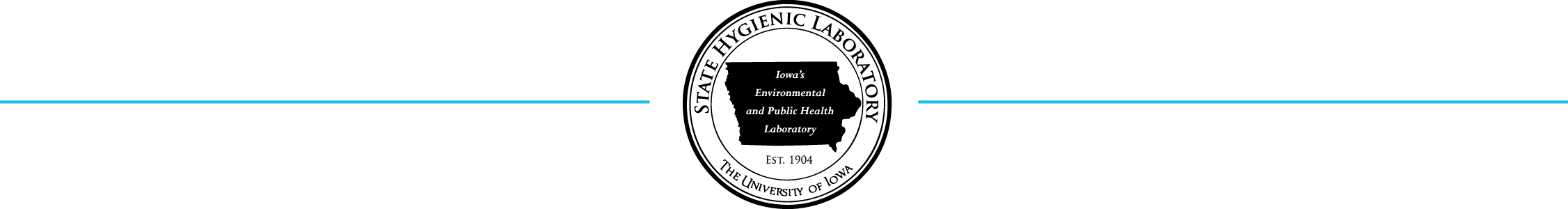
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Finally, many thanks to the individuals who met with the team and provided background information, as well as the colleagues at the State Hygienic Laboratory who supported this effort.



# Executive Summary

The State Hygienic Laboratory at the University of Iowa convened three forums with laboratory system stakeholders to consider how the implementation of the ACA might impact public health laboratories. Willingly or not, the public health laboratory as a key component of the healthcare system must undergo its own transformation in order to continue to be relevant. Gone are the days of status quo; public health laboratories must be bold and innovative and find a niche within the reformed healthcare environment.

There was a consistent message in the forums supporting the value of laboratory testing for population and individual health however what was noted was the lack of inclusion of the voice of the laboratory, particularly state and local public health laboratories, in health reform initiatives. It is up to public health laboratory leaders to insert themselves into conversation for the planning of ACOs and other health reform initiatives and convey the message of the critical need for public health laboratory testing to policy makers, insurance companies, and the public.

The dichotomy of the ACA focusing on individual health versus the public health role in population health creates an opportunity for the laboratory to market the advantages of population health strategies and testing to ACOs and other medical care providers in order to reduce their risks and increase financial incentive returns. Laboratories need to position themselves to take advantage of this and form partnerships that support innovation. As the healthcare system is restructured with a focus on cost containment and quality, the public health laboratory can expect shifts in funding and a greater scrutiny of the value of the laboratory. How public health laboratory leadership responds to national, state and local ACA implementation strategies in the immediate future will significantly impact the future of the public health laboratory system in the United States.

# Overview of the Project

The Patient Protection and Affordable Care Act (ACA) remains in its infancy as far as implementation and a full understanding of its provisions. This federal legislation was enacted on March 23, 2010, with implementation phased in through 2020. Key provisions as they impact the general public are well known and include extending coverage of children to age 26 on a parent’s health insurance, elimination of copays for preventive services, expansion of Medicaid eligibility, and the mandate for health insurance for all Americans either individually or through employers. What is not clear is how the provisions of the ACA will impact the public health laboratory (PHL) system.

For this project, a public health laboratory system, as defined by APHL, is “An alliance of laboratories and other partners within a state that supports the ten essential public health services under the aegis of the state public health laboratory. The system members and stakeholders operate in an interconnected and interdependent way to facilitate the exchange of information, optimize laboratory services, and help control and prevent disease and public health threats.”

While the discussions, analyses, and debates around the implementation of the ACA continue, few seem to have considered, or even recognized, the impact of the ACA on key public health programs and the public health laboratories. Unfortunately, there is very little information available regarding the ACA as it relates to infectious disease surveillance programs and the public health laboratory. This project was designed to address this information gap by engaging relevant stakeholders through the use of multidisciplinary forums in discussions at the policy and programmatic levels to assess the impact of the health care reform on the public health laboratory system. The insights and recommendations contained within this report are intended to provide the information needed for the public health laboratory system to be prepared for upcoming changes and ensure that laboratory capabilities and critical programs are sustained to protect the health of the nation.

## The Iowa Environment

The State Hygienic Laboratory (SHL) is a part of the University of Iowa, one of only two state public health laboratories in the nation that are not linked to or part of the state public health department. Thus, as a matter of policy and sustainability, legislatively, the issues and concerns of the state public health laboratory are intermixed with education issues rather than health care. The laboratory provides both the clinical and environmental public health testing for the state of Iowa. SHL has a main facility and two satellite locations geographically placed to provide service to eastern, central, and western Iowa.

Iowa is a small state (population: 3M) with many counties. “Home rule” is highly valued by local officials, both elected and appointed. Iowa’s 99 counties were established based on the then-common standard that one could ride by horseback to the county seat and back in one day. However, times have changed with the introduction of interstate highways and cars and this concept is outdated, at best. Although frequently discussed, it has been difficult for counties give up their autonomy in terms of public health delivery.

One of the key authors of the Public Health and Prevention provision of the ACA is Iowa’s Senator Tom Harkin. Because Harkin is a longtime champion and advocate for prevention as well as health care, Iowans involved in public health tend to be more aware of these priorities. Although, Senator Harkin has made it clear that he holds the Public Health and Prevention Fund sacrosanct and defies efforts to “raid” that fund for unrelated purposes, public health laboratorians continue to see this area of funding being targeted for other initiatives.

The forums were held prior to the June 28, 2012, Supreme Court decision regarding the ACA. Project leaders and stakeholders agreed at the time of the forums that the discussions were relevant and timely considering that many health care reform initiatives were already moving forward.

## Affordable Care Act: revelant highlights

Components of the ACA considered in the discussions are highlighted here. These provisions include those that expand coverage, shift to a value-based reimbursement system, insurance exchanges, and Accountable Care Organizations. Overall, this market-based health care reform relies significantly on the private sector, and public health will need to be adaptable and receptive to partnering with private entities.

### Prevention and Wellness

The ACA created the Prevention and Public Health Fund to direct resources to related programs. The National Prevention, Health Promotion, and Public Health Council was established to coordinate federal prevention, wellness, and public health strategies. Task forces on Preventive Services and Community Preventive Services were also established. With the allocation of real funding, the Prevention and Public Health Fund has drawn greater attention to and competition for these resources, potentially making it more difficult for PHLs to secure funding.

Included within the prevention and wellness scope of the ACA are:

* A grant program to support the delivery of evidence-based and community-based prevention and wellness services.
* Eliminating cost to persons receiving preventive services through Medicare or Medicaid.
* Providing an annual health risk assessment as part of Medicare coverage for personalized prevention plan services.
* Requiring qualified health plans to provide preventive care without cost to members for certain services, including immunizations for children and preventive health screenings for women.

With the creation of the Prevention and Wellness fund there is sure to be a shift in funding for other programs. This is becoming more apparent as the laboratory continues to receive notification of cuts in funding for infectious disease surveillance. Recently the laboratory was notified funding that the testing related to the Iowa Infertility Prevention Project will be discontinued. Other essential public health surveillance projects are sure to be likewise impacted and this continues to be an area of concern for the laboratory.

The diversion of funds and the focus on private partnerships may necessitate third party billing on the part of the PHL for reimbursements. This may pose a challenge on many fronts. From an operational standpoint, integration of third party billing will be complex and expensive. Also, some PHLs are prohibited from third party billing due to specific language contained within administrative code. Of further concern is the ability to collect after testing has been performed and reported and the risk associated with providing services without reimbursement due to non-payment.

### Individual Mandate

All US citizens and legal residents will be required to have health insurance or face a penalty starting in 2014. The demand for insurance will be met through the creation of Health Insurance Exchanges and through the expansion of Medicaid. Medicaid benefits will be expanded to all non-Medicare eligible individuals under age 65 who have incomes up to 133% of the Federal Poverty Level. While an exact figure is not known, projections in Iowa estimate 320,000 new Medicaid beneficiaries from this expansion.

The G2 Intelligence Report, *Health Care Market Reforms: Implications and Prescriptions for Laboratories*, suggests that this expansion will result in a surge of testing for clinical laboratories. The impact on PHLs is unknown at this time.

### Cost Containment & Accountable Care Organizations

There are many provisions of the ACA relating to cost containment and the shift in focus to value provided in the health care system. Value should be thought of as a combination of quality and cost, with measures taken to prevent quality of services from suffering from measures to simply cut cost. Perhaps one of the most significant measures allows providers to come together to form an Accountable Care Organization (ACO) to serve Medicare patients, with the primary aim to achieve quality thresholds and cost containment. The providers would include physicians, hospitals, “and other health care providers” working in partnership to achieve better health outcomes with the incentive that the ACO partners will share in the cost savings.

The role of the PHL within this framework has not been discussed in depth and many questions have yet to be addressed. One such question is whether the PHL can be a partner in an ACO, and if so, how the relationship is formalized. Current indications suggest that the PHL will play a role in information exchange, and, thus, the laboratory must be ready with a Laboratory Information Management System robust enough to meet future demands for electronic connectivity and information exchange.

The emphasis of ACOs is cost containment and quality improvement. As such, laboratory tests, particularly expensive molecular diagnostics, will be scrutinized for value and quality. The laboratory needs to be ready to confront this scrutiny with data that support the necessity and benefits of molecular and other laboratory diagnostic testing.

### Independent Payment Advisory Board

Focused on reducing the per capita rate of growth in Medicare spending, the Independent Payment Advisory Board will submit recommended legislative proposals to achieve reductions in spending if the rate of growth exceeds a certain level. The Board cannot submit proposals that would ration care, increase revenues, or change benefits, eligibility, or Medicare cost sharing. Many other guidelines are included in this section, including recommendations every other year to slow expense growth while maintaining quality of care.

### Patient-Centered Outcomes Research Institute

The ACA established, upon enactment, the Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The provision includes genetic and molecular research, potentially leading to better health outcomes for individuals. PHLs have not discussed how to partner with this Institute.

### Updates to the Medicare Clinical Laboratory Fee Schedule (CLFS)

This provision, which began in 2011, dictates a reduction in Medicaid reimbursement rates for clinical tests. This will result in decreased fee-for-service revenue and new revenue streams will need to be generated.

### Molecular Diagnostics Demonstration Project

This project began in July 2011 and is intended to address the complex issues relating to reimbursement of molecular diagnostic tests, particularly the ability to receive direct payment from Medicare Part B. A significant portion of current PHLs testing is molecular, and the impact of this demonstration project is unknown.

## Iowa Efforts Underway

A number of federally supported and independent initiatives are underway in Iowa to implement one or more of the elements of the ACA.

* Trinity Regional Medical Center and Trimark Physicians Group will form the first ACO in Iowa. They will become one of the 32 Medicare Pioneer ACO’s in the nation.
* Iowa Health System, Mercy Health System, and Genesis Health System are reportedly each working with Wellmark Blue Cross Blue Shield in development of agreements to deliver services under ACO models.
* Midwest Members Health is one of the first federally approved health care CO-OPs in the nation and will begin to offer services by January 2014.
* Iowa Medicaid Enterprise (IME) is conducting early research and planning around development of an ACO, which would be dependent on changes in current Medicaid regulations.
* IME is developing a Health Home model for CMS approval, under which reimbursement is provided on a per-member, per-month basis.
* Iowa received a $7.75 million grant for the Level 1 of the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges.

