

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: THE EVOLVING ROLE  
OF STATE SEXUALLY TRANSMITTED DISEASE PROGRAMS

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## ABSTRACT

Jennifer A. Ludovic: The Patient Protection and Affordable Care Act: The Evolving Role of State Sexually Transmitted Disease Programs  
(Under the direction of Sandra B. Greene)

The Centers for Disease Control and Prevention estimates that there are 20 million new sexually transmitted infections (STI) every year in the United States, costing about \$16 billion. Less than half of all people who should be screened actually receive recommended STI screening. This is of concern because people with STIs can be asymptomatic, leading to further spread of the disease; potentially costly complications such as infertility, organ damage, and cervical cancer; and increased susceptibility to HIV.

State Sexually Transmitted Disease (STD) prevention programs vary, but generally, they engage in primary prevention, conduct surveillance, operate partner services, and support STD-related clinical services through STD clinics or by partnering with other providers. Over the past few years, budget declines have led to reduced STD-related health resources at the state and local levels. At the same time, states are encountering changing health system structure as a result of the 2010 Patient Protection and Affordable Care Act (ACA).

The purpose of this research study was to explore the financial, service-related, and partner entity-related changes, including relevant policies, that state STD programs were making or planned to make as a result of the changing healthcare environment after passage of the ACA. The researcher employed a qualitative approach, using semi-structured interviews of leadership in eight state STD programs to understand their views about key changes that were planned or implemented as a result of the ACA and a changing healthcare environment. Six major themes were identified: decentralization of public health governance is directly related to the amount and

type of change reported; all states have utilized partners to take advantage of health reform-related changes, or at least identify the opportunity to do so in the future; public health programs continue to have a non-redundant, important role in STD prevention; programs that have not already started to bill for clinical and laboratory services are considering or pursuing billing; health reform generated hopefulness about future improvements in public health surveillance; and barriers exist to making changes. On the basis of this information, the researcher developed recommendations in three areas: training and technical assistance, national activities, and research.

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## **LIST OF ABBREVIATIONS**

AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACIP	Advisory Committee for Immunization Practices
ACO	accountable care organization
ADAP	Acquired Immunodeficiency Syndrome Drug Assistance Program
AIDS	acquired immunodeficiency syndrome
ARRA	American Recovery and Reinvestment Act of 2009
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CBO	Congressional Budget Office
CHC	community health center
CHIP	Children’s Health Insurance Program
CHW	community health worker
CMS	Centers for Medicare & Medicaid Services
CNM	certified nurse midwife
CT	chlamydia
DIS	disease intervention specialists
DSH	Disproportionate share
EHR	electronic health record
EOB	explanation of benefits
EPT	expedited partner therapy
FMAP	federal medical assistance percentage

FOA	funding opportunity announcement
FPC	family planning clinic
FPL	federal poverty level
FQHC	Federally Qualified Health Center
FY	fiscal year
GC	gonorrhea
GISP	Gonococcal Isolate Surveillance Project
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIE	health information exchange
HIT	health information technology
HIV	human immunodeficiency virus
HPV	human papillomavirus
HPV4	quadrivalent human papillomavirus vaccine
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
IRB	Institutional Review Board
MSM	men who have sex with men
NACCHO	National Association of County and City Health Officials
NACHC	National Association of Community Health Centers, Inc.
NCSD	National Coalition of Sexually Transmitted Disease Directors
NFIB	National Federation of Independent Business
NM	nurse midwife

PHSA	Public Health Service Act
PPACA	Patient Protection and Affordable Care Act
PPHF	Prevention and Public Health Fund
SBHC	school based health center
SSuN	STD Surveillance Network
STD	sexually transmitted disease
STI	sexually transmitted infection
TTAC	Sexually Transmitted Disease-related Reproductive Health Training and Technical Assistance Center (also STDRHTTAC)
USPSTF	United States Preventive Services Task Force

## **CHAPTER 1: INTRODUCTION**

The Centers for Disease Control and Prevention (CDC) estimates that there are 20 million new sexually transmitted infections (STI) every year in the United States, costing about \$16 billion.[1] Close to half of these new STD infections occur in young people.[2] African Americans and certain geographic areas also have disproportionate rates of infection.[3] In addition, less than half of all people who should be screened actually receive recommended STD screening. This is of particular concern because people with STDs can be asymptomatic, leading to further spread of the disease; potentially costly complications such as infertility, organ damage, and cervical cancer; and increased susceptibility to HIV.[4] Furthermore, STDs are associated with alcohol and drug use, risky sexual behaviors,[5] and intimate partner violence[6].

STD prevention programs vary from state to state. State programs engage in primary prevention through communication campaigns, provision of free condoms, education, policy/regulation, and training. All states provide partner services through disease intervention specialists (DIS). DIS conduct contact tracing, behavioral counseling, and at times test and provide treatment if a partner is unlikely to seek medical care. In addition, some states provide STD and HIV-related clinical services directly through public health clinics or STD-specific clinics. Many states partner with other providers, such as local health departments, federally qualified health centers, community health centers, family planning clinics, and school-based clinics.

The health care system has already begun to change as a result of the 2010 Patient Protection and Affordable Care Act (PPACA or ACA). The ACA employs a rolling

implementation structure, and most of the key provisions regarding access to health insurance were implemented January 2014.

Several provisions that were implemented prior to data collection for this study, that may have had an impact on provision of STD services and prevention, include:

- covering young adults through their parents' insurance until age 26 (September 2010);
- requiring that the US Preventive Services Task Force "A and B" preventive services be provided with no co-pays by new plans (September 2010);
- requiring that vaccinations recommended by CDC's Advisory Committee for Immunization Practices (ACIP) be provided with no co-pays by new plans;
- requiring that certain services for children ages 0 to 21 be covered by new health plans with no co-pays;
- requiring non-grandfathered plans and issuers to provide coverage without cost sharing of women's preventive services as determined by the Health Resources and Services Administration (HRSA);
- incentivizing primary care providers to work in underserved areas (2010);
- providing support for community health centers (2010);
- increasing efforts to improve quality in Medicaid (January 2011); and
- requiring collection of information on health disparities that will be used to reduce disparities (March 2012).[7]

A number of additional provisions were implemented in January 2014 that may further impact STD-related services and prevention, including:

- allowing states to expand the population covered by Medicaid to 138% of the federal poverty level, initially matched 100% by the federal government for the newly eligible population for three years, and declining to a 90% match over time (January 2014);[8, 9]
- initiating health insurance exchanges offering multiple private health plans that cannot discriminate based upon pre-existing conditions or gender, coupled with income-based tax credits and other subsidies, to make coverage more affordable (January 2014);[7]
- requiring most citizens to obtain health insurance, with tax penalties for those who do not (2014);[8] and
- reducing disproportionate share hospital funding, which has historically provided support for service provision to low-income patients (delayed two years until the beginning of FY 2016, but doubling the reduction that was to be applied that year).[7, 10]

As a result of the June 28, 2012 Supreme Court decision, *National Federation of Independent Business v. Sebelius*, regarding portions of the ACA, states cannot be penalized for choosing not to expand Medicaid coverage.[8] Before the January 2014 Medicaid expansion start date, 25 states and the District of Columbia had decided to expand Medicaid in 2014, and 2 states were seeking expansion after 2014. Twenty-three states were not moving forward with Medicaid expansion as of January 2014.[11] In the 25 states not currently expanding Medicaid, the Kaiser Family Foundation estimates that nearly 5 million poor adults fall into a “coverage gap”, where they are below the poverty level but are ineligible for both Medicaid coverage and subsidies for buying insurance.[12] Consequently, much of the target population for STD



programs could remain without any insurance coverage. In addition, the Obama Administration has delayed implementation of some parts of the law, which are addressed in more detail in Chapter 2.

Funding must be considered in the discussion of health reform policy impacts on states, as the two are intrinsically related. Currently, STD prevention and services are provided by and funded with a complicated mixture of federal, state, local, and some private support. All fifty states currently receive STD prevention funding from the Centers for Disease Control and Prevention (CDC); in some states, programs receive additional state funding, but some do not. Some states have decentralized public health systems, where counties provide the public health services, and may also include local funding support for STD-related services and prevention.

Over the past few years, state and local budget shortfalls and reduced federal spending have led to reduced STD-related health resources at the state and local levels. The National Coalition for State STD Directors conducted a survey of state and local STD Directors that found that between 2008 and 2009, 39 clinics in the United States closed their doors for essential STD services. These clinics included: categorical STD clinics, family planning clinics, community health centers, and school-based clinics supported by state and local health departments. Further, layoffs occurred in 27% of the responding STD programs, half had furlough days, and 63% reported staff vacancies.[13]

In sum, this is a time of great change for state STD programs. They will need to adapt to the ongoing policy changes and funding challenges. As states are handling these changes in different ways, their strategies for adaptation and magnitude of responses differ.

## **CHAPTER 2: ASSESSMENT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

The 2010 Affordable Care Act includes provisions that impact both public and private components of the United States healthcare system. Many of these may have a direct or indirect impact on the provision of STD-related prevention and treatment services in the United States, and/or to populations at risk for STDs. Provisions that could impact STD prevention and treatment services, or represent opportunities for STD program and policy development, can be broken down into three main areas:

- 1) Insurance Expansion
- 2) Coverage of Preventive Services
- 3) Access to Services and Focus on Primary Care

This chapter identifies the relevant provisions in each of these areas, and how they may be relevant to STD prevention programs and their community partners.

### **Private Insurance Expansion, Medicaid Expansion, and Closure of the Medicare “Donut Hole”**

#### Private Insurance Expansion

The ACA includes provisions that impact private insurance, Medicare, and Medicaid/CHIP. First, in regard to private insurance expansion and coverage, the ACA requires that all U.S. citizens who are in certain categories maintain minimum health coverage, or pay a tax penalty.[PPACA Section 1501] Although this aspect of the law was challenged in numerous

state and federal courts, in June 2012 the Supreme Court upheld the insurance “mandate” as a legal tax penalty.[8] Qualified taxpayers with income between 100% and 400% of the federal poverty level will receive federal tax credits to help make insurance more affordable.[PPACA Section 1401]

The Affordable Care Act generates insurance competition and consumer choices through health insurance exchanges. The ACA allows states and territories to establish their own health insurance exchanges, or in partnership with the federal government (HHS), and provides financial support. States that did not establish exchanges had exchanges established by HHS; exchanges opened in October 2013.[PPACA Sections 1311, 1321] The Congressional Budget Office anticipated that 7 million people, including 2.7 million young adults would enroll in the exchanges before they closed on March 31, 2014.[14] In early April 2014, the Obama Administration announced that 7.1 million people had signed up for health insurance through the health marketplaces by the deadline.[15]

Employers with 25 or fewer employees and that have low wages can receive tax credits for providing affordable insurance to their employees, beginning January 2014.[PPACA Section 1421] Employers that employ fifty or more full time employees, do not provide affordable insurance, and whose employees use tax credits to purchase insurance through an exchange will have to pay a penalty to offset the cost of the tax credits.[PPACA Section 1513] The employers that fall in between, with 25-50 employees, are exempt from the mandate but receive no tax credits. The Obama Administration has delayed the employer mandate one year until 2015, and small business online enrollment in the federal exchange has been pushed back until late 2014.[16]

The tax credits and employer mandate provisions are expected to increase coverage and therefore could represent a billing opportunity for safety-net services, in large part because the ACA requires that qualified plans in the exchanges include essential community providers that serve low-income, medically underserved populations.[PPACA Section 1311] This could improve the ability of safety-net providers to be included in the plans offered on the exchanges. For the 2014 benefit year, CMS reported that only one insurance issuer submitted a justification for not meeting the 20% required threshold for Essential Community Provider participation. In February 2014, CMS published a draft letter indicating that it would raise the floor to 30%, with reduced flexibility for plans to justify not meeting the required threshold.[17]

Another requirement of plans in the marketplaces is that they “be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set”, or HEDIS.[PPACA Section 1311] HEDIS includes a measure for chlamydia screening, “percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year”.[18] This could potentially increase the number of plans striving to improve this measure, which could in turn increase screening rates.

The Affordable Care Act also requires that all health plans cover adult dependents up to age 26. [PPACA Section 1001] This regulation went into effect in September 2010, and applies to all group health insurance plans.[PPACA Section 1251] Young adults and adolescents are disproportionately affected by STDs – additional coverage of this population may be of importance for STD programs trying to reach and provide services to that population. Age-based rating by health insurers is restricted by the Affordable Care Act – prior to the ACA, 42 states

had laws that did not meet the ACA standard; this provision may make insurance more or less affordable for this population.[19]

Gender rating, a practice previously allowed in 34 states[20], will not be permitted for plans entering the exchanges; this may promote more affordable care for women of childbearing age. [PPACA Section 1201] Increased coverage of women may have a positive effect on STD prevention, and therefore possibly infertility prevention, as STDs are a proven cause of infertility.[21-23] The ACA also prohibits exclusion for pre-existing conditions or health status by non-grandfathered plans [PPACA Section 1201] and makes provisions to temporarily assist uninsured people with pre-existing conditions with insurance coverage until the exchanges occur.[PPACA Section 1101] This may be of particular importance for people living with HIV.

The ACA also provides states with an opportunity to establish basic health programs for low-income people who are not eligible for Medicaid. States would receive subsidies from the federal government that would have otherwise gone to the eligible individual.[PPACA Section 1331] It is currently unclear if any states will take advantage of this provision, and how that might impact access to care, but if states participate, this could be an opportunity for collaboration by state STD programs.

Although some Americans may choose to pay the penalty and forgo health insurance, this insurance “mandate” is expected to increase the number of people insured. More covered people should mean more people access care, including for STDs. This may provide an opportunity for safety-net providers, including STD clinics, to bill for and be reimbursed for services.

Notable populations are excluded from the exchanges, namely undocumented immigrants and the incarcerated population.[PPACA Section 1312] Both of these populations are at high risk for STDs.[24-26] States are responsible for the health of their incarcerated population, and

frequently public health departments pay for and deliver this service, so the ACA will not alleviate the burden of STD testing and treatment in that population. Re-entry by this population into society may reintroduce STDs if they are not appropriately addressed prior to release. Undocumented immigrants do have some sources for care, including the nation's 8,500 community health centers, and hospitals for certain emergency services.[27] Some states have also chosen to utilize state funds to provide some services to undocumented immigrants.[28] As a result, safety-net provider services will continue to be in demand post-ACA implementation.

### Expanding Medicaid Eligibility

The Affordable Care Act as enacted required states to expand Medicaid coverage, including individuals at or below 138% of the FPL, counting the modified adjusted gross income eligibility five percent disregard. If states did not comply, they would lose existing Medicaid funding.[PPACA Section 2001] However, this was one of the provisions of the ACA reviewed by the Supreme Court, and the June 2012 ruling determined that if states did not expand Medicaid, they would not lose federal support for their existing Medicaid program. However, the higher Federal Medical Assistance Percentage (FMAP) will still apply for newly eligible individuals for states that choose to expand; FMAP starts at 100 percent in 2014, and decreases incrementally to 90 percent by 2020.[8] This decision effectively made state Medicaid expansion optional.

According to Kaiser Family Foundation, as of December 11, 2013, 25 states are not participating in Medicaid expansion in 2014 (AL, AK, FL, GA, ID, IN, KS, LA, OK, ME, MS, MT, MO, NC, NH, NE, PA, SC, SD, TN, TX, UT, VA, WI, WY), and 25 states (AR, AZ, CA, CO, CT, DE, HI, IL, IA, KY, MA, MD, MI, MN, ND, NJ, NM, NV, NY, OH, OR, RI, VT, WA,

WV) plus the District of Columbia are participating.[11] Additionally, states that do expand Medicaid would also be extending Medicaid coverage for former foster children up to age 26.[PPACA Section 2004] This group is at high risk for STDs, even into young adulthood.[29] When Medicaid was first launched in 1966, it took 17 years to get all fifty states on board.[30] However, given the millions, and in the case of some states, billions, in federal Medicaid funding on the table[31], many states that have decided not to participate as of the end of 2013 are likely to expand Medicaid in future years.

States that expand Medicaid will be providing coverage to a low income population, which could improve insurance coverage for STD-related services, creating a potential billing opportunity for safety-net providers, including STD clinics. However, in states that do not implement Medicaid expansion, many poor people would remain uninsured. In the 25 states not currently expanding Medicaid, the Kaiser Family Foundation estimates that nearly 5 million poor adults fall into a “coverage gap”, where they are below the poverty level but are ineligible for both Medicaid coverage and subsidies for buying insurance. [12] This could leave a critical population at risk for STD services uninsured.

Federal support for the Children’s Health Insurance Program (CHIP) is also included in the Affordable Care Act. States would be required to maintain income eligibility levels through 2019. States would receive a 23 percentage point increase in the CHIP match rate from fiscal years 2014-2019, with a cap at 100 percent. [PPACA Section 2101] This could lead to better service provision to children, which is especially important for adolescents, who are at disproportionately high risk for acquiring STD infections. This clause may also lead to billing opportunities for STD services by state or local health department STD clinics school-based

health clinics, family planning clinics, and other safety-net providers. However, implementation where capacity does not yet exist could be challenging.

The Affordable Care Act also includes provisions to streamline enrollment in Medicaid, CHIP, and the state exchanges through a state-run website.[PPACA Section 2201] This may help to sign up those who previously were eligible for Medicaid but not enrolled, as well as the newly eligible, thereby expanding coverage. Additionally, establishment of health information technology standards and protocols are designed to facilitate enrollment.[PPACA Section 3021] Increased enrollment could represent an opportunity for billing and reimbursement for STD services. Medicaid expansion does not include members of the incarcerated population, so any health coverage for this group would continue to be supported through other public funds.[32]

### Changes to Medicare

The Affordable Care Act also makes changes to Medicare, including closing the Medicare prescription donut hole over time.[PPACA Section 1101] This provision should help patients afford their medications for the time period between when they have reached their yearly prescription coverage limit but have not reached the spending amount for which they become eligible for catastrophic coverage. This is of public health importance, because early identification of HIV and consistent use of antiretroviral therapy can reduce transmission of HIV to sexual partners.[33] These anti-retrovirals also keep infected individuals well, effectively allowing management of HIV as a chronic illness, avoiding astronomical costs that untreated HIV may require later in the progress of the untreated or unidentified disease.



## **Coverage of Preventive Services**

### **Private Insurance**

The Affordable Care Act establishes a set of preventive health services that non-grandfathered plans must cover without cost sharing.[PPACA Section 1001] This provision will apply for participants of new (non-grandfathered) insurance plans that are part of the health insurance exchanges. Enacted in the ACA as revisions to the Public Health Service Act (PHSA), this set of preventive services is now Section 2713 of the PHSA. Commonly referred to as “2713 services”, they include:

- Evidence-based services rated “A” or “B” by the US Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
- Evidence-informed preventive care and screening for infants, children, and adolescents supported by HRSA; and
- Additional preventive care and screenings as supported by HRSA. [PPACA Section 1001]

Encompassed in these preventive services are many key STD-related services.

### ***USPSTF A and B Preventive Services***

The US Preventive Services Task Force reviews and grades the quality of the overall evidence for preventive services, assigning grades “A”, “B”, “C”, “D”, or “I” to each one. An “A” or a “B” grade indicates that the service should be provided in practice.[34] Several A and B recommendations cover STD services, including:

- Screening for chlamydial infection for all sexually active, non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
- Screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
- Clinician screening of all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
- Clinician screening for human immunodeficiency virus (HIV) of all adolescents and adults ages 15-65 and all pregnant women, and younger and older adults at increased risk for HIV infection.
- High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
- Clinician screening for persons at increased risk for syphilis infection.
- Clinician screening of all pregnant women for syphilis infection. [35]

### ***Advisory Committee on Immunization Practices***

CDC's Advisory Committee on Immunization Practices (ACIP) comprises a formal group of medical and public health experts who together develop recommendations on the use of vaccinations, including those for human papillomavirus (HPV), a virus that can be sexually transmitted.[36] ACIP recommends:

- Routine vaccination of females aged 11-12 years with 3 doses of quadrivalent HPV vaccine. The vaccination series can be started as young as age 9 years. Vaccination

also is recommended for females aged 13-26 years who have not been previously vaccinated or who have not completed the full series.[37]

- Routine use of quadrivalent HPV vaccine (HPV4; Gardasil, Merck & Co. Inc.) in males aged 11 or 12 years. ACIP also recommends vaccination with HPV4 for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series; males aged 22 through 26 years may be vaccinated.[38]

### ***Bright Futures Recommendations***

Bright Futures is a national health promotion and disease prevention initiative focusing on the needs of children. Launched by HRSA's Maternal and Child Health Bureau in 1990, it includes a collaborative with the American Academy of Pediatrics, which develops pediatric guidelines for infants, children, and adolescents.[39] Several of these recommendations include STD-related topics; Bright Futures recommends:

- Chlamydia and gonorrhea screening appropriate to the patient population and clinical setting for both boys and girls.
- Offering HIV and syphilis testing in certain clinical settings (STI clinic, correctional facility, MSM clinics, and clinics where prevalence is greater than 1% for population served); and for patients with STI risk factors (unprotected sex with more than one partner, prior treatment for an STI, history of intravenous drug use, are men who have sex with men, have traded sex for money (or has a partner who has), and/or have a past or current partner who is bisexual, HIV positive, or is an intravenous drug user).
- The ACIP recommended HPV vaccinations. [40, 41]

***Women's Preventive Services, supported by HRSA, includes July 2011 IOM Report on Clinical Preventive Services for Women***

Included in the 2713-services are women's preventive services guidelines for health plan coverage that are developed by the Institute of Medicine (IOM) and supported by HRSA. These IOM-developed recommendations fill the gaps in other existing guidelines, and must be covered by non-grandfathered health plans with no cost sharing. These recommendations include,

- Annual well-woman preventive care visit annually for adult women.
- Annual counseling on sexually transmitted infections for all sexually active women.
- Annual counseling and screening for HIV infection for all sexually active women.

[40, 42]

HHS also provided clarification in the Final Rule on the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (45 CFR Parts 147, 155, and 156), indicating that section 2713 preventive services must be included by plans as part of Essential Health Benefits.[43] Coverage of these services without cost sharing by non-grandfathered plans could be expected to provide greater ability for patients to afford these services. Additionally, it may provide an increased opportunity for STD clinics and other safety-net providers to bill for and be reimbursed by insurance companies for these services. However, after ongoing challenges with the HealthCare.gov site, and after pushback that resulted from people having their substandard plans cancelled, the Centers for Medicare & Medicaid Services (CMS) issued a bulletin stating that rules will be relaxed in 2014 for people whose plans have been cancelled.[44, 45] On March 5, 2014, the Obama administration announced that consumers could keep insurance policies that were non-compliant with the ACA for two more years.[46] These delays may mean that even more people than anticipated will not have essential benefits covered without a co-pay.

The Obama Administration anticipates a high number of insured people will initially be covered by grandfathered health plans. Large employer plans currently cover 133 million Americans, and from 36 to 66 percent are anticipated to remain grandfathered in 2013. Twenty to 51 percent of small employer plans are expected to remain grandfathered through 2013. [47] A recent report by Kaiser Family Foundation and Health Research & Educational Trust noted that in 2012, 48 percent of people with private insurance had plans that were grandfathered.[48] As plans make changes, the number of grandfathered plans will decline, but this may be a slow process. This means that many Americans who currently have health insurance coverage are not guaranteed the section 2713 preventive services without cost sharing – it is unclear how this may impact both physician recommendations of STD screening and services and patient uptake of these services.

### Medicaid

The Affordable Care Act establishes that the current state Medicaid option for diagnostic, screening, preventive and rehabilitation services would be expanded to include the USPSTF A and B services and the AHCIP recommended immunizations. It also provides financial incentives, in the form of an increase in FMAP of one percentage point for states to provide these services without cost sharing. [PPACA Section 4106] Coverage of these services is not required, so determination of service provision and coverage will be made by each state. STD clinics and other safety-net providers in states where these services are covered by Medicaid may have an increased opportunity to bill for and be reimbursed for these services by Medicaid. A February 1, 2013 letter from CMS to State Medicaid Directors that clarifies section 4106 of the Affordable Care Act also indicates that where USPSTF recommended services overlaps with family planning services, services can be reimbursed at the higher family planning matching rate[49],

for example, for chlamydia testing and treatment provided as part of a family planning visit. Especially for states where these services have previously been supported by state and local funds, this may be a source of potential revenue for program support. CMS published its final rule “Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment” on July 15, 2013, which clarifies that states may identify that other practitioners that could be reimbursed for delivering these services, which could include public health nurses or other designated professionals, which is important for states looking into billing in their STD clinics and for services provided by their STD program staff.[50]

### Medicare

The ACA gives the HHS Secretary authority, within certain bounds, to determine coverage of preventive services by Medicare, and outlines coverage and removal of related barriers.[Sections 4103-4105] As directed by the ACA, in November 2011, CMS issued a decision memo that included coverage of STI-related services by Medicare. The memo states that there is sufficient evidence to conclude that screening for chlamydia, gonorrhea, and syphilis, as well as high intensity behavioral counseling to prevent STIs, as included in the USPSTF A and B services, are appropriate for coverage for people with benefits under either Part A or Part B Medicare. CMS indicates that it will cover up to two individual twenty to thirty minute face-to-face counseling sessions annually by Medicare eligible primary providers. The memo also states that although there were public comments requesting a broader definition of providers for reimbursement purposes, CMS determined that only primary care providers in primary care settings could be reimbursed for services.[51]

Although the Medicare-covered population in general has a low but increasing prevalence of STDs[52], this decision by CMS is noteworthy for STD programs for a number of reasons. First, CMS establishes coverage assessments that are frequently followed by the private insurance market, and this is a very limited set of circumstances under which reimbursement could be obtained. Second, the ACA limits the settings in which these services can be covered, notably excluding “the field”, where STD testing and behavioral counseling may frequently be conducted by public health practitioners, such as disease intervention specialists (DIS). Third, it restricts reimbursement to Medicare-eligible primary care providers. This means that unless the health professional providing services can bill for services through a provider with a provider number, reimbursement cannot be obtained. It is not feasible for a primary care provider to invest this amount of time providing face to face counseling to one patient, especially if this were to be potentially repeated on an annual basis. In contrast, other types of professionals, including DIS, who work for public health STD programs, can and do offer behavior counseling in any setting in which they find the patient. For these reasons, it may be challenging for DIS and other public health professionals who are essential in preventing transmission to be reimbursed for providing these critical public health services.

