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REPORT

FINAL REPORT

Consulting Services for the Affordable Care Act: Final Report

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act was enacted in March 2010, followed by enactment of the Health Care and Education Reconciliation Act of 2010. Together, they are known as the Affordable Care Act (ACA). One of the provisions of the ACA provides federal funding to states that expand eligibility for Medicaid to individuals with incomes up to 138 percent of federal poverty level (FPL) beginning in January 2014. The ACA also provides government subsidies to low-income individuals to purchase insurance on an insurance marketplace, requires those who can afford insurance to obtain it, and requires employers to offer employer-based insurance under certain circumstances. Collectively, the provisions are designed to decrease the number of uninsured Americans. The Supreme Court ruled that states have a choice about whether to expand Medicaid eligibility and participation in the program is not contingent on the decision to expand.[1] After the Ohio Supreme Court ruled that the Ohio Controlling Board had the authority to accept federal money to support expansion of Medicaid eligibility in December 2013, Ohio became one of the expansion states.[2] Ohio is not operating a state insurance marketplace but is using the federally facilitated marketplace (FFM) to direct individuals to health plans that they may purchase with and without government subsidies.

The Ohio Department of Health contracted with Mathematica Policy Research to conduct an assessment of the impact of the ACA and Ohio's decision to expand eligibility for Medicaid on five Ohio Department of Health (ODH) programs: the Bureau of Children with Medical Handicaps (BCMH) program, the Ryan White HIV/AIDS Program (RWHAP) Part B, the Breast and Cervical Cancer Project (BCCP), the immunization program, and two programs for low-income women and children managed by the Bureau of Child and Family Health Services (CFHS) (the Reproductive Health and Wellness Program and perinatal and child health services).

Approach

To conduct the analysis, the Mathematica team (1) collected information about program services, populations served, and resources used to support the programs; (2) interviewed program staff about the programs, the populations served, and their understanding of the impact of the ACA on the programs; (3) mapped the services covered by the ODH programs with the services covered by the Medicaid alternative benefit plan (ABP) and the Ohio benchmark plan; and (4) analyzed the likelihood that populations served in the ODH programs would acquire insurance under the ACA provisions. In addition, we estimated financial impact of the ACA on the ODH programs based on the percentage of people who would gain insurance or coverage for a previously uncovered service, the historical cost of providing the services, and the potential savings to the ODH program as a result of shifting responsibility for paying for program services from ODH to Medicaid or to a plan purchased on the FFM.

[1] Bigby, J. "Medicaid Expansion Challenges States." In The Affordable Care Act, edited by H. Selker and J. Wasser, pp.127–141. New York, NY: Springer, 2013.

[2] Chris Kardish. "Ohio Supreme Court Upholds Medicaid Expansion." *Governing*. December 23, 2013. Available at http://www.governing.com/topics/health-human-services/Ohio-Supreme-Court-Upholds-Medicaid-Expansion.html. (accessed October 13, 2014)

As we performed the analysis, we considered the various ways the major provisions of the ACA could impact the populations using the public health programs. These include:

- Access to insurance through Medicaid eligibility expansion or purchase of insurance from the federally facilitated marketplace
- Access to essential health benefits that marketplace plans must cover by linking the details of the essential health benefits to Ohio's state benchmark plan
- Access for the Medicaid expansion population to essential health benefits through the Medicaid alternative benefit plan
- Maintenance of insurance coverage due to commercial insurance consumer protections that forbid spending caps or restrictions for preexisting conditions
- Access to evidence-based preventive services without cost sharing for consumers
- Delivery system and payment reforms

Major findings

ODH program participants' service needs will change

Each of the ODH programs serves low-income populations that are likely to be affected by implementation of the ACA. In some circumstances in which participants have private insurance, the ODH program serves as a payer of last resort for services that are not covered or not fully covered by other payers. Our overall assessment of the impact of the ACA on the services provided by the ODH programs revealed several potential effects.

- The state's Medicaid ABP and the state benchmark plan provide comprehensive coverage for the majority of medical services that are currently supported by the ODH programs. Some examples of how participants would acquire more comprehensive coverage if they gain insurance include:
    - The RWHAP does not cover inpatient services for acute medical and surgical care, obstetric care, or mental health diagnoses, but these services are covered by the Medicaid ABP and the plans offered on the FFM.
    - The reproductive health services/family planning program does not cover the breadth of women's preventive health services mandated by the ACA that are covered by the Medicaid ABP and the marketplace plans.
- Neither Medicaid nor the FFM plans cover some important nonmedical services that are covered by the ODH programs. For example:
    - Supportive services such as early intervention services for newly diagnosed HIV-positive individuals, nonmedical case management, and medication adherence

counseling covered by the RWHAP are not covered by insurance but are important to maintaining the health of people living with HIV/AIDS.[3]

- The BCMH metabolic formula program covers formulas that provide essential elements to address inborn errors of metabolism. Most formulas are not covered under the ACA provision to provide EHBs as defined by the benchmark plan. However, these formulas prevent developmental disabilities and maintain cognitive ability in affected children.
- Exchange plan coverage for some services, such as pharmacy coverage for HIV/AIDS, may be limited in duration or scope.

Partnerships with the federal government will continue to be necessary

The state and federal government often work in partnership to fund the ODH programs. The funding is categorical in nature and covers specific conditions that determine the participant's eligibility and meet the program goals. The categorical nature of program funding does not permit the programs to meet all of the participants' service needs. For example, the BCCP does not cover all preventive health screenings for women. The ODH will continue to partner with federal government agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, and Centers for Medicare & Medicaid Services in the near future as the federal government assesses the impact of ACA and other reforms.

[3] Mugavero, Michael J., Wynne E. Norton., and Michael S. Saag. "Health Care System and Policy Factors Influencing Engagement in HIV Medical Care: Piecing Together the Fragments of a Fractured Delivery System." *Clinical Infectious Diseases*, vol. 52, no. S2, 2011, pp. S238–S246.

Spending should decrease in some ODH programs as served populations acquire insurance

In Table ES.1, we summarize our analysis of the estimated impact of the ACA on state spending on ODH programs.

Table ES.1. ODH programs, populations, and estimated impact of the ACA

Program	Population served (year)	Percentage uninsured prior to ACA changes	Percentage of uninsured eligible for coverage in 2014	Base state funding	Estimated state funding affected by ACA provisions in 2014[a]
Bureau of Children with Medical Handicaps	39,264 (SFY 2014)	8.4[b]	15 percent Medicaid 21 percent MPE	$7,806,787	$6.8 million
RWHAP Part B	7,023 (SFY 2012)	41	66 percent Medicaid 34 percent MPE	$11,439,626	$6.8–$8.6 million[c]
Breast and Cervical Cancer Project	11,600 (SFY 2012)	100	78 percent Medicaid 3 percent MPE	$823,217	$823,000
Immunization program	73,890 underinsured children (SFY 2012)	n.a. (insured with coinsurance, copayments, or deductibles)	n.a.	$8,847,087	$8.8 million
Bureau of Child and Family Health Services:	6,783 perinatal women (SFY 2013)	25	86 percent Medicaid 1 percent MPE	$2,300,00	$593,400
Perinatal and children programs	15,695 children (SFY 2013)	13	90 percent Medicaid 1 percent MPE		$16,000

Source: Mathematica analysis of program information provided by ODH in February and August 2014
[a]Dollar amount is an estimate of the funding that would no longer be necessary to cover medical services using base state funding as the point of analysis.
[b]Uninsured includes diagnostic and treatment program participants. The diagnostic program did not provide information on insurance, family size, or income and these participants are included among the uninsured in the dataset provided by ODH.
[c]Assumes 75 percent of Ryan White HIV/AIDS Program funds associated with the population are used for medical services; range assumes that 60 to 100 percent of eligible uninsured people acquire Medicaid or private insurance.
ACA = Affordable Care Act; SFY = state fiscal year; MPE = marketplace eligible with or without subsidies; n.a. = not applicable.

Programs that serve low-income adults, including the BCCP and the RWHAP Part B program, are likely to see significant effects on eligibility or demand for their services. Most of the target population for these programs is likely eligible for Medicaid in 2014, and all others, except for undocumented immigrants, become eligible for subsidized coverage in the marketplace.

- We estimate that ODH could expend approximately $8 million less on low-income adults who gain insurance coverage for services provided by the BCCP and the RWHAP Part B programs based on state fiscal year (SFY) 2012 spending.

Uninsured children and adults served by the BCMH program are also likely to be affected by the ACA.

- We estimate that nearly all of the BCMH treatment program children and adults who were uninsured in SFY 2014 would be eligible for Medicaid or insurance through the marketplace. We estimate that ODH could expend $6.8 million less for the BCMH treatment program based on SFY 2014 spending.

The ACA is likely to have less of an impact on programs that serve low-income children or perinatal women. These population groups were largely eligible for Medicaid before implementation of the ACA. However, under the ACA, perinatal women will maintain their eligibility for Medicaid after the postpartum period. States must continue eligibility for adults until 2014 and for children until 2019 to receive federal matching funds.[4]

- We estimate that ODH could expend $600,000 less for the programs serving primarily perinatal women based on SFY 2012 spending.

Impact of the ACA on underinsured

ODH programs that serve individuals who have insurance but are underinsured (that is, existing insurance does not cover all necessary services or requires copayments or deductibles) may see effects from the ACA. Under the ACA, prevention services must be covered without consumer cost-sharing and plans are restricted from capping coverage for necessary services except for grandfathered health plans (group plans in effect prior to March 2010 or individual plans purchased before March 2010 and whose benefits have not changed).

- We estimate that the ODH immunization program that covers vaccines for underinsured children may, over time, require up to $9 million per year less funding. The actual impact depends on the percentage of children who are covered by grandfathered health plans and the pace of change in those plans that would result in loss of their grandfathered status and thus require the plans to offer immunizations without cost sharing.
- We estimate that the BCMH will not likely see an impact on spending for underinsured participants in the treatment or diagnostic programs. BCMH is the payer of last resort; therefore, the majority of payments are made in addition to the payment by the primary payer and represent denied claims for noncovered services.