# Methodology and Process

Three forums were held to identify and discuss how the ACA will impact the public health laboratory system and, thus, the larger public health system. An Innovation Grant was awarded by the Association of Public Health Laboratories to support this project. The project period was January through July 2012.

## Methodology

Bonnie Rubin, Associate Director for Planning and Development, State Hygienic Laboratory at The University of Iowa served as the primary investigator with colleague Amy Terry, Management and Administration Fellow, serving as Project Manager. State Public Policy Group was contracted to facilitate forums, assist with report and agenda development, and assist in identifying key stakeholders.

An initial literature review on the ACA and its impact on the public health laboratory system was conducted to provide context and background for framing the forums. Summary materials ranging in focus from potential impacts on public health laboratories to descriptions of key provisions of the ACA were reviewed. To assist invitees in preparation for forum attendance, a briefing paper summarizing key provisions with potential to impact PHLs was developed and disseminated prior to the forums (Appendix 1)

The agenda and presentation materials were developed using information gained from the literature review and several webinars. The Iowa and Midwestern environment and stakeholder interests were considered during the development of forum materials.

## Stakeholders in the Public Health Laboratory System

A multidisciplinary approach was taken, and stakeholders of the PHL with high-level policy expertise as well as those with experience in local public health (LPH) or a clinical lab were identified and selected with consideration given to geographical distribution and urban/rural balance. In addition, a client report based on test volume and total charges was assessed to determine the “heavy users” of the PHL. Care was taken to select participants to provide robust conversation and support a diversity of thought and range of expertise.

The forum locations of Davenport, Ankeny, and Sioux City were chosen to ensure geographic diversity and statewide perspective. Davenport as an eastern location was selected based upon its size and proximity to the border states of Illinois, Minnesota, and Wisconsin. The central Iowa forum was held in Ankeny, a city just north of the capital city of Des Moines and home to a SHL satellite facility. This strategic location allowed for invitations to key policy, health care, public health, and other central Iowa stakeholders. The western forum was held in Sioux City, which borders Nebraska and South Dakota and reaches into rural areas.

Categories of stakeholders included:

* State Public Health Laboratory Directors from states contiguous to Iowa
* Local public health officials
* Clinical laboratory leaders
* Hospital system representatives
* Nonprofit organizations, e.g., The Iowa Poison Control Center and the Iowa Hospital Association
* Academic experts in health policy and the ACA

Invitations were issued to 25-30 people for each session with a goal of 10-12 participants per forum. The agenda (Appendix 2) and the background summary were provided via email to invitees in advance of the session. A guide to planning similar forums is attached. (Appendix 3)

Forums were scheduled on days, dates, and times that would optimize participation. Sessions were three to four hours in length to allow adequate coverage of targeted discussion while respecting competing demands on participants’ time.

Forums were held on:

* May 1 in Davenport
* June 8 in Ankeny
* June 12 in Sioux City

A flexible format was developed for the sessions to encourage robust and dynamic conversation. The agenda remained consistently focused on the PHL system and how it might be affected by various provisions of the ACA with some modifications based on participant expertise and geographic location. An informational presentation from Bonnie Rubin and handout (Appendix 4) were used as a backdrop for discussion. Participants were actively engaged and excited to provide comments, observations, concerns, questions, and editorial opinions throughout the forums.

The proceedings of each forum were recorded and a summary of the conversation was developed. (Appendices 5, 6, and 7). Common themes emerged including impacts of the ACA on PHLs, state policy, public health services, infectious disease programs, and clinical laboratories.

For the specific list of participants please see the Acknowledgements on page 5.

# Potential Impacts of the Affordable Care Act on the Public Health Laboratory System

The implementation of the ACA will have a lasting impact on the PHL system and this impact, positive or negative, remains a mystery. However, with certainty, the public health laboratory environment will change. Conversations during the forums focused on what these changes might be, how the provisions will impact the system as a whole, and what leaders might do to prepare. Themes that emerged in forum discussions are described in this section and include several representative comments.

## the Role of the Laboratory within the ACA

The public health laboratory system in the health reform conversation was largely unnoticed until these forums. The level of surprise as to why the PHL role in the ACA had not been previously considered was palpable. Participants were largely overwhelmed with the many other provisions set forth by the ACA and thus had not thought about the impact to laboratory services. The tone of early discussion was that while they had not thought of the importance of public health laboratory testing, surely someone was. There was an expectation that the public health laboratories – the State Hygienic Lab in Iowa – have it figured out and under control.

* We have been looking at the impact of the ACA on public health on a national level, but labs were never mentioned in any of the conversations.
* Admittedly, I know almost nothing about labs and the State Hygienic Lab, which is disconcerting considering the director of the lab chairs a committee we are very involved with. But I know I’m not the only one who doesn’t know about labs, and that may explain why labs haven’t been a part of our conversations about the ACA.

Once participants began to think about the public health laboratories – or laboratories in general – in context of the ACA, there were many reactions. Some admitted they had never thought about it and were embarrassed given their experience and the roles they play in ACA activities from local to national levels. At the other end of the spectrum, some participants felt that the discussion was starting with a blank slate – a new topic with no clear path for public health laboratories to fit into some of the directions being taken by the ACA.

* How do public health labs fit into an ACO? Will they ever come to public health labs for testing, or will they do all of their own testing? Public health labs may see a reduction in testing.
* It seems as if there might be an element of surprise coming. A lot of states aren’t doing anything to plan for the ACA until the Supreme Court ruling is issued, but many things have already been set in motion.

The complexity of the challenges and solutions is daunting. Participants across the state in all forums expressed that few are addressing the PHL role in population health and surveillance as they discuss ACA implementation strategies.

* Public health is an unrecognized necessity – not even a mandate. Why isn’t there a part of the ACA that deals with surveillance and investigation?
* Currently with the Chlamydia and Gonorrhea program, samples are collected and sent to the state lab. The funding is through the Department of Public Health. In the world of ACA and ACOs, how will that change?
* I’m concerned that the ACA looks at individual patient care, but not population health. Prevention and surveillance won’t be funded.

## The nature of change

Change is underway, and participants emphasized that public health laboratories must become immediately engaged in the discussions to ensure that critical public health roles are maintained in a reformed system.

* In the old way of thinking, the State Hygienic Lab doesn’t impact patient care decisions. There has to be a new way where the state lab is seen as a way to reduce costs through surveillance and prevention.
* Communication has always been an issue – people don’t know about labs. In laboratory medicine, we don’t think about promoting ourselves to the public or others in the field, we just do our job. We have to become more visible, not just in terms of public health, but as a part of the health of the state.

The focus thus far has been on how to better provide health care to individuals using models that will maintain quality but reduce or contain costs. Other than including laboratory services as a covered service required in health plans, little is said about laboratories, let alone public health laboratories.

Many participants expressed the expectation that the emphasis on cost containment for health care would ultimately compromise surveillance and population health, particularly if public health laboratory system stakeholders do not become involved and recognized as part of the implementation of various components of the ACA. Where and how to fit into the scenario was less obvious.

It was overtly stated and implied across the forums that the SHL can and should be a leader in Iowa to integrate the PHL system into the state’s ACA implementation efforts. It was also noted that becoming actively engaged in these statewide discussions would be a new type of role for the state’s public health laboratory, but those attending the forums saw it is an entirely appropriate role.

A number of participants indicated they believe the value SHL brings to the state and citizens of Iowa and their state agency partners is not completely recognized or appreciated. Participants were emphatic about the value of the information and data provided by the SHL to support outbreak investigations at the local and state level. The PHL is infrequently credited as essential to the discovery and mitigation of adverse health and environmental events. Participants fully support and encourage SHL to improve its visibility in the community and that it is appropriate for the PHL to speak out.

* The State Hygienic Lab is the key – you have more power and resources than us in local public health. We really need some common policy talking points about these issues for consumers and policy makers.
* Public policy needs to value public health all the time. What will make it important enough to be valued? Maybe it takes getting the right metrics in place.
* Labs are not at the table in so many of the conversations about health care and reform. Traditionally, we haven’t inserted ourselves into the conversations, but we are working to do that now.
* Public health’s role is changing, and the need for public health will be greater in the future. As health reform occurs, public health will need to be at the table and have a strong relationship with community organizations and hospitals to take on work those entities no longer have capacity for.
* The ACO concept is moving quickly. Public health labs need to insert themselves into the conversation and planning before it’s too late.

## A sustainable model

Will the current model of public health laboratories need to change to sustain successful programs? The answer is, “Probably,” but what that change might look like is unclear, and participants voiced concern for what the future holds. The ACA emphasizes return on investment which, in business terms, is defined as a performance measure used to evaluate the efficiency of an investment. To calculate ROI, the benefit (return) of an investment is divided by the cost of the investment. Return on investment is a very popular metric because of its versatility and simplicity; if an investment does not have a positive ROI then the investment should be not be undertaken.

In order to have a positive ROI, how should local, state and national public health laboratory testing be delivered? Does the public health system need to consolidate to utilize dwindling resources more efficiently and effectively? Conversation delved into sacrosanct territory even to the point of asking whether a PHL was essential or relevant in the future, and that PHLs can’t exist for the sake of existing, but they must provide an essential service or fulfill a unique need in the reformed environment.

Local public health clearly indicated they must find improved models for providing services and increasing efficiencies. In this controversial discussion, the rationale for 99 counties, which was designed to allow a citizen to travel by horseback to and from a county seat in a day’s time to conduct business, is no longer necessary. Resistance to consolidation is strong particularly when funding is at stake and when discussing downsizing. However, this hot button topic was discussed frankly as a matter of necessity to ensure essential public health laboratory services continue.

Furthermore, a sustainable model was ardently emphasized during discussions. Unfunded mandates continue to impact local and state entities, adding expectations for services and outcomes without adding the corresponding funding necessary to comply.

A limited regionalized structure is successfully being utilized to transcend jurisdictional lines in local public health and for some state laboratory programs. The CDC Laboratory Efficiency Initiative is occurring at the national level with emphasis placed on right sizing programs and seeks to address the question of how PHLs can be the most efficient with the resources available. Expanding these models may hold promise for public health laboratories in cooperation across state lines to provide core public health services in innovative ways and control costs.

* We’re entering a time that will re-emphasize cost and return on investment. Return on investment in public health may be an area in which to focus. Some will argue that someone has to talk about keeping a profitable line. Health care systems do not have the luxury of doing that. Maybe what has been left out is a public health model to provide necessary public health services, and a support system that’s sustainable. Maybe we don’t need all these labs; we need a system, maybe with specializations.
* Follow the money. I don’t like to do that, but focus on demonstrating value to whomever will fund us. In the long run, we have to articulate what we do that brings value to the system.
* In smaller counties, the health department may not have the expertise to serve as a resource. There are opportunities for smaller counties to contract with larger counties, but it is most successful if the smaller county identifies that need.
* An average one-day wagon ride that determines our county size – that model no longer works. The decrease in funding may force a needed change to a regional approach. For example, Michigan used to have three state labs, but now with transportation options, only one is needed.
* Look at the mental health redesign work: If a county can provide certain services, the county can maintain independence. If the county can’t provide those services, the county must seek out cooperative agreements. This will force counties to partner, and could be the future of public health.