#### Public Prevention Services

The ACA provides \$75 million per year through FY2014 for personal responsibility education grants. These grants are for states to support programs that educate adolescents on abstinence and contraception for the prevention of STIs and unwanted. [PPACA Section 2953] This may be an opportunity for STD programs to collaborate to ensure that effective messages and strategies for preventing STDs are included in these programs, and/or for programs to reach a larger number of adolescents.

The ACA also authorizes a CDC program to award grants to state, local, and tribal public health agencies to improve epidemiologic capacity to conduct surveillance of infectious diseases and other conditions of public health importance, including electronic reporting and information exchange, and development of outbreak response strategies.[PPACA Section 4303] Gonorrhea has a history of becoming resistant to antibiotics over time. Currently, there are signs of increasing resistance of gonorrhea to cephalosporins – our last line of antibiotic defense.[52] Laboratory monitoring of gonorrhea samples and testing for resistance is going to be critical for monitoring and slowing spread of resistance. STD programs may be able to participate in this ACA program through their health departments, obtaining support for infrastructure and establishment of quicker, standard electronic reporting.

The ACA requires that federal health programs collect and report data by race, ethnicity, primary language and other indicators of disparity. It also directs HHS to analyze data collected to detect and monitor trends in health disparities and to disseminate this information. [PPACA Section 4302] STDs are among the diseases highest in health disparities. Gonorrhea, in particular, has rates that are grossly disproportionate between white and non-white populations in the U.S. According to the CDC, in 2012, the gonorrhea rate among blacks was 14.9 times the rate among whites. The gonorrhea rate among American Indians/Alaska Natives was 4 times that of whites, the rate among Native Hawaiians/Other Pacific Islanders was 2.8 times that of whites, and the rate among Hispanics was 1.9 times that of whites. The rate among Asians was 0.5 times that of whites.[52] ACA-supported collection of this information may provide additional valuable insight on target populations and which programs reach them effectively.



## **Focus on Primary Care and Access to Services**

The Affordable Care Act includes a number of provisions that are designed to facilitate prevention through the support of primary care and/or that could impact access to services. The ACA establishes primary care service incentives for Medicare, providing quarterly payments equal to ten percent of the amount paid for primary care services under the Medicare Physician Fee Schedule for those services furnished during the bonus payment year.[PPACA Section 5501] The ACA also authorizes HHS to support new or expanded primary care residency programs at health teaching centers.[PPACA Section 5508] Additionally, unfilled residency positions are allocated to primary care, and residency slots are distributed to states with large populations in provider shortage areas and low numbers of physician residents per population.[PPACA Section 5503] Incentives are also provided to clinicians who practice in underserved areas.[PPACA Section 5203] The ACA also supports medical homes by authorizing establishment of community health teams.[PPACA Section 3502]

All of these provisions may increase access to care for primary care services, including for STD screening and treatment. It also creates a larger number of primary care providers who may have differing levels of training about how to take a sexual history or how to screen and treat STDs. Private physicians and HMOs report the highest numbers of STDs among women – 33.5% of reported chlamydia cases and 26% of reported gonorrhea cases in 2011.[CDC, unpublished data] Increased collaboration with this group might be a reasonable approach for STD programs to take to assure provision of recommended STD-related services.

The Affordable Care Act also authorizes and appropriates some funding for safety-net providers. The ACA authorizes construction funds for FQHCs [PPACA Section 5601]; appropriates \$150 million for construction/expansion of school-based health centers [PPACA Section 4101]; appropriates \$100 million for construction debt for clinical care facilities

affiliated with state academic medical centers; and appropriates \$9.5 billion for construction of health centers in medically underserved areas and expanding preventive and primary care services at existing sites and up to \$1.5 billion to support renovation of community health centers [PPACA Section 10503]. All of these providers screen and treat patients for STDs; STD programs could work with these providers to assure consistent and widespread application of screening and treatment recommendations. However, a portion of the ACA FQHC allotment was used to offset cuts to FY2011, FY2012, and FY2013 HRSA appropriations, which reduced discretionary funding to health centers.[53] HRSA reported that as of FY2014, \$1.388 billion of the \$11 billion had been awarded or announced.[54]

The ACA also amends the 340B program, which provides access to low-cost medications for many clinics that receive federal funding. The added entities for 340B eligibility are critical access and sole community hospitals, and rural referral centers.[PPACA Section 7101] This could provide additional safety-net providers with a way to obtain low cost STD medications, and may be an area for extended collaborations by STD programs.

Additionally, the ACA establishes a three year demonstration project in up to ten states to provide access to comprehensive health care services to the uninsured at reduced fees, with an evaluation to assess the feasibility of expanding the project to additional states.[PPACA Section 10504] It is unclear how this may impact STD screening and treatment, but it might be another area of potential involvement for STD programs.

The ACA includes reductions in Medicaid disproportionate share (DSH) hospital payments beginning October 2013.[PPACA Section 2551] Reduction in these payments had been assumed to be offset by other provisions included in the ACA as originally enacted – namely expansion of Medicaid and privately insured populations. This provision has been

delayed two years until the beginning of FY 2016, but it doubles the reduction that was to be applied that year.[10] Hospitals are an important safety-net provider of STD services; seven percent of people in one study reported having gone to the emergency room for an STD [55], and in 2011, hospital emergency departments were the source of approximately four percent of chlamydia cases reported in females, and 5.4 percent of gonorrhea cases in females; the number actually tested was likely much higher.[CDC, unpublished data] If a hospital that depends upon these payments is in a state that opts out of Medicaid expansion, this could have a detrimental effect on the ability of these hospitals to provide services, due to increased wait time or other barriers to care, or may lead to hospital closure. In addition, these DSH payments also have historically offset uncompensated care of undocumented immigrants – no provision in the ACA will offset this loss, as that population is not included in the ACA provisions. [56, 57] This could have a detrimental effect on preventing the spread of STDs.

The ACA provides funding to states, tribes, and territories to develop and implement evidence-based maternal, infant, and early childhood visitation models. Funding is \$100 million in 2010; \$250 million in 2011; \$350 million in 2012; and \$400 million in 2013 and 2014.[PPACA Section 2951] This may have been an opportunity for state STD programs to collaborate to identify pregnant women at risk for STDs and increase their testing and treatment rates, preventing outcomes such as congenital syphilis and transmission of HIV from mother to child.

## **Conclusion**

Overall, the ACA has great potential to impact STD prevention, screening, and treatment in the United States. Expansion of the Medicaid population and privately insured population, combined with increased coverage without cost sharing of preventive services that include STD

screening and behavioral counseling, have the potential to make effective STD-related services more affordable, while providing a prospective revenue source for state and locally funded safety-net providers, including STD clinics, who may bill for services where permitted by law. Public health programs will also need to assess whether implementation of billing combined with confidentiality concerns does not prevent people from seeking needed STD services and make adjustments to ensure that this does not lead to an increase in infections.

However, due to grandfathering of private insurance plans and the uncertain future of Medicaid expansion in many states, growth in coverage may be slow and incomplete. Moreover, insurance does not equal access. Growth in the insured population may create a strain on the healthcare system: capacity may not exist in all areas and some providers may stop accepting new Medicaid patients. The ACA provisions related to access to care may have mixed results – support for expansion of primary care availability may increase access, although reduction in DSH payments to hospitals may create access challenges. Additionally, key populations at risk for STDs are excluded from the ACA – undocumented immigrants and the incarcerated population.

STDs in particular, are associated with stigma and additional concerns about confidentiality, especially among adolescents.[58] This population may be more likely to be insured as a result of the ACA implementation. Adolescents and young adults bear the burden of half of all newly diagnosed cases of STD every year, and perception of confidentiality may impact where they choose to seek services.[52, 59] It is unclear how shifts in insurance and access might impact adolescent and young adult provision of STD care and prevention and perceptions about sources of confidential care.[60] This is an area that public health departments and community health partners might want to study.

The ACA provides some support for public health through the Prevention and Public Health Fund (PPHF), but simultaneous cuts to CDC, which provides substantial funding to state and local public health departments, have reduced the potential of that funding.[61] Also, overall, the ACA does little to change fundamental and deteriorating public health infrastructure,[62] which provides the foundation in most states for prevention and control of STIs. Core public health services remain critical for supporting population health, in the case of STD prevention, this entails assessment and assurance functions. Assessment includes surveillance and evaluation; assurance includes contact investigations of exposed sexual partners and outreach to medical providers, which may include non-reimbursable testing of exposed partners in non-clinical settings in order to prevent the spread of STDs.

Expanding insurance in combination with increasing the number of primary care providers mean that public health departments will need to assure that recommended state of the art and evidenced-based STD services are implemented appropriately and with high quality across a larger population of providers. Additionally, surveillance information about the populations that are accessing STD-related services, and where they are accessing services, will be critical for determining the impact of ACA-related changes, as well as for identifying unmet needs and health disparities.

Although the ACA does not facilitate integration between public health and healthcare, it creates a window of opportunity for increased integration and/or collaboration between them. This will be of increasing importance as the ACA provisions are implemented.[63] Changes in electronic health data collection supported by the ACA have the potential to provide more robust information for public health use – however, taking advantage of this information may require

both additional staff with a different mix skill sets within public programs, and expensive investment in information technology.

Overall, the ACA provides great opportunity for public health to expand collaboration with the health care system, as well as to bill for STD services. However, lack of formal integration, inadequate infrastructure, and razor thin budgets could make capitalizing on these opportunities very challenging.

### **CHAPTER 3: LITERATURE REVIEW**

Prior to designing my study, the researcher conducted a literature review that sought to answer the following question:

**How are the Affordable Care Act and related policy and financing changes expected to influence state STD prevention programs?**

The ACA includes provisions that are likely to impact both the financing and delivery of STD clinical preventive services. Federal policy and funding variables are anticipated to both influence state STD programs directly, as well as indirectly through their impact on state policies and finances. State policies and financing also directly impact state STD programs and services. The literature review seeks to find out in what way these variables impact STD programs, and how these programs may be expected to adapt or prepare.

#### **Methods**

The literature review identified and considered both peer reviewed and “gray” literature that assessed trends or anticipated changes in STD services or programs in the United States since March 2010, when the Patient Protection and Affordable Care Act was enacted. Although implementation of the ACA is ongoing through January 2018, much has already been written about its current and anticipated influence on public health and healthcare.

## Sources

The researcher initially considered PubMed for searching the literature; however, its focus on health without inclusiveness of budget and policy influences on a broad scale made it unfeasible for the purposes of this review. Since Google Scholar looks for key words within articles, the researcher determined that it was a better tool for identifying relevant cross-disciplinary publications about this complex topic. Additionally, since the ACA employs a rolling implementation, much of what has been written may exist in organizational or expert reports or papers, which are generally included in Google Scholar results.

In order to identify publications that include the intersection of policy and related financial influences on state STD programs, the researcher identified the following concepts and used the related search string (Table 1).

**Table 1. Literature review concepts and search strings**

<b>concepts:</b>	<b>Affordable Care Act, sexually transmitted diseases, state health departments</b>
Google scholar search string	“health reform” OR “affordable care act” “sexually transmitted” “state health”
Translation of Google scholar search string	“health reform” OR “affordable care act” AND “sexually transmitted” AND “state health”

The researcher employed the term “sexually transmitted” in order to pick up both “sexually transmitted diseases” and “sexually transmitted infections”. The researcher used “state health” to pick up state health departments, state health programs, state health initiatives, and the impact of the ACA on state (public) health programs and healthcare. The researcher also utilized the following restrictions available within the Google Scholar search engine:

- Return articles published between 2010-2012
- Exclude patents



## **Selection Criteria**

For the purposes of this review, the researcher considered only articles written in English published since March 1, 2010, including articles if they:

- 1) contained discussion of United States health reform occurring since March 2010 (inclusive);
- 2) contained information on sexually transmitted disease prevention and services;
- 3) studied, assessed, or made recommendations regarding states and the implementation of the ACA; and
- 4) identified or inferred a link between the ACA and STD-related programs or services.

This review included descriptive and observational studies; descriptive analyses; consensus and opinion papers by recognized experts; and reports and briefs by government agencies, policy-focused non-governmental agencies, government advisory groups, and health and policy think tanks. This review did not consider academic theses or dissertations, professional association newsletters, meeting notes or reports, resumes, posters, presentations or announcements. The researcher did not include books, because they generally lag article publication. However, the researcher did include Institute of Medicine (IOM) reports, which are published by the National Academies Press, and annotated as “books” in Google Scholar search results.

The researcher first reviewed article summaries and abstracts for relevance given the criteria above. If the initial review indicated that the article may be pertinent, the researcher scanned the article abstract to determine relevance for inclusion in the review. For articles without abstracts, the researcher scanned the entire article to assess relevance within the stated criteria. The researcher also eliminated duplicates during this process. The researcher excluded one IOM report because a more recent one on the same topic superseded it. Three of the articles

were available only through sites that required a subscription to which the researcher did not have access, so were excluded.

## **Review Strategy**

The researcher tracked literature that was assessed to fit the given criteria in a Microsoft Excel spreadsheet (see Appendix A), noting the following information:

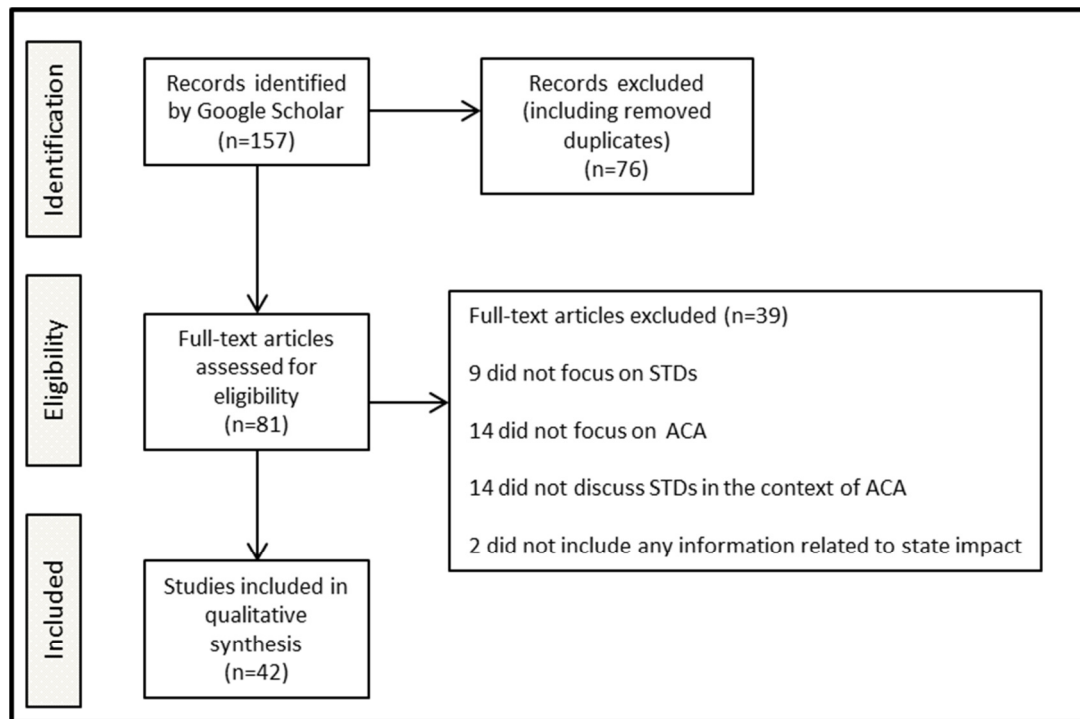
- article title;
- author(s);
- journal or organization source;
- publication date;
- if article was specific to a certain state;
- if article was specific to a specific service provider type (e.g. FQHC, FPC);
- population focus (e.g. general, adolescent, sex workers, women, MSM);
- specific sexually transmitted disease discussed (e.g. general, HIV, chlamydia);
- expected or observed impact of the ACA on STDs;
- recommendations made regarding the ACA and STDs or related recommendations to states; and
- the impact, potential impact, or ramifications for states.

## **Results**

The Google Scholar search yielded 157 results, all of which the researcher considered for inclusion. Duplicates and those that were immediately identified as not meeting one or more criteria were eliminated. The researcher downloaded eighty-two papers for complete review. Of

these, the researcher determined that 42 fit the established conditions. (See Figure 1: Study selection for review).

**Figure 1. Study selection for review.**



Three main themes emerged from the forty-two included articles related to the potential impact of the ACA on the activities of state STD programs. First, despite gaps in expansion for specific populations, more people in the United States are expected to have health insurance coverage under the Affordable Care Act, either through the Medicaid expansion and/or through coverage offered in the health insurance marketplaces. Second, there will be greater coverage of certain services, including expanded coverage of preventive services recommended by USPSTF and ACIP; comprehensive guidelines supported by HRSA, including Bright Futures and Women’s Preventive Services; and filling in the “donut-hole” for medications for Medicare eligible HIV/AIDS patients. These could potentially expand insurance coverage for STD screening, testing, treatment, and behavioral counseling, but does not include important STD

public health services including partner tracing and potentially expedited partners services (EPT). Third, the ACA may change where people get care. In the past, many of the STD services were provided through health departments; under the ACA it may be provided by primary care practices. This will require new partnerships between the public health sector, including health departments, and the private sector, including primary care providers.

### **Expanded Medicaid Eligibility and Increased Private Health Insurance Coverage Rates**

Thirty articles mentioned expanded Medicaid eligibility, and/or an increase in the privately insured population as a noteworthy impact of the ACA, or the potential for billing for services for an expanded insured population overall through the ACA.[59, 64-92] The Affordable Care Act includes provisions for expanding Medicaid eligibility in states, as well as a mandate requiring all non-exempt Americans to carry health insurance. This, in combination with increased coverage of preventive services, including screening for STDs, creates a potential opportunity for states to collect some reimbursement for STD-related services provided in clinical settings. [7] For states and localities that maintain STD clinics or health department clinics, or pay for or subsidize services through other health providers, some of these services could potentially be reimbursed by Medicaid or private insurers.

A 2010 report about Missouri by Ferber and Beekman, noted that the ACA's new state Medicaid option includes "medical diagnosis and treatment services" that are provided in a family planning setting as part of or as follow-up to a family planning visit. The report found that these services could potentially be broader than what Missouri currently covers in its existing family planning Medicaid waiver program, including STD-related services. Additionally, the authors pointed out that the "welcome mat effect" may lead to higher enrollment levels of

currently eligible but un-enrolled people, due to increased awareness of available programs driven by the ACA expansion, broadening the Medicaid enrolled population in Missouri. [75]

The Ferber and Beekman Missouri report also indicated that the ACA gives states the option of establishing a “Basic Health Program” for low-income individuals not eligible for Medicaid but whose incomes are under 200% of the federal poverty level. The state would contract directly with private plans to provide coverage similar to the current Medicaid managed care program, but it would not be a Medicaid expansion, per se. The state would receive 95% of the federal subsidies that would have been paid to individuals who receive premium credits for coverage in the new exchanges, and Basic Health Plans must include at least the “essential health benefits” available through the exchanges. This report additionally noted that the ACA specifically requires state outreach to enroll special populations in Medicaid/CHIP, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS. The authors pointed out that inclusion of this requirement in the ACA suggested a legal obligation beyond what the state and private agencies are doing currently to enroll eligible individuals, and that CMS may need to provide additional guidance for clarification. [75] All of these options for states anticipate an increase in people with insurance and/or access to care.

Frost pointed out that the ACA includes \$11 billion in additional funding to help expand the FQHC network.[87] However, as mentioned previously, this funding was used to offset cuts to FY2011, FY2012, and FY2013 HRSA appropriations, which reduced discretionary funding to health centers.[53] Frost also related that in a survey conducted by the Guttmacher Institute, FQHCs noted that many non-physician clinicians bill through their physician supervisor, rather

than billing Medicaid directly, reducing their eligibility for electronic health record (EHR) incentives, which is assessed and awarded by clinician, not by agency. In order for agencies to maximize the Medicaid incentive funding they can receive, providers must undertake a time-consuming process of becoming credentialed with Medicaid. This may be a barrier for clinics to take advantage of funding that would support their ability to bill for provision of services to an expanded Medicaid population. The article noted additional comments made by agencies about state-related decision-making that may impact their ability to obtain incentives to establish EHRs: at the time of the survey, at least one state had not yet established rules for having incentive payments go directly to an agency, rather than to individual clinicians. Another agency reported that it needed to develop new contracts with its clinicians to ensure that the EHR incentive payments do eventually go to the agency. [87]

A number of articles identified certain populations that could have better access and/or coverage of health services as a result of the ACA. One of these populations is people with HIV who are not currently covered. A 2011 IOM report on HIV emphasized that the ACA expands Medicaid without additional categorical requirements (e.g., disability), includes a health insurance mandate with low-income subsidies, and prevents private insurers from restricting coverage due to HIV history.[90]

For HIV patients who are covered by Medicare or who are Medicare/Medicaid “dual eligible”, the ACA changes in “donut hole” provisions of Medicare Part D prescription drug coverage may be particularly beneficial, though phased in over a number of years.[67] These provisions should help patients afford their medications for the time period after they have reached their yearly prescription coverage limit, but before they have reached the spending amount for which they become eligible for catastrophic coverage. This is of public health

importance because early identification of HIV and consistent use of antiretroviral therapy can reduce transmission of HIV to sexual partners.[33]

This additional coverage under the ACA is not without potential challenges; Martin and Schackman noted that HHS has recognized that managing enrollment and transfer of patients between programs, due to changing eligibility, may be complex. This has led HHS to propose exchange eligibility and employer standards for eligibility processes and for state-administered consumer assistance programs to help residents locate and enroll in plans. There will be interstate variation in HIV-related coverage, including whether the AIDS Drug Assistance Program (ADAP) covers premiums or other costs, and the extent of any state-imposed enrollment restrictions for ADAP clients. [67] This could impact affordability and access to care.

Other articles discussed special populations who may be disproportionately affected by STDs. Three Amicus Briefs filed by the National Women's Law Center in response to ACA-related lawsuits prior to the Supreme Court decision contained nearly identical language regarding target populations. These briefs pointed out that the ACA ends gender rating for health insurance, which was permitted by most states prior to enactment, and potentially making insurance more affordable for women. In addition, prior to the ACA, nine states still allowed health insurers to refuse coverage to domestic partner violence survivors, who have a high risk for STDs; the ACA may make health insurance more obtainable. Within the three briefs, a national group representing Latinas asserted that Latinas also have low access to healthcare, but suffer from STDs, among other diseases.[71-73] Another article highlighted the ACA's expanded Medicaid eligibility for pregnant women, noting that STD testing is an important service for pregnant women.[74] Prenatal care and STD testing prior to birth can identify STDs

that can be treated prior to the mother passing the disease to her baby, preventing congenital syphilis and other diseases in the infant.

An article by Kozhimannil et al. noted that state insurance exchanges, elimination of preexisting condition exclusions, and subsidies will provide additional private insurance options to pregnant and reproductive-age women, and that preventive services coverage requirements may enhance available benefits for this population. Additionally, the authors observed that health plans will have to cover services, including some for STDs, under the ACA. The article noted that continuous monitoring of insurance trends among reproductive-age and pregnant women will be critical to understanding how changes in health insurance regulations, access, benefits, and mandates affect this population.[76]

Youth have increased access to health insurance under the ACA. As of December 2011, 3.1 million young adults between 19 and 25 were able to retain or obtain coverage on their parents' insurance plans.[93] The 2011 IOM report on children and adolescents noted positive aspects of the ACA on child health, including the coverage of children up to age 26 on parental plans. The report indicated that this reflects the need to maintain access, utilization, and quality during the transition to adulthood.[92] A 2011 report by Boonstra projected that Medicaid coverage of youth will increase, including coverage of youth who were in foster care at age 18, up to age 26; this population is especially susceptible to STDs.[78] Due to the Supreme Court decision, this may only apply to foster care youth in states that choose to expand Medicaid.

The ACA-required IOM report recommending clinical preventive services for women noted that the ACA expands adolescent and young adult access to insurance, but that challenges persist for ensuring delivery of confidential care to newly insured adolescents and young adults, who are likely to forgo health care when they do not think they have access to confidential



care.[91] For example, newly covered adolescents and young adults may have confidentiality concerns related to explanation of benefits statements (EOBs) that are sent home to parents, who are the policyholders. Overcoming perceived and actual barriers to confidential care will be critical for expanding adolescent and young adult access to care, especially for sexual health related services, for which timely treatment is critical to preventing the spread of disease and potential sequelae, including infertility. However, the report also stated that time alone with the provider can enhance a young patients' sense of confidentiality, and it has been shown that adolescents attending a preventive care visit are more likely to have time alone with their provider than with those with a non-preventive care visit (40 and 28 percent, respectively). [91] Expanded coverage of preventive care services may then provide increased opportunities for perceived provision of confidential care in this population.

Not all populations will choose to be insured, and some are excluded from insurance expansion. Gostin et al. identified a number of groups that will remain uninsured, including undocumented immigrants, low-income people who do not enroll in Medicaid, mandate-exempt individuals, and those who will chose to opt-out and choose paying the penalty rather than paying for coverage. They further noted that the decision to exclude illegal immigrants and other disadvantaged populations has serious public health implications, especially with respect to communicable diseases. The article also noted the likelihood of development of drug-resistant disease strains among these populations, and that certain infections, including STDs such as syphilis and HIV when undiagnosed and untreated infections are a risk to the entire population. [70]

Glen picked up the issue of the exclusion of illegal immigrants from the ACA reforms, noting that including them may lower the costs of the system by lowering premiums, and

lowering emergency medical expenditures through a shift from acute treatments to preventive and ambulatory care. This article also projected that extending coverage to this population would have public health benefits, such as helping to prevent the spread of communicable diseases, such as STDs, through early treatment. [94] The Alsentzer et al. report on Florida also noted the potential issue of lack of coverage for undocumented immigrants. [82] These exclusions may require state public health agencies and other public providers to continue bearing the burden of providing services to these populations, while receiving declining federal, state and local funding and for hospitals also losing the disproportionate share payments that previously provided funding that may have been used for providing medical services for these populations.