Maximize the effect of the ACA on the newly insured

As ACA implementation and Medicaid eligibility expansion progress, it is important for ODH to track the populations they serve and whether these populations access insurance

[4] The ACA requires states to maintain eligibility and enrollment policies that are no more restrictive than those in place on March 23, 2010 (the enactment date of the ACA), until 2014 for adults (unless granted an exception) and until 2019 for children in Medicaid or the Children's Health Insurance Program. See "Kaiser Commission on Medicaid and the Uninsured, Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues," April 2011. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8174.pdf.

coverage through Medicaid or the FFM. Whether there are cost savings in the ODH programs is dependent on whether populations who have used the programs gain insurance or transition to the more comprehensive coverage. Some programs plan to provide assistance to their served populations to ensure access to coverage. Because ODH programs do not systematically collect insurance status, income, and other data that could inform eligibility for Medicaid or subsidized insurance, ODH may find it difficult to consistently identify and track individuals who are potentially eligible for coverage. Therefore we recommend the following:

- ODH should collect a common set of eligibility, enrollment, and service utilization data across programs. The common set of eligibility data elements should be consistent with data required by federal programs and other Ohio programs serving low-income individuals.
- ODH should track people who are eligible for insurance and monitor their success in acquiring insurance.
- It is imperative that ODH coordinate with other agencies to assess the impact on ODH program users who transition to other services and on the populations that ODH continues to serve as provider of last resort, including for populations in rural areas or for populations with unique social circumstances.

The seamless integration of medical and population health (or nonmedical) services is an important feature of ODH's efforts to be responsive to the needs of program participants and their families. ODH can leverage the longstanding experience of programs and providers delivering comprehensive services to provide insight to medical systems on how to serve these populations or on how to best integrate with other systems of care. Our analysis offers the following implications for promoting service integration:

- An array of providers participates in the ODH programs. These providers have extensive experience with outreach, care coordination, case management of chronic medical conditions, patient education and counseling, and other skills that are important for integrated delivery systems. As reforms to integrate and coordinate care progress, opportunities emerge to leverage the experience of these ODH providers and to incorporate their expertise in the emerging integrated systems.
- ODH program staff also demonstrate expertise in outreach, care coordination, care management of chronic medical conditions, patient education and counseling, and other skills across an array of programs and settings. ODH staff should also leverage their skills to promote integrated services and care in both the public health and health care systems.
- Some ODH provider grantees are exploring ways to partner with medical care providers. For example, the reproductive health program providers are exploring partnerships with primary care providers or federally qualified community health centers (FQHCs) to integrate reproductive health services into primary care.
- The HIV/AIDS population will increasingly achieve coverage in the Medicaid program. The concentration of people living with HIV/AIDS in the Medicaid program represents a unique opportunity to design integrated systems of care that specifically meet the needs of this population. Together, payers and medical and nonmedical providers should develop a strategy on how to best integrate the RWHAP services into the evolving health care system

and to strengthen collaboration between medical and supportive services providers as RWHAP participants gain insurance.

- The federal government provides much of the funding for the ODH programs we reviewed. ODH and other Ohio health officials are in a unique position to inform the federal government's decisions about the future of these programs. Ohio's State Innovation Model (SIM) grant is one example of a mechanism through which the state can provide input about federal policy, the role of public health, and the integration of public health and medical care as reforms progress.

Public health systems will change as the role of public health departments evolves

ODH providers face several challenges as health reforms progress. Many providers that give care to ODH program clients have historically been grant funded and do not have the capability to perform third-party billing. Providers are exploring mechanisms to support third-party billing, but many lack the resources to develop the necessary infrastructure.

- As ODH explores its role in supporting transformation of public health services, it should identify mechanisms for improving the infrastructure to support public health providers and local health departments (LHDs) to provide core public health services.

Conclusion

Populations that have used and benefited from several ODH programs will gain insurance that will cover many of the medical services the ODH programs have provided with state and federal funds. ODH may find significant opportunities to redirect public health funds from covering medical services to providing nonmedical services as more people who use public health programs gain insurance. ODH may find significant opportunity to redesign certain programs to account for the populations that will likely become insured under the ACA and no longer need access to medical care through ODH programs. At the same time, the ODH can find ways to provide access to services that insurance does not cover but that enhance clients' engagement in effective prevention or treatment programs. In addition, ODH should explore the need for continuing programs that serve as the option of last resort for relatively small populations living in rural areas or in other communities where services are limited. The challenge of serving rural communities or socially isolated communities also presents an opportunity for LHDs to better integrate services among the few providers in those communities.

I. INTRODUCTION

A. Purpose of the report

Under contract CSP90914, "Consulting Services for the Affordable Care Act," Mathematica Policy Research provided consultation to the Ohio Department of Health (ODH) about the impact of the Patient Protection and Affordable Care Act (ACA) on public health programs. Mathematica reviewed selected public health programs including the Bureau of Children with Medical Handicaps program (BCMH), Ryan White HIV/AIDS Program (RWHAP) Part B, Breast and Cervical Cancer Project (BCCP), immunization program, and Bureau of Child and Family Health Services (CFHS). Mathematica (1) conducted an assessment of each program to identify the populations served, the services delivered, and the characteristics of providers; (2) performed an analysis to model the potential impact of expanding Medicaid eligibility and access to insurance in the federally facilitated marketplace (FFM) on insurance status for program participants and on demand for and changes in the delivery of the services provided in public health programs and initiatives; and (3) performed a programmatic and financial analyses to inform the department's budget planning. Mathematica also researched the potential impact of the ACA on local health departments (LHDs) by interviewing national experts and public health officials in five states with characteristics similar to Ohio's. This report describes the likelihood of program participants gaining insurance that would cover the services provided by the ODH programs and the relief that coverage might provide to the ODH program budgets. We also provide a brief summary of interviews with representatives from five states about their plans for the roles of LHDs given the likely increase in the number of insured individuals under ACA.

B. Context and conceptual framework

The Patient Protection and Affordable Care Act was enacted on March 23, 2010, followed by the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. Together they are known as the Affordable Care Act (ACA). The ACA envisions that the United States can achieve significantly greater health care coverage if (1) the lowest-income residents can enroll in Medicaid, (2) the government provides tax subsidies to purchase insurance in a state or federally facilitated insurance marketplace for those who cannot qualify for Medicaid and cannot afford market rates for insurance, (3) people who can afford insurance purchase it, (4) employers who can offer insurance offer it, and (5) older adults and disabled people who are eligible for Medicare continue to have access to it. One of the provisions pertinent to Medicaid provides for federal funding to states that expand Medicaid eligibility to individuals with incomes up to 138 percent of federal poverty level (FPL) beginning in January 2014. The U.S. Supreme Court clarified that states have the option to continue their participation in the Medicaid program with or without expanding eligibility. After the Ohio Supreme Court ruled that the Ohio Controlling Board had the authority to accept federal money to support expansion of Medicaid eligibility, in December 2013 Ohio became one of the expansion states.[5] Ohio is not operating a state insurance marketplace but is using the FFM to direct individuals to health plans they may purchase with or without government subsidies.

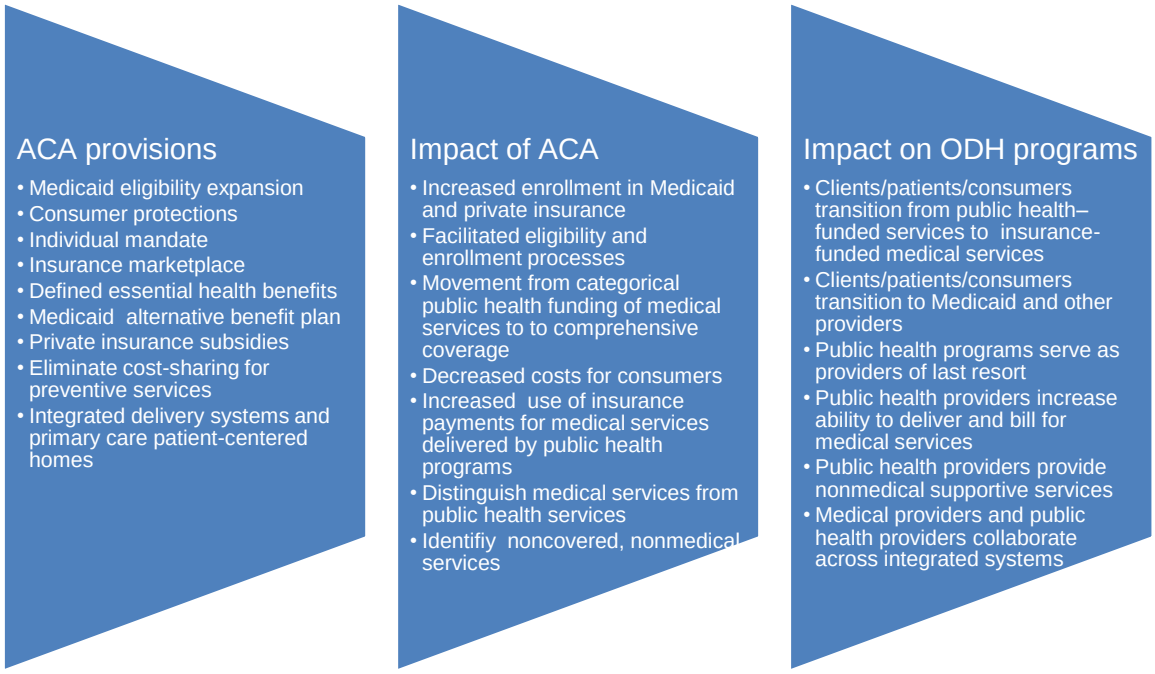
[5] Chris Kardish. "Ohio Supreme Court Upholds Medicaid Expansion." *Governing*. December 23, 2013. Available at http://www.governing.com/topics/health-human-services/Ohio-Supreme-Court-Upholds-Medicaid-Expansion.html. (accessed October 13, 2014)

Prior to the ACA, Ohio's Medicaid program did not cover childless adults, covered parents with incomes up to 90 percent of FPL, and covered disabled people with incomes up to 64 percent of FPL. About 47 percent of Ohioans with incomes up to 133 percent of FPL were uninsured.[6] One study estimated that with expanded Medicaid eligibility, 667,000 to 901,000 people would enroll in Medicaid between 2014 and 2019.[7] The Ohio Medicaid Expansion Study estimates that the net fiscal gains from expansion would range from $50 million in state fiscal year (SFY) 2014 to between $119 and $140 million in 2020.

1. Potential impact of the ACA on public health

The ACA may affect public health programs in several ways. Figure I.1 illustrates the key ACA reform strategies and their relevance to public health populations, programs, and functions.

Figure I.1. Framework for understanding impact of ACA on ODH public health programs



[6] Holahan, J. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission for Medicaid and the Uninsured. Washington, D.C.: Henry J. Kaiser Family Foundation, November 2012.