With reductions in funding and anticipated shifts due to the ACA, a change in the current model is inevitable. However, concerns remain about what consolidation will mean for capabilities.

* I have concerns about some of the regionalization conversations. It is working well for some tests, such as newborn screening. But what if an outbreak occurs? Could a governor decide to only do testing for his or her state, since it’s a state agency? Population health could be compromised by political factors.

## Health Care Delivery Models and Laboratory Services

Significant discussion centered around how laboratories, both clinical and public health, can predict and nimbly adapt to whatever changes occur as health delivery systems evolve. There remains a great deal of uncertainty, and participants were apprehensive about what these impacts would be.

The advent of ACOs as a health care services delivery model does not appear to consider the interdependencies among clinical labs, local public health, and the PHL. The uncertainty of how the ACO delivery model would impact these interdependencies was frequently noted and concern expressed that the model could adversely affect laboratory testing delivery.

Participants knowledgeable about clinical laboratories linked to larger hospital and health systems remarked that while all other department and sections of their organizations had seen increases in reimbursements from payers over the years, lab reimbursement rates have received cuts. They noted that a large percentage of health care diagnoses and treatments rely on laboratory testing.

* Labs don’t often have communications staff, and because of that, we tend to be overlooked.
* The general public doesn’t realize the part we play in health care, but 70% of information clinicians use to treat patients comes from laboratory testing while representing only 2% of the cost of health care.

Under an ACO scenario with patient satisfaction, improved patient outcomes, and value as the focus, many speculated that complex high-cost testing that does not make money for the organization may be shifted to another laboratory – the public health lab or one of the large, private laboratories. Routine tests (ex. STD testing), which have seen cuts in reimbursement rates, thus making them unprofitable, might get shifted. If the testing is shifted to the public health lab, where will the funding come from? On the other hand, some speculated that specialty testing may be moved to other types of labs because of the high cost involved in performing those tests. While that may be an option, it was noted that the reimbursement rates for the more specialized tests allowed the clinical lab to make a profit, so they may choose to retain those tests in-house. One thing is clear – uncertainty remains among all types of labs regarding how the implementation of the ACO model will affect each type of laboratory.

Some fear that there will be a significant shift to the large, private for-profit laboratories for testing which is now done in the hospital laboratory or by SHL. Concerns include those related to turnaround time, quality assurance throughout the process, timely and accurate reporting to epidemiologists, and a business model that may sacrifice patient needs for a lower cost for the ACO.

* When I get a result from the State Hygienic Lab, I trust the results because I know they validate. I’ve received results from other labs that didn’t make sense. If I have a result I don’t understand, I can call the State Hygienic Lab and get an answer from a lab scientist. When I call the big reference labs, I can only talk to an advertiser.
* Clinical labs will do basic tests, such as determining if a test is positive for H1N1 for treatment purposes, but the State Hygienic Lab does the detailed sub-typing and geno-typing necessary for population surveillance. If the state lab can make a case to ACOs to look at their patient population and the opportunity for positively impacting population health, maybe that would be an opportunity for partnership.
* ACOs may want to do their own testing, so we could see a reduction in tests sent to public health labs. How do we ensure that enough tests are sent to public health labs to allow for monitoring and surveillance, which is then sent to the CDC?

Reimbursement rates for laboratory services were an important element of the discussion. As noted earlier, those working in the lab system have experienced significant constraints on their budgets. In 2011, Congress approved a revision to the Medicare clinical laboratory services fee schedule to reduce reimbursement rates. Another 2% cut has been approved for 2013. The perception of laboratorians is that because their services are largely behind the scenes, costs to provide these services are not fully understood and appreciated. This makes labs easy targets for cuts when overall organizational budgets are tightened. The threat that the cost containment element of the ACO model will exacerbate the tendency to cut lab budgets is a significant concern to laboratories.

* We need to find alternate funding methods. For those of you on the front lines of public health agencies, this discussion shows that the business model for public health lab functions is under significant challenge right now. As much as we talk about a business model, we support the work you do in the larger public health environment. If we’re going to get out of significant clinical health testing, or if we move towards environmental/infectious disease exposure, labs need to re-engineer, and this needs to be coordinated with local public health.
* Emergency medicine has asked to sit at the table and have been routinely refused. If the ER has to give away the services for free, why should we pay for it? If IDPH and the Siouxland health department have to give their services away for free, why should we pay for it? What failures occur to both the public health system and the ACO? How are you planning to ensure that mandated services are covered?

## Sustaining the Public Health Laboratory System Infrastructure

The nation has come to rely on the PHL system to protect individuals from disease and danger from health and environmental threats. As primary components of this system, local public health, clinical laboratories, and PHLs must find ways to continue to work with the CDC and others to improve and enhance our public health infrastructure. Some see health care reform as an opportunity to become more aggressive in this effort.

Since the ACA does not clearly place the PHL system and its component entities directly at the table, the expectation is that laboratories must invite themselves to the table. As they more visibly join the discussions, they must bring ideas for innovation and opportunities in addition to the data that demonstrate the health benefit and value of investment in a robust public health laboratory infrastructure.

This must occur despite perceptions that the ACA may set in motion policy that may weaken the public health infrastructure. Unless the health care reform initiatives include funding and guidance to maintain and improve the PHL system, sustainability and enhancements will need to come through other federal, state, and local plans and initiatives.

Vigorous forum conversation centered on maintaining the core functions of the public health laboratory system while increasing revenue, decreasing expenses, and offsetting costs associated with unfunded programs.

One cost containment approach throughout the health care and public health system is cost avoidance. Attention to and investment in population health and surveillance functions can ultimately reduce the medical care costs to the traditional health care providers. Plainly stated, if public health prevents people from getting sick, patients will have better health outcomes and will not need expensive services. Winners in this scenario are the ACOs and the PHL system.

* The State Hygienic Lab is the gatekeeper on infectious disease. If ACOs choose to send fewer specimens, the state lab won’t have as much information to work with to do surveillance and prevention activities.
* We need accuracy – there is value in accurate diagnosis which leads to lower treatment costs.
* In the old way of thinking, the State Hygienic Lab doesn’t impact patient care decisions. There has to be a new way where the state lab is seen as a way to reduce costs through surveillance and prevention.
* We have a challenge to document how we prevent things and how much we save. We need numbers and cost-savings analysis. We haven’t been doing that. We need to figure out a way to get the data to say, “Here’s what you save in public health dollars.”

It was clear to participants that the PHL system, with state public health laboratory leadership, will need to bring innovation and new perspectives to their own roles and business models. New models for service delivery, such as shared services or collaboration for regional services mentioned in previous sections, are worthy topics of discussion.

Public entities, including the SHL, are not eligible as a partner organization in an ACO. An impact of this development may be to draw business away from the public health laboratory. It is expected, however, that ACOs may contract with non-partner organizations for services. To prepare for such an opportunity, the SHL will need to have billing and contracting systems in place.

* Maybe there could be a broker function, so the ACO would know they could call you [the public health lab] for advice, avoid emergency fees, and you would be paid on contract from the ACO. Have to look at it as preventing the need for the visit.
* There are a lot of opportunities in this to be the third party, honest broker of information. Explore a model that provides data that shows you are giving advice that prevents the need for a visit to the emergency room.
* Instead of assuming risk, would it be possible to provide services on a transaction basis? There is going to be a fundamental shift in the delivery system.

The overarching concern of participants is that the cost containment priority of the ACA, without active involvement and innovative approaches from the public health laboratory system, will result in an erosion of the nation’s surveillance infrastructure as well as the ability of SHL and all public health laboratories to continue to deliver services.

# Recommendations for the Public Health Laboratory System

The future of public health laboratories is at a crossroads; change is coming, and how the laboratory system responds will shape the future. The following recommendations were developed as a result of the discussions at the forums.

* The public health laboratory system must transform itself and embrace the changes on the horizon. Leaders must be innovative; business as usual can no longer continue in the current environment. Alternative delivery/business models must be seriously explored. Furthermore, new areas of service and partnerships outside the comfort zone in the chronic disease sector and environmental exposure arena such as epigenetics and health impact assessments should be explored.
* The key functions of public health laboratories should be thoroughly reviewed within the framework of the ACA. From this review the laboratory needs to identify programs that need to be sustained and be willing to work in partnership with other organizations and laboratories to ensure capabilities are maintained. This may necessitate giving things up, downsizing, exploring controversial alternatives, or partnering with strange bedfellows.
* The laboratory system needs to insert itself into local, state, and national conversations regarding the ACA to ensure the interests of laboratory testing are being considered.
* The laboratory must demonstrate its worth with a consistent message. The shift to value and cost containment will necessitate quantitative and qualitative return on investment data, and the laboratory must be ready to substantiate its value for population and individual health. Planning should begin now for how to measure cost savings and cost avoidance.
* State public health laboratories should work with health reform (ACA, ACO, Exchanges, CO-OP) implementation teams on cost avoidance strategies.
* Communicate the concept of population health and value of surveillance
* All state public health laboratories must become actively engaged in strategic planning to address the ACA. The time to plan for the future is now.
  + There is a sense of urgency as change is already underway. States cannot risk standing on the sidelines and miss these opportunities.
  + There is risk in waiting; it is better to be part of the solution than having someone else’s solutions imposed later.
  + States should be strategic in policy recommendations to support a long-term change in the traditional practices of the public health laboratory system.
  + States should seek champions of their strategic policy aims, perhaps through academic arenas and atypical partners such as hospital associations.
* State public health laboratories should identify constructive and mutually-beneficial opportunities to work with Accountable Care Organizations.
  + Many health systems in Iowa and across the nation are developing ACOs in addition to those pilots underway through Medicare.
  + The CMS Innovation Center has funded development of Pioneer ACO Models in 32 states. A fact sheet about these models and a list of grantees may be found at <http://innovations.cms.gov/initiatives/aco/pioneer/> or in Appendix 8 of this report.
  + Public entities need to develop formalized contracts with ACOs even though they are not allowed to be a member/partner within the ACO.
* The APHL could assist in the following strategies and activities:
  + Work at the national level to insert public health laboratories into new and ongoing policy discussions to ensure robust population health and surveillance nationwide.
  + Educate public health laboratories as to why they should be actively involved and aggressive in these issues.
  + Provide guidance or other support for public health laboratories to assess their own value to the state and to the public health of the population.
  + Help public health laboratories demonstrate the interdependency of the health care and public health systems.

This effort was successful in revealing a significant set of issues and opportunities for the public health laboratory system. However, there remains a vast amount of work and these conversations must continue.