Brown's article echoed these concerns regarding the ACA and lack of coverage for certain populations, noting that both unauthorized immigrants and insured who cannot find other providers to treat them may continue to seek care from the safety-net. Brown continued, pointing out that

"provision [of services] is likely to remain a not insubstantial function of public health authorities for the indefinite future. How these duties are acquitted in the future will depend, then as now, on a set of little-studied political variables that include: the legal status and strength of state and local public health agencies; the power of local medical societies (which may resist public health encroachments on any and all patients but the unprofitable and unappealing – e.g., substance abusers and those with sexually transmitted disease); and the entrepreneurial energies of local public health leaders." [95]

### **Service Implications for State STD Programs**

Forty of the articles included implications for states related to STD service provision and coverage. [59, 64-77, 79-90, 92, 94-105] These articles pointed out both opportunities and threats from a state public health perspective.

An article by Owusu-Edusei compared other countries to the U.S., noting that some high-income countries with universal health insurance, and with lower STD burden than the U.S.,

have chosen to maintain specialized STD clinics. It also pointed out that STD clinics in the U.S. frequently serve MSM and racial/ethnic minorities disproportionately affected by STDs, noting that STD clinics should be maintained, or that other options for STD detection or control in the U.S. should be identified. The article continued, warning that the combination of health reform and federal and state budget shortfalls leading to the discontinuation of provision of direct services by health departments, including STD care, may have a national impact on STD prevention and control.[64]

A 2011 Kaiser Family Foundation article and the Mayes and Oliver article noted that the Affordable Care Act includes coverage of STD and HIV tests (some in certain populations) by non-grandfathered insurers without cost sharing.[66, 77] Arkoosh et al. pointed out that the Affordable Care Act also directed the Institute of Medicine to develop recommendations for additional preventive services specifically for women. This IOM report, published in July 2011, included recommendations for improved screening, counseling for STDs and HIV, as well as one well-woman preventive care visit annually.[65] Coverage of these services without cost sharing went into effect in August 2012, and applies to those insured by new health plans.

The IOM report referenced by Arkoosh et al. was also included in the literature review. The report identified that the ACA's Women's Health Amendment requires that new private health plans cover, without cost-sharing, a newly identified set of preventive health care services for women. The report recommended several STD-related screening items, in addition to what is included in the USPSTF and Bright Futures recommendations. The IOM committee further stated that it would make the most sense to use a parallel approach to addressing preventive services that should be covered for men, children, and male adolescents. [91] Since the USPSTF

A and B STD-related services mainly are targeted to women, that approach, if taken, could be helpful in identifying and increasing coverage of STD-related preventive services for men.

A report by Flowers and Fox-Grage, published by AARP, pointed out that enhanced coverage of family planning-related services includes diagnosis and treatment services that are provided as a follow-up to a family planning service in a family planning setting, including pharmaceutical treatment for sexually transmitted diseases or infections, which the report projected would be significantly cost saving in most states.[69] Watts et al. recommended specific strategies for encouraging women to follow through on this testing; “technological strategies, such as text message reminders, may improve clients’ acceptance of annual chlamydia testing. Evidence-based screening and counseling protocols for this preventive service under the Affordable Care Act of 2010 should be designed and disseminated.”[97] Expanded coverage for young adults under their parents’ plans and Medicaid eligibility for low-income childless adults, combined with prohibited copays for preventive care, were projected by Tiro et al. to improve access to the HPV vaccine. [79] The prohibited preventive care copays apply to the commercial market only.

A 2011 IOM report on HIV noted that the federal government provided a one percent increase in the federal match to states that offer Medicaid coverage of, and remove cost sharing for, A and B USPSTF recommended services and ACIP recommended immunizations, effective January 1, 2013. The demand for some HIV services, now covered by Ryan White, will decline as uninsured individuals gain coverage; however, the report expresses some concerns that the reauthorization of the Ryan White program will take place in 2013, before full implementation of the ACA, and that there are risks associated with changing the program before the implications

of the ACA are known. [90] As of April 1, 2014, the Ryan White Program had not been reauthorized.

In addition to health and medical services, the ACA has provisions that may impact educational services provided by state health agencies. An IOM report on Healthy People 2020 noted that the ACA directs the Secretary of HHS “to allot funds to states to award grants to local organizations and other specified entities to carry out personal responsibility education programs to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections”. [105] Three other articles also noted this provision as providing an opportunity for states to reach out to adolescents, who are at high risk of STIs. [92, 100, 104]

Additionally, the new National Prevention Strategy, mandated in the Affordable Care Act, is an opportunity to improve data quality related to the provision of preventive services for children and adolescents. This initiative will determine measures of health and health care quality for children and adolescents,[92] producing information that could be used to identify improvement in provision of STD services to this population or to weaknesses in the system that should be addressed.

A 2010 brief by Figueroa and Westbrook to the incoming Connecticut Governor regarding health reform picked up on this part of the law, noting that health reform should support patient education, which is “the ultimate strategy of disease prevention”. [103] In contrast, the Alsentzer et al. report on Florida implied that politics interfered with implementation of this provision, so that the \$2.8 million in ACA funding for comprehensive health education awarded to the state was rejected, despite the fact that no state matching funds were required. [82] The funds provided to states for personal responsibility education programs to prevent youth pregnancy and STDs must not be abstinence-only; however, states may choose

not to apply for and implement programs with these funds. This also indicates that portions of the ACA may not be implemented uniformly nationally.

Several articles identified non-service-related areas impacted by the ACA, such as electronic data and research, which may have implications for the type of services that should be provided by state health agencies, or how to better target services. Villegas et al. noted that Medicaid programs and other federally supported health care services are required to report data on ethnicity, gender, primary language, and disability status of program beneficiaries, which are anticipated to provide estimates on health initiatives targeting health disparities of ethnic minorities.[98] Grembowski et al. pointed out that the ACA “authorized studies examining the effectiveness and costs of state and local health departments, and to collect data on health disparities for research.”[101] A 2011 IOM report on children and adolescents stated that the new initiatives around health information technology (HIT) and EHRs have a lot of potential to support inclusion of children and adolescents, but noted that this will not be fully realized without greater alignment across federal agencies with respect to technology and measurement.[92] The degree to which this is realized could impact data availability for state health programs to appropriately target certain populations.

### **Partnership Implications for State STD Programs**

Thirty-five of the articles discussed implications of the Affordable Care Act on potential or existing healthcare provider partners of state STD programs [59, 64, 67-73, 75-77, 80-92, 95-97, 99-105]. The focus of the ACA on primary care was a repeated theme. Wapner noted that the Public Prevention and Health Fund (PPHF), established by the ACA, designated \$198 million for training 500 primary care physicians and 600 primary care nurse practitioners nationally by 2015.[96] Mayes and Oliver identified that the ACA includes new funding for complementary

public health and primary care programs.[77] An article by Osborne pointed out that as primary providers of women's health care, certified nurse-midwives (CNMs) and nurse midwives (NMs) can help meet the ACA-generated increasing demand for health care services. CNMs and CMs provide primary care for women, including the provision of all essential elements of primary care and case management: evaluation, assessment, treatment, and referral as necessary. [81] This is notable, because primary care providers are crucial state partners for increasing STD screening and treatment rates in target populations, and as of 2010, with managed care plans, were the largest source of reported chlamydia and gonorrhea cases[52].

Gostin elucidated the link between public health and healthcare, pointing out that,

“[p]revention and wellness require integration of health care and public health, with active interaction and coordination between the two systems. At the individual level, primary care physicians and nurses provide counseling, early detection, and treatment for primary and secondary disease prevention. At the population level, public health officials engage in surveillance and monitoring, social marketing, safety standards and inspections, and control of infectious diseases. Individuals and society at large need both health care professionals attending to the needs of each patient, as well as public health officials acting on broader socioeconomic determinants of health.” [70]

This indicates a potential need for state public health agencies to continue to strengthen partnerships with private healthcare professionals, schools, and other organizations.

Mason et al. also picked up on this theme, specifically addressing the need for collaboration between health care and public health through community health workers (CHWs), asserting that the ACA “provides a policy window of opportunity to integrate community health workers into our health system”. In advancing this goal, the article recommended several elements of the Massachusetts campaign that were essential to its success, including nurturing independent CHW leadership and organizational capacity as part of building a public health partnership, defining CHW workforce issues as linked to politically salient problems (e.g., health

reform), building viable policy proposals that advance CHW workforce and public health goals, and pursuing an advocacy strategy attentive to current political dynamics that expanded recognition and support for the field. [68] In STD prevention, disease intervention specialists, known as DIS, conduct contact tracing and provide behavioral counseling as part of the public health system, and may also be utilized to connect patients to care in the era of health reform. There has been much discussion in the STD field of how to incorporate DIS with the private healthcare system during this window of opportunity, and CDC is looking into the possibility of credentialing as part of the effort to lead to widespread recognition of the role of these professional community health workers.

A report by Berry et al. of the National Healthy Start Association, asserted that the federal Healthy Start Initiative has a role to play in the ACA Maternal, Infant and Early Childhood Home Visiting Program's national efforts to assist in improving quality of health care, enhancing disease prevention, and strengthening the health care workforce. Healthy Start provides health education including about prevention, early detection, testing, and treatment for HIV and STIs, especially syphilis.[102] State STD programs may want to consider this type of organization as a potential partner in the prevention of congenital syphilis and early identification of HIV in pregnant women.

Other articles identified the ACA's potential impact on community health centers. Martin and Schackman noted that there is a shift of public resources from hospitals (eliminating disproportionate share payments) to community health centers, which may increase demands on states' abilities to determine insurance eligibility.[67] In the case of Florida, Alsentzer et al. noted that HHS gave \$479,190 in funding under the Affordable Care Act to six nonprofits in northern Florida so that they can become community health centers. This report identified some



important aspects of this shift, noting that despite the state's failure to initiate planning for new healthcare access opportunities under the ACA, Florida's HIV/AIDS community should take the initiative to coordinate between existing programs, such as Ryan White, and to facilitate access to insurance for the newly eligible for Medicaid and subsidies for private insurance in order to ensure uninterrupted access to care. The report further recommended that organizations that provide support services such as case management for people living with HIV and AIDS, should think about becoming official patient navigators and apply for related grants. [82]

Gold discussed the overall investment in community health centers in greater detail, noting that the ACA directs \$11 billion toward health centers by 2015, and \$1.5 billion for the National Health Service Corps (NHSC), in order to expand sites and capacity for a surge in healthcare usage beginning in 2014. As noted earlier, these funds were offset by appropriated budget reductions in FY2011, FY2012, and FY2013. [53] In addition, the ACA facilitates partnerships to broaden access to care through community-based collaborative care networks and patient-centered medical homes. Gold mentioned that health centers are expected to participate in Accountable Care Organizations (ACOs), and that health centers offer STD screening, but may not offer the high level of confidentiality available at family planning clinics; both types of agencies are eligible for discounts on the costs of procuring prescription drugs under the federal 340B program. The article ultimately recommended collaboration between family planning clinics and community health centers, pointing out that most of the newly insured and the remaining uninsured will be residents of medically-underserved communities; positioning the safety-net to meet demand will be highly important.[80]

The Sonfield et al. article identified the role of family planning clinics in STD prevention, noting that screening for HIV and other STDs has become standard practice for family planning

providers. Screening is particularly important for the populations targeted by the family planning expansions, young and low-income women and men, because they are at highest risk of STDs. Existing Medicaid expansions have paid for millions of STD tests and helped to diagnose large numbers of STD cases. The article concluded that if states can build on their successes in expanding access to family planning care, they can improve the odds that the Affordable Care Act meets its full potential. [88]

Frost et al. suggested that partnerships may be formed to overcome some potential obstacles related to financing and limited expertise. Specifically, family planning agencies supported with public funds identified needed technical assistance around electronic health records and third party billing. She recommended outsourcing, and/or collaboration with others who are facing the same challenges, including specialized providers such as STD clinics to share information and solutions while creating economies of scale. She observed that agencies without HIT systems will have a disadvantage as funding sources change, and will especially be at risk as of 2014 due to the ACA implementation. [87] Indeed, as these changes in funding sources shift, STD clinics and other agencies will need to be sure that they have the appropriate systems in place to be able to follow the funding, which may include a shift to billing and reimbursement for a more highly insured population, as permitted by state laws.

The ACA includes \$200 million in funding for School Based Health Centers (SBHCs); three articles noted that these grants will establish SBHCs or help existing centers expand their capacity.[59, 84, 85] The Rucoba article further stated that HHS anticipates that this will increase the number of children SBHCs serve by 50%, also pointing out that adolescents are more likely to use SBHCs because of confidentiality concerns, and noted that SBHCs can enroll children and families into Medicaid. [59]

Keeton stated that SBHCs are most often sponsored or operated by a local health care organization such as a community health center (CHCs; 28%), hospital (25%), or local health department (15%), and in some cases, by a school system (12%). The article pointed out that SBHCs can be medical homes, part of the ACA's Accountable Care Organizations, which the American Academy of Pediatrics (AAP) has emphasized is the ideal form of health care delivery for children and adolescents. Keeton further noted that almost 70% of SBHCs offer sexually transmitted disease diagnosis and treatment, and that SBHCs often offer opportunities for preventive counseling to teens regarding sexually transmitted diseases; the availability of confidential services has been cited as an incentive for teens using SBHCs, although laws concerning confidentiality for sensitive services differ by state. [85]

Creech et al.'s article detailed a program in Flint, MI, in which the community introduced a health plan to make basic health care available to uninsured, low-income adults. The community's existing free medical clinic experienced a decrease in visits as the program enrollment grew, and the health plan pays their local FQHC to be the medical home for a large number of the program's members. Demand for STD screening and treatment declined at the health department as members increasingly sought those services from their primary care providers, freeing \$340,000 in local public health funds dollars for other use. Creech asserted that with the ACA Medicaid expansion, this model may actually be more cost-effective and provide better access to care through a medical home, than might be expected by expansion of Medicaid alone. [83]

Overall, the ACA's emphasis on primary care could greatly increase the number of providers that state public health programs may need to educate regarding STD and HIV prevention, treatment, and linkage to care. Additionally, family planning clinics, hospitals,

community health centers, school based health centers, and maternal and child home visitation programs are likely partners for public health programs moving forward. Building partnerships may help agencies overcome obstacles related to funding and gaps in technical expertise.

## **Discussion**

Insurance expansion has important implications for state STD programs. The ACA has increased insurance access for adult children up to age 26 through coverage on parents' plans. It also requires most people to obtain insurance coverage or pay a penalty, offers subsidies to some to increase insurance affordability, and offers state incentives to expand Medicaid to additional low-income people currently without insurance. In combination, these provisions will lead to an increase in the covered population. States that provide STD-related services, or that work with community partners to provide STD-related services, may be able to take advantage of this increased coverage by billing insurers for reimbursement of these services, where not prohibited by law.

Most of the articles included in the review identified key provisions in the Affordable Care Act that expand coverage of certain preventive services, including screening for STDs and coverage of certain immunizations. The Affordable Care Act requires non-grandfathered commercial plans to provide coverage of all A and B preventive services recommended by the USPSTF and all immunizations recommended by ACIP without cost sharing. The ACA also includes additional preventive services for women and children. These provisions may free limited state public health funds that are currently being used to provide some of these services, for other public health purposes. However, states will need to monitor the provision of services to the target populations to determine what safety-net needs will continue to be unmet, including services for undocumented immigrants.

A majority of the articles and reports included in this literature review identified the Affordable Care Act's focus on specific types of healthcare providers and agencies, which are key partners for state STD public health programs. Primary care providers, hospitals, local health departments, FQHCs, CHCs, SBHCs, FPCs, and maternal/child home visitation programs are all impacted in different ways by the Affordable Care Act. State programs may want to re-examine how they are working with their community partners, in order to identify any possible redundancies and take advantage of new opportunities for collaboration.

It is important to note that the articles included in this literature review were published post passage of the Affordable Care Act, but prior to the Supreme Court's June 2012 decision on several of the ACA provisions. The Supreme Court ruled that the Affordable Care Act's expansion of Medicaid constituted an entirely new program. As a result, there can be no penalties for states that choose not to expand their state's Medicaid program. [8] This decision immediately led to a few governors and state legislatures announcing that they would not choose to expand their state Medicaid programs, while a few indicated that they would still choose to expand their state Medicaid program. As of December 11, 2013, the Kaiser Family Foundation reported that 25 states plus DC will be expanding Medicaid in 2014, 23 states will not be moving forward with expansion, and two plan to expand post-2014.[11]

This state resistance to Medicaid expansion has several implications for expanding insurance coverage. States that have chosen to expand Medicaid will be increasing insurance coverage within their state, but half of the states will maintain a Medicaid program that is exactly as it was prior to the ACA. Since people purchasing insurance on the exchange are eligible for subsidies only if they are between 100% and 400% of the federal poverty level, in states that do not expand Medicaid, some portion of people who fall between the state Medicaid eligibility

ceiling and 100% FPL will be eligible for neither subsidies nor Medicaid. As of January 1, 2014, there was no national solution to close that hole.

### **Literature Review Limitations**

Due to the timing, the original literature review was limited to articles that reflect implementation of the Affordable Care Act as it was originally designed, and therefore did not reflect the implications of the Supreme Court's decision. The decision could lead to different outcomes than originally anticipated with respect to Medicaid expansion. Additionally, prior to the Supreme Court's decision, the issue of the insurance mandate was the one which expert commentators seemed to believe was at the core of the decision.[106] This may be reflected in the literature review: while many articles addressed the anticipated impact of Medicaid coverage expansion, far fewer focused on private insurance expansion.

The literature review only found six reports specifically focused on a particular state. Most states were not explicitly represented in the literature review; therefore, it is challenging to understand the picture of the impact of the ACA on specific states. As a result, this review largely reflected expert opinion about the impact on states in a very general way. It may also be partially biased because of the inclusion of articles about only six specific states – Connecticut, Florida, Missouri, Massachusetts, Michigan, and California. Four of the six states will be participating in Medicaid expansion of some kind in 2014 (California, Connecticut, Massachusetts, Michigan).[11] Since these articles were published when Medicaid expansion in states was presumed, four of the six reports will likely continue to be fairly accurate.

None of these articles focused primarily on the anticipated impact of the ACA on state STD programs. As a result, some important points that are STD-specific were not discussed. For example, state STD programs are the main source of provision for partner services, which

includes outreach to sexual partners who may have been exposed to STDs, and providing testing, treatment, and behavioral counseling services. Since these services are generally not provided in a clinical setting, they are largely not reimbursable by insurance. The ACA provisions do not have any impact on these non-clinical services. In order to bill for testing these partners, community health workers would, in general, need to convince these partners to come to a clinical site for service provision, which can be challenging. Timely identification and treatment of these partners is critical for reduction of prevalence of STDs and to prevent the spread of STDs within a population.

#### **Literature Review Update Post *National Federation of Independent Business v. Sebelius* Decision**

Due to the timing of the literature review and the unanticipated nature of the *National Federation of Independent Business v. Sebelius* U.S. Supreme Court decision, which upheld the legality of the individual mandate but unexpectedly made Medicaid expansion optional, the researcher re-ran the Google Scholar search in early April, 2013. The goal of the update was to find articles that included and discussed any potential impacts of the Supreme Court decision on states and as related to STDs/HIV. The researcher utilized the original search terms, plus “Supreme Court”. After a review of the search results, eight new articles or reports fit the old plus the new review criteria. Five of the new articles concentrated on reproductive health and/or family planning [107-111], one by DiVenere et al. focused on women’s health[112], one by Regenstein and Christie-Maples contemplated insurance for people in jail pending disposition[113], one IOM report, edited by Ford and Spicer, focused on HIV[114], and a Mercer County, NJ report detailed the results of a recent community health assessment[115].

Despite the new potential for numerous states to decline expanding Medicaid, five articles indicated that increased rates of insurance, including Medicaid in many states, were both anticipated and likely to have significant impacts.[108-110, 112, 114] Three of these pointed out the importance of increased coverage for young adults on parental plans up to age 26, noting that this population is of reproductive age.[108-110] Sonfield and Pollack further noted that 3.1 million youth have already obtained coverage since ACA was passed, and that this group also has high STD rates. However, they also pointed out that as a result of the Medicaid expansion being optional, a “donut hole” is created in states that do not expand Medicaid, leaving some low income people ineligible for both Medicaid and individual subsidies. However, they contended that states have strong economic and political reasons to participate, including: it eases financial pressures on hospitals and others from uncompensated care; it benefits residents, safety net providers, local governments, and private health insurance companies that run Medicaid managed care plans; and it increases employment in the health care sector. They also emphasized that states start out with a 100 percent match, reduced only ten percent to a ninety percent match over time, which is considerably more federal financial support than states get for current Medicaid coverage. [109]

The 2012 IOM report anticipated that regardless of the decision, coverage for people with HIV was expected to increase, decreasing demand for services provided by the Ryan White program. The report predicts that more people with HIV will be covered through Medicaid expansion, as well as through private insurance, and that this increase would be further promoted by eliminating pre-existing condition consideration and lifetime limits. [114] The importance of the latter two provisions was echoed by Sonfield and Pollack, who added that ending gender rating and prohibiting retroactive policy cancellation would also have a positive impact.[109]



Stulberg also mentioned the employer mandate as a driver for insurance expansion.[108]

Alternatively, the Mercer County, NJ, Community Health Assessment mentioned that in its focus groups and interviews, conducted post ACA passage but prior to the *NFIB v. Sibelius* decision, community informants raised concerns about the uninsured and underinsured, and indicated a perceived potential shortage of family planning and related services due to post-ACA government funding cutbacks, which could potentially lead to increased risky sexual behaviors and related consequences, such as STIs. [115]

Population exclusions were the sole focus of the Regenstein and Christie-Maples article. They pointed out that people in jail awaiting disposition are eligible to enroll in state health insurance exchange plans, and argue that they should also be eligible for Medicaid, noting that they could be enrolled in Medicaid once released, especially in states that expand Medicaid, because more of this population will otherwise meet eligibility requirements. They argued that this is a critical opportunity to get four to six million people of a vulnerable population enrolled in Medicaid, and that this could save states a lot of money over the long term, as states and localities have the burden of inmate health care. As an example, they pointed to a North Carolina program that enrolls inmates in Medicaid, which if fully realized, could save \$178,000 per inmate, totaling \$2 billion in one year. Savings were anticipated largely from lowered recidivism and increased time between incarcerations for people who have Medicaid after being in jail. In addition, most people in jail have chronic conditions. This includes a rate of HIV/AIDS that is four to six times that of the general population, representing approximately 19 percent of all people in the U.S. who have HIV, and they may not get appropriate and timely medications while in jail. They also noted that the incarcerated population also has higher STD rates overall than the general population. [113]

Three articles noted the omission of undocumented immigrants from Medicaid, health insurance subsidies, and health insurance exchange plans.[109, 110, 112] Gee and Rosenbaum quantified this population as numbering 12 million or more.[110] Sonfield and Pollack further noted that this means that community health centers will continue to be an important safety net.[109]

Five of the articles echoed and added to the findings of the initial literature review with respect to the ACA requirements for covering preventive services, including those for STDs and HIV, without cost sharing.[108-110, 112, 114] Both the Gee and Rosenbaum, and DiVenere articles pointed out that the ACA provides more direct access by women to obstetrical/gynecological services, without referral from primary care physicians.[110, 112] Gee and Rosenbaum also mentioned that obstetricians and gynecologists should be prepared for greater scrutiny by insurance providers for following recommended practice guidelines.[110] This could include HEDIS measures and USPSTF guidelines, which contain STD-related screening and services. Stulberg also pointed out that state-based insurance exchanges and Medicaid expansion create opportunities for consumers and states to hold plans accountable for quality, including for family planning, and provides opportunities for data collection that could be used for consumer choice, shaping policy, provider improvement, and insurance plan and research use.[108]

The January 2013 Title X Family Planning Program report by Napili of the Congressional Research Service, mentioned that as a result of expansions from the Affordable Care Act, the Office of Population Affairs has made it a priority to enhance the ability of Title X clinics to bill public and private insurers.[111] It is not yet clear to what extent this has been implemented nationally, but it is a strategy that may be shared by STD clinics—both types of

clinics provide screening and other preventive services that under the ACA will be covered by private and public insurance providers. Capitalization on this opportunity may be critical for sustaining both types of clinics.

Notably, these articles did not discuss the portion of the ACA upheld by the Supreme Court—the individual mandate. The literature review update echoed findings from the initial review regarding preventive services. Several also pointed out the potential for states to not expand Medicaid as a result of the Supreme Court decision, which could leave many uninsured in states that do not expand, including a population that will be low income and ineligible for both Medicaid and subsidies. However, they concurred that national insurance rates are anticipated to increase overall as a result of the ACA.

Although the search criteria did not pick up the revised Congressional Budget Office (CBO) estimates issued after the Supreme Court ruling, their estimates are worth noting here, as they reflect what the researcher found in the articles from the second search. As listed in Table 2, overall, CBO increased the estimates for uninsured, and reduced the Medicaid and CHIP estimates, even through 2022.[116]

**Table 2: Comparison of Estimates of the Effects of the Insurance Coverage Provisions Contained in the ACA on Health Insurance Coverage**

Changes in Insurance Coverage (millions of nonelderly people)	March 2012 Baseline	May 2013 Estimate	Difference
2014			
Medicaid and CHIP	13	9	-4
Employer	-2	*	2
Nongroup and Other	-1	-2	-1
Exchanges	8	7	-1
Uninsured	-18	-14	4
2022			
Medicaid and CHIP	17	13	-4
Employer	-3	-7	-4
Nongroup and Other	-3	-5	-2
Exchanges	22	24	2
Uninsured	-33	-25	-8

(modified from Table 1 in CBO report 43472-07-24-2012-Coverage Estimates[117] and Table 1 in CBO's May 2013 Estimates[116])

\*= between 0.5 million and -0.5 million people

## Implications for Future Research

Peer reviewed articles, and even commentaries from recognized policy experts and related articles in professional association newsletters, are subject to a lag between the time of occurrence of major activities (such as the Supreme Court decision) and publication. It could be anticipated that much research related to the impact of the decision on states is ongoing.

Future research will have to account for differences arising from whether states have implemented expanded Medicaid populations. In addition, much uncertainty remains. The November 2012 elections led to continued Republican control of the House of Representatives, leading to a deeply divided Congress; the House has passed 17 bills in the 112<sup>th</sup> and 113<sup>th</sup> Congress to repeal or defund all or parts of the Affordable Care Act.[118] It is unclear what may occur after the 2014 elections.