[7]. Health Policy Institute of Ohio Expanding Medicaid in Ohio: Analysis of Likely Effects. February 2013. Available at http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/medicaidexpansionstudy_brief_final_02262013.pdf. Accessed September 22, 2013.

Although we considered all of these mechanisms for how the ACA can impact public health programs, in this project we focused on the impact of insurance coverage expansion and access to the essential health benefits (EHBs) that include preventive services. We assessed how individuals who use the five ODH programs might be affected by the ACA policies.

2. Framework for assessing the potential effects of the ACA

As we reviewed the ODH programs, we considered specific ways in which ACA provisions could impact ODH programs and the individuals who use the programs.

Medicaid expansion and marketplace insurance. Ohio elected to expand eligibility for Medicaid to include adults up to age 65 with incomes up to 138 percent of FPL.[8] Ohio is not operating a state health insurance marketplace. Ohioans with incomes between 100 percent and 400 percent of FPL who do not have access to affordable employer-sponsored insurance, Medicaid, or Medicare may purchase insurance through the FFM with possible federal subsidies. In addition, lawfully residing immigrants with less than five years of residence with incomes from 0 percent up to 400 percent of FPL may purchase insurance in the marketplace with possible federal subsidies. These provisions may provide access to affordable insurance for individuals using the ODH programs or for the parents of children who use the programs. Insurance premium tax credits are available to individuals and families with incomes between 100 to 400 percent of FPL. Cost sharing subsidies help pay for the copayments and deductibles for in-network services provided to individuals and families with incomes between 100 and 250 percent of FPL.

Essential health benefits. The ACA establishes an EHB package that provides a comprehensive set of 10 services.[9] All health plans offered through the FFM must include these services. However, the extent of the benefits is determined by a benchmark plan in each state. The default benchmark plan for Ohio is the state's largest small-group product: Blue 6 Blue Access PPO Medical Option D4 Rx Option G. This plan does not include habilitative services, but they are required in the EHB. Per rules from the U.S. Department of Health and Human Services, the governor identified habilitative services as services for children diagnosed with autism spectrum disorder.[10] The ACA requires all qualified health plans (including those offered through the marketplaces and those offered in the individual and small-group markets outside the marketplaces, except grandfathered individual and employer-sponsored plans) offer at least the EHB package as defined in each state.

A state may elect to cover its Medicaid expansion population through the Medicaid state plan adult benefit package or through an alternative benefit plan (ABP), which must also cover the 10 EHBs and non-emergency transportation; family planning services; and early and periodic

[8] The ACA expands Medicaid eligibility to 133 percent of FPL but because of a fixed dollar amount that varies by family that is disregarded, the effective eligibility is up to 138 percent of FPL.

[9] The 10 services are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse, including behavioral health; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[10] The habilitative services defined by the governor include speech and language therapy, occupational therapy, clinical therapeutic intervention, and outpatient mental health and behavioral health treatment.

screening, diagnosis, and treatment services. Ohio has elected to create an ABP for the Medicaid expansion population. It is more comprehensive than the Medicaid state plan adult benefit package as it eliminates caps on mental health and substance abuse services.

The EHB defines the core set of services for insured populations and provides a standardized set of comprehensive clinical services to which newly insured populations have access. These services are more comprehensive in breadth than the ODH program services, which are categorical. However, if the ODH programs provide a more comprehensive range of services for categorical diagnoses than the EHB, some individuals may continue to benefit from an ODH program or ODH could consider covering certain nonmedical services to complement or wrap around the services covered by Medicaid or insurance.

Preventive services without cost sharing. The ACA requires health plans to cover preventive services for children, adults, and women, including services for pregnant women that have an A or B rating by the U.S. Preventive Services Task Force, without cost sharing.[11] The provision to eliminate out-of-pocket costs removes one of the barriers to accessing screening tests, such as HIV tests, mammograms, and colonoscopies, for low-income populations. This policy may free up some ODH resources that are devoted to screening services.

Commercial insurance consumer protections. Consumer protections afforded by the ACA prevent commercial insurance plans from excluding individuals, including children, with preexisting conditions. The ACA also prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibits insurers from rescinding coverage except in cases of fraud. One example of how these provisions may be relevant is for a family with children with special medical needs and significant medical care costs who may use ODH programs to pay for care after they have reached their private insurance cap. Under ACA, providers are able to bill the primary insurance company for all the covered services provided to the family. The family will have out-of-pocket costs relative to their copayments and deductibles for diagnostic and treatment services.

Delivery system and payment reforms. The ACA contains several provisions that encourage states and health care organizations to test and implement delivery system and payment reforms to improve health care, improve the quality of care, and decrease costs. Many of these reforms promote integrated systems of care and better care coordination. ACA provisions support care coordination through initiatives such as increased Medicaid payments for primary care services, patient-centered medical homes, Medicaid health homes for individuals with multiple chronic medical conditions, and integrated care and financing for people eligible for both Medicare and Medicaid. The ACA also supports payment reforms, such as bundled payments, accountable care organization shared savings, and other changes designed to reduce costs while maintaining or improving health care quality.

Ohio is implementing several innovations to transform the state's health care delivery and payment system. The state's transformation initiative relies heavily on a "modernizing Medicaid" strategy that focuses on better care coordination, paying for clinical outcomes instead of service volume, rebalancing long-term care, promoting medical homes, and coordinating with

[11] http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

other state programs. Care coordination efforts focus on all populations, but the transformation identifies children with disabilities, adults with disabilities and enrolled in Medicare, adults with serious persistent mental illness, and adults with intellectual disabilities as particularly benefiting from care coordination.[12] These federal and state reforms provide an opportunity to explore ways to deliver integrated, coordinated services to ODH program participants and to improve the way health care and public health systems deliver care by coordinating and integrating their services.

3. Impact of ACA on local health departments

Just as the ACA may have an impact on state public health programs, it will also impact LHDs that deliver a range of public health and medical services. As individuals acquire insurance coverage, fewer individuals may need to use LHDs to access core medical services. Nationwide, many LHDs have moved away from providing intensive individually focused, personal health services toward more population-based domains of public health practice. [13, 14] LHDs may experience a decrease in utilization of their services, state and federal governments may reexamine funding for medical services delivered by LHDs, and LHDs that are also safety net providers may need to examine the infrastructure supports required to bill for services they deliver as more of their populations become insured.

C. Approach

1. Assessing the impact of ACA on ODH programs

Mathematica's approach to completing the assessment of ODH programs required three major strategies:

1. Review the ODH programs to determine the populations served, the services provided, and the funding sources.
2. Map the ODH population eligibility criteria and the services covered to eligibility criteria and services covered in the Ohio benchmark plan and the Medicaid ABP.
3. Model the likely movement of uninsured and underinsured populations in the ODH program to Medicaid coverage or to coverage through the FFM with and without subsidies.

Review ODH programs. Mathematica requested information about the populations served by the ODH programs to identify which of the served populations might be eligible for Medicaid or insurance through the FFM. We also requested information about the services provided in those programs to discover whether there was overlap with services that would be covered in Medicaid or through health plans purchased on the FFM. For each program, Mathematica reviewed the information shown in Table I.1. ODH programs have different data collection and data management policies. Mathematica worked with program staff to retrieve data that were as

[12] http://www.healthtransformation.ohio.gov/CurrentInitiatives/ModernizeMedicaid.aspx (accessed October 21, 2014)

[13] National Association of County and City Health Officials. "Changes in Local Health Department Activities and Services: Longitudinal Analysis of 2008 and 2010 Profile Data. 2012." Available from http://www.naccho.org/topics/infrastructure/profile/resources/upload/ResearchBrief-Activities-final_01-25-2012.pdf (accessed April 30, 2014).

[14] Frieden, T. R. "Asleep at the Switch: Local Public Health Programs and Chronic Disease." *American Journal of Public Health*, vol. 94, no. 12, 2004, pp. 2059–2061.

complete as possible. The results in this report are based on the data we received between February and August 2014.

Mathematica developed structured interview protocols to review and clarify the information provided in response to the initial data request. The Mathematica team conducted 90- to 150-minute in-person interviews with program staff in February 2014. The structured interview guide included a core module of questions that are relevant to all programs and separate modules of questions customized to address program-specific issues and to inform our understanding of health care and delivery system reform in Ohio. Mathematica interviewed key leaders from ODH, the Governor's Office of Health Transformation, the Medicaid program, and program managers. (See Appendix A for personnel interviewed.) We asked about the reforms affecting each public health program, including ways in which each program was responding in terms of changes in (1) the range of direct services provided, (2) the program budget, (3) the types of providers and settings in which the services are provided, (4) the enrollment and eligibility criteria, (5) demographic characteristics of the people enrolled in the program, and (6) program goals and outcomes. We recorded the interviews to ensure the accuracy of our notes and conducted follow-up telephone interviews with program staff to fill in information gaps and obtain additional information as necessary. Mathematica also reviewed information provided by ODH staff and reviewed program information and documents on the ODH website.

Table I.1. Background information sources obtained for analysis of the impact of the ACA on selected ODH programs

1.	Narrative description of the program, such as annual report or progress report
2.	Eligibility criteria and determination processes by program
3.	Current and historical trends in population served/enrolled (actual data for FYs 2012 and 2013; projected for FY 2014)
4.	Demographics of population served or enrollees (age, gender, race, ethnicity, individual and household income, insurance status, and perhaps county of residence) by program (actual data for FYs 2012 and 2013)
5.	Services provided (medical and nonmedical) by service and provider type (for example, ODH/state program staff, hospital outpatient, Medicaid clinic/professional services, other clinic/professional services)
6.	Service utilization by service type and payments (or cost) by service type (actual data for FYs 2012 and 2013; projected for FY 2014)
7.	Budget (actual data for FYs 2012 and 2013; projected for FY 2014)
8.	Funding sources, including third-party billing and cost sharing by consumers if applicable (actual data for FYs 2012 and 2013; projected for FY 2014)
9.	Types of providers and settings where services are offered; ability of current ODH-contracted providers to bill both public and private providers for services they deliver
10.	Overview of program performance measures, outcomes tracked
11.	Organizational chart of the function, staffing, and location of program units

ACA = Affordable care act; ODH = Ohio Department of Health; FY = fiscal year

Crosswalk ODH population eligibility criteria and the services covered. We characterized program functions as either (1) direct, individual-level services provided or funded by the department (such as breast cancer screenings, screening tests for HIV and other sexually transmitted diseases [STDs], and perinatal care), which are likely to be covered by insurance; or (2) population-level public health functions, such as monitoring the incidence and prevalence of targeted diseases (such as breast cancer and HIV/AIDS), mobilizing community partnerships to address program-related issues (for example, prevention of HIV and STDs and promotion of well-child check-ups), or nonmedical case management services, all of which are not likely to be covered by insurance. We summarized the information in a memo that was reviewed by program staff for accuracy and correctness of interpretation and delivered to ODH on June 30, 2014.