In the period between conducting the forums and finalizing this report, the Supreme Court ruling was handed down. Although it added a degree of knowledge and certainty, implementation of this extremely complex law remains evolutionary. What is certain is that as the ACA is implemented, the public health laboratory system has a critical role in sustaining core population health, improving individual health, and maintaining and enhancing surveillance capabilities.

# Appendices

1. Background Information on the ACA and Public Health Laboratories for Participants
2. Sample Forum Agenda
3. Forum Planning Guide
4. Forum Handout
5. Forum Summary – Ankeny
6. Forum Summary – Davenport
7. Forum Summary – Sioux City
8. CMS Pioneer ACO Fact Sheet

**APPENDIX 1.**

The Patient Protection and Affordable Care Act (referred to here as the Affordable Care Act or ACA) remains in its infancy as far as implementation and a full understanding of its provisions. This federal legislation was enacted on March 23, 2010, with implementation phased in through 2020. Key provisions as they impact the general public are well known and include extending coverage of children to age 26 on a parent’s health insurance, elimination of co-pays for preventive services, expansion of Medicaid eligibility, and the mandate for health insurance for all Americans either individually or through employers. The ACA will fundamentally change the way health care is delivered and the public health laboratory and the programs it supports are sure to be impacted by these changes.

 Public Health Laboratories in the Shadows of the Affordable Care Act

While the discussions, analysis, and debates around the implementation of the ACA continue, few seem to have considered, or even recognized, the impact of the ACA on key public health programs and the public health laboratories. Recently the State Hygienic Laboratory began discussions to plan for the implementation of the ACA and how Iowa’s public health laboratory might best prepare for the changes to come. Unfortunately there is very little information available regarding the ACA as it relates to infectious disease surveillance programs and the public health laboratory.

To address this information gap, the SHL is sponsoring forums throughout the state of Iowa to engage our partners in this conversation. These forums have been made possible through an Association of Public Health Laboratories innovation grant.



 Clinical and Public Health Laboratories and Their Importance in the Public Health System

In framing the discussion of the market impacts of the Affordable Care Act on public health laboratories, we offer these definitions of clinical laboratories and public health laboratories:

Clinical Laboratory – In a clinical laboratory tests are conducted on clinical specimens in order to discern information about the health of the patient for diagnosis, treatment, and prevention of disease. These profit or non-profit laboratories are located in hospitals or doctors’ offices and can also be free-standing. These laboratories are also known as medical or reference laboratories.

Public Health Laboratory – A public health laboratory is population-focused and provides diagnostic testing, disease surveillance, environmental and radiological testing, emergency response support, applied research, laboratory training, and other essential services for the community. Public health labs are usually affiliated with a Department of Public Health and work in collaboration with other members of the nation’s public health system.

 The Patient Protection and Affordable Care Act: Relevant Highlights

Elements of the ACA considered in the discussions of the impacts on the public health system and public health laboratories are highlighted here. The provisions highlighted include those that expand coverage, shift to a value-based reimbursement system, insurance exchanges, and Accountable Care Organizations. Overall, this market-based health care reform relies significantly on the private sector, and public health will need to be adaptable and receptive to partnering with private entities.

***Prevention and Wellness***

The ACA created the Prevention and Public Health Fund to direct resources to related programs. The National Prevention, Health Promotion, and Public Health Council were established to coordinate federal prevention, wellness, and public health strategies. Task forces on Preventive Services and Community Preventive Services were also established. With the allocation of funding to the Prevention and Public Health Fund has come greater attention to and competition for these resources.

Included within the prevention and wellness scope of the ACA are:

* A grant program to support the delivery of evidence-based and community-based prevention and wellness services.
* Eliminating cost to persons receiving preventive services through Medicare or Medicaid.
* Providing an annual health risk assessment as part of Medicare coverage for personalized prevention plan services.
* Requiring qualified health plans to provide preventive care without cost to members for certain services, including immunizations for children and preventive health screenings for women.

With the creation of the Prevention and Wellness fund there is sure to be a shift in funding for other programs. This is becoming more apparent as the laboratory continues to receive notification of cuts in funding for infectious disease surveillance programs. Recently the laboratory was notified that screening for chlamydia as part of the Infertility Prevention Project will no longer be funded. Other essential public health surveillance projects are sure to be likewise impacted and this continues to be an area of concern for the laboratory.

The diversion of funds and the focus on private partnerships may necessitate third party billing on the part of the Public Health Laboratory for reimbursements. This may pose a challenge on many fronts. From an operational standpoint, integration of third party billing will be complex and expensive. Also, some county and state public health laboratories are prohibited from third party billing due to specific language contained within legislation. Of further concern is the collection of funds after billing and the risk associated with providing services without reimbursement due to non-payment.

**Individual Mandate**

All US citizens and legal residents will be required to have health insurance or face a penalty starting in 2014. The demand for insurance will be met through the creation of Health Insurance Exchanges and through the expansion of Medicaid.

Medicaid benefits will be expanded to all non-Medicare eligible individuals under age 65 who have incomes up to 133% of the Federal Poverty Level. While an exact figure is not known, projections in Iowa estimate 150,000 new Medicaid beneficiaries from this expansion.

The G2 Intelligence Report, Health Care Market Reforms: Implications and Prescriptions for Laboratories, suggests that this expansion will result in a surge of testing for clinical laboratories. The impact on Public Health Laboratories is unknown at this time.

**Cost Containment & Accountable Care Organizations**

There are many provisions of the ACA relating to cost containment and the shift in focus to value provided in the health care system. Value should be thought of as a combination of quality and cost, with measures taken to prevent quality of services from suffering from measures to simply cut cost. Perhaps one of the most significant measures allows providers to come together to form an Accountable Care Organization (ACO) to serve Medicare patients, with the primary aim to achieve quality thresholds and cost containment. The providers would include physicians, hospitals, “and other health care providers” working in partnership to achieve better health outcomes with the incentive that the ACO partners will share in the cost savings.

The role of the Public Health Laboratory within this framework has not been discussed in depth and many questions have yet to be addressed. One such question is whether the Public Health Laboratory can be a partner in an ACO, and if so, how the relationship is formalized. Current indications suggest that the PHL will play a role in information exchange and thus the laboratory must be ready with a Laboratory Information Management System robust enough to meet future demands for electronic connectivity and information exchange.

The emphasis of ACOs is cost containment and quality improvement. As such, laboratory tests, particularly expensive molecular diagnostics, will be scrutinized for value and quality. The laboratory needs to be ready to confront this scrutiny with data that support the necessity and benefits of molecular and other laboratory diagnostic testing.

**Independent Payment Advisory Board**

Focused on reducing the per capita rate of growth in Medicare spending, the Independent Payment Advisory Board will submit recommended legislative proposals to achieve reductions in spending if the rate of growth exceeds a certain level. The Board cannot submit proposals that would ration care, increase revenues, or change benefits, eligibility, or Medicare cost sharing. Many other guidelines are included in this section, including recommendations every other year to slow expense growth while maintaining quality of care.

**Patient-Centered Outcomes Research Institute**

The ACA established, upon enactment, the Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The provision includes genetic and molecular research, potentially leading to better health outcomes for individuals.

**Updates to the Medicare Clinical Laboratory Fee Schedule (CLFS)**

This provision, which began in 2011, dictates a reduction in Medicaid reimbursement rates for clinical tests. This will result in decreased fee-for-service revenue and new revenue streams will need to be generated.

**Molecular Diagnostics Demonstration Project**

This project began in July 2011 and is intended to address the complex issues relating to reimbursement of molecular diagnostic tests, particularly the ability to receive direct payment from Medicare Part B.

**And Much More**

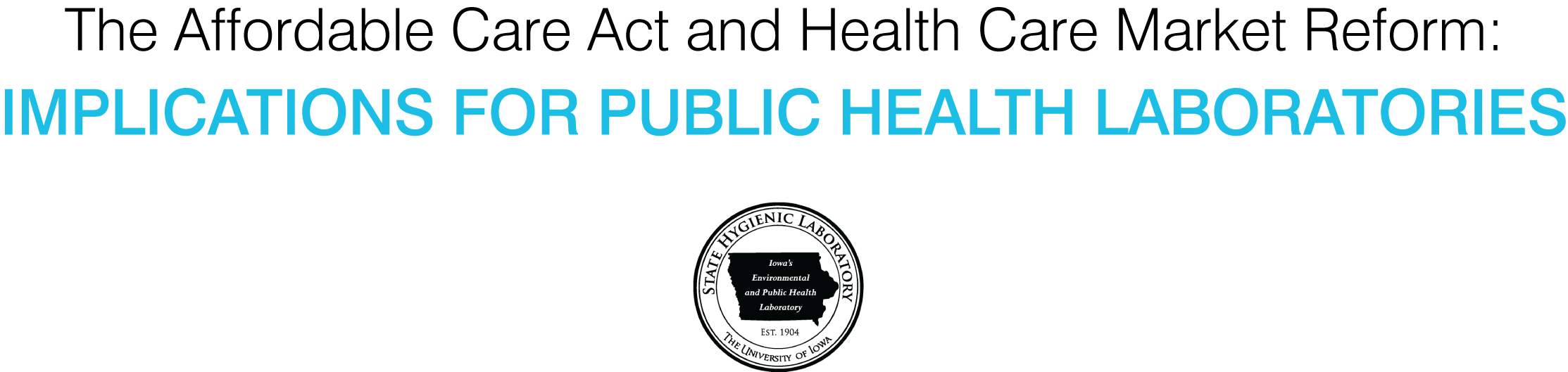
There are many more provisions in the Affordable Care Act, but in this brief document, we attempted to highlight the key elements that may have implications for the public health system and public health laboratories throughout the United States.

 A Sampling of Ongoing Projects in Iowa Relating to the ACA

* Midwest Members Health: One of the first federally approved health care CO-OPs in the nation. The endeavor is being led by David Lyons (former Iowa Insurance Commissioner), Cliff Gold (former Wellmark executive), and Steve Ringlee with an anticipated start-up date in January 2014.
* Health Care Safety Net in Iowa Post-Health Care Reform: A study conducted by the Public Policy Center at the University of Iowa investigating the impact of the ACA on safety net programs with an emphasis on local Public Health Departments that provide primary care, free clinics, family planning clinics and a number of other safety net programs. More information can be found at <http://ppc.uiowa.edu/health/study/health-care-safety-net-iowa-post-health-care-reform>.
* Affordable Care Organization: Trinity Regional Medical Center and Trimark Physicians Group will form the first ACO in Iowa. They will become one of 32 Medicare Pioneer ACOs in the nation.