## **CHAPTER 4: STUDY METHODOLOGY**

The purpose of this research study is to explore the financial, service-related, and partner-related changes that state STD programs have made or plan to make as a result of the changing healthcare environment after passage of the Affordable Care Act. A qualitative approach was employed, using semi-structured interviews of leadership in eight state STD programs to understand their views about key changes that have been made since 2010, and are planned through FY 2016, as a result of the Affordable Care Act and a changing healthcare environment. The researcher was restricted to interviewing no more than one person in nine states due to the limitations imposed by the Paperwork Reduction Act on employees of federal agencies. This Act requires a burdensome, lengthy, and intensive process for approval to collect answers to questions posed to ten or more persons, which was unfeasible for the purposes of this project. [119] The interviews sought to identify and describe main points in the three key areas of financial changes, service-related changes, and community partner-related changes.

### **Research Question**

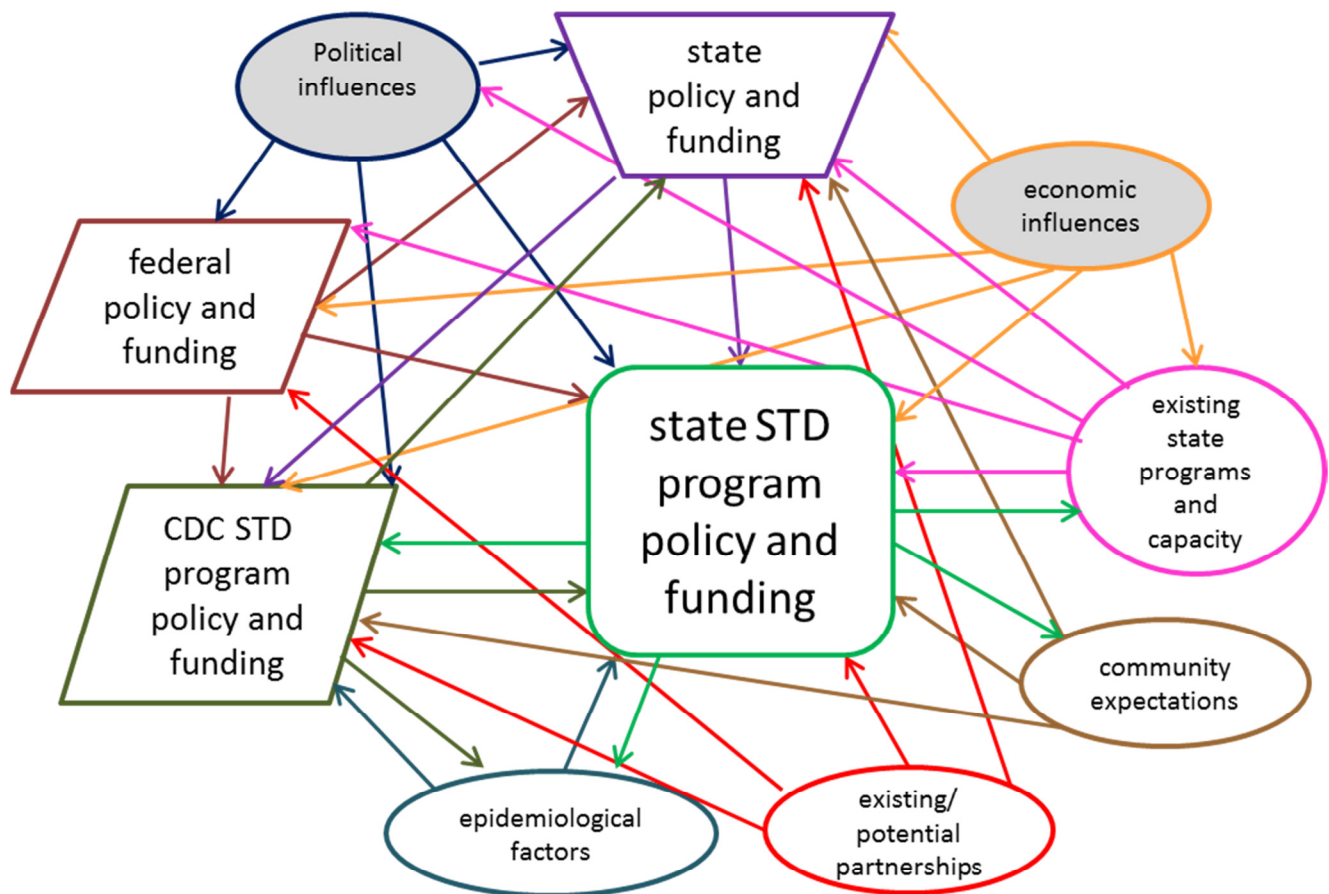
This study sought to answer the following question:

**What programmatic changes are state sexually transmitted disease programs making as a direct or indirect result of the Patient Protection Affordable Care Act?**

## **Conceptual Model**

The Affordable Care Act includes sections that may change the mix of service providers with which states would be anticipated to partner. A change in the insured population and the requirement that private plans cover certain screening services, including many for STDs, in combination with an increased insured population, may also lead states to shift what services they are providing, possibly impacting education, training, sexual partner services, screening, and treatment. Expanded coverage of the population by Medicaid and private insurance could lead federal, state and local governments to expect state and local health departments to bill insurers directly for reimbursement of services provided. To further complicate the situation, state programs are also subject to impact by numerous factors, including: institutionalization of existing programs, community expectations, existing and potential partners, epidemiological factors, economic influences, and political influences. This dissertation did not seek to describe the latter two types, shown with gray boxes in Figure 2. Both of these influences are extremely complex, and could be the subject of additional research.

**Figure 2. Conceptual model – influences on state STD program policy and funding.**



### Qualitative Study Approach

The researcher used a qualitative approach to gather information about the experience of state STD program leadership regarding changes their program has made or plans to make regarding the Affordable Care Act. Since every state program has a different local environment, and programs are likely still in the process of planning or implementing these changes, a survey would not have sufficiently captured the variety of ways in which programs may consider adapting. Additionally, the researcher predicted that these changes could be complex and a fixed set of questions would have been insufficient for capturing this complex information. The

researcher conducted key informant interviews, asking open-ended questions with prompting questions as needed, to solicit information from the participants. The researcher expected that because state programs and their environments vary, they likely approached this differently, and anticipated that each interview would progress dissimilarly. In order to capture the nuances of each state's approach, the researcher utilized a responsive interviewing approach to flexibly adjust in response to the flow of the interview, the interviewee's narrative style, and so that the researcher could follow-up on any unanticipated responses.[120]

### **Institutional Review Board Approval**

The researcher requested Institutional Review Board (IRB) approval from the University of North Carolina IRB prior to conducting the research, and was granted approval on September 12, 2013 (Appendix C).

The researcher anticipated that the state environment and other factors specific to the state might be important for understanding the context of the interview responses. Therefore, the researcher filed the IRB request to allow identification of the states, but not the names or roles of the respondents. The researcher surmised that there was a possibility that the participants could be identified by someone using publicly available information, but participation in this study was anticipated to provide minimal risk to the respondents. Answers were related to the person's occupation, and reflected the actual or planned environment within the state's STD public health program in relation to an enacted law that has been ruled upon by the Supreme Court.



## **Selection and Exclusion of Study Participants**

As the researcher was interested in the changes being planned and implemented within state STD programs, the researcher wanted to conduct key informant interviews with senior staff in up to nine out of fifty state STD programs that were making changes directly or indirectly related to the ACA. One of the primary decisions was to determine whether to include STD programs in states that had not chosen to expand Medicaid. CDC funded a related project with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), the National Association of Community Health Centers, Inc. (NACHC), and the National Coalition of STD Directors (NCSD), to engage with several state and local public health programs in order to determine the degree to which public health and health care are integrated related to HIV and STD prevention and services. Interviews and discussions with public health staff, community health center staff, and representatives of primary care associations were conducted in June through August 2013, culminating in an in-person meeting in August 2013. Initial findings were presented at the meeting, during which the investigators reported that they found that only Medicaid expansion states reported making programmatic changes as a result of or in preparation for the full implementation of the ACA. As a result, the researcher chose to exclude all states that had not passed legislation to expand Medicaid as of July 2013, as reported by the Kaiser Family Foundation. The 27 states that were excluded for this reason were: Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.[121]

The researcher also decided to exclude the Massachusetts STD Program, primarily because the Commonwealth of Massachusetts had already passed its own state health reform in

2006, completing implementation by 2008.[122] Although the Massachusetts reform had many similarities to national health reform, Massachusetts was at a different point on the continuum for conducting programmatic changes as a result of health reform. In addition, Massachusetts implemented changes without the benefit of the proffered Medicaid expansion with the much higher federal matching rate (100% in the first three years, reduced over time to 90%) that was included in the Affordable Care Act. Furthermore, the economic downturn experienced shortly after Massachusetts' 2006 health reform was different than the national economic situation after national health reform. Shortly after its health reform, Massachusetts experienced notable budget shortfalls, and made cuts to the STD program, including sudden closure of all STD clinics except one. For these reasons, Massachusetts was anticipated not to be comparable to any other state for the purpose of this study, and was excluded from this study. The researcher did pilot test the interview questions with staff from the Massachusetts program, with the knowledge that despite the reasons for exclusion mentioned above, important lessons or examples might still be gleaned from their experience.

Although insurance expansion has the potential to impact provision and coverage of STD-related services, depending upon the current activities of the state STD prevention program and its budget, some state STD prevention programs may not have made any changes and may not have planned to make any programmatic changes as a result of or anticipation of the Affordable Care Act in the next two years. States without any plans for change within the next three years were also excluded from this study, because the intent was to identify and elucidate the nature of the changes being planned or implemented.

The researcher consulted with CDC STD program staff and reviewed 2012 state STD program annual reports to CDC for the remaining 22 state programs (Arizona, Arkansas,

California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Oregon, Rhode Island, Vermont, Washington, West Virginia) in order to determine which state STD programs would most likely make changes because of the ACA. The researcher used this information to target the invitations to participate in the study; the researcher ultimately sent emails to senior staff in sixteen state STD programs to invite them to participate in the study.

### **Key Informant Interviews**

After IRB exemption was obtained, the researcher first pilot tested the interview questions with a representative from Massachusetts over the phone on October 21, 2013, obtaining verbal consent using the approved language (Appendix F). The pilot test provided the type and detail of information the researcher sought without being too lengthy, so the researcher did not make any changes to the semi-structured interview guide (Appendix G). The Massachusetts pilot confirmed that elimination of all but one STD clinic, due to state budget cuts, was likely the strongest driver for programmatic change, rather than MA health reform or national health reform, validating the decision to exclude that program from this research.

After completion of the interview pilot test, the researcher invited sixteen state STD program staff to participate in the study via an email letter of invitation. This group consisted of responsible professionals, lending credibility to the information the researcher sought to collect.[120] To recruit key informants, the researcher sent an e-mail to state STD program senior staff that explained the study and asked whether they would be willing to participate in a telephone interview (Appendix D). In addition to inviting participants, the letter identified the purpose of the research project, in order to ensure that only state programs that had made changes or had plans to make programmatic changes in one of the three areas (services,

community partnerships, and finances/budget) were included in the interviews. The email also had attached a copy of the verbal consent (Appendix F).

The researcher followed my initial emails with emails or calls within one to two weeks (Appendix E). For the recipients that indicated via email that they were willing to participate, the researcher followed up with the volunteer to schedule an interview at a time convenient to him or her. Ultimately, staff in eight states either volunteered themselves or shared the email with staff who volunteered. Participating programs included California, Connecticut, Illinois, Iowa, Maryland, Nevada, Oregon, and Washington. All interviews were conducted over the phone between October 31, 2013 and December 4, 2013.

During each phone interview, the researcher first explained the purpose of the study and asked for the informed consent of the volunteers. The researcher walked the participant through the consent form (Appendix F) and obtained their consent, making sure to explain that their answers could be associated with their state in order to tie the responses to other state-specific information, such as STD burden, budget, and other related factors. The researcher also let them know that they could opt out of the interview or choose not to answer questions, although no participants opted to do so. The researcher asked for permission to record the interview, as well as to take notes. The researcher informed them that while the transcript was to be utilized for the study and for programmatic purposes, their responses would not be used by the CDC program to penalize or reward the state. The researcher also stated that no portion of the audio recording would be utilized in an audio format for any purpose, and would be destroyed by the researcher after the study. All volunteers consented and agreed to be voice recorded as permitted under the IRB approval.

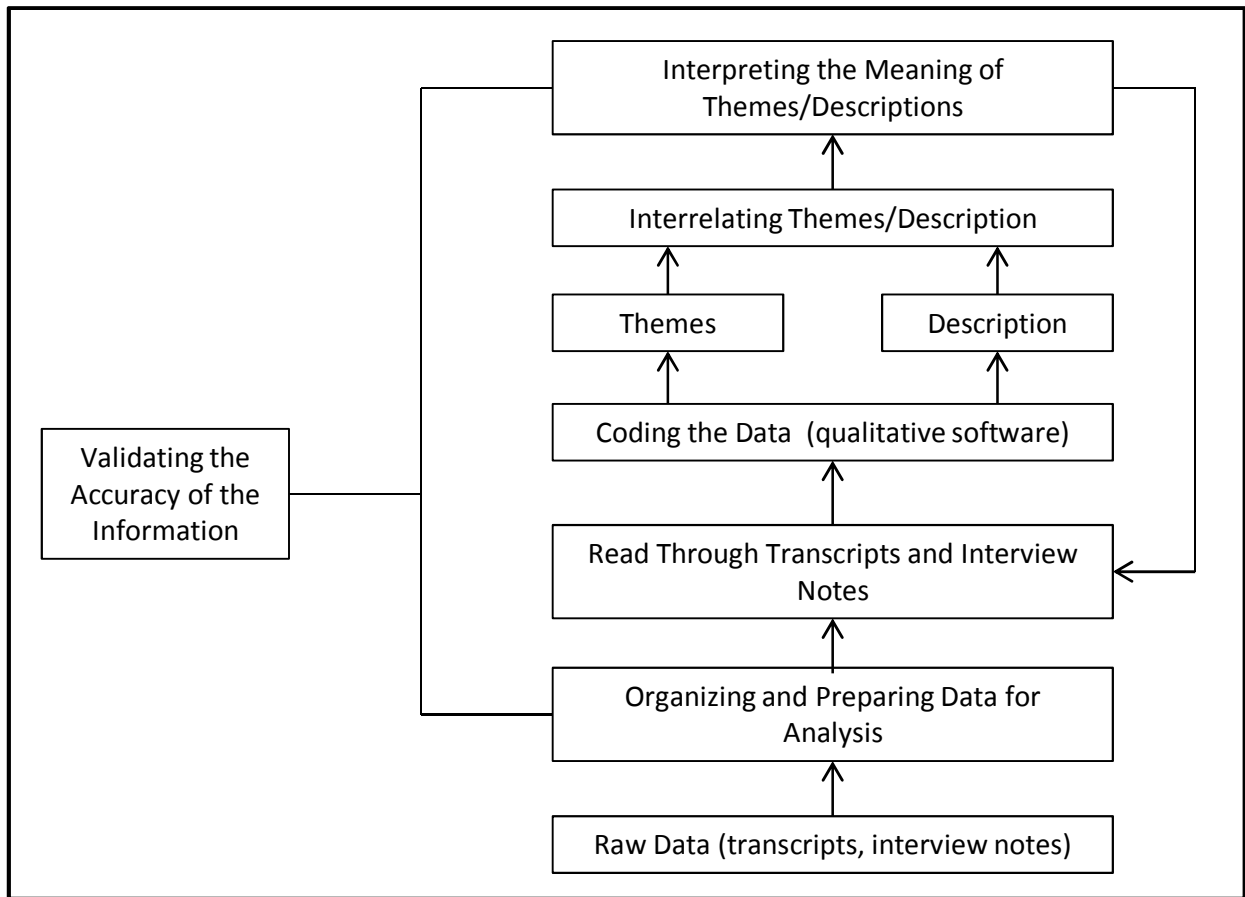
The interview questions focused on program and policy changes in three areas: service-related changes, financial changes, and community partner-related changes. The questionnaire guide is included as Appendix F. Questions focused on how state programs were adapting to the changing healthcare environment created by the Affordable Care Act, and how they may have been using this as an opportunity to make programmatic changes, including reaching out to new partners, partnering in new ways with a change in services, or through billing for services by the public health department. If the program was not making changes in a particular area, the researcher was interested in determining if barriers may have prevented changes from being made, and what technical assistance they thought would be helpful in identifying and/or making changes.

## **Data Analysis**

The researcher digitally recorded each interview. The researcher also took notes during the interview for back-up purposes, and in order to note the highlights of the responses to questions in each of the three areas (financial changes, community partner changes, and service changes), mark progress, and note follow-up questions. The researcher utilized Dragon NaturallySpeaking 12.0 speech recognition software to assist in creating a written transcription of each digital recording, and then manually checked each transcription against the audio files for accuracy, fixing mistakes made by the software.

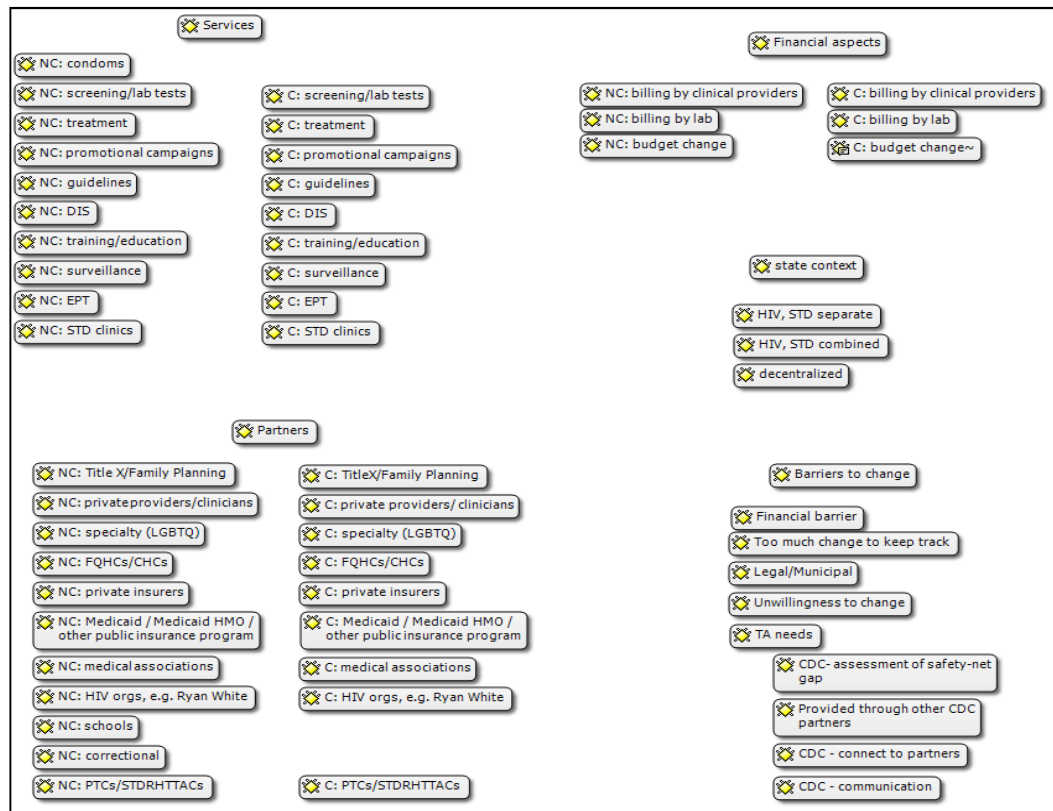
The researcher followed Creswell's general steps for qualitative data analysis, but with additional loops of checking themes and description as the researcher worked through each of the interviews (Figure 3).[123]

**Figure 3: Data Analysis Process (Adapted from Creswell)**



The researcher reviewed the transcripts and notes, and then coded the data utilizing ATLAS.ti version 7.1.6, a computer software program designed for qualitative analysis. Analysis was divided into the three main linked areas – financial changes, community partner-related changes, and service-related changes. The researcher identified for each transcript whether specific changes in each of these areas (services, financial, partners) were or were not being made. The researcher also identified barriers, including needs for technical assistance. The researcher also kept a “notable quotes file” as the researcher conducted her analysis, as described in Rubin and Rubin.[120]

**Figure 4. Interview Codes Used in Atlas.ti**



NC=no change; C=change

The researcher surmised prior to the study that state context may be relevant to understanding the participants' responses.[120] To see if responses were related to context, the researcher looked at two sets of factors. First, the researcher looked at the STD burden and CDC funding level for each of the interviewed programs (Table 3). CDC directly provides funding through a cooperative agreement to all of the states from which a leader was interviewed. In the case of California, San Francisco and Los Angeles are separately directly funded by CDC for STD prevention. Chicago is also funded separately from Illinois, as is Baltimore from Maryland. When looking at these factors, and the analysis of the interview transcripts, the researcher

determined that there was little or no association between these factors and the responses to the questions.

**Table 3. Interviewed states and CDC STD state funding, population (ages 15 to 44), and burden of select STDs.**

State	FY2013 CDC STD Funding*	2010 Population Ages 15-44**	Reported Rate per 100,000 Population, 2007-2011		
			Primary & Secondary Syphilis	Gonorrhea	Chlamydia
California <sup>†</sup>	\$5,413,704	11,563,373	4	58.5	380.5
Connecticut	\$718,672	1,383,547	1.7	71.9	353.1
Illinois <sup>‡</sup>	\$2,070,464	3,997,598	1.8	95.2	352.1
Iowa	\$727,137	1,177,318	0.7	59.7	322.5
Maryland <sup>+</sup>	\$1,232,806	2,076,687	3.7	74.7	336.5
Nevada	\$699,354	1,130,438	4.1	75.6	374
Oregon	\$968,331	1,531,577	1.4	32.3	305.3
Washington	\$2,438,155	2,765,726	3.2	44.3	320.5

\* Some states also allocate state funds for STD prevention; some counties/cities also allocate funds for STD prevention. Funding information - CDC internal.

\*\*2010 U.S. Census[124]

<sup>†</sup> excluding San Francisco and Los Angeles

<sup>‡</sup> excluding Chicago

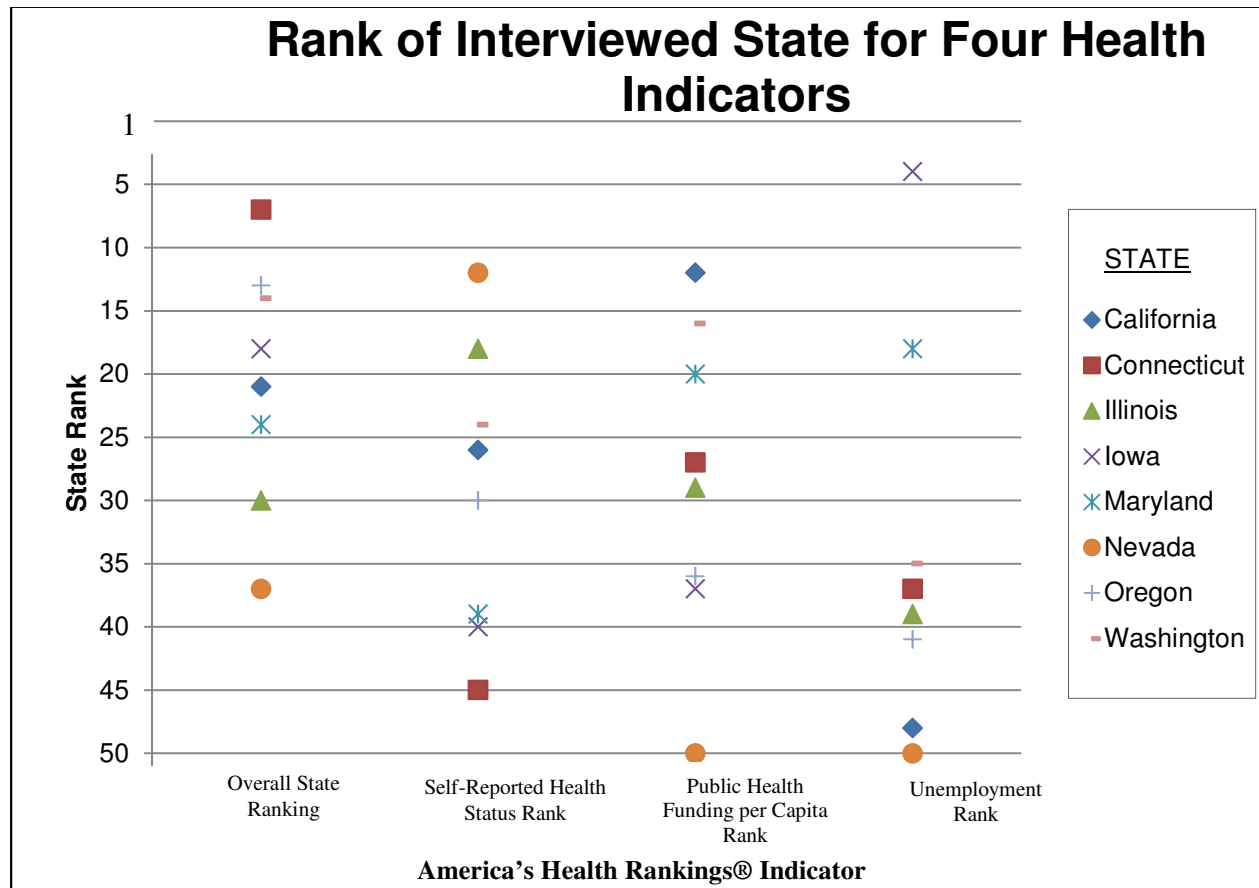
<sup>+</sup> excluding Baltimore

Second, the researcher looked at how the eight states included in the study compared in general with respect to several items pertinent to health, utilizing 2013 America's Health Rankings®. Using the visual distribution of these factors for the eight states (Figure 5), the researcher determined that these states represented a reasonable range across these indicators. From metrics included in America's Health Rankings®, the researcher chose overall rank to ensure that a range of state ranks were represented for the most comprehensive indicator for this dataset. The researcher looked at health self-assessment rank as an indicator of perceived health status by state residents, which may be indicative of potential healthcare utilization moving forward. The researcher included public health funding per capita to determine if the states were skewed to either high or low funding. The researcher selected unemployment rank as a gauge for



the state economic status relative to other states. Overall, the researcher determined that the eight states represented a reasonable cross-section with respect to these indicators, and that these state-specific factors did not appear to be associated with differences in the information collected during the interviews. [125]

**Figure 5. Interviewed States and Selected Health Indicators [125]**



As a result of the two assessments, the researcher chose not to attribute the responses by state.