Mathematica used the information obtained from interviews, reports, and the ODH website to map the populations served by the ODH programs to eligibility criteria for the Medicaid ABP and for the qualified health plans available through the marketplace. We also mapped the services provided by the ODH programs to the services covered by the Medicaid ABP and to Ohio's benchmark plan (which is used to define benefits in the insurance marketplace). The ACA requires that all qualified health plans offer at least the EHB package.[15] The benchmark plan for Ohio is the state's largest small-group product, specifically the Blue 6 Blue Access PPO Medical Option D4 Rx Option G.[16] We provided a summary of the crosswalk for each program to ODH for review and clarification before considering the information as final. The results of the assessment are described in the program-specific sections of this report.

Model likely movement of uninsured and underinsured populations in the ODH program to Medicaid or coverage through the exchange. Mathematica downloaded the Ohio household sample of the American Community Survey (ACS) file released by the Census Bureau in December 2013 and created Medicaid, Children's Health Insurance Program (CHIP), and other public program enrollment and eligibility flags pre- and post-ACA. We created a subset of the ACS that mirrored eligibility for each ODH program and reflected the population served by each ODH program. We then estimated the impacts of the ACA by observing changes in eligibility for Medicaid and subsidized FFM coverage after implementation of ACA policies. Estimates of Medicaid eligibility and coverage, among the target population in 2012 are presented, as well as estimates of private insurance coverage. The marketplace eligibility estimates are further disaggregated into as many as four groups, as relevant to the target population:

1. Those likely to be privately insured. These include Ohioans under age 65 with employer coverage or, if individually insured, eligible for reduced cost sharing or an advance premium tax credit (APTC) through the marketplace.

[15] All plans offered through the marketplaces and those offered in the individual and small-group markets outside the marketplaces–except grandfathered individual and employer-sponsored plans–must cover EHB services.

[16] This plan does not include habilitative services, which are required as an EHB. Per rules from the U.S. Department of Health and Human Services, the governor therefore identified habilitative services as services for children diagnosed with autism spectrum disorder. The habilitative services defined by the governor include speech and language therapy, occupational therapy, clinical therapeutic intervention, and outpatient mental health and behavioral health treatment.

2. Others eligible for both the APTC and reduced cost sharing who might become insured. These individuals, with incomes below 250 percent of the federal poverty level (FPL), were uninsured before the ACA and, under ACA, are ineligible for Medicaid or Medicare and do not have employer coverage.
3. Others eligible for only an APTC who might become insured. These individuals, with incomes from 250 to 400 percent of FPL, were uninsured prior to the ACA and, like those in group 2, subsequent to ACA implementation are ineligible for Medicaid or Medicare and do not have employer coverage.
4. Others, with incomes above 400 percent of FPL, without employer coverage who might enroll in unsubsidized coverage through the marketplace.

We assumed that each person's need for services remained constant from the base year to 2014. Appendix B contains a detailed description of the methodology. We used the information from this analysis to approximate how shifts in insurance status affected program expenditures. Because the BCMH program did not report family size and household income data on clients using the diagnostic program and these families are characterized as uninsured, we used income and family size data on the uninsured population that uses the BCMH treatment program to conduct the final analysis of the impact of the ACA on BCMH.

2. Assessing the impact of the ACA on LHDs

Mathematica reviewed the *2013 National Profile of Local Health Departments* from the National Association of County and City Health Officials (NACCHO) to identify relevant characteristics and reviewed state profiles to identify states with governance structures, population size, and urban/rural mix similar to Ohio's (see Table I.2).[17,18] In April 2014, we conducted telephone interviews with LHD liaisons from the state public health departments of Arkansas, Indiana, Iowa, Kansas, and Missouri to learn about their approach to assessing and possibly redefining the roles of LHDs after ACA implementation. We also conducted a telephone interview with NACCHO president Dr. Terry Allan. We asked state representatives to discuss the following topics during 60 to 90 minute telephone interviews:

1. Role of the state public health department in funding, setting policy for, and managing local health departments
2. Current discussions or planning in the state, if any, on the role of local and state health departments to deliver direct medical services after implementation of the ACA
3. Health care changes in the state that are affecting public health departments' delivery of medical services
4. State plans for supporting prevention and community health initiatives in the future

[17] Local health department profiles were accessed at http://www.naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf.

[18] State profiles were accessed at http://nacchoprofilestudy.org/state-reports/.

Table I.2. Characteristics of Ohio and states interviewed

Characteristic	Ohio	Arkansas	Indiana	Iowa	Kansas	Missouri
Number of LHDs	124	75	93	101	100	115
Governance	Local	State	Local	Local	Local	Local
Median per capita LHD revenue from clinical sources (range)	0–$5	NA	0–$5	$10–$14	$10–$14	0–$5
Rurality[a]	22.08	43.84	27.56	35.98	25.8	29.56
Medicaid expansion[b]	Yes	Yes	Decision pending	Yes	No	No

Source: State profiles were accessed at http://nacchoprofilestudy.org/state-reports, unless otherwise noted.

[a] Percentage of population living in a rural area. Data is from 2010 census. Urban vs. rural classification definition: https://www.census.gov/geo/reference/urban-rural.html.

[b] Current status of state Medicaid expansion decisions was accessed at http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

LHD = local health department; NA = not available.

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II. ANALYSIS OF THE IMPACT OF ACA ON ODH PROGRAMS

In this section, we summarize the results of the analysis of the impact of the ACA on each program.

A. Bureau of Children with Medical Handicaps program

1. Program overview

The Bureau of Children with Medical Handicaps (BCMH) program provides diagnostic, treatment, and supportive services to children with chronic handicapping medical diagnoses and their families. Children must have a medically eligible condition that is chronic, physically handicapping, and amenable to treatment. Services covered by the program[19] must relate to the qualifying chronic medical condition and be provided by BCMH-approved providers.[20] Services are authorized for up to one year, and participation is renewable to age 21. Qualifying families have family income up to 185 percent of FPL and/or medical expenses that consume a significant amount of the family income and/or children with Medicaid; Special Supplemental Nutrition Program for Women, Infants, and Children; or Supplemental Security Income. The program serves families whose income is more than Medicaid limits; who are over the asset limit; whose insurance coverage has high deductibles; and who have inadequate coverage for ancillary services necessary to manage and treat the various diagnoses that determine eligibility for the BCMH treatment program. The BCMH programs include:

- **Diagnostic program**—covers services to rule out a special health care need, diagnose a condition, or develop a treatment plan. Services are authorized for three months, and participation is renewable to age 21. [21]
- **Service coordination program**—helps families locate and coordinate services for a limited number of diagnoses.[22]

[19] Covered services include, but may not be limited to, days in the hospital; visits to BCMH-approved physicians (medical or osteopathic); public health nurse services; hearing aids; glasses or contact lenses; prescription drugs; medical supplies or equipment; physical, occupational, and speech therapy; nutrition consultations or services; surgery and anesthesia; and special formulas.

[20] Eligible conditions include, but may not be limited to, birth defects, chronic lung disease, heart defects, cerebral palsy, spina bifida, phenylketonuria and other metabolic conditions, hearing loss, epilepsy, cancer, sickle-cell disease, hemophilia, congenital heart disease, and diabetes. Ineligible conditions include learning disabilities, behavioral problems, mental retardation, allergies, conditions that will improve through growth, acute or infectious conditions, psychological or emotional disorders, routine orthodontic problems, experimental care, well-child care, and developmental delay.

[21] Diagnostic services include tests and X-rays; visits to BCMH-approved physicians (medical or osteopathic); up to five days in the hospital; public health nursing services; occupational, physical, and speech therapy evaluations; dental consultations; and community nutrition consultations.

[22] Service coordination services are provided by a hospital-based service coordinator and a local public health nurse, who—together with the family—develop a plan to meet the child's needs. BCMH supports 62 teams located in three tertiary centers and eight children's hospitals designated to provide special care to children with specific conditions such as cystic fibrosis, craniofacial anomalies, cancer, and hemophilia anomalies.

In addition, BCMH coordinates with two ODH programs that assist families with children enrolled in a BCMH program to qualify for Medicaid or remain on private insurance. Under the Medicaid spend-down payment assistance program, BCMH may pay for the family's Medicaid spend-down to enable the family to obtain a medical card for a child enrolled in a BCMH treatment program. The premium payment assistance program serves families using a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) option or who pay annual health insurance premiums greater than or equal to 2.5 percent of their adjusted gross annual income. In addition, the BCMH metabolic formula program serves individuals with phenylketonuria, homocystinuria, and other metabolic disorders, and provides metabolic formula. This program will not likely see significant change, as the formula is considered medical food and is not covered by most insurance plans.

The BCMH program employs 23 to 25 pediatric nurses in ODH and 315 pediatric nurses in LHDs. A diverse group of health care providers participate as BCMH providers, including 5,128 physicians, 365 dentists, 58 dieticians, and 309 nurse anthetists. Tertiary care hospitals also participate.

2. Funding

In SFY 2013, the BCMH program was funded through multiple sources including $7.5 million from the general revenue fund (GRF), $19.7 million from county assessments, $3.9 million from the Maternal and Child Health block grant, $3.7 million from hospital audits, $1.2 million from Medicaid administrative claiming, and other appropriations for the genetics, hemophilia, and other special BCMH programs.

3. Implications of the ACA

Table II.1 provides a comparison of the populations served and services provided among the BCMH treatment program, Medicaid, and the marketplace plan and highlights specific services the program covers that are not covered by Medicaid or the marketplace plan.