*Information contained in the Highlights section came from a variety of sources, including the Henry J. Kaiser Family Foundation (*[*http://www.kff.org/healthreform/8061.cfm*](http://www.kff.org/healthreform/8061.cfm)*) and Health Care Market Reforms: Implications and Prescriptions for Laboratories (*[*www.G2Intelligence.com*](http://www.G2Intelligence.com)*), and the Public Policy Center at the University of Iowa (*[*http://ppc.uiowa.edu/health/study/health-care-safety-net-iowa-post-health-care-reform*](http://ppc.uiowa.edu/health/study/health-care-safety-net-iowa-post-health-care-reform)*).*

**APPENDIX 2.**

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JUNE 8, 2012  ANKENY

**9:30 A.M. – 12:00 P.M.**

Iowa Labs Facility Conference Center, Room 209

2220 S. Ankeny Blvd. (west side on the DMACC Campus)

Ankeny, IA 50023

**AGENDA**

9:15 a.m. **|** Arrive and Sign In

9:30 a.m. **|** Welcome

*Bonnie Rubin*

9:40 a.m. **|** Introductions and Overview of the Day

*Arlinda McKeen*

9:50 a.m. **|** The Patient Protection and Affordable Care Act (ACA) Highlights

*Rubin*

10:15 a.m. **|** ACA from Your Perspective - Facilitated Discussion

*McKeen*

11:00 a.m. **|** Impacts of ACA on Public Health and Public Health Laboratories - Facilitated Discussion

*McKeen*

11:45 a.m. **|** Key Points and Summary Remarks by Participants

*McKeen*

12:00 p.m. **|** Closing Comments and Lunch

*Rubin*

**APPENDIX 3.**

**Forum Planning Guide**

* Three or More Months Prior to Event (See exhibit 1 for sample timeline)
  1. Draft list of key stakeholders and determine a geographically convenient area for the meeting based on stakeholder locations.
  2. Reserve meeting room space
     1. Research appropriately sized venues based on convenience for stakeholders, price, audio visual needs, and parking availability
     2. Libraries, community centers, community colleges, and universities are good options as they are typically free or charge a nominal fee
* Three to Six Weeks Prior to Event
  1. Draft invitation letter and send invitation 3-6 weeks prior to event. (See exhibit 2 for example)
  2. Develop materials to send to participants prior to the meeting
* One to Two Weeks Prior to Event
  1. Send confirmation e-mail to participants with directions to the meeting location, agenda, and background information
  2. Send follow-up email to confirm attendance and send any updated material
  3. Arrange catering if food will be provided
  4. Arrange hotels if needed
* One Week Prior to Event
  1. Create materials for the forum
     1. Sign in sheets
     2. Table tents
     3. Name tags

**Hold Forums**

* One to Two Weeks Post Event:
  1. Convene post forum meeting to review notes
* Within One to Two Months Post Event:
  1. Send summary of event to sponsors and participants

**Exhibit 1. Sample Project Timeline**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Steps** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** |
| Hold pre-planning meeting, develop invitation list |  |  |  |  |  |  |
| Schedule forum dates, location, meeting and travel logistics |  |  |  |  |  |  |
| Invitations to participants |  |  |  |  |  |  |
| Design/develop forum agenda, confirm participants, develop participant informational documents |  |  |  |  |  |  |
| Confirm Participants and catering arrangements |  |  |  |  |  |  |
| Distribute forum materials & agenda to stakeholders |  |  |  |  |  |  |
| Hold forums |  |  |  |  |  |  |
| Analyze forum discussions and recommendations. Hold post-event meeting, complete analysis, and summary of the forum discussions and recommendations |  |  |  |  |  |  |

**Exhibit 2. Sample Invitation Letter**

Dear Colleague,

I would like to invite you to participate in a half-day forum hosted by the State Hygienic Laboratory and facilitated by the State Public Policy Group.  The purpose of the forum is to stimulate discussion about the potential impact of the implementation of the Patient Protection and Affordable Care Act (ACA), particularly to the public health laboratory system.  We have identified you as a subject matter expert in your field and would value your insight into this complex issue.

The recently passed Affordable Care Act  is designed to move the nation from a fragmented and expensive health care system focused on sickness and disease to a more cost effective and inclusive system that promotes wellness and prevention.   There has been a great deal of analysis of how ACA initiatives will impact providers and hospitals however an in-depth analysis of the impact to laboratories and population based laboratory testing has been sorely lacking.

SHL has recently received funding from the Association of Public Health Laboratories to provide strategic recommendations for the public health laboratory system throughout the nation.  From this forum, we hope to collect input for future projects that will demonstrate the impact of the ACA on the entire state and national laboratory system.

**You are invited to attend the Western Region forum, on May 18, from 9:30 to 12:30 in the Gleeson Room at the Sioux City Public Library in Sioux City Iowa.  Lunch will be served following the forum to facilitate networking and stimulate further discussion.  Please RSVP to Mary Jones** [**maryjones@example.com**](mailto:maryjones@example.com) **or 555-335-4385. Travel expenses will be reimbursed .  Your participation will be greatly appreciated.**

I look forward to your input and perspective in this initiative!



**APPENDIX 4.**

The State Hygienic Laboratory at the University of Iowa

Davenport – Sioux City – Ankeny

**The Affordable Care Act and Health Market Reform: Implications for Public Health Laboratories**

Bonnie Rubin

[bonnie-rubin@uiowa.edu](mailto:bonnie-rubin@uiowa.edu)

Amy Terry

[amy-terry@uiowa.edu](mailto:amy-terry@uiowa.edu)

Today’s Goal: To utilize your multi-disciplinary expertise and knowledge to:

Evaluate and forecast the impact of the ACA on the PHL system and the public programs it supports

Provide strategic recommendations to PHLs and their related stakeholders to prepare for the implementation of the ACA

Forums have been developed by the State Hygienic Laboratory at the Univ. of Iowa & made possible through a grant from the Association of Public Health Laboratories

Core Public Health Laboratory Functions

* Disease prevention, control, & surveillance
* Integrated data management
* Reference & specialized testing
* Environmental health & protection
* Food safety
* Laboratory improvement & regulation
* Policy development
* Emergency response
* Public health-related research
* Training & education
* Partnerships & communication

**RELEVANT HIGHLIGHTS OF THE AFFORDABLE CARE ACT FOR LABORATORIES**

Mandatory Insurance Coverage

* CBO estimates there will be additional 32 million insured nationally (320,000 increase for Iowa)
* For clinical laboratories, this could equal 60 million new tests in 2014
* For public health laboratories, this could result in either an increase or decrease in volumes.

**RELEVANT HIGHLIGHTS OF THE AFFORDABLE CARE ACT FOR LABORATORIES**

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* For public health laboratories, this could result in either an increase or decrease in volumes.

Accountable Care Organizations

* Hospitals (and thus their clinical laboratories) and health care systems are already forming ACOs.
* Private, for-profit reference labs can become members of an ACO
* Public entities cannot be a part of an ACO
  + How will the public health laboratory system partner with private entities to maintain the information flow for population based surveillance?

Prevention and Wellness Promotion

* Anticipated Impacts
  + Funding shifts from infectious disease programs to chronic disease prevention
  + Prevention and Public health fund will be underfunded (robbing Peter to pay Paul)
  + What testing does public health perform that will qualify as “prevention and wellness”?

Medicare Fee Schedule Reductions

* Medicare reimbursement rates will continue to be reduced
* PHLs that currently bill fee-for-service will see a decrease in revenues which has previously been used to offset costs of underfunded programs
* PHLs that do not currently bill will need to implement a billing system
* Some PHLs are prevented from billing by their state codes

Other Quality Improvement Provisions

* Utilization programs for molecular diagnostic testing
  + Will PHLs need to justify our molecular testing? (I.E. influenza, foodborne outbreak testing, chlamydia, and gonorrhea)
* Incentive to order tests based on evidence of effectiveness or risk
  + How will this affect population surveillance?

Current Events Impacting Public Health Programs

* CDC Laboratory Efficiency Initiative
* CDC Influenza “Right Sizing” Initiative
* Local public health departments expected to contract with private entities for services
* Electronic connectivity and data exchange
* Direct ordering and results downloaded to EMRs or to health department systems
* Connectivity between clinical laboratories and health departments

**5 POTENTIAL OUTCOMES OF SUPREME COURT DECISION**

1. The entire Act is upheld.

2. The entire Act is struck down.

3. The minimum coverage requirement (individual mandate) is struck down.

4. The minimum coverage is struck down, along with the guaranteed issue of community rating requirements.

5. The Medicaid expansion is struck down.

1. Entire Act Upheld

* All provisions will remain in force

2. Entire Act is struck down.  
None of provisions will remain in force as law. BUT, a number of prevention and health promotion related provisions could continue to be implemented.

* The National Prevention, Health Promotion, and Public Health Council have already been created through a Presidential executive order.
* The National Prevention Strategy has already been released and the Council could continue to issue updates.
* Congress could choose to continue to appropriate funds for the same purposes the Prevention and Public Health Fund funding has been applied.
* The Clinical and Community Preventive Services Task Forces would continue.
* Private group and individual insurers could continue to cover preventive services without cost-sharing, as could state Medicaid Programs.

3. Minimum coverage requirement struck down

* But, could potentially leave all other provisions of the statute standing.
* Thus, all the prevention and public health provisions would remain in effect.

4. Minimum coverage struck down, along with the guaranteed issue and community rating requirements

* All of the prevention and public health provisions would remain in effect.

5. Medicaid expansion is struck down

* Will likely only be struck down as applied to states that consider the option “coercive.”
* States that wish to expand eligibility should still be able to.
* The prevention and public health provisions would remain in place.

Discussion time:   
ACA From Your Perspective

The Affordable Care Act and Health Care Market Reforms:   
**IMPLICATIONS FOR PUBLIC HEALTH LABORATORIES**

**APPENDIX 5.**

JUNE 8, 2012  ANKENY

**9:30 A.M. – 12:00 P.M.**

Iowa Labs Facility Conference Center, Room 209

2220 S. Ankeny Blvd. (DMACC Campus)

Ankeny, IA 50023

**Forum Summary**

**Ankeny Participants**

Gayle Culbertson, Iowa Health System

Nancy Mathahs, Mercy Hospital

Abby McGill, Iowa Department of Public Health, Office of Health Care Transformation

Mary Mincer Hansen, Des Moines University

Pam Mollenhauer, State Hygienic Laboratory at the University of Iowa

Jeneane Moody, Iowa Public Health Association

Kari Prescott, Iowa Counties Public Health Association and Webster County Health Department

Dan Royer, Iowa Hospital Association

Virginia Tonelli, Iowa Primary Care Association

Gloria Vermie, Iowa Department of Public Health, Office of Rural Health

**Project Team**

Bonnie Rubin, State Hygienic Lab

Amy Terry, State Hygienic Lab

Erin Davison-Rippey, SPPG

Arlinda McKeen, SPPG

**Welcome**

Participants were provided an overview of the Innovation Grant from the Association of Public Health Laboratories the goals of the discussions. Rubin explained the aims of the grant to gather input on the impacts of the Patient Protection and Affordable Care Act (ACA) on the public health laboratory system. The meetings seek to bring together key stakeholders to share information, analyze anticipated impacts, and formulate next steps and possible responses.

**Core Public Health Laboratory Functions**

To provide a foundation of the conversation, the 11 core public health laboratory functions were reviewed and briefly discussed. Iowa is in a unique position with the state public health laboratory residing in a university setting, instead of within state government as in most states. This positions the state lab to function both as a state agency and as an academic center.