## **CHAPTER 5: RESULTS**

The main purpose of this study was to identify changes that state STD programs were making either directly or indirectly because of the Affordable Care Act. The researcher focused on three potential areas for change: services, partnerships, and financial changes.

### **General Findings**

In general, all of the states included in the study were making changes in at least one area. To gauge the involvement of the STD program in state level health reform discussions, the researcher started with a general question:

Has your Governor's Office, State Public Health Department, or other State Governmental leadership engaged the STD programs in conversations about the Affordable Care Act and its potential impact to state programs, and what have the conversations entailed?

Only one of the respondents stated that people charged with making changes were within the same level of the organization:

“Not from the Governor's office, and there's people here that have been assigned to try to get up to speed with the Affordable Care Act, and so they have stopped doing other tasks and have started to think about how our programs will interface and be changed by the Affordable Care Act.”

The remainder of the respondents reported that their program and staff had not been charged by state senior officials with direct involvement in health reform. Several respondents explained that health reform discussions were primarily happening elsewhere in the organization, one said:

“I would say, in general, no...all the preparation is happening in a separate organization within the Health and Human Services Agency...They are operating at a very high level in government, and the STD program is at a very low level in government, in the grand scheme of government organizations.”

Another stated, “No...The whole expanded coverage and all that, that’s happening at a really high level.” A third interviewee reported that the STD program had an opportunity to provide some input “up the chain”,

“In a trickle-down manner, yes. And by that I mean they didn’t talk directly to me, but the Gov.’s office did talk to...the [Health Authority] Director and the Public Health Division Administrator-Director... yes, there was that opportunity even though we didn’t talk to the folks directly.”

In general, activities and engagement related to the Affordable Care Act were primarily leadership driven at the STD program level, or in the cases of combined programs, the HIV/STD program level, or TB/HIV/STD program level. One respondent explained,

“The governor’s office did not engage the STD program specifically...But at the state STD program level, we have been very active and engaged in it. So we initiated a lot of questions to the state...[The state is] still very, very busy setting up the system, so their focus has been the overall system. And we have contacted them as needed for things that relate to our program specifically.”

Overall, structure of the state government and placement of the STD program within it also had some impact, as did the degree of decentralization, which is addressed later in the results.

## **Major Themes**

The researcher identified six major themes from the interviews (Table 4). Although the questions were mainly focused on three main areas of changes, four of the six themes identified from the interviews were cross-cutting (Themes 1, 2, 3, 6). The following section addresses each theme, including quotes from the interviews to illustrate responses to each.

**Table 4. Major Themes Identified from Interviews with State STD Program Senior Staff**

Theme #	Major Theme
1.	The degree of decentralization of public health governance and provision of services in a state is directly related to the amount and type of change reported.
2.	All states have either utilized partners to take advantage of changes related to health reform, or at least recognize the potential opportunity for doing so in the future.
3.	Public health programs will continue to have an important non-redundant role in STD prevention.
4.	Programs that have not already started billing for laboratory services and/or clinical services directly, or working with programs that bill, are considering or actively pursuing billing.
5.	For public health STD programs, ACA (and ARRA) have generated hopefulness about future improvements in surveillance, but for most, those changes are likely still years out and additional resources will be required.
6.	Barriers to making changes include financial challenges, existing laws and municipal structures, and unwillingness to change.

Theme 1: The degree of decentralization of public health governance and provision of services in a state is directly related to the amount and type of change reported.

All of the states included in the study had some degree of decentralization in governmental public health, although the nature and degree of decentralization varied. Some interviewees reported passing a portion of federal and/or state funds to counties, regions, or cities. The most decentralized state reported passing almost all funding to local infrastructure, retaining only a small program at the state for technical assistance; overseeing funding; and managing statewide surveillance, with reports from the smaller units across the state. These dissimilarities meant that while all state STD program leadership had a degree of professional influence, they had varying degrees of control over what changes were made in STD programs state-wide. In more centralized states, the state STD program has a greater direct impact on the rate of changes in STD program activities throughout the state—which could lead to either slower or faster rates of change, depending on the state. In very decentralized programs, local

authorities had more autonomy to make changes (or not) at the pace that they desired and their local circumstances indicated.

One of the major examples provided regarding decentralization was regarding who “owns” the STD clinics. The interviewee from the most decentralized state explained,

“We are a decentralized state. It is the local county health departments that have the jurisdiction. It’s their game. We provide either per-capita funding, specific funding, pass-through funding, whatever. It’s the county health department that is the shaker and mover in their jurisdiction.”

Another interviewee explained a similar relationship,

“We have independent and autonomous local health jurisdictions in [the state]. And each of those have the authority and the autonomy to do service delivery in their jurisdiction. So the state health department doesn’t run any clinic services and doesn’t in fact, in general, with some important exceptions, doesn’t really have direct patient contact, direct client contact. So really our role is to provide leadership and funding and support for the local jurisdictions.”

A third respondent explained what parts of STD program activities and funding were decentralized,

“We are a decentralized state; we don’t dictate that [local health departments provide clinical services]. Our STD program does not give funds specifically for clinical services. Local health department support their clinical services through what is called ‘core public health funds’, which is state general funds that go to local health departments, and whatever additional local money they can put in. There are only a few counties that have local funds available. Our state categorical STD money, and there are some state funds that are categorical for STD—most of our categorical STD funds are from the CDC grant and that goes to support partner services. So we can assure that is available statewide. Also laboratory services, and then central services such as statewide surveillance.”

One interviewee explained that while the relationship with some partners is retained at the state level, county and city health departments are similarly treated as partners of the state:

“Really, our relationship with [county and city health departments] is very similar to what it’s like with several of our family planning clinics, in that we provide CT/GC test kits, and of course, we’re also a resource for technical assistance, as needed. And meds. We do provide treatment medications for the STDs as well.”

Several of the interviewees explained how partnerships are initiated and maintained in decentralized states. Three explained how public/private health connections may be encouraged by staff at the state level, but ultimately would be under the authority of the local jurisdictions.

One stated,

“We have a lot of STD clinics and they’re in larger cities and they’re still here. So I’m still working with them, and I know that they are locally going to need to get more affiliated with community health centers, but that’s kind of at the local level, and they’re going to need to address that.”

A second state interview had a similar response,

“...a lot of that is all local connection – local health department plus local FQHCs. It really is about them working out how they work together, so we have been promoting that with the local health departments, ‘get to know your local FQHC’, see if there are agreements you want to develop about who does what.”

A third echoed a similar situation, “Not at my level, we can have that [partnering with primary care providers] conversation with the locals, but...it still stays really centralized in the local centers.”

Several of the respondents explained that other types of partnerships were also under the authority of the locals, not the states. One interviewee highlighted interaction with jails, “Many counties work closely with their jails, but that is a county by county designated piece, and the counties that don’t have that many funds aren’t able to really do that much with their jails.”

Another respondent underscored how decentralization affects school partnerships, “We encourage local health departments to work with schools. That varies widely across the state... there are some counties that have school-based clinics, and as part of healthcare services available through school-based clinics, they can offer STI screening, STI/HIV. But that’s just a few counties.”

Many of the states had DIS who reported up to the state level for sexual partner tracing, but in others, this was also a decentralized function. One stated, “We as a state agency don’t hire DIS, that’s all done at the local health department level. They perform the DIS activities, and we actually provide TA and assistance on the phone, and we also do the training, the twice a year training.”

Theme 2: All states have either utilized partners to take advantage of changes related to health reform, or at least recognize the potential opportunity for doing so in the future.

All of the states recognized the power of partnerships, and how partnerships would be important for navigating through and retaining viability throughout the process of health reform. Although the most decentralized states were mainly encouraging the city and local public health authorities to form partnerships with healthcare providers, some were looking into doing that at the state level. Several interviewees were focused on trying to form connections with safety-net providers. One respondent explained some of the challenges, “Oh, it’s just painful, how many times you can sit at the table with different people, [FQHCs] keep changing them over. So, it’s hard, that’s kind of a hard group, but I think, you know with what’s going to happen with ACA here, that’s going to be a big deal.”

Several respondents explained how they were already able to point to functional and beneficial partnerships that were helpful in preparing for health reform. One interviewee stated, “We work very closely with Planned Parenthood and they’ve come in and done some presentation on [billing] because they’re way ahead of the game...They’re, at least for me, a great learning experience for how this is going to be happening...” And further, “we are hoping

in the future to get some better data from them, and with the contract we're going to have with them, we're going to be able to establish that and make that happen.”

Another state respondent explained how they connected one set of partners with another to facilitate changes in preparation for ACA-related changes, “...we are not billing experts here at the state health department, at least not in my bureau. So what we've tried to do is work with some other partners, and connect them so that they can get some infrastructure set up so that they can start billing for STD services.”

Five of the interviewed respondents mentioned a specific set of partners that were providing assistance, the STD-related Reproductive Health Training and Technical Assistance Centers (TTACs). The TTACs comprise a regional infrastructure that is funded by CDC to provide training and technical assistance to the state, territorial, and local STD programs. Several indicated that the TTAC in their region was providing provider training and/or billing-specific assistance to STD clinics within the state. One of the interviewees said,

“[The TTAC] has been very helpful for us as a facilitator, the whole managing everything with this with the local clinics, so I depend a lot on them. They've come in and done trainings for all the clinicians and then met with them individually, and as a group, for different topics related to Affordable Care. So, they're managing a lot of this.”

A second interviewee shared details about sustainability training provided by their TTAC to the local clinics,

“the STDRHTTAC—terrible name but very good service...we had them come down and do a two-day training for STD clinic sustainability, we offered it to all, and 15 local health departments accepted, which meant each department sent a team of three people: a clinician, somebody from their fiscal office, and somebody with administrative decision-making powers.”



Most of the states were also looking at partnering with private providers, whom they anticipated would be seeing more patients within the target population for STD screening. One respondent explicated,

“Yeah, there’s probably a ton [of partnership activities]. I sort of mentioned reaching out to providers, recognizing that a lot of new providers, non-STD, non-family-planning providers, are going to be seeing our at-risk patients, are going to be responsible for doing sexual history and counseling and screening. And so we are trying to reach out to those providers in particular.”

One respondent explained how he/she planned to use partner connections to reach private providers,

“In 2014 I hope to be able to use [the primary care association] as an avenue to get in with the private providers, because, quite frankly we need all of the help that we can get with private providers. We have problems with reporting, so I’m nervous about getting them to ramp up screening if I can’t even get them to report.”

Another approach to improving provider STD screening rates was through partnering with health plans. Six of the state program interviewees said that they had worked previously with, currently work with, and/or plan to work with Medicaid and/or private health plans to improve STD screening. One state respondent explained his/her strategy,

“I’m working with health plans, we mentioned Medicaid before. Also we are hoping to work with our largest private insurer in [the state] to get some data from them to see if we can figure out who is screening, in terms of what providers, and once we get those data, being able to go in and target our efforts for increasing training and education.”

An interviewee from a different state cautioned overstating potential results from partnership with health plans,

“So yeah, we’re planning on working with the HMOs, trying to increase awareness, and trying to problem solve some of those barriers with them. We’re also going to work with our Medicaid managed care providers to also do the same thing with HMOs, to increase...I don’t know how successful going to be...[chlamydia screening of sexually active women age 24 and under] is a HEDIS measure, it’s one of the accreditation measures now, so that’s given a

little more teeth for them to try to improve those rates, but it's hard to change provider behavior.”

Theme 3: Public health programs will continue to have an important non-redundant role in STD prevention.

All of the state program interviewees agreed that public health would continue to play an important role in STD prevention, regardless of health reform. The interviewees mentioned several of the important functions that public health STD programs fulfill. One major role was assessment, which included surveillance, and will be discussed under theme 5. The other major role was assurance, which included: working with partners to ensure that the population for whom STD screening is recommended receives screening, providing or working with partners to provide safety-net STD services, tracing sexual partners, and supporting specialized clinical services.

One of the respondents illustrated how assessment and assurance were inextricably linked in public health programs,

“...when we look at the big data sources, we find the private providers and smaller practices don't do as well on some of the quality measures that we're interested in. So there are some concerns that even though people will have better insurance, that covers more services, they may be going to a family doctor or private provider who doesn't normally do a routine sexual history or whatever.”

Many of the states planned to use that type of information to work with partners to ensure that the population for whom STD screening is recommended receives screening. One respondent explained,

“Most of the changes I have in my head right now are trying to change mindsets and attitudes, mostly of private providers and trying to get them to do screening and treat properly and take a sexual history and things like that...We just find a lot of those doctors don't want to think that the kid they examined for an ear infection might have gonorrhea.”

Another interviewee planned to address this through “...continual education of [clinicians], making them aware of what’s available for them out there, so they’re not stuck on their own.” A third interviewee explained both the challenge and some of their approaches to overcome this,

“physicians historically aren’t comfortable with performing a sexual history on clients. The EOB, the explanation of benefits, that goes home...that’s a huge barrier. I think also a lot of pediatricians have a long-standing relationship with the teenager since birth, teenagers aren’t always comfortable, approaching their primary care provider for STI screening. So yeah, we’re planning on working with the HMOs, trying to increase awareness, and trying to problem solve some of those barriers with them. We’re also going to work with our Medicaid managed care providers to also do the same thing with HMOs, to increase.”

All of the programs mentioned the continued need to provide safety-net STD services, either directly or through partners. One state said that this would continue to be needed, “And again we’re going to be supporters of those [partners serving] the un- and underinsured. I have funding in place to support those I’ve been helping with that.” One of the respondents explained that local public health officials shared this opinion, “[health officers] in general feel very strongly that this is core public health. They feel like it is a necessary service for their communities. They are very concerned this service remains available.” Some interviewees saw public health as a fail-safe that must be there regardless of the form and progress of health reform moving forward. One respondent explained,

“...we’re worried about testing. Because we do not have state funds for public testing, and depend on CDC funds for that. If we were doing universal health care I wouldn’t be so worried about it, but we’re not. Health reform helped many people but not all, but it’s insurance reform. You’re still depending on, will it get reimbursed, whether you’re a private provider, or a public provider, it’s still, I think that whole reimbursement thing can be a barrier to testing. It certainly was for HIV. Now with the new USPSTF guidelines, that should turn around—we’ll see if it does. Lots of times people would not test because insurers wouldn’t pay for it.”

Another state respondent expressed the need to support safety-net services where the Affordable Care Act simply does not, “So, within these [incarceration] intake facilities, we are beginning a

conversation about doing kind of an STD screening, including HIV, so everyone would get offered this... Affordable Care, as far as we're concerned, will have no impact on inmates."

One respondent thought that the Affordable Care Act could lead to higher utilization of state and local facilities,

"They think they're going to see higher utilization is what they think. In [W] County. I just didn't see it that way, but it is really smart, they're actually planning to see more...if more clients that would previously be hesitant to go to a health clinic because they weren't sure how to pay, maybe now they will have insurance and maybe now the wait will be too high at their primary care doctor."

For decades, public health has conducted DIS work, which included tracing sexual partners. All of the interviewees thought that this would continue to be a needed public health function that the ACA does not directly address. One simply stated, "I think even with the Affordable Care Act, that traditional partner services that is being conducted will continue."

Several of the state interviewees emphasized the value of retaining specialized clinical expertise about STDs in the public health arena. One respondent thought that as a result of the ACA, "...the local health departments...are going to be getting more calls because they're the experts." Another state respondent thought that this was also important for providers seeking expert advice for their patients, "There still is a place for some people who want to go to a clinic where they know that that's what they do all the time, there are experts there. And that does happen. [M] County does kind of serve for not only people but also for providers."

One interviewee expressed general concerns with making changes too quickly to the public health infrastructure because of political uncertainty at the national level around the ACA,

"I'm just not sure what's going to happen if a Republican president comes in. I would hate to dismantle all this infrastructure that we have in place. If a Republican president would get into office, how would they dismantle the system, what pieces would they keep in place? You know, everything we're talking about now is, we're trying to plan for the future, but sometimes that's difficult. Because we're really not sure what's going to happen."

Theme 4: Programs that have not already started billing for laboratory services and/or clinical services directly, or working with programs that bill, are considering or actively pursuing billing.

State programs have been encouraging STD clinics to bill for services as a way to remain solvent in the wake of health reform. In decentralized states, this meant working with counties or other partners over whom they have little or no authority. As a result, within a state, some clinics were billing and others were not yet billing. One interviewee stated,

“...some counties, even smaller counties, have 10, 12 contracts in place and yeah it was a lot of work, but they’re in place and they’re ready to bill and ready to collect that information and other counties, a couple ... seem to be lagging behind and hopefully they’ll catch up and really participate as a provider and be able to survive in the new environment.”

Another interviewee explained that the effort to bill was not limited to STD services,

“We’re only working with our Medicaid agency at the state health department, but a lot of our local health departments are realizing that if they want to stay in the game, they have to bill private pay and Medicaid...There are a couple counties without health departments, so we at the state agency cover those areas. [Local health departments] actually are in the process of trying to set up billing, not only for STI services, but immunization services, anything they can get revenue sources from.”

One respondent explained how they were working to promote billing for services despite decentralization,

“So what [state staff have] tried to do is work with some other partners, and connect them [to counties] so that they can get some infrastructure set up so that they can start billing for STD services... It was a long discussion amongst them about how to accomplish this, because they also understand changing resources, etc. So this policy is in the process of being changed, and probably in 2014 most local health departments will begin billing. Limited billing. They will probably bill Medicaid and private insurers. But the whole private insurer thing is complicated by things like whether you are in network or not. The state health department is working with private insurers to try to develop umbrella contracts that all local health plans can come under. But that kind of thing goes slowly, so that’s not in place yet, but it’s certainly being pursued. Things like ways to make credentialing easier is being pursued. All those building blocks. It’s

certainly not handled here in the STD program, it's a department-wide thing. But that work is in process."

The interviewee from a state that centrally managed a contract to partially fund STD clinics said that they were moving forward with billing as well, "We have been speaking with [contract STD clinics] probably for about a year now, to explain the need to become third-party reimbursable...I would say of the nine, most of them are going to go to third-party billing, we [partly] fund nine but there are 10 [STD] clinics we work with very closely." Two respondents stated that other types of clinics that they partner with are ahead of the game. One said, "In our state, over 10 years ago, most of the county health departments closed their STD clinics...we work with Title X/Family Planning—these groups have started to bill." The other stated, "We're still trying to get our clinics to bill for STD services, exams, and the testing, and the medications. Again, it kind of depends on whether you are talking about a family planning clinic, versus our traditional STD clinic. Our family planning clinics are way ahead of the game by comparison."

It was clear from the interviews that the ways in which states operated their public health laboratories were quite variable, and often the labs reported up to a different part of the agency. This has led to some challenges for STD programs, but the interviewees remained undaunted. One expressed partial success, with some ongoing difficulties,

"Currently the only agency we are billing [for state lab STD tests] is Medicaid... We are trying [to encourage the state lab to bill private insurers]. It is something that we've at the STD program and the state, we've really been trying to have a conversation about. There has been a lot of turnover lately in our state public health lab. Quite frankly, we don't feel that there is buy-in from their upper administration to do billing."

Another interviewee explained that he/she had to involve other partners to gain traction,

"The other piece of this that has been a real struggle for us, is getting the state laboratory on board with third-party billing. You really need to do this, or you're putting yourself out of business. Planned Parenthood, who does a large business with the state laboratory has said, if they do not get on board with third party

billing, more than likely they're going to go away... we finally got the word from the powers over there, 'yes, let's move forward with this'... We are not anticipating any changes with the state lab until probably 2015 so."

Two states reported no challenges, and have been billing for STD laboratory services for a while. One shared the success of laboratory billing in his/her state, "We actually have over the last couple years been able to bill Medicaid, which has brought in a substantial amount of dollars, to help support the gonorrhea and chlamydia screening and syphilis and HIV testing that we do at the state laboratories."

Theme 5: For public health STD programs, the ACA (and ARRA) have generated hopefulness about future improvements in surveillance, but for most, those changes are likely still years out and additional resources will be required.

All of the interviewees recognized the opportunities that health reform created to potentially improve electronic surveillance. This included not only the ACA, but also the American Recovery and Reinvestment Act of 2009, which required adoption of electronic medical records by 70% of the primary care population by 2014[126] and provided funding of \$2 billion for health information technology and other health-related programs.[127] One respondent shared, "[Improved data is] I think the big change, absolutely, I think that the ARRA funds funded a lot of movement toward electronic health records." Another respondent explained the potential with respect to health information exchanges, "What we want to do is develop a plan for creating a better surveillance system that doesn't rely on clinician reports. That would tap into some of these large health information exchanges and data sources. So we are actually pretty optimistic." One interviewee explained the benefit of electronic laboratory reporting,

"The other thing that's happened in the last couple of months is electronic lab reporting...electronic laboratory reporting is going to be huge, a huge savings in

terms of time and effort, and hopefully we will not lose anything by quality, may even gain some things by quality as there may be things that weren't reported before, we'll get more key data than we were getting before, from the labs at least."

Alternatively, other interviewees brought up challenges to implementing improved surveillance. One problem they mentioned was lack of public health funding for system improvement. One of the respondents explained,

"The potential is there, but there has to be quite a bit of funds that go to public health to develop the systems here to capture that electronic reporting...It is not only STDs, it is all communicable diseases that have the possibility of reporting. And all states are in the same situation, there weren't funds that went out to states to develop their electronic capturing of the electronic medical records that hospitals and clinics are using now."

Another state interviewee reported that getting improved data systems established can be time consuming, and expectations needed to be reasonable,

"Electronic medical records kind of create these dreams. [The] state is setting up a health information exchange, the HIE. It's taking a while to get it to do what they want. It seems to be working well for the hospitals so far, but they still have a long way to go on the meaningful use part that they wanted, so that reportable conditions would come in. That's definitely the plan and the idea, but it's taking a while."

A third respondent explained that everyone wants more and better data, and STDs may not be the highest priority,

"We have had some discussions over just the past week about meaningful use data II, and working with some of the larger medical providers in the [large metro] area, because they have health systems, where maybe 10 or 12 hospitals belong to one health system, and trying to do some data mining of their EMR, EHR, where they can just develop an HL7 file format, which we can dump into our [state] NEDSS, which is our National Electronic Disease Surveillance System. We are looking at that. Unfortunately, I guess that's going to compete with some other health indicators, we are looking at that. We may have to prioritize which ones we want to work on first, and STI may not be one of them. But we are working also with laboratories to get data with electronic lab reporting that comes right into our [state] NEDSS system. But yeah, we are actually looking at a lot of different ways that we can increase data collection accuracy, timeliness."



A fourth interviewee shared that while there was a potential for more electronic data, he/she cautioned that this new data may still have some gaps due to confidentiality laws,

“If somebody doesn’t want confidential information pulled out of their health record, you can’t do that, it is sort of all or nothing. So that exchange of information and polling data from those is quite a ways down the road for us. But we are involved in those conversations.”

Some interviewees reported on the progress of partners’ ability to provide data. One had established a way to get improved data through a contract partner, “So [family planning clinics] are going to give us some really good data on their Medicaid population, private insurance, uninsured.” Another said that their reporting partners were ready to provide electronic data, but the health department was not yet able to receive it,

“Yes, I think [surveillance] is actually going to be one of the largest changes, and it is a little bit unknown how fast this could happen, because data systems are very expensive, and changes to them are very expensive and sometimes time consuming... so hospitals and other types of providers are now totally on electronic medical record systems but they still have to send physical copies into the local health department when they are reporting disease... So there will be, though, this health information exchange, that was funded, and there was an intent, when the money went out to providers to have meaningful use of the data that they are having on their electronic medical records, and some of that language that said ok, you need to report notifiable conditions to public health. But public health isn’t ready to accept that, so it’s a catch-22, because they’re ready to report it that way.”

Theme 6: Barriers to making changes include financial challenges, existing laws and municipal structures, and unwillingness to change.

In addition to the barriers to surveillance improvements mentioned above, state STD program respondents shared challenges that included lack of funding, rigidity of existing infrastructure, and unwillingness to change within the public health system. One state explained the difficulty in working with a budget that required time and paperwork to shift purposes,

“Unfortunately we’re not funded well enough to work with them to mitigate those pains of having to repurpose funds”. The respondent went on to explain the challenge of ensuring safety-net services, despite having funds cut prior to identifying other funding sources or full implementation of reforms,

“The state is like, ‘okay, we’re ready to cut your funds, you’re on your own’. I think it pushed [health department clinics] to get the [billing] contracts in place, but also created a lot of fear and uncertainty about how they were going to continue to provide those basic services. And you know sometimes STD falls off the radar when you’re talking about multiple millions of dollars of basic healthcare services for low-income populations.”

Another explained that funding challenges led to staffing problems, slowing the program’s ability to make changes,

“I just had an employee leave last week, and he got extra thousand dollars a month taking a job in another section. And last December I had a very good data person, and she had an entry-level position doing some of our data manipulation, and she got a promotion to make more money a month.”

In addition to the barrier of decentralization, other municipal structural barriers were reported by the interviewees. One thought that size of the infrastructure slowed the ability for changes to be implemented,

“I think once health departments get to be a certain size, things just take longer. Getting things through the council just takes longer, making huge significant changes like counties that decided to go to an electronic medical system and they had two different hospitals and seven different clinics, and it’s just a bigger job to move in a new direction, and so whether it’s EHR or billing, or whatever, it takes a little bit longer.”

Another stated that having different parts of the program overseen by different parts of the state government created some challenges,

“As you can imagine, there are a lot of politics between the state health department and the state lab...[our state] is a little unique, in that the health department and the state lab are not really together. Our state public health lab is a part of a university system...we are separated by 100 miles. So it causes some complications. We don’t really have a good, I guess, administration over both the

state public health lab and the state health department, so those administrators are constantly going back and forth trying to reach some kind agreement, and it hasn't happened yet."

One interviewee explained that existing staff regulations created an obstacle, "...personnel here at the state level has been a barrier. The ability to hire qualified staff at the state level is an issue... We have to follow the union hiring rules, and that's been really difficult...sometimes takes 6 to 9 months to replace somebody."