Table II.1. BCMH treatment program eligibility and services compared to Medicaid and marketplace plan

	Income eligibility	Medical services	Special concerns	Support services
BCMH treatment program	Family income up to 185% of FPL and/or as defined by maximum ability to pay program rules	Services related to care only for the chronic medical handicapping condition	Metabolic formula is covered Gap coverage for DME and other services	Case management and care management, home visiting, public health nursing, in-home nutritional counseling, care coordination to facilitate access to payment sources
Medicaid	Adults up to 138% of FPL Children up to 200% of FPL	Comprehensive coverage for the 10 EHBs	Metabolic formula not covered 30-day limits each on occupational, physical, and speech therapy per 12 months Hearing aids, eye glasses are covered DME covered but with limits	Supportive services generally not covered Targeted case management for beneficiaries with psychiatric diagnoses and developmental disabilities
Marketplace plan with tax credits	Adults 138%–400% of FPL Children 211%–400% of FPL (0–400% of FPL for legally residing immigrants who do not meet residency requirement)	EHB compliant, including comprehensive coverage for all medical care and habilitative services for children with autism	Coverage of drugs in all classes with copayments Metabolic formula not covered	Supportive services generally not covered

Source: Mathematica review of BCMH program information provided by ODH, review of the Ohio Medicaid alternative benefit plan, and review of Ohio benchmark plans

BCMH = Bureau of Children with Medical Handicaps; ODH = Ohio Department of Health, EHB = essential health benefits; FPL = federal poverty level; DME = durable medical equipment.

4. BCMH insured population

In SFY 2014, the BCMH programs served 39,264 unduplicated users. Sixty-seven percent of BCMH expenditures ($23.6 million) reflect coverage of out-of-pocket expenses or noncovered services for children with Medicaid or private insurance. The BCMH program provides payment for approved expenditures using a claims adjudication process. BCMH is the payer of last resort, so the majority of payments made on behalf of insured individuals are made in addition to those by the primary payer. When claims are adjudicated, the process includes a review of the client's insurance status and a review of the amount paid by the primary insurer. If there is an amount paid, BCMH coordinates the benefit and pays the provider based on the BCMH fee schedule, minus the amount paid by the primary insurance. If the provider does not bill the primary insurance, BCMH denies the claim. If the claim includes an explanation of benefits stating the

reason for the denial by the primary payer (such as deductible not being met or the service being uncovered), then BCMH processes the claim for payment. This process ensures that BCMH does not pay for services that should be covered by private insurance or by Medicaid. It is therefore unlikely that ACA insurance provisions will impact these families. The populations served by insurance status and their expenditures are described in Table II.2.

Table II.2. BCMH programs: Populations served and expenditures, by insurance status, SFY 2014

Primary source of payment	Clients	Clients as percentage of total	Total expenditures	Expenditures as percentage of total	Mean expenditure per client
Medicaid	21,700	55.3	$5,593,523	15.8	$258
Private insurance	14,265	36.3	$18,031,064	51.0	$1,264
Uninsured[a]	3,299	8.4	$11,706,787	33.1	$3,549
Total	**39,264**	**100**	**$35,331,374**	**100**	**$900**

Source: Data from ODH, BCMH (August 5, 2014).

[a]Includes participants in the diagnostic program (for which income and family size data were not reported) and the uninsured population in the treatment program.

BCMH = Bureau of Children with Medical Handicaps; ODH = Ohio Department of Health; SFY = state fiscal year.

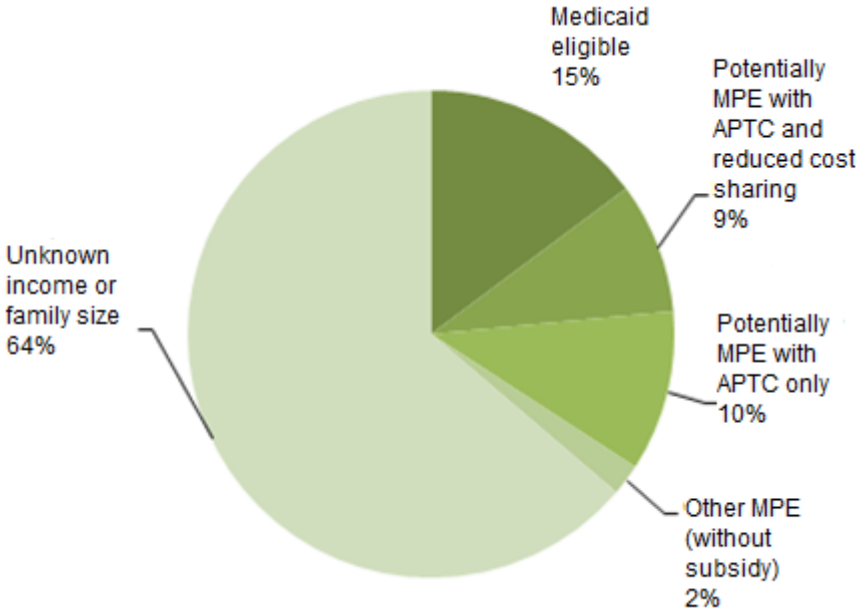
5. BCMH uninsured population

The major impact of the ACA on BCMH programs relates to the uninsured population. The ACA affects eligibility for Medicaid coverage and subsidies for private coverage among the uninsured population that BCMH programs serve. Although Medicaid coverage for children through age 18 did not change with implementation of the ACA, young adults ages 19 to 21 with incomes up to 138 percent of FPL qualified for Medicaid coverage effective January 2014. The ACA also provides Medicaid to adults older than 21 with incomes up to 138 percent of FPL.

In the following paragraphs, we describe findings with respect to the uninsured adults and children BCMH served in SFY 2014,[23] and expenditures (diagnostic and treatment programs) for these populations. The data are displayed by beneficiaries' eligibility for Medicaid or potential eligibility for subsidized FFM coverage as of January 1, 2014. Among uninsured adults and children served by the program for whom FPL status could be calculated, an estimated 15 percent were eligible for Medicaid or would have been eligible as of January 1, 2014 (Figure II.1). Another 19 percent were potentially eligible for subsidized coverage in the FFM either for both an advanced premium tax credit (APTC) plus reduced cost sharing or for an APTC only; 2 percent were eligible for coverage in the FFM without subsidies.

[23] Data on SFY 2014 BCMH populations and expenditures provided by ODH in August 2014.

Figure II.1. Estimated Medicaid and marketplace eligibility among uninsured children and adults served by BCMH in SFY 2014



Source: Mathematica analysis of data provided by BCMH.
Note: Unknown reflects participants in the diagnostic program.
APTC = advanced premium tax credit; MPE = marketplace eligible; SFY = state fiscal year.

BCMH counts individuals who use the diagnostic program among the uninsured. There is no income eligibility for these services. BCMH did not report income or family size for this population. The uninsured population also includes those who are actually uninsured and for whom income and family size information was collected.

Although uninsured individuals made up only 8.4 percent of the population, they accounted for 33.1 percent of the expenditures or $11.7 million. Families who gain insurance may still face gaps in coverage if the health plans do not cover certain drugs, specialty metabolic formulas, therapies, or durable medical equipment or do not include their children's specialty providers in their plan's network. Even when insured, these families face higher out-of-pocket costs due to the volume and breadth of services needed to treat their child's qualifying condition and as evidenced by the expenditures covered by BCMH for the uninsured (see Table II.1). However, parents who gain insurance may experience less financial pressure and may be better able to afford these services for their children.

Table II.3 displays the expenditures associated with uninsured clients and the estimated number that became eligible for Medicaid or marketplace coverage and the corresponding expenditures. In SFY 2014, BCMH spent approximately $11.7 million on services for uninsured clients. Of this amount, $7,806,787 (67 percent) was spent on services for which beneficiaries' family income and size were reported. Thirty-four percent of SFY 2014 expenditures were for services for children or adults who were Medicaid-eligible or for adults who became Medicaid-eligible as of January 1, 2014. An additional 30 percent of expenditures were for services for adults and children who, if without qualified employer-based coverage, became eligible for

subsidized marketplace coverage as of January 1, 2014. BCMH currently covers $258 per Medicaid client and $1,264 per privately insured client among the insured population using the treatment program (see Table II.2.) We assume that BCMH, as the payer of last resort, would cover a similar amount for clients newly insured by Medicaid or by marketplace health plans. Therefore, the estimated impact of the ACA on BCMH program expenditures is $6.8 million and assumes most of the newly eligible clients would acquire insurance during SFY 2015.

Table II.3. SFY 2014 actual and estimated clients served and expenditures for uninsured BCMH population, by estimated insurance status as of January 2014

	Clients (percentage of total)	Expenditures (percentage of total)
Uninsured	3,299 (100)	$11,706,787[a] (100)
Treatment program clients with known income and family size	1,194 (36)	$7,806,787[a] (67)
Estimated Medicaid-eligible population	495 (15)	$3,872,290[b]
Estimated marketplace-eligible population	699 (21)	$2,916,464[c]
Diagnostic program clients with unknown income and family size	2,105 (64)	$3,900,000[a] (33)

Source: Mathematica analysis of data provided by BCMH.

[a]Actual from SFY 2014 BCMH program data.

[b]Assuming service utilization remains constant and all expenditures would be covered by Medicaid except $258 per client (see Table II.2), estimated to be $127,710.

[c]Assuming service utilization remains constant and all expenditures would be covered by private, marketplace health plans except for $1,264 per client (see Table II.2), estimated to be $883,536.

BCMH = Bureau of Children with Medical Handicaps; SFY = state fiscal year.

B. Ryan White HIV/AIDS Part B program

1. Program overview

The Ohio Ryan White HIV/AIDS Program (RWHAP) Part B provides core medical services for individuals with HIV/AIDS through a grant from the Health Resources and Services Administration that requires a state match. Core medical services include outpatient/ambulatory medical care, oral health care, early intervention services, home and community-based health services, hospice services, mental health services, medical nutrition therapy, and outpatient substance abuse services.[24] Individuals must be HIV positive and have an income no more than 300 percent of FPL. The income limit does not apply to individuals who receive case management services only. The program also covers insurance premiums, maintaining the payer of last resort status, leveraging clients' ability to use their insurance, and therefore sharing the cost of care with the insurance carrier. The program may use up to 25 percent of the grant for support services that include outreach and enrollment, drug adherence counseling, housing

[24] U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. "Ryan White HIV/AIDS Program Part B Manual," revised 2013. Available at http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf. Accessed April 26, 2014.

assistance, and case management services. This program also provides emergency financial assistance for HIV-related needs.

The RWHAP Part B program also includes the AIDS Drug Assistance Program (ADAP). ADAP provides direct access to HIV-related medications and assists with premiums, copayments, and deductibles for private health insurance plans that cover ADAP's drug formulary. Ohio functions as a drug rebate state, using a 'pay and choose your medicine' strategy. The Part B program also coordinates with other RWHAPs and programs that are not within the purview of ODH, including Part A (metropolitan area grants) and Part C (comprehensive primary care grants for populations at risk and women, infants, children, and youth programs).