Participants discussed the communications function of the public health laboratory system and the importance of that role. Laboratories are often challenged by this function as they are primarily focused on the day-to-day operations of the laboratory. Participants felt this function could be an expanded area of focus for the public health laboratory system. Selected comments from the group included:

* Communication has always been an issue – people don’t know about labs. In laboratory medicine, we don’t think about promoting ourselves to the public or others in the field, we just do our job. We have to become more visible, not just in terms of public health, but as a part of the health of the state.
* We have been looking at the impact of the ACA on public health, but labs were never mentioned in any of the conversations.
* Labs don’t often have communications staff, and because of that, we tend to be overlooked. The general public doesn’t realize the part we play in health care, but 70% of information clinicians use to treat patients comes from laboratory.
* Labs are not at the table in so many of the conversations about health care and reform. Traditionally, we haven’t inserted ourselves into the conversations, but we are working to do that now.
* Public health labs are recognized for response efforts, but not in surveillance and population health. When public health is working, no one pays attention to it. It’s only when there is an event that people notice public health and labs, like the current pertussis outbreaks.

Participants discussed ways that public health laboratories could use existing communication channels, such as newsletters, partner websites, and meetings of related stakeholders.

***Highlights of the Affordable Care Act***

Details about the ACA and related initiatives were presented to the group. Discussion occurred throughout and following the presentation.

**Mandatory Insurance Coverage**

CBO estimates there will be an additional 32 million insured nationally (320,000 increase for Iowa). For clinical laboratories, this could equal 60 million new tests in 2014. For public health laboratories, this could either result in an increase or decrease in volume of tests.

**Accountable Care Organizations**

Hospitals (and thus their clinical laboratories) and health care systems are already forming ACOs. Private, for-profit reference labs can become members of an ACO, but public entities cannot be a part of an ACO. How will the public health laboratory system partner with private entities to maintain the information flow for population-based surveillance?

Participants discussed the impact of ACOs on the public health laboratory system. Selected comments included:

* How do public health labs fit into an ACO? Will they ever come to public health labs for testing, or will they do all of their own testing? Public health labs may see a reduction in testing.
* The State Hygienic Lab is the gatekeeper on infectious disease. If ACOs choose to send fewer specimens, the state lab won’t have as much information to work with to do surveillance and prevention activities.
* ACOs may want to do their own testing, so we could see a reduction in tests sent to public health labs. How do we ensure that enough tests are sent to public health labs to allow for monitoring and surveillance, which is then sent to the CDC?

The group discussed the pricing structures of testing, the reasons for differences in cost of testing, and the impact that large reference laboratories have on this system. It was noted that some tests are sent to the State Hygienic Lab under mandates, even though the cost is higher than to run the tests in-house or through a reference lab. While the cost is higher, the services provided by the state lab are greater, such as providing the consultation of a specialist to review results with a primary care physician.

There is an expectation of quality of results from tests conducted by the state lab, and the ability to conduct specialized tests. Participants noted:

* There are public health labs, particularly in smaller, less populated counties that don’t have the ability to support dedicated lab staff, that need the state lab’s expertise. Rural labs are not designed to do microbiology, and there are many tests that are too difficult and complex, and are sent on to the state lab.
* There is a shortage of highly trained laboratorians. People in labs may only have on-the-job training, and are not required to be individually licensed to do tests. People don’t understand that not all test results are reliable, but we can count on the state lab results.
* Clinical labs will do basic tests, such as determining if a test is positive for H1N1 for treatment purposes, but the State Hygienic Lab does the detailed sub-typing and geno-typing necessary for population surveillance. If the state lab can make a case to ACOs to look at their patient population and the opportunity for positively impacting population health, maybe that would be an opportunity for partnership.
* We need accuracy – there is value in accurate diagnosis which leads to lower treatment costs.

**Prevention and Wellness Program**

There are several impacts anticipated as a result of the focus on prevention and wellness promotion. Funding may shift from infectious disease programs to chronic disease prevention. The Prevention and Public Health Fund will be targeted as a source of funding for other programs. At the time of the forum, funding from the Prevention Fund was being considered to alleviate student loan debt. It is unclear what testing performed by public health will qualify as “prevention and wellness.”

**Medicare Fee Schedule Reductions**

Medicare reimbursement rates will continue to be reduced and public health laboratories that currently bill fee-for-service will see a decrease in revenues. This revenue has previously been used to offset costs of underfunded programs. Public health labs that do not currently bill may need to implement a billing system, but some public health labs are prohibited from doing so due to state statutes and regulations.

Participants discussed the impact that fee reductions, both from Medicare and insurance companies, have had on clinical labs. Clinical labs are losing money on basic tests because they are not able to do the tests at the rates that reference labs are charging, which is what the fees are based on. Clinical labs would gladly hand those tests over to public health labs, particularly given that the fees will be reduced by 10% over the next several years. The more complex tests are more profitable and provide the ability to generate revenue to cover the losses involved with the basic tests.

The consensus of the group was that public health labs need to balance expertise in older tests with staying on the cutting edge in order to remain relevant and competitive. Participants commented:

* Public health labs need to maintain older tests that clinical labs no longer do, such as ova and parasite tests. These tests are labor intensive and require expertise that many other labs don’t have.
* Public health labs also need to be able to do the newest tests using the newest technology. At one point, that was molecular diagnostics, which required expensive equipment and expertise. Now that’s moving into the mainstream because it can be automated. So what is the next science – DNA sequencing?

**Other Quality Improvement Provisions**

Molecular diagnostic testing, which is specifically mentioned in the ACA, is a growing part of the field. What is not clear is if public health laboratories will need to justify molecular testing for diseases such as influenza, Chlamydia, and gonorrhea or for foodborne outbreak testing. There must be an incentive to order tests based on evidence of effectiveness or risk, and how will this affect population surveillance?

**Potential Outcomes of Supreme Court Decision**

Washington University prepared a memo outlining the possible outcomes of the Supreme Court ruling on the ACA. The group agreed that there are many pieces that have been set in motion and will continue, regardless of the court’s decision.

**Current Events Impacting Public Health Programs**

The Centers for Disease Control and Prevention (CDC) have introduced initiatives that will impact the public health laboratory system. The Laboratory Efficiency Initiative is looking at ways to make laboratories more effective and efficient, and is considering strategies such as regionalizing public health laboratory systems, and standardization of instrumentation platforms within the CDC. The Influenza Right-Sizing Initiative is analyzing the number of influenza tests needed to conduct surveillance, and if the current numbers of tests required could be adjusted.

Conversations are occurring related to local public health departments contracting with private entities for services. Efforts around electronic connectivity and system interoperability are being implemented, but there are challenges with compatibility between public health laboratories and the vast number of different systems in clinical laboratories. Additionally, there is a lack of funding to support the implementation of these efforts, although Preparedness funds supported the development of some systems in Iowa.

The State Hygienic Lab sends some tests to the CDC electronically, but does not get any information back from the CDC through this process. There are also challenges with the platforms required by different parts of the CDC. If entities within the CDC would coordinate platforms, efficiency would be gained as laboratories would not have to purchase multiple platforms unnecessarily. Efficiencies could also be gained if the CDC, Environmental Protection Agency, and the Food and Drug Administration would coordinate platforms.

**Participant Discussion**

Several participants noted that the impact of the ACA on the public health laboratory system had not been on their radar before this conversation, but now realize the importance of this issue and the potential impact on their organization or stakeholder group. Participants offered to share information with their colleagues and circles of influence, and expressed interest in further information. Many comments reflected on the positive experience of having different stakeholders at this event, and the need for public health to be represented in future conversations about health care reform. Selected comments included:

* Public health’s role is changing, and the need for public health will be greater in the future. As health reform occurs, public health will need to be at the table and have a strong relationship with community organizations and hospitals to take on work those entities no longer have capacity for.
* It seems as if there might be an element of surprise coming. A lot of states aren’t doing anything to plan for the ACA until the Supreme Court ruling is issued, but many things have already been set in motion.
* It was good to have clinical labs represented today. There are a lot of connections between clinical and public health labs, and it will be important to maintain communication in this time of change.
* In the old way of thinking, the State Hygienic Lab doesn’t impact patient care decisions. There has to be a new way where the state lab is seen as a way to reduce costs through surveillance and prevention.
* Admittedly, I know almost nothing about labs and the State Hygienic Lab, which is disconcerting considering the director of the lab chairs a committee we are very involved with. But I know I’m not the only one who doesn’t know about labs, and that may explain why labs haven’t been a part of our conversations about the ACA.
* The ACO concept is moving quickly. Public health labs need to insert themselves into the conversation and planning before it’s too late.
* We need to engage people outside of the “regulars” who already know something about public health. This issue won’t get any traction unless it makes it into the mainstream.
* The State Hygienic Lab is the key – you have more power and resources than us in local public health. We really need some common policy talking points about these issues for consumers and policy makers.
* The public health lab is vital for us in clinical labs. We serve different purposes, but have the same overall goals. Without a strong partnership, health and wellness for Iowans will be in jeopardy.

Participants were thanked for their participation in the forum. Participants will receive a copy of the final product, and were encouraged to share information with their colleagues about the impacts of the ACA on the public health laboratory system.

The Affordable Care Act and Health Care Market Reforms:   
**IMPLICATIONS FOR PUBLIC HEALTH LABORATORIES**

**APPENDIX 6.**

MAY 1, 2012  DAVENPORT

**9:30 A.M. – 12:00 P.M.**

Genesis Medical Center

1230 East Rusholme Street, Medical Office Building II Conference Center  
Davenport, IA

**Forum Summary**

**Davenport Participants**

Christopher Atchison, State Hygienic Laboratory at the University of Iowa

Joanne Bartkus, Minnesota Department of Health

Charles Brokupp, Wisconsin State Laboratory of Hygiene

Stacey Cyphert, University of Iowa Hospitals & Clinics

Nadine Fisher, Johnson County Public Health

Louis Katz, Mississippi Valley Regional Blood Center

Tricia Kitzmann, Johnson County Public Health

Keith Mueller, UI College of Public Health, Health Management and Policy

Michael Pentella, State Hygienic Laboratory at the University of Iowa

Edward Rivers, Scott County Health Department

Annette Scheib, Johnson County Public Health

**Project Team**

Bonnie Rubin, State Hygienic Lab

Amy Terry, State Hygienic Lab

Arlinda McKeen, SPPG

Erin Davison-Rippey, SPPG

**Welcome**

Atchison welcomed the group and reviewed the importance of the public health laboratory system being on the leading edge of conversations about health system reform. McKeen noted that participants were convened based on their expertise in a number of areas, and will bring valuable insight to this issue. Participants were provided an overview of the Innovation Grant from the Association of Public Health Laboratories the goals of the discussions. Rubin explained the aims of the grant to gather input on the impacts of the Patient Protection and Affordable Care Act (ACA) on the public health laboratory system. The meetings seek to bring together key stakeholders to share information, analyze anticipated impacts, and formulate next steps and possible responses.