Six of the eight STD program staff interviewed reported barriers that arose due to unwillingness to change. Several respondents explained that the ongoing uncertainties around health reform implementation had led to some unwillingness to change. A respondent summed up, "I think a lot of people are in a 'we'll see pattern'." One interviewee explained the challenge of convincing other parts of his/her agency to change,

"So the other piece of this that has been a real struggle for us, is getting the state laboratory on board with third-party billing... We've had several meetings on this and I don't feel like the majority of the staff over there are really listening to what I'm saying. You really need to do this, or you're putting yourself out of business."

Another respondent reported difficulties that arose from the lab staff not seeing the potential value that health reform would bring in making changes,

"To [the lab the] chlamydia/gonorrhea program is just one of many, and their feeling is that this is the only program they'll be able to bill for, so why do they want to build the infrastructure, and do all the start-up costs for just one of their dozens and dozens of programs? They have indicated time. They would have to hire another person. They don't know who all they would need to contract with."

Several respondents reported that many in public health saw STD prevention as a public health function, which should remain unchanged, regardless of health reform. One explained,

"...my suspicion is there's been long-standing, an ethical feeling that these services should be provided for free, and the lab shouldn't bill, and just, you know, thinking that that is the role of public health and public health shouldn't be participating in a market in the way that the future's being painted. And I think it's old-school, probably, and I think it's just created some delays in having to

convince the leadership that that's just not going to work. And there needs to be some adaptation or they're just literally not going to exist."

A second respondent echoed that problem, "Our STD clinics, you know, they're old-school, and they think anybody who comes in should get a test, free of charge, regardless of insurance status. So we're having to work with them individually, and again it is something that we have struggled with..." .

Another interviewee, in a state where the local clinics were billing or in the process of implementing billing, thought that behind the resistance to change he/she encountered was a domain ownership issue, "I think just the challenge here, some of it is their capacity but some of it is territorial. Why would I work with an FQHC when STD/HIV is my specialty, and how would that work?"

One of the respondents did report finally making some headway with those who had initially been unwilling to change, "I think change is difficult for people, but I'm definitely seeing it and the landscape is changing in terms of the public clinics, and getting serious about participating in the billing process."

## **CHAPTER 6: DISCUSSION AND CONCLUSIONS**

Many details varied from one state STD program interview to another in the three major areas examined in the study: partnership changes, service changes, and financial changes. Nevertheless, the six themes discussed above were common to all or most of the interviewees. The interviewed senior staff were all professionally motivated to implement changes that would take advantage of opportunities created by the Affordable Care Act in a way that would support continuation of essential public health STD prevention. However, their degree of authority to implement changes varied, based upon the degree of decentralization of governmental services in their states. As a result, they reported utilizing their strengths to influence changes in areas not under their direct command.

### **Discussion**

All of the state interviewees reported working with partners. The number and types of partners differed based upon the nature or degree of decentralization. Each program had engaged in some discussions about changes that could or should be made with at least two partners. Overall, partners were thought to be useful regarding implementing ACA-related changes because: 1) they had more resources to assess what changes should be made, 2) they had technical resources that could be shared, 3) they were further ahead in making changes, and/or 4) other partners were perceived to be more willing to listen to their partners than to STD program leadership.

Most respondents recognized an increased need for clinician training, especially for private providers, as they anticipated that in each of their states more people would have public or private insurance and therefore improved ability to seek primary care. Several interviewees supported this assessment by pointing out that although the HEDIS measure for chlamydia screening of at-risk young women had increased, it was still low. In 2012, the measure averaged about fifty percent across states [128], with slightly better performance among Medicaid HMOs [129], leaving substantial room for improvement especially among private providers. In the states, some reported providing training directly, while others worked with CDC-funded regional training centers. In general, this was not a uniformly “owned” service by the interviewees, but its importance was recognized.

All interviewees stated that either their program, or another part of the state governmental infrastructure, had a role in collecting and reporting surveillance data for their state. The increase in electronic medical and laboratory records were reported by all to be sources of optimism about future advances in surveillance. Several also mentioned the potential benefit of health information exchanges. Nevertheless, several reported still having surveillance systems that required substantial manual intervention and oversight to upload and/or report data. Although this was perceived as an area of great promise, changes have been moving slowly, and public health programs in many jurisdictions may not be able to take full advantage of this with existing resources – including staff and technology.

The variability of decentralization also directly impacted what clinical services were overseen at the state level. However, all interviewees were knowledgeable about the general state of ACA-related changes, or lack thereof, regarding services at the regional or county level.

Every interviewee reported the expectation or intention to continue providing some STD clinical preventive services through STD clinics and/or other safety-net clinical partners.

In states that were not fully billing Medicaid and private plans, all interviewees acknowledged either the opportunity or threat of the ACA with respect to billing for services. In the case of the former, some saw it as a way to get a much-needed and steady or increasing infusion of funds for the services they provide. In the case of the latter, some predicted pending funding cuts from the local, state and/or federal level for services, and identified the need to bill to bolster programs for ongoing and anticipated increasing budget reductions.

Despite the fact that the states in which the respondents work are all Medicaid expansion states, barriers were reported in making changes related to the Affordable Care Act. Some reported resource challenges, some identified difficulties in navigating through the bureaucracy to make changes, and most mentioned encountering unwillingness to change. This was not unexpected, because change requires time and energy, can be difficult, and people often fear it. Regardless, these leaders were undaunted, moving forward with various plans to influence or make changes that they thought would sustain or improve STD prevention in their state.

Policymakers, funders, and other stakeholders will need to be supportive, recognizing that it will take time for programs to navigate the quagmire of state and local conditions to implement changes. One interviewee summed up, “I really think that it’s going to take a lot longer to implement the ACA than people really think, so it will be interesting. And I’m one that really likes to change, but it has to make sense and it has to be for a good reason.”

## **Study Limitations**

There were a number of limitations to the research approach. As CDC grantees, it is possible that the participants were not be completely candid with the researcher, such as by overselling anticipated changes, or by omitting planned changes that they were concerned that the CDC STD program may not approve or support. Also, as an employee in CDC's STD program, which funds the state STD programs, it is possible that the researcher may have unintentionally introduced bias into the study.

The CDC STD Division Director has promoted certain approaches to taking advantage of the Affordable Care Act to state programs, including in the funding opportunity announcement (FOA) for the new five year cooperative agreement that began January 1, 2014.[130] At the time of the interviews, the deadline had passed and all programs had submitted their funding applications, so requirements and recommendations included in the FOA may have influenced plans for reported program changes. Similarly, part of the new STD program FOA included separate funding and awards for the Gonococcal Isolate Surveillance Project (GISP), for which programs may have applied and planned, but may or may not have been selected. At the time of the interviews, award announcements had already been made for a separate STD-related FOA for participation in the STD Surveillance Network, or SSuN. The interviewed programs may have applied for the funding but were not selected, which could also cause a future change in plans. Indeed, one of the state interviewees volunteered that they had applied and had made some plans that would not occur as a result of non-selection. However, recognizing this, the interviewee did not include those plans in the interview discussion.

Further, although the researcher chose not to examine political and fiscal environments in the states, they could be important influences on STD program changes. As a result, the researcher is unable to determine whether reported changes were due to the Affordable Care Act,



declining budgets or other economic influences, the political environment, other recent state program impacts, or a combination thereof. For example, over the past few years, state budget shortfalls and reduced federal spending have led to reduced STD-related health resources at the state and local levels. The National Coalition for State STD Directors conducted a survey of state and local STD Directors that found that between 2008 and 2009, there were widely reported layoffs, furloughs, and other programmatic cuts that impacted STD programs. Similar cuts may have occurred in 2010 and afterward, complicating determination of the causes of state program and policy changes over the time period studied (2010 through the end of fiscal year 2016).[13] In the future, these types of changes may have as much of or more of an impact on the types of services or partnerships that the state programs engage in than the Affordable Care Act.

Another recent occurrence is the increasing identification of cases of cephalosporin-resistant gonorrhea[131], which may also impact the approach and focus of the DIS and potentially divert attention from ACA-related changes moving forward. In addition, planned changes may not be implemented for a multitude of possible reasons, including local, state and/or federal budget decreases, feasibility, technical problems, lack of partner cooperation, and/or higher level changes in implementation of the ACA.

A public health / health care collaboration project supported by the CDC STD program found that only public health programs in Medicaid expansion states were making demonstrable changes. Due to that finding, the researcher chose only to interview programs that had passed 2014 ACA Medicaid expansion prior to July 2013. This choice limited the pool of potential applicants, so if non-Medicaid expansion states were planning changes that were different than those in Medicaid expansion states, those changes would not have been identified by this study. The eight volunteers also self-selected, so it is possible that they may have had unique

characteristics among the Medicaid expansion states, such as being further ahead with changes related to the ACA, or having more support from their state government than non-interviewed states. The small sample size, representing more than one third of ACA Medicaid expansion state STD programs but only sixteen percent of all state STD programs, may limit generalizability of the findings.

Despite the information showing broad distribution among states for certain characteristics presented in three areas: 1) program funding, 2) STD burden, and 3) America's Health Rankings®, the interviewees' states as a group could have other characteristics that vary from an "average" state. When looking at the eight states interviewed: California, Connecticut, Illinois, Iowa, Maryland, Nevada, Oregon, and Washington, one characteristic in particular may prevent generalization to other states. According to Gallup's State of the States website, in 2012, six of the eight states had more residents who identify as liberal than the national average (California, Connecticut, Illinois, Maryland, Oregon, Washington). Only one of the eight had more residents who identified themselves as conservative than the national average (Iowa).[132] It is unclear how placement on the political spectrum may have been related to the findings of this research or how it might impact generalizability.

## **Conclusions**

Regardless of the limitations of the study presented above, some information can be gleaned to inform program direction and recommendations. The degree of state decentralization impacted the rate and types of changes that can be made at the local level, leading to more rapid or less rapid changes in different localities in decentralized states. For example, decentralization was related to the rate of change of billing, but it could lead to either faster or slower changes. To illustrate, two relatively progressive, centralized states reported having implemented billing of

private insurance and Medicaid plans for STD services one to two years prior. In comparison, a relatively decentralized state reported one locality that had been billing for STD services for several years, while another of its localities had no immediate plans to bill. Yet another fairly decentralized state reported that only a handful of localities were billing for STD services. In general, state public health and safety-net clinics are billing or are moving toward billing and may need assistance to accomplish this.

Partnerships can be useful for making changes in STD prevention—sometimes a powerful national- or state-level partner can provide critical support for changes within a public health program. For example, one state leader reported bringing in a powerful partner to influence change. In this case, the partner threatened taking business elsewhere, if the state laboratory did not implement billing in the next one to two years. Other states reported bringing in partners with appropriate experience to provide technical assistance for billing. One decentralized state reported that one of its more progressive localities was promoting changes to other localities on a peer to peer basis.

The increase in electronic medical and laboratory information holds promise for improvements in public health surveillance, but changes may be slow and require additional resources. Some states reported upgrading STD surveillance systems to prepare for the eventuality of being able to bring in other types of data, such as electronic medical records. In comparison, one state reported having a very outdated electronic surveillance system with limited resources for improvement, but also noted that compliance with reporting requirements was just as important in ensuring the quality and completeness of surveillance data. Overall, barriers exist to making changes, so implementation may not be as quick as anticipated or hoped.

Ultimately, the role of public health may change as a result of the ACA, but public health STD prevention remains an important and necessary public service. Ongoing study and evaluation of the impact of the ACA will be important to ensure that impacted populations obtain appropriate STD prevention, screening, and treatment.

## **CHAPTER 7: PLAN FOR CHANGE**

One of the inherent challenges of public health programs is that “the nature of the activities that ‘flow’ to the government may be fundamentally different than those that are taken in the private sector”.[133] As a result, the government sector may get charged with the least efficient types of “business”.[134] This is certainly the case for Sexually Transmitted Disease programs; they are charged with identifying, preventing, screening and treating stigmatized and largely asymptomatic diseases. However, STD programs have no choice but to prepare for and respond to market pressures—in this case, expectations tied to the implementation of the Affordable Care Act and decreasing budgets. Oliver E. Williamson, an American Nobel Laureate in Economic Sciences and expert in transaction cost economics, thinks that these agencies may be held to an unattainable benchmark.[134] However, this does not give public health leaders nearly enough credit for being successful despite perennial pressures from policymakers, the public, and other stakeholders.

Massachusetts passed health reform in 2006, four years ahead of the Affordable Care Act. Massachusetts was excluded from this study because the timing of the reform and its economic context differed, plus the reform was entirely state-supported with strong political buy-in. However, within the STD prevention public health community, the Massachusetts program is spoken of as an example for making changes and adapting to the new reality of health reform. Although the MA public health leader interviewed modestly said, “I don’t know if I’m the role model but I’m a model. It’s a model”, now more than seven years after health reform was passed,

Massachusetts has a successfully transformed STD prevention program. Therefore, some lessons about the transformation of the Massachusetts STD program could be useful to the other state STD programs.

In the case of Massachusetts, state health reform combined with a state funding cut that forced an abrupt end of financial support for all but one STD clinic, creating a crucible from which the program had to emerge. How did they do it? Arguably, they did it through strong leadership. Bennis and Thomas point out that the most crucial skill for leadership is “adaptive capacity...an almost magical ability to transcend adversity, with all its attendant stresses, and to emerge stronger than before.” [135] In fact, the MA leader interviewed in the pilot test for this project reported receiving calls from other state STD programs, asking how he/she approached making the necessary program changes,

“One of them just said, ‘I just want to know, how did you do it?’, and I said to myself, ‘what a big question that is’. Because literally it is just day by day, it’s as basic as apple pie. Figure out your landscape, figure out what your colleagues are funding, build your bridges there, build up the skill set of your DIS team, you pump them up so that they think they are Arnold Schwarzeneggers, straight on, and that they can do anything. Hire the people that you believe can do anything. And that’s the best you get, right there.”

Not only does this statement exhibit leadership qualities applauded by Bennis and Thomas, it embraces key aspects of Jim Collins’ “good to great” leaders, namely, get “the right people on the bus”, and exhibit a “hedgehog like understanding of three intersecting circles: what a company can be best in the world at, how its economics work best, and what best ignites the passions of its people”.[136] Other state STD programs also have strong leaders—but sometimes, recognizing that another leader in a similar, or even more challenging, situation was able to successfully navigate these changes could be sufficient encouragement for their own transformation efforts.

So the question becomes, what is the plan to promote and support the transformation necessary to survive in the changing healthcare environment? Is it feasible to create one model at the national level that is disseminated at to the states? In short, it is not. In *Strategy Safari*, Mintzberg et al. state, “strategies should be one of a kind: the best ones result from a process of individualized design”.[137] This conclusion is supported by the breadth and variety of answers received during the interviews. Much will depend upon the environment of the state, including the level of decentralization, and other factors not examined here, including the political and economic environment within the state. In addition, because this study included only Medicaid expansion states, a model developed from these findings only would likely not be applicable in non-expansion states.

Gary Yukl defines leadership as, “the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives”. Yukl shared a list of what leaders can influence, which includes,

- the choice of objectives and strategies to pursue
- the motivation of members to achieve the objectives
- the organization and coordination of work activities
- the allocation of resources to activities and objectives
- the development of member skills and confidence
- the learning and sharing of new knowledge by members
- the enlistment of support and cooperation from outsiders [138]

Therefore, this plan for change focuses on CDC leading, in collaboration with its partners, the implementation of recommendations in three areas: 1) training and technical assistance for the

STD programs; 2) strengthening or forging national partnerships that are supportive of health reform changes in the STD programs; and 3) aspects of health reform changes in STD programs that should be studied.

## Recommendations for Training and Technical Assistance

This study found that each of the interviewed states was at a different point in the change process, and focused on different programmatic aspects to change. However, all had made or were in the process of planning or making changes. Since public health programs provide a human service, and “[i]n human services, the *practitioner is the intervention*”,[139] the focus of the first two recommendations is on influencing and providing support to STD program leaders (Table 5).

**Table 5. Recommendations for Training and Technical Assistance for State STD Programs**

Training and Technical Assistance
1. Provide training on organizational transformation to the STD programs
2. Establish a formal system for technical assistance for STD programs

### Recommendation 1: Provide training on organizational transformation to the STD programs

Learning from the example of the power of leadership provided by Massachusetts, providing training on organizational transformation can help leaders identify the steps they need to take to successfully plan for and navigate changes. The researcher identified two potential opportunities to provide this type of training. The first is through webinars that Division of STD Prevention and its partners are planning for the grantees over the course of the next year. The second is to provide it during the grantee meeting that is being held in conjunction with the STD Prevention Conference, planned for the summer of 2014 in Atlanta. The researcher has proposed



this type of training to the relevant groups within the division. This training would provide strategies and information following Kotter's *Eight Steps to Transforming Your Organization*:

1. Establish a sense of urgency
2. Form a powerful guiding coalition
3. Create a vision
4. Communicate the vision
5. Empower others to act on the vision
6. Plan for and create short-term wins
7. Consolidate improvements and produce still more change
8. Institutionalize new approaches [140]

Recommendation 2: Establish a formal system for technical assistance for STD programs

A Division of STD Prevention partner has already been funded to establish a system to receive requests from STD program grantees for technical assistance. This system will facilitate peer exchange of technical assistance. For example, staff from one STD program will work with a program in another state in order to provide support and to share the benefit of wisdom gained through having successfully navigated similar challenges or crucibles.

The researcher and other division staff will also be providing STD programs with technical assistance this year, with respect to policy and partnership activities that could support changes related to health reform. For example, staff could help identify a model law for billing for states that currently are prohibited for billing for STD services. Another possibility would be to help a state program identify and connect with partners that could be assistive with providing

training or other materials or activities that would promote increased STD screening by private health care providers.

### **Recommendations for National Partnership Activities**

In Leadership and the New Science, Margaret Wheatley writes, “Power in organizations is the capacity generated by relationships”.[141] Ancona et al. recommend cultivating relationships by inquiring, advocating, and connecting.[142] There are a number of national partnership activities that would be assistive to the state STD programs in making health reform-related changes (Table 6). These relationships can be established and/or strengthened using the tenets of Ancona et al.

**Table 6. Recommendations for National Partnership Activities**

<b>Recommendations for National Partnership Activities</b>
3. Work with partners to facilitate billing private insurers
4. Continue support for STDRHTTACs partners to work with the STD programs
5. Partner with national laboratories on electronic laboratory record sharing to standardize and/or facilitate electronic data-sharing
6. Partner with organizations involved in establishing data standards for health information exchanges and electronic medical records to standardize and/or facilitate electronic data-sharing
7. Continue to work with partners to raise the visibility of the importance of public health STD prevention

#### Recommendation 3: Work with partners to facilitate billing private insurers

Although billing agreements will generally need to be made one clinic at a time, and each clinician will need to be separately credentialed by each carrier, an interviewee thought that the division might be able to approach the larger national insurance carriers to help smooth the process. The researcher has an established relationship with a national partner that could provide a starting point. Division staff are in the process of scheduling a site visit for them, and the

researcher plans to introduce them to another partner, who may also be able to work with them to facilitate engagement.

Recommendation 4: Continue support for STDRHTTACs to work with the STD programs

Since several of the interviewees mentioned the excellent assistance that they were receiving from the STDRHTTACs on billing, the division should continue to support these entities given funding availability. The success of this project activity has been communicated by several parties to the Division Director, who has committed to support these activities through next year. This project holds potential for collaboration with HIV and other groups as well; \$10 million of the CDC HIV/AIDS budget was redirected for HIV and related co-infection billing-related support in the CDC FY 2014 Congressional Justification Budget.[143] Additionally, division staff, including the researcher have become involved as subject matter experts for the STDRHTTAC cooperative agreement to ensure that this partnership is providing needed support to the STD program grantees moving forward.

Recommendation 5: Partner with national laboratories on electronic laboratory record sharing to standardize and/or facilitate electronic data-sharing

Some state STD programs may have already forged agreements with laboratories to obtain robust electronic laboratory data, but at the other end of the spectrum, some states may not yet be ready to accept electronic laboratory data. Regardless, the division or CDC at large should consider approaching the larger national laboratories to facilitate robust data sharing in a standardized way that could simplify utilization of the data for improved surveillance moving

forward. Appropriate division staff are on an agency-wide workgroup that is pursuing partnerships that can facilitate information sharing agency-wide.

Recommendation 6: Partner with organizations involved in establishing data standards for health information exchanges and electronic medical records to standardize and/or facilitate electronic data-sharing

An informatics team has been recently created within the STD program to pursue these types of activities for the division. The division has already funded a pilot project with a set of public health and health center partners that is working with electronic medical record vendors to create a standard workflow for EMR systems that would facilitate appropriate STD screening of patients in the target population. The informatics lead also has the appropriate partnerships in place within the agency regarding meaningful use data and other standards that will be used in the establishment of health information exchanges.

Recommendation 7: Continue to work with partners to raise the visibility of the importance of public health STD prevention

This is an ongoing activity that CDC pursues in conjunction with established national public health partners. All of the national STD partners ensures that stakeholders are educated about the important work of STD prevention. In addition, CDC's STD pages are the most highly visited web pages on its site, approaching 5 million visits every month.[144] The division also works with numerous partners to promote division activities and interacts with media about the research and activities of division senior leaders and subject matter experts. All of these activities combine to raise the visibility of the importance of public health STD prevention. The researcher

will continue to work with external and internal collaborators to promote the continuation of these activities.

## **Recommendations for Research**

The information collected through the interviews pointed to several areas where the impact of the changes should be measured and analyzed, to assure that intended impacts are being achieved and no unanticipated consequences have been created. Assessing important aspects of overall performance and providing data are important for organizational decision-making. This information supports the ability to make potential course corrections and to determine best practice recommendations to support continuous improvement. [139]

Recommendations in this area are presented in Table 7.

**Table 7. Recommendations for Research**

<b>Recommendations for Research</b>
8. Measure and study impact of billing and insurance status on STD and partner clinic utilization
9. Measure and study private and public provider adherence to STD guidelines
10. Conduct further research on varying levels of decentralization and approaches to change at different levels

### Recommendation 8: Measure and study impact of billing and insurance status on STD and partner clinic utilization

Interviewees recognized the potential financial benefit or necessity of implementing billing for services in their states. However, one mentioned that he/she wanted to be sure that implementation of billing would not create a situation where people would avoid or delay seeking services due to confidentiality issues. Since STD prevention is a sensitive service, this is a valid concern. Research should be conducted to identify who is not accessing safety-net services and why. This information could be used to ensure that people who need STD-related

services seek them and receive them. The researcher has discussed this area of research with division staff and has confirmed that plans are underway to conduct related research.

Recommendation 9: Measure and study private and public provider adherence to STD guidelines

In order to best assess with which providers STD programs should partner, it is important to study which types of patients are going to which types of providers, as well as provider STD screening rates. The HEDIS measure on chlamydia screening, “percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year”[18] will provide some information, but it covers only a subset of the target population receiving clinical services. The division has identified measures from the data provided by the clinics that are part of division sentinel surveillance systems to monitor for adherence to gonorrhea treatment guidelines, important for delaying increasing antibiotic resistance, and for HIV testing adherence. These measures have been incorporated into regular internal progress reviews. This monitoring and potential additional research in this area could be used to better target provider training needs, or to determine how to encourage or incentivize providers to increase STD screening.

Recommendation 10: Conduct further research on varying levels of decentralization and approaches to change at different levels

The first theme discussed in the study results was that the degree of decentralization of government authority and service provision within the state was directly related to the types of changes that were being made, as well as how changes were being approached. Research in this area could be useful for identifying successful approaches to influencing changes where states

have little or no authority, as well as best practices in states that are more centralized. Division staff are working with several funded partners to continue work in this area. A new project aims to pick up with a pilot test where the previously mentioned research on public-private health partnerships ended.

In addition to the activities related to the recommendations above, the researcher plans to submit a late breaking abstract on the findings of this study for the STD Conference that will be held in Atlanta in June 2014. If the abstract is not accepted, the researcher will pursue other venues for disseminating the results of this study.

## APPENDIX A: DEFINITIONS

*Disproportionate Share Payments:* these payments provide support to hospitals for service provision to low-income patients whose services are not paid by other payers, such as Medicare, Medicaid, the Children’s Health Insurance Program (CHIP) or other health insurance. [145] These payments will be reduced by the ACA and replaced with another system, which has not yet been announced.[146]

*Family Planning Medicaid Waiver:* states can apply for a family planning waiver from the Centers for Medicare and Medicaid Services to extend benefits to offer family planning services to additional populations.

*Federally Qualified Health Centers (FQHCs):* FQHCs are safety-net providers, including some community health centers and providers of services to indigent populations. The goal of FQHCs is to enhance primary care in underserved urban and rural areas.[147]

*Grandfathered Health Plans:* The Affordable Care Act establishes that health plans that existed when enacted are not subject to a number of the requirements included in the ACA, such as the requirement to provide certain preventive health services without cost sharing.

*Public Health Service Act Section 318:* generally referred to as “318”. This is the authority under which agencies in the Department of Health and Human Services are authorized to assist private and public entities in the prevention and control of STDs and AIDS. [148]

*Public Health Service Act Section 340B:* generally referred to as “340B” or “the Drug Pricing Program”. Passed in 1992, this authorizes certain federal grantees, including FQHCs, Title X clinics, federally funded state AIDS drug assistance programs, entities receiving 318 funds, and qualified hospitals, to purchase discounted outpatient drugs for their patients. HRSA estimates that this program provides 20% - 50% cost savings for these medicines.[149]



*Ryan White Program:* this program works with cities, states, and local community-based organization to provide HIV-related services yearly to more than half a million people who do not have sufficient health care coverage or financial resources for coping with HIV.[150] Part B of this program is the AIDS Drug Assistance Program (ADAP), which provides funds to states and territories for drugs for HIV/AIDS treatment, among other services.[151] The Ryan White Program is up for Congressional reauthorization in 2013.[152]

*Safety-net:* providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.[153] Provider types include federally qualified health centers (FQHCs) and FQHC look-alikes; community health centers (CHCs), which may be FQHCs, or may be funded through non-governmental sources; family planning clinics (FPCs); school-based health centers (SBHCs); local health department clinics; and free clinics, among others.

*Sexually Transmitted Disease:* sexually transmitted diseases (STDs) are infections that you can get from having sex with someone who has the infection. The causes of STDs are bacteria, parasites and viruses. There are more than 20 types of STDs, including: chlamydia, gonorrhea, Genital herpes, HIV/AIDS, HPV, Syphilis, and Trichomoniasis. [154] Also called sexually transmitted infections (STIs) and formerly venereal disease (VD).