Providers who participate in the RWHAP must qualify and be approved as Medicaid providers. The ODH funds 80 to 100 case managers who provide both medical and supportive case management services. The RWHAP program has trained case managers to help clients enroll in Medicaid and to determine the best available plan. For clients already enrolled in private health insurance, case managers evaluate whether the plan meets the EHB requirements and whether their spouse's insurance status has changed.

In SFY 2012, the program served 7,023 individuals. Forty-one percent were uninsured, 18 percent had private insurance, 16 percent had Medicare, 13 percent had Medicaid, 9 percent were dually eligible for Medicare and Medicaid, and 1 percent was covered by the U.S. Department of Veterans Affairs medical system. More than 50 percent had annual incomes less than $10,000. ADAP, medical, and oral health services were the most commonly used services.

2. Funding

For SFY 2013, Ohio received RWHAP grants totaling $28,255,504, requiring a Part B state match of $11,439,626. Ohio fulfilled the required match with GRF of $5,066,559, additional GRF funds of $6,373,067 from pharmaceutical rebates, and with an unspecified amount spent by the Ohio Department of Rehabilitation and Correction for the care of state prison inmates with HIV.

3. Implications of ACA

Services covered. The state's Medicaid ABP and the benchmark plan for private insurance offer more comprehensive coverage for medical services than the RWHAP. (See Table II.4). The Medicaid ABP offers more comprehensive drug coverage than ADAP but the copayments might present a barrier to this group of low-income individuals. The benchmark plan also offers comprehensive drug coverage and requires copayments. However, individual circumstances that may require special consideration for specific medication categories due to drug resistance, drug failure, and other issues also determine the comprehensiveness of the service. All marketplace plans in Ohio must cover the same number of drugs in each category and drug class as the benchmark plan.[25] Program staff raised concerns about whether Medicaid ABP and the benchmark plan will cover the same classes of drugs and drug preparations as ADAP. Multi-

[25] Title 45: Public Welfare. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets. http://www.ecfr.gov/cgi-bin/text-idx?SID=15de60610cf0c40f7d440375d54cf9bd&node=45:1.0.1.2.63.0.27.18&rgn=div8. Accessed April 30, 2014.

class combination drugs are particularly important, as they contribute to compliance. Review of the Medicaid and the benchmark drug lists indicates combination drugs would be covered.[26]

Table II.4. Coverage of services under RWHAP Part B, Medicaid ABP, and benchmark plans

Service	RWHAP	Medicaid ABP	Benchmark plan
Ambulatory, outpatient care	X	X	X
Diagnostic tests		X	X
Oral health care	X	X	children only
Early intervention services	X		
Home health care	X	X	limited
Community-based services	X	X	
Medical case management	X	plan dependent	
Mental health—outpatient	X	X	X
Mental health—inpatient		X	X
Substance abuse—outpatient	X	X	X
Substance abuse—inpatient		X	X
Nutritional counseling	X	X	
Non-emergency medical transportation	X	X	
Rehabilitation services	X		limited
Hospital inpatient		X	X
Prescription drugs	HIV and related conditions	X	X
Family planning		X	X
Obstetric and prenatal care[a]		X	X
Physical, occupational, and speech therapies		30 visits each per year	X
Skilled nursing care		X	X

Sources: Center for Health Law and Policy, Harvard Law School. "State Health Reform Impact Modeling Project: Ohio," January 2013. Available at http://www.hivhealthreform.org/wp-content/uploads/2013/03/Ohio-Modeling-Final.pdf. Accessed April 28, 2014.
Centers for Medicare & Medicaid Services. "Ohio State Plan Amendment," December 20, 2013. Available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-13-0032.pdf. Accessed April 18, 2014.
Centers for Medicare & Medicaid Services. "EHB Benchmark Plan for Ohio." Available at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ohio-ehb-benchmark-plan.pdf. Accessed April 18, 2014.

[a] RWHAP Program Part B covers linkage to care for HIV positive pregnant women to prevent perinatal viral transmission

ABP = alternative benefit plan; RWHAP = Ryan White HIV/AIDS Program.

[26] Anthem BlueCross BlueShield Prescription Program Drug List: https://www.anthem.com/health-insurance/nsecurepdf/pharmacy_abcbs_anthem_natl_dl_tiered; Ohio Medicaid Drug List: http://medlist.ohio.gov/main_domain/home.jsf.

HIV care could be disrupted to the extent that specific features of a health plan's provider network and service coverage limits choices. However, Ohio requires RWHAP providers to be approved Medicaid providers as well, a policy that decreases the likelihood of disruptions.

Table II.5. RWHAP eligibility and services compared to Medicaid and marketplace plans

	Eligibility	Medical services	Formulary	Other services
RWHAP Part B[a]	Up to 300% of FPL	Outpatient and ambulatory health services Oral health care Home health care Medical nutrition therapy Hospice services Home and community-based health services Mental health services Outpatient substance abuse care	ADAP HIV-related medications Assistance with health insurance premiums, copayments, deductibles for medications, and for spend-down costs for FFS Medicaid and Medicare Part D. ODH pays for one 4-way combination drug	Early intervention services Child care, housing assistance, respite care, legal services Medical case management, including treatment adherence counseling Quality assurance reviews
Medicaid	Adults up to 138% of FPL Children and pregnant women up to 200% of FPL	ABP covers comprehensive outpatient and inpatient medical services including dental, mental health, substance abuse services, home care, hospice, transportation	Comprehensive formulary HIV/AIDS drugs covered, but exact drugs may differ from ADAP; copayments higher than ADAP's	Case management services determined by managed care plan
Marketplace with federal tax credits	100% to 400% of FPL (0–400% of FPL for legally residing immigrants who do not meet residency requirement)	Comprehensive medical services, including mental health and substance abuse	Comprehensive formulary HIV/AIDS drugs covered, but exact drugs vary from plan to plan; copayments (not required in ADAP)	None

Source: Mathematica review of program information provided by ODH, review of the Ohio Medicaid alternative benefit plan, and review of Ohio benchmark plans

[a]U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. "Ryan White HIV/AIDS Program Part B Manual," revised 2013. Available at http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf. Accessed April 26, 2014.

ABP = alternative benefit plan; ADAP = AIDS Drug Assistance Program; FPL = federal poverty level; FFS = fee for service; ODH = Ohio Department of Health; RWHAP = Ryan White HIV/AIDS Program.

Although the Medicaid ABP and the marketplace plans offer more comprehensive medical care and pharmacy coverage than the RWHAP, many services (see Table II.5) that the RWHAP provides play a role in improving access to and the quality of care for people living with HIV. States that receive a RWHAP grant must address the implementation of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent guidelines for the treatment of HIV/AIDS and related opportunistic infection. They must also develop strategies to ensure that services are consistent with the guidelines for improvement in the access to and quality of HIV health

services.[27] The adherence counseling, surveillance, and quality assurance features of the program may be important public health interventions for controlling the spread of HIV.

Change in coverage. Based on recent estimates from the Centers for Disease Control and Prevention (CDC) on the prevalence and rates of new diagnoses, we estimate that approximately 20,000 Ohioans younger than 65 and with income under 300 percent of FPL were living with a diagnosis of HIV/AIDS in 2012, that rate increasing to about 23,000 in 2014.[28] Approximately 8,200 nonelderly Ohioans living with HIV/AIDS in 2012 were uninsured or are assumed to have been uninsured at some time during the year (Table II.6), including a small number of children younger than 19. We estimate that in 2012 Ohio's HIV/AIDS programs served nearly 60 percent of the uninsured population younger than 65, with income below 300 percent of FPL, and living with HIV/AIDS. The program also served a relatively fast-growing number of adult men younger than 65 (accounting for 80 percent of all people served in 2014), and a growing number of black Ohioans (44 percent of all people served in 2014). Coverage of the low-income population in each of these groups is expected to change significantly under the ACA.

Table II.6. HIV/AIDS programs: Estimated population living with HIV/AIDS under 300 percent of FPL and percentage of population served, 2012

	Estimated population with HIV/AIDS under 300 percent of FPL (thousands)		Total population served (thousands)	Served population as a percentage of estimated uninsured population with HIV/AIDS
	Total	Uninsured, adjusted for part-year coverage		
Total	**20.4**	**11.7**	**7.0**	**59.5**
By age (years)				
0–18	1.1	0.3	0.0	10.9
19–39	11.4	6.8	2.4	35.7
40–64	8.0	4.6	4.5	98.6
Adults ages 19–64				
Men	14.5	9.0	5.5	60.6
Women	4.8	2.4	1.3	52.7
By race/ethnicity				
Black	9.0	4.9	3.0	61.5
White	10.0	5.8	3.6	62.0
Hispanic or other race/ethnicity	1.5	0.9	0.3	37.6

Source: Mathematica analysis of the 2011 Ohio sample of the American Community Survey and program data provided by the Ohio Department of Health.

Note: Estimates of the HIV/AIDS population assume average rates of HIV/AIDS infection by gender, race/ethnicity, and age.

FPL = federal poverty level.

[27] U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. "Ryan White HIV/AIDS Program Part B Manual," revised 2013. Available at http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf. Accessed April 26, 2014.

[28] Centers for Disease Control and Prevention. "HIV Surveillance Report, 2011. Vol. 23," February 2013. Available at http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf#Page=17. Accessed July 15, 2014.

We estimate that 64 percent of the target population is eligible for Medicaid in 2014, compared with 25 percent in 2012 (Table II.7). All others are estimated to be insured or otherwise eligible for individual coverage through the marketplace with an APTC either with (24 percent) or without (11 percent) reduced cost sharing.

Impact on specific populations. A significant increase in eligibility exists for Medicaid and subsidized coverage through the marketplace among the served Ohio HIV/AIDS populations that grew fastest from 2012 to 2013 (adults ages 19 to 39, men younger than 65, and black Ohioans). We estimate that 68 percent of low-income adults ages 19 to 39 with HIV/AIDS are eligible for Medicaid in 2014, compared with 23 percent in 2012. All others, except for undocumented immigrants, are eligible for reduced cost sharing or premium assistance through the marketplace. Nearly three-fourths (72 percent) of low-income black Ohioans with HIV/AIDS are estimated to be Medicaid eligible in 2014, an increase from 31 percent in 2012. Among low-income men ages 19 to 64, 62 percent are expected to be eligible for Medicaid in 2014 compared with just 18 percent in 2012. The concentration of low-income HIV/AIDS populations enrolled in Medicaid offers opportunities for improved education, treatment, and quality of care that are often more costly and difficult to implement when coverage is either unavailable or more diffuse among different payers.[29, 30] This increased concentration of low-income HIV/AIDS populations enrolled in Medicaid also highlights the need for close collaboration between Ohio Medicaid and the RWHAP.[31, 32]

[29] Gallant, Joel E., Adaora A. Adimora, J. Kevin Carmichael, Michael Horberg, Mari Kitahata, E. Byrd Quinlivan, James L. Raper, Peter Selwyn, and Steven Bruce Williams. "Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition." *Clinical Infectious Diseases*, vol. 53, no. 11, 2011, pp. 1043–1050.