To provide a foundation of the conversation, the 11 core public health laboratory functions were reviewed and briefly discussed. Iowa is in a unique position with the state public health laboratory residing in a university setting, instead of within state government as in most states. This positions the state lab to function both as a state agency and as an academic center.

***Highlights of the Affordable Care Act***

Details about the ACA and related initiatives were presented to the group. Discussion occurred throughout and following the presentation.

**Mandatory Insurance Coverage**

CBO estimates there will be an additional 32 million insured nationally (320,000 increase for Iowa). For clinical laboratories, this could equal 60 million new tests in 2014. For public health laboratories, this could either result in an increase or decrease in volume of tests.

**Accountable Care Organizations**

Hospitals (and thus their clinical laboratories) and health care systems are already forming ACOs. Private, for-profit reference labs can become members of an ACO, but public entities cannot be a part of an ACO. How will the public health laboratory system partner with private entities to maintain the information flow for population-based surveillance?

**Prevention and Wellness Promotion**

There are several impacts anticipated as a result of the focus on prevention and wellness promotion. Funding may shift from infectious disease programs to chronic disease prevention. The Prevention and Public Health Fund will be targeted as a source of funding for other programs. At the time of the forum, funding from the Prevention Fund was being considered to alleviate student loan debt. It is unclear what testing performed by public health will qualify as “prevention and wellness.”

**Medicare Fee Schedule Reductions**

Medicare reimbursement rates will continue to be reduced and public health laboratories that currently bill fee-for-service will see a decrease in revenues. This revenue has previously been used to offset costs of underfunded programs. Public health labs that do not currently bill may need to implement a billing system, but some public health labs are prohibited from doing so due to state statutes and regulations.

**Other Quality Improvement Provisions**

Molecular diagnostic testing, which is specifically mentioned in the ACA, is a growing part of the field. What is not clear is if public health laboratories will need to justify molecular testing for diseases such as influenza, Chlamydia, and gonorrhea or for food-borne outbreak testing. There must be an incentive to order tests based on evidence of effectiveness or risk, and how will this affect population surveillance?

**Current Events Impacting Public Health Programs**

The Centers for Disease Control and Prevention (CDC) have introduced initiatives that will impact the public health laboratory system. The Laboratory Efficiency Initiative is looking at ways to make laboratories more effective and efficient, and is considering strategies such as regionalizing public health laboratory systems, and standardization of instrumentation platforms within the CDC. The Influenza Right-Sizing Initiative is analyzing the number of influenza tests needed to conduct surveillance, and if the current numbers of tests required could be adjusted.

Conversations are occurring related to local public health departments contracting with private entities for services. Efforts around electronic connectivity and system interoperability are being implemented, but there are challenges with compatibility between public health laboratories and the vast number of different systems in clinical laboratories. Additionally, there is a lack of funding to support the implementation of these efforts.

**Participant Discussion**

Facilitated discussion followed the presentation. The participant group in included public health laboratory directors from three states, academic experts, SHL staff, and nonprofit organizations providing services at the local level, and local public health agencies. The conversation provided a wide range of perceptions on a variety of questions, many of which are included here. Discussion questions and representative participant comments are included in this section.

What does it mean to partner with an ACO and how might that look for a public health lab?

* Instead of assuming risk, would it be possible to provide services on a transaction basis? There is going to be a fundamental shift in the delivery system.
* Currently, with the Chlamydia and gonorrhea program, cultures are collected, sent to the state lab, and the funding is by Department of Public Health. In the world of ACA and ACOs, how will that change? These people are now seen in safety net clinics, but if they are being seen by a clinic group in the future, the test will likely go to whatever lab they choose. The test could go to a lab in Texas. The positive test is only part of the equation – public health handles the investigation that identifies the transmission line, and that is a necessity for population health.
* There will always be people that, for one reason or another, don’t want to have tests performed by their physician or billed to their insurance. That might be out of a desire for discretion related to drug use or infidelity, or for other reasons. Also, the ACA won’t cover undocumented immigrants. There will always be people who will still go to public health for testing, and who will pay for that?

With the expansion of Medicaid, there will be more adults without children who are eligible for coverage. Iowa Medicaid Enterprise is showing that these people have a higher rate of unmanaged chronic disease that may result in an additional surge to the system. How will this affect labs?

* Public health labs don’t deal with chronic disease unless there are infectious diseases connected to chronic disease. Environmental factors could also be linked to chronic disease, which would involve public health labs. These connections may be the future model.
* When I get a result from the State Hygienic Lab, I trust the results because I know they validate. I’ve received results from other labs that didn’t make sense. If I have a result I don’t understand, I can call the State Hygienic Lab and get an answer from a lab scientist. When I call the big reference labs, I can only talk to an advertiser.
* I have concerns about some of the regionalization conversations. It is working well for some tests, such as newborn screening. But what if an outbreak occurs? Could a governor decide to only do testing for his or her state, since it’s a state agency? Population health could be compromised by political factors.

What types of activities and what other issues do you see related to the implementation of the Affordable Care Act?

* Public health is an unrecognized necessity – it is not even a mandate. Why isn’t there a part of the ACA that deals with surveillance and investigation?
* In the public health title of the ACA, I find it disturbing that the first year people weren’t ready to spend money, so it was used for other purposes. Now it’s being spent, but how are the community health transition funds being used? That fund will continue to be raided if people can’t say how the money was used.

The public health laboratories need to be preparing for implementation of the Affordable Care Act. What should they be sure to be addressing now? What is still unknown?

* There are problems on the food front. We need funding to do typing, and to get specimens and cultures. As these non-cultured diagnostics are developed, we can’t get the materials for cultures. All clinical samples will be sequenced by the local clinical labs. What does that mean for public health labs? If there are massive amounts of DNA sequences, will they go directly to CDC? Will we just have a lab liaison? The emphasis on the IT structure is huge.
* Public health labs aren’t necessarily set up to do things in the most efficient way. In the ACO model, public health labs cannot compete in that environment. But public health labs have a responsibility for population health. I can’t go to the media in the middle of an outbreak and say “Sorry, I’m not going to vaccinate the community because we don’t have money.”
* There’s a model – you want certain things that are done at a local level to have an impact quickly. But other things, further testing that has to occur, those tests that could be passed on to others, such as a tiered system of public health labs. How do you redesign to make a logical tiered system, so other labs do in-depth work?
* We have a challenge to document how we prevent things and how much we save. We need numbers and cost-savings analysis. We haven’t been doing that. We need to figure out a way to get the data to say here’s what you save in public health dollars.
* Public policy needs to value public health all the time. What will make it important enough to be valued? Maybe it takes getting the right metrics in place.
* We need to find alternate funding methods. For those of you on the front lines of public health agencies, this discussion shows that the business model for public health lab functions is under significant challenge right now. As much as we talk about a business model, we support the work you do in the larger public health environment. If we’re going to get out of significant clinical health testing, or if we move towards environmental/infectious disease exposure, labs need to re-engineer, and this needs to be coordinated with local public health.
* We’re entering a time that will re-emphasize cost and return on investment. Return on investment in public health may be an area in which to focus. Some will argue that someone has to talk about keeping a profitable line. Health care systems do not have the luxury of doing that. Maybe what has been left out is a public health model to provide necessary public health services, and a support system that’s sustainable. Maybe we don’t need all these labs; we need a system, maybe with specializations.
* In the current system, you don’t have to demonstrate value in order to provide services. You have to have a physician’s order for every test you do. In an ACA, you will accept risk and you’ll have to practice lab medicine in a smart way, such as reflex testing based on results.
* It’s good to have this conversation with people who are really in the health care system. Too often these conversations are only had with laboratorians, and not even epidemiologists. We need to have a wider perspective.
* When we talk about regionalization, there are 99 different answers. The State Hygienic Lab may not be able to meet the needs of all counties.
* At the local public health level, I don’t hear anything about the ACA. And we’re not hearing much from the state to local public health about the ACA.
* What is the purpose of upcoming changes? Is it to assure that certain functions will exist in future, or that a certain form will exist in future? Raise the function, and change to meet the functional needs. Whether anyone wants it or not, the form will change. Regionalization is form, but form should follow function. We need to know what public health entity represents, and our functions will follow that. And then form will follow that.

Participants were thanked for their participation in the forum. Participants will receive a copy of the final product, and were encouraged to share information with their colleagues about the impacts of the ACA on the public health laboratory system.

The Affordable Care Act and Health Care Market Reforms:   
**IMPLICATIONS FOR PUBLIC HEALTH LABORATORIES**

**APPENDIX 7.**

JUNE 12, 2012  SIOUX CITY

**9:30 A.M. – 12:00 P.M.**

Sioux City Public Library – Wilbur Aalfs (Main) Library

529 Pierce Street

‬Sioux City, IA

**Forum Summary**

**Sioux City Participants**

Thomas Benzoni, Mercy Medical

Edward Bottei, Iowa Statewide Poison Control Center

Tyler Brock, Siouxland Public Health Department

Jim Clark, Sioux City Fire Department

Kevin Grieme, Siouxland District Health Department

**Project Team**

Bonnie Rubin, State Hygienic Lab

Amy Terry, State Hygienic Lab

Arlinda McKeen, SPPG

Erin Davison-Rippey, SPPG

**Welcome**

Participants were provided an overview of the Innovation Grant from the Association of Public Health Laboratories the goals of the discussions. Rubin explained the aims of the grant to gather input on the impacts of the Patient Protection and Affordable Care Act (ACA) on the public health laboratory system. The meetings seek to bring together key stakeholders to share information, analyze anticipated impacts, and formulate next steps and possible responses.

***Highlights of the Affordable Care Act***

Details about the ACA and related initiative were presented to the group. Discussion occurred throughout the presentation.

**Mandatory Insurance Coverage**

CBO estimates there will be an additional 32 million insured nationally (320,000 increase for Iowa). For clinical laboratories, this could equal 60 million new tests in 2014. For public health laboratories, this could either result in an increase or decrease in volume of tests.

Participants discussed that small local public health entities do not do much clinical or reference testing, and may not feel affected by these changes. As smaller entities, they hope to be able to adapt to the future changes. For STD testing, there may actually be a decrease in testing as people who previously had no payment source and received tests from public health transition to a doctor’s office.

The group discussed the potential for unintended consequences. As more individuals are moved to Medicaid, if Medicaid reimbursement rates remain very low, physicians may not accept Medicaid patients, similar to the situation in dental care. Even if individuals have coverage, but are unable to access care, they would still access public health and emergency care.

**Accountable Care Organizations**

Hospitals (and thus their clinical laboratories) and health care systems are already forming ACOs. Private, for-profit reference labs can become members of an ACO, but public entities cannot be a part of an ACO. How will the public health laboratory system partner with private entities to maintain the information flow for population-based surveillance?