*CHIP* – The Children's Health Insurance Program (CHIP), formerly the State Children's Health Insurance Program (SCHIP)) was created in 1997 to help states insure low-income children who are Medicaid ineligible but cannot afford private health insurance.[155]

*Title X Family Planning Program:* enacted in 1970 as Title X of the Public Health Service Act, it is a federal program that supports comprehensive family planning and related preventive health services, including contraceptive services, supplies and information, with a

priority on low-income populations. [156] The services provided by these clinics are also confidential.[157]

*U.S. Centers for Disease Control and Prevention (CDC):* this public health agency is an operating unit of HHS, with a mission to protect the public's health through "health promotion, prevention of disease, injury and disability, and preparedness for new health threats".[158]

*U.S. Department of Health & Human Services:* also known as HHS and DHHS, this agency is part of the executive branch of the U.S. government, and is charged with protecting the health of all Americans and providing essential human services, especially to those who cannot help themselves. [159] CDC and HRSA are both operating divisions of HHS.

*U.S. Health Resources and Services Administration (HRSA):* this agency is an operating unit of HHS, and has a mission to "improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs".[160]

# APPENDIX B: ARTICLES ABOUT THE AFFORDABLE CARE ACT, STD SERVICES, AND STATE IMPACT

article author	pub date	article title	article type	journal / org.	general or specific state?	service provider type (e.g. FQHC, CHC)	population focus (e.g. general, adolescent, women, MSM)	STD type (e.g. general, CT, GC)	expected or observed impact of ACA re STDs	recommendation re ACA and/or re STDS	impact on state(s)?
Original Literature Review (July 2012)											
Collins C, Diallo DD	12/15/2010	A Prevention Response That Fits America's Epidemic: Community Perspectives on the Status of HIV Prevention in the United States	journal	J Acquir Immune Defic Syndr	general	general	general	HIV		Community Transformation Grants are an opportunity to address the community context of HIV.	CTGs opportunities for states/locals [99]
Owusu-Edusei K, Doshi SR	Oct-11	County-Level Sexually Transmitted Disease Detection	journal	Sexually Transmitted Disease Preventi	Texas	STD Clinic and Title V, X, & XX	general	general	STD services are being discontinued post ACA and because of budget shortfalls. Discontinuation of provision of direct	Efforts should be made to save STD clinics.	States should consider continuation of provision of STD testing and

		and Control in Texas: Do Sexually Transmitted Diseases and Family Planning Clinics Matter?		on		Family Planning clinics			services including STD care, may impact the detection and control of STDs at local and national levels.		care. [64]
Arkoosh VA	Jun-12	The Patient Protection and Affordable Care Act: no rhetoric, just the facts	journal	Community Oncology	general	general	general	general	ACA had IOM develop recommendations for add'l preventive services specifically for women (including STD-related) that begin Aug. 2012.		ACA expands Medicaid. [65]
Wapner J	Jul-11	Poor Man's Burden. Why are HIV rates so distressingly high in the southern U.S.?	journal	Scientific American	southern states	general	general	HIV	PPHF, part of ACA, allotted \$198 million to train 500 new primary care physicians and 600 new primary care nurse practitioners by 2015.		Mississippi's health experts hope that their education and testing initiatives can reduce high rates of HIV infection and death. [96]
Watts LA, et al	28-Mar-12	In A California Program, Quality And Utilization Reports On	journal	Health Affairs	CA	general	women	general	Technological strategies like text message reminders may improve clients' acceptance of annual chlamydia testing. ACA considers improving the quality	Evidence-based screening and counseling protocols for technological preventive services under ACA should be designed and disseminated.	Opportunities for states to implement strategies to increase STD testing and implement quality

		Reproductive Health Services Spurred Providers To Change							of care a key priority.	Should develop and implement a uniform performance measurement system for FP services for women and men.	improvement. [97]
Kaiser Family Foundation	Sep-11	Preventive Services Covered by Private Health Plans under the Affordable Care Act	report	Kaiser Family Foundation	general	general	general	general	ACA includes coverage of STD and HIV tests (some in certain pop'ns by non-grandfathered insurers without cost sharing.		Impact of this coverage on premiums will vary by state. [66]
Martin EG, Schackman BR	1-May-12	What Does US Health Reform Mean for HIV Clinical Care?	journal	J Acquir Immune Defic Syndr	general	general	general	HIV	Medicaid expansion, state health insurance exchanges, improved preventive care, increase in primary care availability, link between payment and quality. Includes coverage for currently ineligible HIV+. Revised ADAP prescription drug coverage may be beneficial.	Challenging for low-income individuals to retain a consistent source of insurance coverage. HHS proposed exchange eligibility and employer standards for eligibility processes. ACA has state-administered consumer assistance programs to help residents enroll.	Cost of Medicaid expansion. Shifting of resources from hospitals (eliminating disproportionate share payments) to CHCs. Will increase demand on states' ability to determine eligibility. [67]
Mason T, et al	Dec-11	Winning Policy Change to Promote Community Health	journal article	AJPH	MA	public health	general	general	ACA defines CHWs as health professionals and recommends engaging CHWs. 2006 MA health reform law required the state dept.	Nat'l health reform opens a policy opportunity to integrate CHWs into the health system. Essential elements	State and locally employed CHWs reach underserved communities

		Workers: Lessons From Massachusetts in The Health Reform Era							of public health to develop proposals for building a sustainable program to promote employment of the state's approximately 3000 CHWs.	from MA may inform other states.	to reduce inequities related to STDs, HIV. States have potential to work them into the healthcare system. [68]
Flowers L, Fox-Grage W	Jul-11	Health Reform Law Creates New Opportunities for States to Save Medicaid Dollars	report	AARP Public Policy Institute	general	general			Medicaid expansion - FP svcs and supplies eligible for enhanced match include preconception care. FP-related services include STD diagnosis and treatment as follow-up to a FP svc in a FP setting. Includes Rx for STDs.		Medicaid expansion will reduce uncompensated care in states. [69]
Gostin L, et al	2011	Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Wellbeing	Law Review	Georgetown Scholarly Commons	general	general	general	general	Under ACA, uninsured will be illegal immigrants, low-income people who don't enroll in Medicaid, and individuals exempt from mandate or who choose to pay the tax penalty. Undiagnosed and untreated STDs, including HIV, syphilis, pose a major risk to the pop'n related to resistance.	Invest more in PH. Prevention and wellness require integration of HC and PH.	ACA encourages prevention at the community level, important for improving PH. A state-based grant program will fund the development and evaluation of Medicaid initiatives to promote behavioral

											change to an expanded Medicaid pop'n. Grant program will fund health departments implementing these proven community-based initiatives. [70]
Rucoba RJ, et al	Feb-12	Lessons learned: School-based health centers break through barriers to medical care	News-magazine article	AAP News	general	general	adolescents	general	ACA included \$200 million to establish or expand SBHCs, increasing # of children served by SBHCs nearly 50%.	Kids more likely to use SBHCs because of confidentiality concerns.	SBHCs can enroll kids and families into Medicaid. Expansion of SBHCs. [59]
Villegas S, et al	9/22/2010	Health outcomes for adults in family foster care as children: An analysis by ethnicity	journal	Children and Youth Services Review	general	general	children	general	Research needed on long-term health outcomes of adults who were foster children. 18% of women with foster care experience had intercourse during past 12 months with STD+ partner. Abuse is a problem in this pop'n and is associated with increased risk for STDs.	ACA requires Medicaid to report data on ethnicity, gender, primary language, and disability status of program recipients. These reports are expected to generate nat'l estimates on health initiatives that target health disparities for ethnic minorities.	Requires Medicaid reporting. Recommendations around data collection and foster care. [98]
National	3/11/2011	Virginia v. Sebelius -	legal brief	Santa Clara	Virginia	general	women	general	Latinas are one of the populations least likely	ACA is constitutional.	ACA ends 1) gender rating

Women's Law Center		National Women's Law Center Amicus Brief		Law Digital Commons	case but argument national				to have access to health insurance. ACA legal challenges will profoundly affect Latinas' health and access to care.		for health insurance, now allowed by most states; and 2) states cannot refuse coverage to domestic partner violence survivors, now allowed by 9 states. [71]
National Women's Law Center	1/1/2011	Seven-Sky v. Holder - Amicus Brief of the National Women's Law Center et al.	legal brief	Santa Clara Law Digital Commons	general	general	women	general	Latinas are one of the populations least likely to have access to health insurance. ACA legal challenges will profoundly affect Latinas' health and access to care.	ACA is constitutional.	ACA ends 1) gender rating for health insurance, now allowed by most states; and 2) states cannot refuse coverage to domestic partner violence survivors, now allowed by 9 states. [72]
National Women's Law Center	1/1/2011	Liberty University v. Geithner - Amicus Brief of National Women's	legal brief	Santa Clara Law Digital Commons	general	general	women	general	Latinas are one of the populations least likely to have access to health insurance. ACA legal challenges will profoundly affect Latinas' health and access to care.	ACA is constitutional.	ACA ends 1) gender rating for health insurance, now allowed by most states; and 2) states cannot



		Law Center									refuse coverage to domestic partner violence survivors, now allowed by 9 states. [73]
Moody N	2011	Comment: Health Reform and the Plight of the Uninsured Pregnant Woman	Law Review	Oregon Law Review	CA and OR but ACA in general	general	women	general	STD testing provided as an essential service for pregnant women.		Expanded Medicaid eligibility for pregnant women. [74]
Ferber J and Beekman M	Sep-10	Implementing The Medicaid Provisions of the Affordable Care Act in Missouri: Early Observations, Challenges and Opportunities	report	Legal Services of Eastern Missouri	Missouri	general	general	general	New state option includes “medical diagnosis and treatment services” provided in a FP setting as part of or as follow-up to a FP visit, potentially broader than what MO covers in its existing family planning waiver program. CMS guidance needed to clarify extent of the states’ new obligation to conduct outreach to vulnerable and underserved populations under ACA. Specifically requires outreach to children,	MO can strengthen the program by providing the expansion population with coverage equal to or better than full Medicaid benefits. The “presumptive eligibility” option could be a reason to convert Missouri’s family planning waiver to a state plan program.	Awareness driven by ACA could lead to “welcome mat effect” with higher enrollment levels of currently eligible but unenrolled. ACA gives states option to establish a “Basic Health Program” for household income under 200% FPL but not eligible for

									unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance related disorders, and individuals with HIV/AIDS.		Medicaid. MO could contract directly with private insurance to provide coverage (like current Medicaid MCO) but not Medicaid expansion per se, and MO would get 95% of federal subsidies that would have gone to individuals. Basic health plans must include at least essential health benefits included in exchanges. Citizenship assessment through SSA is cost effective and required for health insurance exchange. [75]
Kozhim	2012	National	journal	Women'	gener	general	repro	gener	State-based exchanges,	Policymakers and	State-based

annil KB et al		Trends in Health Insurance Coverage of Pregnant and Reproductive-Age Women, 2000 to 2009	article	s Health Issues	al		ductiv e age wome n	al	preexisting condition exclusions, and subsidies may provide new private insurance choices for pregnant and reproductive-age women, and required preventive services may enhance benefits. Health plans will have to cover services, including for STDs, under ACA.	clinicians need to be aware of changing access to health insurance for reproductive aged/pregnant women and how it may impact care. Monitoring insurance trends among these women critical to understand how changes in health insurance regulations, access, benefits, mandates affect this pop'n.	exchanges could lead to higher insurance rates - this should be monitored and studied. [76]
Mayes R and Oliver T	5-Dec-11	Politics of Prevention . Chronic Disease and the Shifting Focus of Public Health: Is Prevention Still a Political Lightweight?	journal article	Journal of Health Politics, Policy and Law	general	general	general	HIV	ACA has major expansion of insurance, new benefits for preventive services, and new funding for PH and primary care programs. If implemented and continued, likely to reduce impact of socioeconomic factors on HIV/AIDS.	PH needs to do a better job explaining how ACA investment and regulatory infrastructure is essential for both US fiscal health and people's health. PH must rally influential partners to sustain and build on it.	Medicaid expansion. [77]

Brown LD	2010	The Political Face of Public Health	journal article	Public Health Reviews	general	general	general	general	ACA doesn't address needs of illegal immigrants, who will need safety-net care, as will insured who cannot access "mainstream" providers. Provision likely to remain essential function of PH authorities. Future will depend on little-studied variables including: the legal status, strength of state and local PH agencies; the power of local medical societies (which may resist PH encroaching on patients except those unprofitable and unappealing, like ones with STDs); and local PH leaders.		Illegal immigrants will still need care from the safety-net, funded by a combination of fed-state-local funds. Provision is at the state and local level. [95]
Boonstra HD	Spring 2011	Teen Pregnancy Among Young Women In Foster Care: A Primer	policy review	Guttmacher Institute	general	general	young women	general	Youth in foster care more likely to have STIs.		ACA Medicaid expansion can include former foster youth up to age 26.[78]
Tiro JA et al	2012	Human Papilloma virus Vaccine Use Among Adolescen	journal article	Journal of Women's Health	CA but ACA in general	general	young and adolescent women	HPV	ACA expands coverage for young adults under parents' plans and Medicaid eligibility to low-income childless adults and prohibits		Medicaid expansion [79]

		t Girls and Young Adult Women: An Analysis of the 2007 California Health Interview Survey							copays for preventive care; will likely improve access to the HPV vaccine.		
IOM	2011	Leading Health Indicators for Healthy People 2020: Letter Report	letter report	Institute of Medicine	general	general	general	general	Appendix A crosswalks ACA and HP2020 indicators. Related measures: 1) Proportion of the population engaged in responsible sexual behavior, 2) Increase proportion of sexually active persons who use condoms. Makes appropriations for FY10-14 for abstinence education. LGBT population - health disparities include higher STD rates, identified specific objectives for use with this population.		Secretary directed to allot funds to states to award grants to local organizations and other specified entities to conduct personal responsibility ed programs to ed adolescents on abstinence and contraception to prevent pregnancy and STIs, and on certain adulthood preparation subjects. Makes appropriation

											s for FY10–14. [105]
Gold RB et al	2011	Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief #26 A Natural Fit: Collaborations Between Community Health Centers and Family Planning Clinics	Policy brief	George Washington University School of Public Health and Health Services	general	FQHC and FP	general	general	ACA makes 5 yr, \$11B investment in HCs in FY11-15, and \$1.5B for NHSCs. Congress reduced these funds by \$600 M for health centers and \$117M for the NHSC by lower FY11 approps. ACA promotes integrated and community-based partnerships to broaden access, including community care networks and medical homes. HCs expected to participate in ACOs. FP clinics provide screening for STIs. Unlike HCs, FP clinics don't offer more integrated and comprehensive care. HCs offer STI screening but serve broader range of clients; may not offer confidentiality available at FP clinics. Agencies funded through both programs eligible for discounts on the costs of prescription drugs under 340B.	Most of the newly insured and remaining uninsured will be residents of medically-underserved communities; positioning the safety-net to meet demand important. Collaboration important between the two types of health care providers.	Consideration of collaboration between different providers [80]
Buhi ER et al	2011	Adolescent Sexual	journal article	Health Educati	general	general	adolescents	general	ACA reinstates funding for sexual	Impact of ACA should be studied.	[100]

		Abstinence: A Test of an Integrative Theoretical Framework		on & Behavior					abstinence programs. Adolescents are at high risk of STIs.		
Grembowski D et al	2010	Are local health department expenditures related to racial disparities in mortality?	journal article	Social Science & Medicine	general	general	general	general	In black and white pop'ns, subgroups with greatest differences in mortality may be most likely to benefit from investments in LHDs. Concludes that LHD spending is associated with health disparities among certain sub-populations.		ACA authorized studies examining effectiveness and costs of state and local HDs, and to collect data on health disparities for research. Greater state-level funding is related to lower gonorrhea and syphilis rates.[101]
Osborne K	2011	Regulation of Prescriptive Authority for Certified Nurse-Midwives and Certified Midwives: A	journal article	The Journal of Midwifery & Women's Health	general	general	general	general	As primary providers of women's health care, CNMs and CMs can help meet ACA-generated demand for HC services, providing evaluation, assessment, treatment, and referral. Prescribing medications is essential component. Inconsistencies across	ACA and impending shortage of primary care provider make it crucial for clinicians and policymakers to remain aware of regulatory requirements for all HC providers and to remove legal barriers to practice and patients' access	Much work is needed to remove state legal barriers for CNMs and CMs to prescribe.[81]

		National Overview							state statutes for requirements to carry medical malpractice insurance and permission to treat the partners of patients with STIs (EPT).	to primary care.	
Alsentz et al	September 28, 2011 (draft)	State Healthcare Access Research Project (SHARP): An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access in Northern Florida	report	Health Law and Policy Clinic of Harvard Law School and the Treatment Access Expansion Project	Northern Florida	general	general	general	1 million women in FL need publicly supported contraceptive services because income < 250% of FPL or because sexually active teen. In FL >320 publicly funded FP centers provide contraceptive care to ~ 345,500 women (27.6% teens). Minors in FL can consent to STI services. FL has "stress abstinence" to prevent STDs policy. ACA improves access for documented immigrants but not undocumented. DHHS gave \$479,190 in ACA funding to 6 nonprofits in north FL to become community health centers. FL applied for and awarded nearly \$2.8M in ACA funds for comprehensive health ed, but has rejected those funds, despite no requirement for state matching.	FL failed to plan for new HC access opportunities under ACA, so FL's HIV/AIDS community should take steps so 2014 transition is smooth for people living with HIV/AIDS who will be Medicaid eligible or may qualify for subsidized private insurance through the exchange. Existing agencies providing case management and support services to HIV+/AIDS patients should consider becoming "navigators" by applying to exchange for grants. Coordination Ryan White and other HIV/AIDS programs is essential to ensure continual access to care.	Lack of state action in taking advantage of funding from ACA. [82]



Creech CJ et al	2012	A Model Plan for the Uninsured : Delivering Quality and Affordability in a Limited Benefit Managed Care Safety-net Program in Flint, Michigan	journal article	Journal of Health Care for the Poor and Under-served	Michigan (Flint)	general	general	general	Genesee Health Plan (GHP) is a community-initiated non-profit covering uninsured adults in Genesee County, MI. Genesee County safety-net providers all reported benefits from GHP. Flint community also has FQHC which serves as primary care home for large number of program's members. GHP pays FQHC for services to its members, creating new revenue stream. Demand for STD screening and treatment at public clinics declined as members sought those services from primary care providers. Shift in service location freed \$340K in local PH funds.	3 year quality and cost savings data show success in providing primary care for the uninsured of Flint, MI and may be useful as model for other states. Planned Medicaid expansion included in HC reform may provide more funds to this program via further expansion of MI's adult benefit Medicaid waiver program. Providing coordinated care in model like this likely preferable to adding people to Medicaid in terms of cost-effectiveness and access to care via a primary HC or medical home.	This is a model for programs states can undertake under ACA's Medicaid expansion. [83]
Baumrucker EP et al	19-Aug-10	Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary	report	Congressional Research Service					340B expanded by ACA to include (1) certain children's and free-standing cancer hospitals excluded from the Medicare prospective payment system, (2) critical access and sole community hospitals, and (3) rural referral centers. ACA requires		340B expansion for state providers (among others)[84]

		and Timeline							HHS to develop systems to improve compliance and resolve disputes. GAO required to submit to Congress a Sept. 2011 report about whether individuals receiving services through 340B covered entities receive optimal health care services. Also funding for SBHCs.		
Keeton V et al	2012	School- Based Health Centers in an Era of Health Care Reform: Building on History	journal article	Curr Probl Pediatr Adolesc Health Care	gener al	SBHC	adole scents	gener al	SBHCs are most often sponsored or operated by a local HC organization such as CHCs (28%), hospitals (25%), or local HDs (15%). 1 of 10 (12%) SBHCs sponsored by school system. AAP emphasized “medical home” as ideal HC delivery for children and adolescents, and is part of ACA as ACOs. 70% of SBHCs offer STD diagnosis and treatment, even if not on site contraception provision not permitted. Availability of confidential services cited as an incentive for teens using SBHCs; laws governing confidentiality differ by state. Evidence	SBHCs can be considered a medical home if can integrate more completely into systems of care in the community. As providers of patient-centered, accessible, and culturally responsive care, SBHCs already have core qualities of a medical home.	SBHCs can be medical homes. Medicaid expansion will cover population previously unable to access care.[85]

									shows adolescents with high-risk health behaviors likely to cite confidentiality as reason for foregoing HC. In 2011, HRSA awarded \$95M to 278 SBHCs, expanding the number of available sites and capacity to participate in implementation of HC reform.		
Kelly AV	2010	Expedited Partner Therapy: Innovative Health Policy Reduces Sexually Transmitted Infections and Prevents Infertility	report	The Council of State Governments	general	general	general	CT and GC	Under ACA, more testing and treatment of patients with chlamydia anticipated. Since many chlamydia infections are undetected, wider testing will lead to a greater need for sexual partner treatment services, and greater demands on HD resources.	EPT could help address predicted increase in demand for partner treatment. Supporting laws for EPT will allow states to implement this cost-effective PH practice, reduce infections and their serious consequences, including infertility.	State HD funding continues to be reduced; more than 75% of state PH agency budgets were cut in FY09 and ~40% expected cuts in FY10. STI prevention program funding has been reduced, so HD programs that provide direct services (partner examination and treatment) will not have resources to respond to

											increased demand. [86]
Frost JJ et al	Mar-12	Health Information Technology and Publicly Funded Family Planning Agencies: Readiness, Use and Challenges	report	Guttma cher Institute	gener al	FPHCs , state HDs, FPCs	gener al	gener al	ACA requires FQHCs have at least 30% of clients who are “needy individuals” (covered by Medicaid or CHIP, those receiving uncompensated care or care on sliding-scale). ARRA gives \$2B/yr for FQHCs for new centers, renovations, invest in HIT. ACA included \$11B to expand FQHC network. Access to incentives unclear for FP providers, including Title X providers that are not FQHCs. FP providers face challenges (tech support, training, interoperability, confidentiality concerns); must tailor technologies to Title X and other grant requirements. More FQHCs and Planned Parenthood affiliates than HDs have assessed clinician eligibility (70% and 63% vs. 14%).	Could outsource specialized tasks related to EHR or 3rd-party billing. FP programs could collaborate with other specialized HC providers, like STI clinics. Agencies w/o HIT systems will be at an extreme disadvantage as systems and sources of funding change and may not survive in 2014. Many non-physician clinicians bill through physician supervisor, rather than billing Medicaid directly, which requires time-consuming Medicaid credentialing, but they must to maximize agency’s Medicaid incentive fund eligibility.	States should implement HIT while maintaining confidentiality. Publicly funded clinics should partner with each other. [87]
Sonfield A and Gold RB	Dec-11	Medicaid Family Planning Expansion	report	Guttma cher Institute	gener al	FPCs	gener al	gener al	Half of states have expanded eligibility for Medicaid FP services, reimbursed	Publicly funded FP services, including within state Medicaid programs,	Medicaid expansion (build on waiver

		s: Lessons Learned and Implications for the Future							federally at 90%. States may include other related care, such as treatment for STIs diagnosed in a FP visit, but state must claim federal reimbursement for it at the regular rate (50%-76% of cost). States reimbursed by federal government at regular rate for cost of pregnancy-related care. Screening critical for the pop'ns targeted by FP expansions (young and low-income women and men) because they are at highest risk of STIs. Medicaid expansions have paid for millions of STI tests and helped to diagnose many STI cases.	are valuable. When the government collaborates with FP providers, all benefit. If states can continue to expand access to FP, help ACA meet its potential.	program successes) [88]
Berry EL et al	Aug-10	Federal Healthy Start Initiative: A National Network for Effective Home Visitation and Family Support	report	National Healthy Start Association	general	Head Start providers	underserved urban and rural low income	general	Healthy Start Initiative has role to play in ACA to build quality early childhood systems for pregnant women, parents, caregivers and children from 0-8 years. 104 federal Healthy Start sites provide health ed about prevention, early detection, testing, and treatment for HIV and	Soon federal government will need proven program like Healthy Start Initiative to implement key provisions of health reform. Healthy Start is “shovel ready” network for home visitation.	Healthy Start has 104 sites within states that could play a role. [102]