[30] Zhang, S., S. L. McGoy, D. Dawes, M. Fransua, G. Rust, and D. Satcher. "The Potential for Elimination of Racial-Ethnic Disparities in HIV Treatment Initiation in the Medicaid Population among 14 Southern States." *PLoS ONE*, vol. 9, no. 4, 2014, e96148.

[31] Leibowitz, Arleen A., Robbie Lester, Philip G. Curtis, Kevin Farrell, Aaron Fox, Luke H. Klipp, and Jason Wise. "Early Evidence from California on Transitions to a Reformed Health Insurance System for Persons Living with HIV/AIDS." *Journal of Acquired Immune Deficiency*, vol. 64, no. S1, 2013, pp. S62–S67.

[32] Kates, Jennifer, Rachel Garfield, Katherine Young, Kelly Quinn, Emma Frazier, and Jacek Skarbinski. "Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV." Henry J Kaiser Family Foundation, 2014. Available at http://www.deltaaetc.org/forms/ACAdocuments/assessing-the-ACA-mpact-on-health-insurance-coverage.pdf. Accessed August 13, 2014.

Table II.7. HIV/AIDS programs: Estimated population with HIV/AIDS younger than 65 and under 300 percent of FPL eligible for Medicaid or subsidized private insurance, 2012 and projected 2014

	Estimated population younger than 65 and under 300 percent of FPL, with HIV/AIDS (thousands)	Percentage Medicaid eligible	Percentage Medicaid eligible but not enrolled	Percentage uninsured	Privately insured under 250 percent of FPL or MPE with APTC and reduced cost sharing	Privately insured under 250–400 percent of FPL or MPE with APTC
2012						
Total	**20.4**	**24.7**	**3.2**	**30.6**	**NA**	**NA**
By age (years)						
0–18	1.1	84.1	22.2	6.8	NA	NA
19–39	11.4	23.4	2.8	32.2	NA	NA
40–64	8.0	18.6	1.2	31.6	NA	NA
Adults ages 19–64						
Men	14.5	18.0	1.8	35.4	NA	NA
Women	4.8	31.6	3.3	21.4	NA	NA
By race/ethnicity						
Black	9.0	30.9	3.6	34.2	NA	NA
White	10.0	19.3	2.7	19.9	NA	NA
Hispanic or other race/ethnicity	1.5	22.7	4.1	14.6	NA	NA
2014						
Total	**23.4**	**64.5**	**—**	**—**	**23.6**	**10.8**
By age (years)			—	—		
0–18	1.2	84.1	—	—	7.3	8.5
19–39	13.1	68.1	—	—	22.5	9.2
40–64	9.1	56.8	—	—	27.5	13.2
Adults ages 19–64			**—**	**—**		
Men	16.7	62.0	—	—	25.3	11.4
Women	5.6	67.7	—	—	22.2	9.3
By race/ethnicity			**—**	**—**		
Black	10.3	72.3	—	—	18.5	8.3
White	11.4	57.6	—	—	27.8	13.3
Hispanic or other race/ethnicity	1.1	63.9	—	—	27.2	8.3

Source: Mathematica analysis of the 2011 Ohio sample of the American Community Survey.

Note: — indicates number not estimated.

APTC = advanced premium tax credit; FPL = federal poverty level; MPE = marketplace eligible; NA = not available.

Under the ACA and with expanded Medicaid eligibility, many clients receiving RWHAP services will be eligible for subsidized coverage through the health insurance marketplace or Medicaid. We found a significant potential impact of the ACA on the HIV/AIDS population. Because nearly all of current clients will be eligible for insurance coverage in 2014, we estimate the potential financial impact of the population gaining coverage to be between $6.8 million and $8.6 million, assuming 60 to 100 percent of the target population acquires insurance in SFY 2015. We also assumed that RWHAP requires at least 75 percent of funds to be expended on medical services.

C. Breast and Cervical Cancer Project

1. Program overview

The Breast and Cervical Cancer Project (BCCP) provides breast and cervical cancer screening, diagnostic testing, and case management services for eligible women in Ohio. It is Ohio's CDC-sponsored Breast and Cervical Cancer Prevention and Treatment Program. Women are eligible for BCCP if household income is under 200 percent of FPL, if they meet specific age and risk requirements, and if they have no Medicare, Medicaid, or private insurance coverage. The program aims to reach women age 40 or older for cervical cancer screening and diagnostic services, and those age 50 or older for breast cancer screening and diagnostic services. In 2013, funding supported access for 11,600 women to Ohio's BCCP for breast and cervical cancer services.

The program provides uninsured women individualized screening services from a network of more than 600 contracted medical providers. Women who qualify for the program and have potential abnormalities are referred to these providers by one of the BCCP 11 regional enrollment agencies for further medical evaluation and diagnostic services. The medical evaluations include mammography, clinical breast examination, breast ultrasound, Pap smears, colposcopy, biopsy (breast or cervical), and office visits. Women diagnosed with cancer through ODH's BCCP have been eligible for the BCCP Medicaid program. BCCP Medicaid is a special-populations Medicaid program for women diagnosed with breast or cervical cancer through the BCCP. BCCP regional enrollment agencies provide transition support services for women with breast or cervical cancer to facilitate enrollment in the BCCP Medicaid program. Such services include help with scheduling medical appointments, follow-up to ensure enrollment in treatment, and coordination of transportation, patient navigation, or medical language interpretation services.

Additionally, the BCCP conducts education and outreach programs for the general public and for health care providers. The program targets social marketing and advertising campaigns to at-risk populations and coordinates with other screening programs, such as the Susan G. Komen Foundation and American Cancer Society, for these populations.

2. Funding

State spending on the BCCP for SFY 2015 is $823,217 from state GRF, and $763,208 in-kind spending, which represents the variance between rates charged by providers and rates allowed by ODH. The funding for the actual screening and follow-up services comes from the CDC.

3. Implications of the ACA

Covered services. Under the ACA, most health plans, including Medicaid ABPs, Medicare, and private insurance plans, must provide certain preventive services with no patient cost sharing. Traditional Medicaid programs are not required to provide these services free of cost sharing, but the federal government provides a 1 percent increase in Federal Medicaid Assistance Percentage payments for preventive services that states provide without cost sharing to Medicaid recipients. The services covered include women's preventive services; annual examinations; alcohol and tobacco use screening and counseling; blood pressure, colorectal cancer, diabetes, HIV, and sexually transmitted infection screening; immunizations; and other services rated A or B by the U.S. Preventive Services Task Force. These provisions eliminate an important financial barrier to testing for many people living with the disease. Marketplace plans also cover preventive screening and treatment services. Table II.8 compares the services covered by the BCCP to those covered by Medicaid and marketplace plans.

If the BCCP is not continued, women who gain insurance through the marketplace or expanded Medicaid may not continue to receive transitional support services. These services have been useful in engaging vulnerable women in screening and treatment.[33] [34]

[33] Battaglia, T. A., Roloff, K., Posner, M. A., and Freund, K. M. "Improving Follow-Up to Abnormal Breast Cancer Screening in an Urban Population." *Cancer*, vol. 109, no. S2, 2007, pp. 359–367.

[34] Phillips, Christine E., Jessica D. Rothstein, Kristine Beaver, Bonnie J. Sherman, Karen M. Freund, and Tracy A. Battaglia. "Patient Navigation to Increase Mammography Screening Among Inner City Women." *Journal of General Internal Medicine,* vol. 26, no. 2, 201, pp. 123–129.

Table II.8. BCCP eligibility and services compared to Medicaid and marketplace plans

	Eligibility	Specialized medical services	Support services and care coordination	Educational outreach
BCCP	Family income up to 200% of FPL	Screening services and diagnostic services only (mammography clinical breast examination, breast ultrasound, Pap testing, colposcopy, biopsy, and office visits)	Enrollment in treatment coordination Transportation coordination General navigation support Medical language interpretation services	Educational outreach to providers Educational outreach to potential clients Social media campaigns Coordination with other screening providers
Medicaid	Income up to 138% of FPL	Alternative benefit plan; comprehensive services including breast and cervical cancer screening without copayments and treatment for all cancers	Plan specific	None
Marketplace plan with federal tax credits	Individual or family income 100% to 400% of FPL (0–400% for lawfully residing residents who do not meet residency requirement)	Comprehensive services as defined by essential health benefits, including breast and cervical cancer screening without copayments and treatment for all cancers	Plan specific	None

Source: Mathematica review of program information provided by ODH, review of the Ohio Medicaid alternative benefit plan, and review of Ohio benchmark plans

BCCP = Breast and Cervical Cancer Project; FPL = federal poverty level.

Transition to insurance. The BCCP currently provides screening and diagnostic services to uninsured women with incomes up to 200 percent of FPL. Under ACA, women with incomes up to 138 percent of FPL will have access to preventive and treatment services under expanded Medicaid coverage unless they are undocumented immigrants or otherwise ineligible. Women with incomes 139 percent to 400 percent of FPL are eligible to purchase insurance with federal subsidies through the insurance marketplace.

With implementation of the ACA, the number of women in BCCP's target population will change substantially. Among all women with income under 200 percent of FPL, Medicaid eligibility increased from 18.8 percent in 2012 to 78 percent in 2014. The high rate of Medicaid enrollment among eligible women in 2012 suggests that nearly all who are eligible will enroll in Medicaid and, as a result, no longer require BCCP services. However, ODH should consider the role the BCCP has played in engaging women and facilitating their enrollment in Medicaid. Without outreach and engagement services, the percentage of women who are eligible and also enrolled could be lower.

With the exception of women older than 65 and undocumented immigrant women, all of the women who might remain uninsured in 2014 are eligible for coverage through the marketplace

with an APTC, which reduces their premiums to no more than 6.3 percent of household income and reduces cost sharing. As a result, the program's target population likely will shrink substantially, and those who continue to be eligible for BCCP services will more likely be either older than 65 or younger than 65 but undocumented (see Table II.9).