Participants discussed the impact of ACOs on the public health laboratory system. Selected comments included:

* Major reference lab companies that serve the entire US are able to do it with very low prices. ACOs that are forming are looking at how to reduce costs, which may mean sending tests to large reference labs instead of using their own labs.
* In small local health departments, staff time is paid through tax dollars, but the majority of tests are sent to the state lab. If we had to do our own Chlamydia and gonorrhea testing, we would have to completely change our business model.
* I don’t like to order flu tests from the hospital because they do reflex testing. For treatment, I don’t need the subsequent testing that ends up being expensive for the patient.
* There is surveillance information that is important to gather in large doses, and it’s hard to see the clinical impact. By the time I call people to find out if they have been coughing for two weeks – it doesn’t impact how the person is treated, it’s for surveillance purposes.
* I’m concerned that the ACA looks at individual patient care, but not population health. Prevention and surveillance won’t be funded.

**Prevention and Wellness Program**

There are several impacts anticipated as a result of the focus on prevention and wellness promotion. Funding may shift from infectious disease programs to chronic disease prevention. The Prevention and Public Health Fund will be targeted as a source of funding for other programs. At the time of the forum, funding from the Prevention Fund was being considered to alleviate student loan debt. It is unclear what testing performed by public health will qualify as “prevention and wellness.”

Participants commented:

* Prevention doesn’t work unless you place a value on the feeling I get biking down the trail. No financial benefit is shown because the cost is not borne by the individual doing the activity.
* So many people come to the doctor asking for an MRI for back pain – the patient demands unnecessary testing, but because insurance will pay for the test, they want it.

**Current Events Impacting Public Health Programs**

The Centers for Disease Control and Prevention (CDC) have introduced initiatives that will impact the public health laboratory system. The Laboratory Efficiency Initiative is looking at ways to make laboratories more effective and efficient, and is considering strategies such as regionalizing public health laboratory systems, and standardization of instrumentation platforms within the CDC. The Influenza Right-Sizing Initiative is analyzing the number of influenza tests needed to conduct surveillance, and if the current numbers of tests required could be adjusted.

Conversations are occurring related to local public health departments contracting with private entities for services. Efforts around electronic connectivity and system interoperability are being implemented, but there are challenges with compatibility between public health laboratories and the vast number of different systems in clinical laboratories. Additionally, there is a lack of funding to support the implementation of these efforts, although Preparedness funds supported the development of some systems in Iowa.

Participants discussed the origins of regulations against public health laboratories billing for testing. It started out as an effort for the public good, but as testing has become more costly, and Public Health Laboratories develop the tests, they bear the costs of development. If Medicaid or Medicare can be billed, the state lab bills for the test; however, sometimes the lab is accused of “double-dipping” by receiving public funds for payment.

**Participant Discussion**

Participants had a variety of comments related to the ACA in general, the impact on the public laboratory system, and how it will affect key stakeholders. Selected comments included:

* There is an opportunity for efficiency within the state – different entities define regions differently.
* Emergency medicine has asked to sit at the table and have been routinely refused. If the ER has to give away the services for free, why should we pay for it? If IDPH and the Siouxland health department have to give their services away for free, why should we pay for it? What failures occur to both the public health system and the ACO? How are you planning to ensure that mandated services are covered?
* EMS and fire providers will be impacted as frequent fliers use the ambulance as their taxi. People will say “I have coverage, you have to provide this.”
* People are focused on immediate benefit, not long term. Is there motivation to be a part of these ACO conversations, and is it being talked about on the national level, since everyone is doing things differently in each state? If there are 10 different ACOs in Iowa, that’s a lot of work and time. Can we all partner up and become involved together?
* We have had conversations about the ACA as our funding is shifting [at Poison Control]. We have seen before where entities that have a role of cost avoidance are undervalued. In the 1980s, Los Angeles shut down their poison control center, and as a result, ended up paying 2.5 times more in emergency room fees after closing poison control.
* Maybe there could be a broker function, so the ACO would know they could call you [the public health lab] for advice, avoid emergency fees, and you would be paid on contract from the ACO. Have to look at it as preventing the need for the visit.
* In smaller counties, the health department may not have the expertise to serve as a resource. There are opportunities for smaller counties to contract with larger counties, but it is most successful if the smaller county identifies that need.
* An average one-day wagon ride that determines our county size – that model no longer works. The decrease in funding may force a needed change to a regional approach. For example, Michigan used to have three state labs, but now with transportation options, only one is needed.
* Look at the mental health redesign work: If a county can provide certain services, the county can maintain independence. If the county can’t provide those services, the county must seek out cooperative agreements. This will force counties to partner, and could be the future of public health.
* We have a multi-county approach to environmental health. We discovered that we could add one county without adding another staff, so we were able to offer our services to another county at a reduced cost.

Some suggested that there should be changes to the ACA to ensure population health and other public health functions, including providing services to close delivery gaps that might not be covered by the ACA. The State Hygienic Lab is needed because of its relationship with the Centers for Disease Control and Prevention (CDC) and because there are functions that other laboratories will not perform. The heart of the question is that all laboratory types have been functioning in the system quietly, but they must now come out and be more actively visible. Accountable Care Organizations are being piloted through CMS, but everything else is wide open to innovation. Labs need to find opportunities to become parts of these private ACOs that cover people with traditional coverage. The value of prevention also needs to be brought into the discussion.

The group discussed how it has been determined that some tests are not charged to individuals. If the results impact how public health is provided in Iowa, it is not charged. These are funded through state appropriations, but represent a small portion of the revenue received by the State Hygienic Laboratory. The public health laboratory system needs to balance ensuring that test cost is not a barrier, but avoid creating a system where physicians don’t consider costs for unnecessary testing.

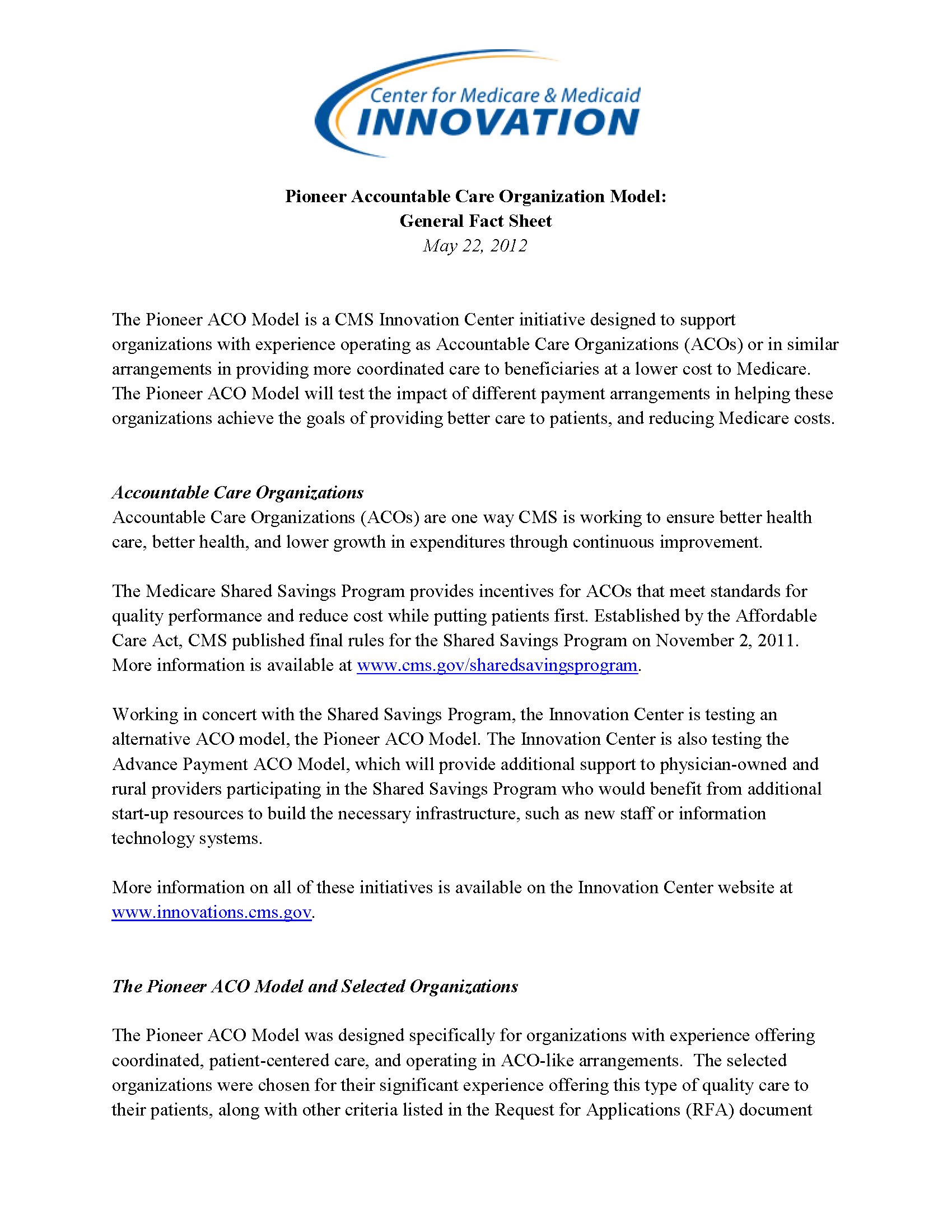
* There is a simple model to use with physicians. If you can’t tell what difference this test will make, don’t do the test. So often, they do a test without thinking what the result will be used for.
* There may be a new role for public health in educating physicians. There are some tests that are done to guide treatment, and others done for surveillance purposes; these must be distinguished from the unnecessary tests.
* What we’re talking about ACA is because there is such a demand for health care, but it’s already here. We have people looking for easy medical solutions, when the answer may be as simple as making healthy choices. This is reinforced by insurance companies who will pay for gastric bypass surgery, but not for a gym membership or a bike helmet.
* Labs in doctors’ offices and hospitals are profit centers. As the ACA squeezes costs for other things, they’ll try to make a profit off of lab tests. We are stewards for public health dollars, and I don’t think we know how to deal with that.
* I get really tired of people talking about how expensive emergency room visits are. It turns out, they are only 2% of health care costs. We have to make sure we’re using actual data.
* There is a need to educate the public and educate patients. There are physicians doing tests that aren’t necessary and doctors ordering DNA and molecular tests who have no idea that these are $3,000 tests. Physicians need to be held accountable.
* There is a need for laboratorians to do education with physicians. When we see an order from a physician that doesn’t make sense, we need to ask.
* Right now, a hospital loves it if a CT scan is ordered on everyone, because it’s a center of profit for everyone in the room.

**Potential Outcomes of the Supreme Court Decision**

Washington University prepared a memo outlining the possible outcomes of the Supreme Court ruling on the ACA. The group agreed that there are many pieces that have been set in motion and will continue, regardless of the court’s decision.

* Hospitals aren’t waiting for a verdict on the health care law, and the economic pressure to provide care for lower costs won’t go away.
* There’s a lot of money to be lost in the health care system. There’s a whole industry now looking to make a profit on prevention. I would not be surprised if that’s the next industry.
* There are a lot of opportunities in this to be the third party, honest broker of information. Explore a model that provides data that shows you are giving advice that prevents the need for a visit to the emergency room.

Participants were thanked for their participation in the forum. Participants will receive a copy of the final product, and were encouraged to share information with their colleagues about the impacts of the ACA on the public health laboratory system.



**APPENDIX 8.**