		Services							STIs, especially syphilis. One city program evaluated outcomes of social determinants component of pre- and inter-conception care, showing promising results in reducing high-risk factors for poor birth outcomes, incl. STIs.		
Figuerola J et al	Dec-10	Health Care Working Group Recommendations	report	CT Healthcare Working Group	CT	general	general	general		CT Investment in FP and sexual health prevent cost, stigma, sequelae of STIs (high among youth) and HIV/AIDS. CT hasn't met a number of women's health national benchmarks. CT should 1. Focus on women to reduce HC disparities, including STDs (among others). 2. Focus on women without health insurance, especially 18-44 years, and support and improve access to community and hospital and based-programs, ACA medical homes, and EHRs. 3. Support reform to create affordable, efficient,	Recommendation to state to adopt more FP prevention strategies. [103]

										and culturally sensitive health services for women.	
IOM	2011	Clinical Preventive Services for Women: Closing the Gaps.	report	IOM	general	general	women	general	ACA expands access to coverage to millions of uninsured women, ends discriminatory practices like insurance gender rating, eliminates exclusions for preexisting conditions, and improves women's access to affordable, necessary care. ACA requires private health plans cover without cost-sharing a set of preventive health care services for women. As ACA expands access to insurance for adolescents and young adults, may raise challenges for ensuring their care is confidential, because this group likely to forgo HC when have concerns about confidentiality. Adolescents attending a preventive care visit more likely to have time alone with clinician.	Committee reviewed preventive services and made recommendations for coverage as essential benefits under ACA, including: 1) high-risk HPV DNA and cytology testing in women with normal cytology results, beginning at 30 yrs of age and no more frequently than every 3 yrs. 2) annual counseling on STIs for sexually active women. 3) counseling and screening for HIV annually for sexually active women. 4) 1 well-woman preventive care visit annually for adult women to obtain the recommended preventive services, including preconception and prenatal care; several visits may be needed, depending on woman's health status, health needs,	State laws may impact confidentiality (and therefore uptake of adolescent women preventive services). [91]

										and other risk factors. Committee notes a parallel approach could be useful for setting covered preventive services for men, children, and male adolescents.	
Heisler EJ	4-Apr-12	The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs	report	Congressional Research Service	general	general	infants and adults of childbearing age	general	ACA Section 2953 established a new grant program for states to establish “Personal Responsibility Education” programs. This may impact the infant mortality rate.		These programs, which target adolescents, include instruction in both abstinence and contraception for the prevention of pregnancy and STIs. [104]
Glen PJ	2012	Health Care and the Illegal Immigrant	Research Paper	Georgetown Law Scholarly Commons	general	general	illegal immigrants	general	Illegal immigrants not eligible for any benefits or subsidies under ACA. Children and women, even if not legally in US, may have certain procedures covered by Medicaid, and all must be given emergency care and for active labor. The “intentional decision” not to cover undocumented immigrants has significant public	Extending coverage to illegal immigrants would be good policy; inclusion may lower costs of the system in numerous ways (lower premiums through expanded risk pool with people who generally have lower medical usage/costs, lower emergency medical expenditures, shift	Many state and local governments provide limited HC services to illegal residents of their states. [94]



									health implications, especially for infectious diseases; undiagnosed and untreated infectious and STIs, such as HIV and syphilis, pose major risk.	from late-stage treatments to preventative and ambulatory care).	
IOM	2011	HIV Screening and Access to Care: Health Care System Capacity for Increased HIV Testing and Provision of Care	report	IOM	general	general	general	HIV	ACA expansion of Medicaid with no need to meet additional categorical requirements (e.g., disability). Health insurance mandate. Private insurers limited to underwriting on age, geography, and smoking history (e.g., no HIV history restrictions). Subsidies for 133 to 400% of FPL. Efforts to expand HC capacity under ACA, including to expand safety-net; \$11B over next 5 years to CHCs. In FY10, \$30M went to CDC, of which \$21.6M for HIV testing. ACA supports training, development, and placement of >16,000 new primary care providers over 5 years. Undocumented HIV+ may access care through CHCs, which do not have service eligibility restrictions,	A phased transition of financing HIV/AIDS care is needed as future methods of reimbursement under the ACA are untested and will require years to develop (e.g., ACOs, Alternative Quality Contract). The demand for some services, now covered by Ryan White, will decline as uninsured individuals gain coverage. Concern that the reauthorization of the Ryan White program will take place in 2013 before full implementation of the ACA. There are risks associated with changing the program before the implications of the ACA are known.	Medicaid expansion. ACA requires insurance in exchanges to include all 340B eligible providers (e.g. FQHCs and state ADAP programs) in networks. Insurance exchanges will pay FQHCs no less than their Medicaid PPS rate. Coverage of preventive services will expand for privately insured, and under Medicaid. 1% percent increase in federal match to states that

									so access to care depends on CHC support. Ease of enrollment for those in/out of jail and IV drug users important to ensure access to care.		offer Medicaid coverage of, and remove cost sharing for, A and B USPSTF services and ACIP recommended immunizations (effective 1/1/2013). [90]
Hyams T, Cohen L	Jun-10	Massachusetts Health Reform: Impact on Women's Health	report	Brigham and Women's Hospital	MA	general	women	general	Mass Health Reform - very similar to ACA. Incarcerated women among sickest and least likely to have easy access to health insurance and care. Female inmates 3X more likely to report poor health than women in general pop'n and higher rates of STDs. Lessons for National Reform: Changes in coverage and access challenging, for women, who often also in charge of family health. System simplification and navigational support can increase coverage. Coverage expansions may exacerbate	Documented challenges in accessing care suggest future health reform efforts should address access in the prison system and post-incarceration support, including reproductive health needs of incarcerated women.	States have Medicaid eligible incarcerated populations with health issues. [89]

									existing primary care shortages. Since women use more primary care, this is important women's health concern. Women disproportionately affected by HC costs; affordability standards based only on premiums are unfair to women, who have higher out-of-pocket health expenses.		
IOM	2011	Child and Adolescent Health and Health Care Quality: Measuring What Matters	report	Institute of Medicine	general	general	children and adolescents	general	Parents may lack awareness of adolescents' health-seeking behaviors or health status, which may lead to inaccurate reporting/ underreporting of risk behaviors and/or health conditions. Reauthorization of CHIP a few months before ACA passed. Due to ACA, number of children and adolescents with health insurance coverage increased, as a result of the inclusion of private-sector coverage through age 26. The new National Prevention Strategy mandated in ACA	Examples of state and local efforts that encourage collaboration include: fostering use of pop'n health and administrative data sets among HC providers and their institutions and other service settings; supporting quality improvement practices; and informing coordinated interventions to prevent and mitigate health risk behaviors, and address social and environmental contexts. Scaling will require examination of	EMR and HIT will be implemented by states. \$ provided under ACA. [92]

									offers opportunity to improve quality of data sources re measurement of preventive services for children and adolescents.	HIPAA regulations and state and local capacity to analyze, interpret, and report on data. Greater alignment among federal agencies concerned with technology and quality measurement is necessary.	
Literature Review Update (April 2013)											
Gee RE, Rosenbaum S	12/2012	The Affordable Care Act. An Overview for Obstetricians and Gynecologists.	Journal article	Obstetrics & Gynecology	general	OB/Gyn	women	general	Insurance coverage will increase due to coverage of kids on parent plans, state health insurance exchanges, more affordable coverage, and permits direct access to OB/Gyn care without referrals. Care delivery redesign with health insurance expansions support systems of care for women over life. Emphasis on primary care an opportunity for access to OB/Gyn, increasing demand. Immigrants left out. No cost regulations so can expect short term spending spike. ACA expands coverage for preventive svcs. without cost sharing, including STD, HIV screening, HPV	Expansion of training programs for clinicians likely. OB/Gyn should expect greater insurance company scrutiny on following practice guidelines.	16 states developing health insurance exchanges. Will facilitate enrollment of coverage, including into Medicaid and CHIP. States that opt out of Medicaid expansion will have dramatic effect on poor adults, as DSH pmts go away in 2014.[110]

									testing.		
Sonfield A, Pollack HA	4/2013	The Policy and Politics of Reproductive Health. The Affordable Care Act and Reproductive Health: Potential Gains and Serious Challenges	journal Article	Journal of Health Politics, Policy, and Law	General	Providers of FP	Primarily women	general	Individuals and small employers to purchase insurance through exchanges, with subsidies for <400% FPL. Coverage of dependent to age 26 on parental plans, already 3.1M youth gained coverage. Youth generally have higher STD rates. Ends gender rating, retroactive policy cancellation, coverage limits, preexisting condition denials/limitations. (2010-2014) Women can visit OB/Gyn w/o referral. Greater preventive service coverage, including STDs, HPV vacc. Provisions to incr. service providers. Undoc. immigrants not eligible for exchanges or Medicaid, so CHCs important safety net. PPHF supports surveillance.		States can expand Medicaid eligibility by revising Medicaid plans, rather than through an FP waiver. Medicaid expansion now optional. Creates potential donut hole – could be low income but ineligible for subsidies and Medicaid. 11. 5M uninsured adults could have no affordable coverage options. States have strong econ. And political reasons to participate – benefits residents, eases financial pressures on hospitals and others from uncompensated

											ed care, benefits safety net providers, local governments, private health insurance companies that run Medicaid managed care plans, increased employment in HC sector. 100% to 90% match. PREP funds to states for preventing teen pregnancy and STIs – cannot be abstinence only.[109]
Stulberg D	4/2013	The Policy and Politics of Reproductive Health. The Affordable Care Act and Reproductive	Journal article	Journal of Health Politics, Policy, and Law	General	General	Reproductive age people	General	Individual and employer mandates will lead to more reproductive age people covered. Young adults on parental plans until 26. Preventive services without cost sharing. Exchanges with subsidies. Potential to expand collection and	Recommend states use contracting structure of exchanges to required collection and reporting of info about reproductive health svcs. and outcomes.	State-based insurance exchanges and Medicaid expansion create opportunities for consumers and states to hold plans accountable

		Health: Harnessin g Data to Improve Care							dissemination of health care data. USPSTF prev srvc covered w/o cost sharing, incl. STD screening and counseling.		for quality, including for reproductive care. States could require an FP clinic in each county. Greater info collection and reporting could be used for consumer choice, to shape policy, provider improvement, plan use, and research use.[108]
DiVene re L	9/20 12	Women's health under the Affordabl e Care Act: What is covered?	Trade Article	OBG Manage ment	Gener al	Ob/gy n	Wom en	Gener al	Preventive services without deductibles or co-pays, including STD screening/counseling, HPV testing. Improved coverage for women. No referral to see OB/Gyn. No lifetime coverage limits. Potential provider shortage. Poor Medicaid reimbursement a provider concern. Insurance exchanges with subsidies. Essential health benefits include preventive svcs.		Now that Medicaid expansion is optional, some states may not expand. State FP waivers no longer needed. Personal responsibility education to reduce youth pregnancy and STDs. Cannot be abstinence only.[112]

									Creates medical homes for women in Medicare and Medicaid. Undocumented ineligible for exchanges, subsidies, and Medicaid.		
Regenstein M, Christie-Maples J	11/1/2012	Medicaid Coverage for Individuals in Jail Pending Disposition: Opportunities for Improved Health and Health Care at Lower Costs	Article	Health Policy Faculty Publications	General	General	Incarcerated pending disposition	General	People in jail awaiting disposition are qualified to enroll in state health insurance exchange plans. If released on bail, also Medicaid eligible if meet other requirements. Expansion means more of this pop'n meets eligibility requirements. This is a good opportunity to get vulnerable pop'n enrolled in insurance (4-6 million people)	In local jails pending disposition not currently eligible for Medicaid but should be. Studies show recidivism lowered if have Medicaid after jail. 8/10 men and 9/10 women in jail have chronic condition, including HIV/AIDS, and may or may not get meds while in jail. Jail pop'n has higher STD and HIV rates (4-6 X more likely to have HIV than general pop'n). 19% of people with HIV in U.S. in jail	States and localities currently have burden of inmate health care. Medicaid enrollment for this pop'n could save states substantial amounts of \$. Example of NC program that enrolls inmates in Medicaid – could save \$178K per inmate, total of \$2 billion in one year.[113]
Napili A	1/23/2013	Title X (Public Health Service Act) Family Planning Program	Report	Congressional Research Service	General	Title X clinics	General	General	Title X supports confidential svcs. related to family planning, including STD/HIV prevention ed., counseling & referral to men and women. Also 2013	Due to ACA, an OPA priority is to enhance Title X clinic ability to bill public and private insurers.	[111]



									goal to prevent 1600 cases of infertility through chlamydia screening. Some expectation that demand for safety net provider services, including FP, due to confidentiality will continue after ACA.		
Ford MA and Mason Spicer C, ed.	2012	Monitoring HIV Care in the United States. A strategy for generating national estimates of HIV care and coverage	Report	IOM	General	General	People with HIV/AIDS	HIV/AIDS	ACA will increase access to coverage and care for people with HIV through the Medicaid expansion, closing the donut hole, increasing access to private insurance, consumer protections (eliminates pre-existing condition consideration and lifetime \$ limits), and expansion of preventive service coverage. CDC MMP collects data on care and other statistics for people with HIV, which can be used to monitor impact of ACA on those with HIV. Needed b/c ACA doesn't guarantee linkage to, receipt of, or quality of care. Project a shift from Ryan White program to other sources as Medicaid coverage	Need to monitor possible problem with individuals ineligible for Medicaid in states that opt out and also can't get subsidies for state exchanges. Also potential for churn for people near "borders" of coverage eligibility. HHS should study how Ryan White is used post ACA.	MMP may not have enough state by state data (not all states), designed for national info. ACA implementation across states may vary.[114]

									increases.		
Health Resources in Action	7/12/2012	Mercer County, NJ Community Health Assessment	Report	Submitted to Greater Mercer Public Health Partnership	NJ	General	General	General	Consequences (incl. STIs) related to risky sexual behaviors discussed, esp after cutbacks in govt funding for related svcs. FP shortages may lead to increased risky behaviors. Ongoing concerns about impact of uninsured and underinsured on cost of care and on physicians increasingly moving to specialties. Concerns about ACA, political debate, and potential impact on FP.	Residents want to see more comprehensive prevention-related efforts, including sexual health – STDs and HIV/AIDS.	[115]

Table sorted by order listed in Google Scholar search results.

Abbreviations used in table: HC = health care; EMR = electronic medical record; HIT = health information technology; CHCs = community health centers; FP = family planning; pop'n = population; ACOs = accountable care organizations; CHW = community health worker; approps = appropriations; LHD = local health department; HD = health department; ed = education; nat'l = national; svcs = services; ADAP = AIDS Drug Assistance Program; EPT = expedited partner therapy; SBHCs = school based health centers; PH = public health; CNM = certified nurse midwife; CM = certified midwife; LGBT = lesbian, gay, bisexual, and transgendered

## APPENDIX C: UNC IRB APPROVAL



THE UNIVERSITY  
of NORTH CAROLINA  
at CHAPEL HILL

OFFICE OF HUMAN RESEARCH ETHICS  
Medical School Building 52  
Mason Farm Road  
CB #7097  
Chapel Hill, NC 27599-7097  
(919) 966-3113  
Web site: [ohre.unc.edu](http://ohre.unc.edu)  
Federalwide Assurance (FWA) #4801

**To:** Jennifer Ludovic  
Health Policy and Management

**From:** Non-Biomedical IRB

**Approval Date:** 9/12/2013

**Expiration Date of Approval:** 9/11/2014

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

**Submission Type:** Initial

**Expedited Category:** 7.Surveys/interviews/focus groups,6.Voice/image research recordings

**Study #:** 13-0765

**Study Title:** The Patient Protection and Affordable Care Act: The Evolving Role of State Sexually Transmitted Disease Programs

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

### **Study Description:**

**Purpose:** To identify what programmatic changes that state sexually transmitted disease programs are making as a direct or indirect result of the Patient Protection Affordable Care Act.

**Participants:** Key informants from state STD programs

**Procedures (methods):** Nine key informant interviews with staff from nine different states will be conducted over the telephone and assessed qualitatively.

### **Regulatory and other findings:**

The IRB has determined that the study-specific rationale provided by the investigator is sufficient to justify a waiver of written (signed) consent according to 45 CFR 46.117(c)(2) for the telephone interviews.

### **Investigator's Responsibilities:**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Your approved consent forms and other documents are available online at  
[http://apps.research.unc.edu/irb/irb\\_event.cfm?actn=info&irbid=13-0765](http://apps.research.unc.edu/irb/irb_event.cfm?actn=info&irbid=13-0765)

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Any unanticipated problem involving risks to subjects or others (including adverse events reportable under UNC-Chapel Hill policy) should be reported to the IRB using the web portal at <http://irbis.unc.edu>.

Researchers are reminded that additional approvals may be needed from relevant "gatekeepers" to access subjects (e.g., principals, facility directors, healthcare system).

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

CC:  
Sandra Greene, Health Policy and Management

## **APPENDIX D: EMAIL FOR RECRUITING PARTICIPANTS**

Dear [insert participant's name],

Hello, this is Jennifer Ludovic, a Doctoral student at the University of North Carolina at Chapel Hill in the Gillings School of Global Public Health. I am conducting this project as part of my dissertation, under the supervision of my faculty supervisor, Sandra B. Greene, DrPH. I also work for the Division of STD Prevention at the Centers for Disease Control and Prevention. I will share this information, without identifying your name, with CDC, but it will not be used by CDC to either penalize or reward the programs that participate. CDC may use this information to identify programmatic needs, such as technical assistance, training, or identification of best practices.

I am conducting a small research study to help evaluate what changes STD program leaders are making or plan to make as a result of the Affordable Care Act, with implementation of these changes to services and policies from 2010 through 2016 in three areas: 1) financial changes, including billing; 2) changes in what community partners programs are working with and how; and 3) changes in services and support being provided by STD Programs.

I would like to invite you to participate in this study if your program is making changes, or has made plans to make changes within the stated time period, in at least two of these three areas. Participation in this small study is strictly voluntary. The interview would take place over the telephone, and is anticipated to last about 60 minutes.

The information I collect from interviews with state STD program staff, coupled with other data about the state STD programs, may be used by CDC's STD Program to determine or develop needed technical assistance, identify "best practices" for dissemination, or for other facets of program support and development. Although interviewee names will not be reported, I will be reporting state-by-state information.

Thank you for considering participating in this study. Please contact me at [jludovic@email.unc.edu](mailto:jludovic@email.unc.edu) or 770-605-9463 if you have questions or would like to volunteer to participate in an interview. I have also attached a consent form that may provide answers to some questions. I will follow-up with you to see if you are willing to schedule an interview in five to ten days.

I know that you are very busy, and I greatly appreciate your time and assistance with this effort.

Best regards,  
Jennifer Ludovic, MPH

Doctoral student, University of North Carolina, Chapel Hill, Gillings School of Global Public Health  
and  
Policy Team Lead, Office of Policy, Planning, and External Relations  
Division of STD Prevention, NCHHSTP

Centers for Disease Control and Prevention

## **APPENDIX E: SCRIPT FOR RECRUITMENT FOLLOW-UP**

Hello, this is Jennifer Ludovic, a Doctoral student at the University of North Carolina at Chapel Hill in the Gillings School of Public Health. I also work for the Division of STD Prevention at the Centers for Disease Control and Prevention.

I emailed you previously about a small research study I am conducting as part of my dissertation to help evaluate what changes STD program leaders are making or plan to make as a result of the Affordable Care Act.

I would like to invite you to participate in this study if your program is making changes, or has made plans to make changes within the stated time period, in at least two of these three areas. Participation in this small study is strictly voluntary. The interview would take place over the telephone, and is anticipated to last about 60 minutes.

For your convenience, I have attached the consent form that I sent with the original email. Please let me know if you have any trouble downloading or viewing it. Please also let me know if you have any questions about the form or the study.

I know that you are very busy, and I would greatly appreciate your time and assistance with this effort.

If you are willing to participate in this research study, I would be happy to schedule a time that is convenient for you and will call you at the number you designate. You may provide me with the contact number now if you are willing to be interviewed.

Thanks and have a great day!

Best regards,

Jennifer Ludovic, MPH

Doctoral student, University of North Carolina, Chapel Hill, Gillings School of Global Public Health  
and

Policy Team Lead, Office of Policy, Planning, and External Relations  
Division of STD Prevention, NCHHSTP  
Centers for Disease Control and Prevention

## **APPENDIX F: CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**Title of Study:** The Patient Protection and Affordable Care Act: The Evolving Role of State Sexually Transmitted Disease Programs

**Principal Investigator:** Jennifer Ludovic, MPH, UNC Gillings School of Global Public Health DrPH student and Policy Team Lead, Division of STD Prevention, NCHHSTP, CDC

**Study Contact telephone number:** 678-596-6089

**Study Contact email:** [jludovic@email.unc.edu](mailto:jludovic@email.unc.edu)

**Study UNC Faculty Advisor Contact:** Sandra Greene, DrPH, [SandraB\\_Greene@unc.edu](mailto:SandraB_Greene@unc.edu), 919-966-8930

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**Introduction:** I would like to invite you to participate in a research study. Please ask questions if there is anything you do not understand.

### **What is the purpose of this study?**

The purpose of this research study is to learn about the views and opinions of state sexually transmitted disease (STD) program staff regarding current or planned changes within the state's STD program related to or because of the 2010 Affordable Care Act. This information may be used to determine or develop needed technical assistance, identify "best practices" for dissemination, or for other facets of program support and development.

### **How long will you need me?**

You will be asked to be interviewed over the telephone for approximately 60 minutes. You may also be contacted by me by either telephone or email for clarifications about the interview or follow-up questions, if needed.

### **What do you want me to do if I decide to be in this study?**

Participation in interviews for this study will involve the following steps:

- Read this consent fact sheet to decide if you are interested in participating
- Contact the researcher [jludovic@email.unc.edu](mailto:jludovic@email.unc.edu) with any questions or concerns regarding your participation
- Schedule a time to participate in a 60 minute telephone interview
- Provide your consent for participating in this study over the telephone
- Provide your consent for an audio recording of the interview – you may request that the audio recorder be turned off at any time
- Participate in an interview over the telephone in October or November
- Address follow-up questions or clarifications if needed after the interview

### **Are there any risks to me if I decide to be in this study?**

I will protect and will not identify the role or names of the individuals that I interview, however, the states for which interviewees work will be identified in association with information collected during the interview. It is possible that someone may be able to use public information to deduce who I have interviewed. However, the interview questions are of a factual nature about the program for which you work, minimizing any potential risk. In addition, the information



provided to me during the interview will not be used by CDC to either penalize or reward the program.

**Are there any benefits from being in this study?**

Your participation will benefit STD public health program development and assistance activities in other states through the sharing of best practices. Your program may also learn from other states' experiences. However, you may not benefit personally from being in this research study.

**Will the information I give you be kept private?**

Due to the contextual nature of the information being collected for this study, and its focus on the environment specific to the state, it is not possible to keep the information collected for this study completely private. While information collected through the interviews will not identify the name of the person interviewed, the identity of the people interviewed may be discernible. Due to the factual and objective nature of the information I will collect from you about your program, sharing this information is anticipated to have minimal risk for the participants. In addition, although I will share this information, without identifying your name, with CDC, it will not be used by CDC to either penalize or reward the programs that participate. CDC may use this information to identify programmatic needs, such as technical assistance, training, or identification of best practices.

**Will I receive anything for being in this study?**

You will not receive anything for taking part in this study.

**Will it cost me anything to be in this study?**

No, other than use of your time, there will be no costs for participating in the study.

**Who should I call if I have questions about this study?**

If you have questions or concerns, you should contact the researcher listed on the first page of this form. If you have questions or concerns, you may contact Jennifer Ludovic at 678-596-6089. Leave a message with your name, phone number, and refer to this project, and someone will call you back. If participants have questions about their rights as a research participant, they should contact the UNC-CH Institutional Review Board at 919-966-3113, or via email to [IRB\\_subjects@unc.edu](mailto:IRB_subjects@unc.edu).

**Do I have to be in this study?**

Your participation in this study is voluntary and you may stop the interview at any time and for any reason.

**Participant's Verbally Obtained Agreement:**

Do you have any questions?

Have you had all of your questions answered?

Do you agree to be in the study and to be recorded? (If participant does not agree, the interview will end here.)

## **APPENDIX G: KEY INFORMATION SCREENING QUESTIONS AND INTERVIEW QUESTION GUIDE**

### **Solicit Questions and Permission to Record Conversation**

Thank you for volunteering to participate in this conversation. The purpose of this interview is to identify how your STD program may be adjusting or planning to adjust in anticipation of full implementation of the Affordable Care Act in January 2015. State STD (and HIV) program directors or their staff will participate in the conversations. Each conversation is anticipated to take approximately 60 minutes. I would like your permission to record our discussion and to utilize the responses in my study.

- Do you have any questions about the study or this conversation?
- May I record our conversation?

### **Screening Questions for Verification of Program Changes or Plans to Make Changes**

First, I would like to verify that your STD program has made changes, or has planned changes in at least one of the following three areas as a result of the Affordable Care Act:

- 1) changes in services and support being provided by your program;
  - 2) financial changes, including billing; and
  - 3) changes in what community partners your program is working with and how.
- Has your STD program made changes in at least one of these areas?  
(If “no”, then thank them for their time and end here. If “yes”, then continue.)

### **Overall State Activity Level Regarding the Affordable Care Act**

- Has your Governor’s Office, State Public Health Department, or other State Governmental leadership engaged the STD programs in conversations about the Affordable Care Act and its potential impact to state programs, and what have the conversations entailed?
  - If you had any discussions specific to the STD (and HIV) program, what was discussed?

### **Services**

- What type of activities does your program engage in to prevent STDs (and HIV)?
  - Does your program work with public and/or private health care service providers, including serving the incarcerated, and how?
  - Does your program work with public or private insurers?
  - Does your program conduct promotional campaigns?
  - Does your program work with schools, and how?
  - Are there other types of activities conducted by your program?
- Have the activities we discussed changed since the passage of the 2010 Affordable Care Act, and how?
  - Have you encountered any barriers to making the needed changes, and if so what are the barriers you have encountered?

- Do you anticipate making (additional) programmatic changes by the end of 2016? If you aren't planning any changes, why not? What types of assistance might be needed to help you make changes?

## Financial Adjustments

- Do you anticipate that the implementation of the Affordable Care Act will affect the funding or income of your STD (and HIV) program? If so, how?
  - *If needed for prompting:*
    - If yes, what kinds of programmatic changes are you making to adjust?
- What providers, if any, does your program provide in-kind or direct funding to in order to provide STD services?
  - *If needed for prompting:*
    - Are you funding or providing in-kind services to STD clinics, the public health department clinic, federally qualified health centers, community health centers, family planning providers, or other providers?
  - *[Ask only if the state is funding STD clinics or public health departments]* Are you billing for STD-related services, or considering billing for services in the future?
  - Are there barriers to billing in your state that you are working to overcome?
  - *[Additional questions if needed for prompting]*
    - Is the STD program working with other state health programs on this effort?
    - Are you planning to bill both Medicaid and private insurers?
    - Do you foresee any barriers to implementing billing?
    - What services are you planning to bill for?
      - Are you billing or planning to bill for lab services?
      - Are you billing or planning to bill for treatment?
      - Are you billing or planning to bill for behavioral counseling?
    - *[Ask only if program funds STD clinics or public health clinics, but not considering billing]* Why is your program not considering billing?

## Partners

- In this context, partners means any group or organization with whom your state STD prevention program collaborates both formally or informally, such as schools, family planning clinics, and medical associations.
- Who were your partners prior to the Affordable Care Act?
  - *[If necessary for prompting]:* for example, schools, family planning clinics, medical associations
  - How did you work with partner X, Y, Z?

- Can you describe any ways in which the Affordable Care Act, and/or other recent changes may have led you to change the partners that you are working with, or perhaps the way you work with your partners?
  - *[If necessary for prompting]*
    - Who are you working with now that you didn't work with previously?
    - Have you discontinued working with any partners, and who are they?
    - Are you engaging with your partners in different ways?
    - Do you anticipate making any changes in the next few years, and if so, what kinds of changes?

### **Conclusion**

Thank you for taking time out of your busy schedule to have a conversation with me about your STD Program. The information you provided has been very informative, and I greatly appreciate your assistance with this study.

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