Table II.9. BCCP: Estimated women, by potential sources of coverage, 2012 and projected 2014

	Total, all low-income women age 40 or older (thousands)	Medicaid eligible	Medicaid eligible but not enrolled	Estimated BCCP-eligible women: Uninsured full or part year	MPE with APTC and reduced cost sharing (not otherwise privately insured)
2012 (pre-ACA coverage expansion)					
Total	**1,565.7**	**18.8**	**0.8**	**14.7**	**n.a.**
By age (years):					
40–49	311.2	32.3	3.4	30.2	n.a.
50–64	596.9	15.2	0.4	22.2	n.a.
65+	657.6	15.6	0.0	0.7	n.a.
By race:					
White	1,301.2	16.0	0.6	13.6	n.a.
Black	199.3	34.9	1.6	18.9	n.a.
Hispanic or other race/ethnicity	65.2	24.1	2.8	25.4	n.a.
2014 (with ACA coverage expansion)					
Total	**1,570.0**	**77.9**	**—**	**—**	**2.7**
By age (years):			—	—	
40–49	311.9	76.4	—	—	6.3
50–64	598.6	80.4	—	—	3.8
65+	659.4	76.4	—	—	n.a.
By race:			—	—	
White	1,304.9	77.3	—	—	2.5
Black	199.7	82.3	—	—	3.0
Hispanic or other race/ethnicity	65.4	77.9	—	—	4.7

Source: Mathematica analysis of the 2011 Ohio sample of the American Community Survey.

Note: — indicates number not estimated.

ACA = Affordable Care Act; APTC = advanced premium tax credit; BCCP = Breast and Cervical Cancer Project; MPE = marketplace eligible; n.a. = not applicable.

D. Immunization program

1. Program overview

The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children from low-income families. The CDC buys vaccines at a discounted rate and distributes them to state health departments, including ODH. ODH distributes the vaccine at no charge to private physicians' offices and public health clinics that are registered as VFC providers. The ODH does not administer the vaccines. The VFC program covers vaccines recommended by the Advisory Committee on Immunization Practices that protect against 16 communicable diseases. Eligibility for VFC includes: children younger than 19 who are eligible for Medicaid/CHIP, uninsured children, underinsured children who receive immunizations at FQHCs or rural health clinics, and children who are American Indian or Alaska Native. The ACA does not alter any aspects of the VFC program.

The VFC program does not cover the providers' cost to administer the vaccine. In Ohio, as in other states, not all primary care practices provide immunizations because of the expense to properly store vaccines, unpredictable usage rates, and the low reimbursement rates for purchasing and administering the vaccines for children who are not eligible for VFC. As a result, in some communities, public health departments provide immunization services that are more convenient and accessible than from a community provider such as a physician's office. Health departments that provide immunization services to insured children who are not eligible for VFC must identify nonfederal funds for vaccine purchases.

In 2013, 1,515,758 children were eligible for VFC, including 1,117,445 children in or eligible for Medicaid; 240,972 uninsured children; 73,890 underinsured children; and 23,451 American Indian or Alaska Native children.

2. Funding

State spending in SFY 2013 was $8,847,087 for vaccines that are supplied to a limited number of providers for children who did not qualify for VFC but face financial barriers such as copayments and high deductibles that may cause parents to defer vaccination until the school mandate is effective.

3. Implications of ACA

Effective for plan years beginning September 23, 2010, the ACA requires private health insurance plans to cover preventive services as recommended by the U.S. Preventive Services Taskforce (including all recommended vaccines for children and adolescents) without cost sharing. Only grandfathered plans—that is, plans that existed on March 23, 2010, and have not since been changed in ways that cut benefits or increase costs for consumers—are exempt from this requirement.[35]

[35] Estimates of grandfathered employer-based and individual plans in Ohio and their provisions regarding coverage of vaccinations were unavailable within the scope of this study. However, at least some large insurers in Ohio continue to offer grandfathered plans regionally, if not statewide, continuing into 2014. For example, see http://www.neorsd.org/I_Library.php?SOURCE=library/GrandfatheredStatus2014.pdf&a=download_file&LIBRARY_RECORD_ID=5837. Accessed June 2014.

Although it is likely that the number of children in Ohio with private insurance will increase with ACA implementation, the increase is likely to be small. The estimates offered in Table II.10 assume the same percentage of children with private insurance in 2014 as in 2012. We estimate that only about 0.4 percent of children who would be uninsured in 2014 live in families with income sufficiently low enough to qualify for marketplace coverage with APTC and reduced cost sharing and only 0.8 percent qualify for marketplace coverage with an APTC only. ACA implementation does not change eligibility for Medicaid among children in Ohio, who prior to 2014 were Medicaid eligible up to 200 percent of FPL. Thus, the percentage of all children in Ohio who are Medicaid eligible would not change in January 2014 (Table II.10).

Table II.10. VFC: Estimated number and percentage of all children in Ohio by eligibility for Medicaid or subsidized private insurance[a], 2012 and projected 2014

	Total children	Medicaid eligible	Medicaid eligible but not enrolled	MPE with APTC and reduced cost sharing, but not otherwise insured	MPE with APTC only, but not otherwise insured	MPE without subsidy, but not otherwise insured
2012						
Number of children (thousands)	2,794.1	1,463.0	440.2	n.a.	n.a.	n.a.
Percentage	100.0	52.4	15.8	n.a.	n.a.	n.a.
2014						
Number of children (thousands)	2,800.3	1,466.7	—	11.8	22.5	12.0
Percentage	100.0	52.4	—	0.4	0.8	0.4

Source: Mathematica analysis of the 2011 Ohio sample of the American Community Survey.

Notes: — indicates number not estimated.

[a]2014 estimates assume the proportion (and characteristics) of individuals with employer-sponsored insurance or private insurance in 2012 continue coverage in 2014, including some individuals who would qualify for an APTC, with or without reduced cost sharing, if they enroll through the marketplace.

APTC = advanced premium tax credit; MPE = marketplace eligible. n.a. = not applicable; VFC = Vaccines for Children.

Many communities depend on LHDs to administer the vaccines, and this function will need to be considered when exploring the future role of LHDs. ODH staff estimated that six LHDs are the only providers administering vaccines in their communities.

The ODH budget includes $8.8 million in state funds to cover vaccines for children who are underinsured. It follows that the major potential impact of the ACA on the VFC will derive from the provisions requiring coverage of preventive services without cost sharing. In our analysis, we

assume that 100 percent of children covered by the state program will be eligible for vaccinations without cost sharing. We do not estimate the number of grandfathered health plans, but assume that over time health plans will shed grandfathered status, leaving fewer children underinsured. The immunization program may require nearly $9 million in less funding due to families no longer having to pay copayments or deductibles for their child's vaccinations but the timing for this transition is unknown.

E. Programs of the Bureau of Child and Family Health Services (CFHS)

1. Program overview

The Bureau of Child and Family Health Services (CFHS) is a community effort to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, and children in Ohio. CFHS currently includes the following four components: community health assessment and planning; child and adolescent health (direct health care, obesity, safe infant sleep); perinatal health (direct health care, socio-emotional support); and the Ohio Infant Mortality Reduction Initiative (home visiting program). Services are provided with grant awards to local agencies in 59 of the 88 counties. Although the majority of these agencies are LHDs, Community Action Agencies, FQHCs, hospitals, and a college of medicine also receive CFHS grants. Eighty percent of program funds are directed toward infrastructure and population-based and enabling services; 20 percent of CFHS funds are directed toward the provision of direct health care services.

2. Reproductive health services (family planning clinics)

The Reproductive Health and Wellness Program (RHWP) addresses issues of reproductive health and wellness (including family planning) for vulnerable populations. The goal of the RHWP is to improve the overall health and well-being of women and men by improving health care access, promoting healthy lifestyles, and encouraging the establishment of a reproductive life plan. Services include voluntary choice of contraception, including abstinence and natural family planning; pelvic examinations; laboratory testing; screening for cervical cancer, breast cancer, and sexually transmitted diseases; patient education and pre-pregnancy counseling on the dangers of smoking, alcohol, and drug use during pregnancy; and education on sexual coercion and violence in relationships.

The RHWP is currently composed of 36 agencies that have 65 sites in 50 of Ohio's 88 counties. Annually, the health centers serve an average of 32,000 patients. Seventy percent of patients have incomes under 100 percent of FPL. Thirty-one percent are enrolled in Medicaid, 9 percent use private insurance, and 42 percent are not required to pay for services due to Title X funding. Agencies are required to bill private and public health insurance.

Funding. Funding for the health centers comes from both state and federal sources, including GRF ($513,869), Maternal and Child Health Block Grant ($544,941), and Title X ($5,456,861).

3. Perinatal program and child health services

The CFHS direct care program is a safety-net program that provides services to high-risk or vulnerable women to decrease poor birth outcomes. Twelve agencies provide perinatal direct

health care services (prenatal visits and immediate postpartum visits). Twenty agencies provide child and adolescent direct health care services. Clinics can bill Medicaid or private insurance for comprehensive visits and acute care visits. Families who are uninsured can pay on a sliding scale. Medicaid-eligible women and children living in service areas with limited access to timely medical care are eligible to use the service. Women are eligible for the program if they have incomes no more than 200 percent of FPL. In SFY 2013, the perinatal program served 6,873 women; child health services served 15,695 children and adolescents. In SFY 2013, 23 percent of perinatal program participants were uninsured and 73 percent were on Medicaid.

Funding. The total funding in SFY 2013 was $7.8 million, which included $5.5 million from the Maternal and Child Health block grant and $2.3 million from the GRF.

4. Implications of ACA

A Medicaid state plan amendment expanded Medicaid Family Planning to people with incomes up to 200 percent of FPL. However, Ohio planned to eliminate the Medicaid Family Planning in January 2014. In January 2014, women with incomes up to 138 percent of FPL became eligible for Medicaid and those above 138 percent of FPL became eligible to purchase insurance in the marketplace with federal subsidies.

Table II.11 compares the services delivered in the CFHS programs with medical services provided by Medicaid and marketplace plans and identifies other nonmedical services that each program covers.

Table II.11. CFHS program eligibility and services compared to Medicaid and Marketplace plans

	Eligibility	Medical services	Other services
Reproductive health program	Up to 200% of FPL	Pap smears, STD screening and treatment, HIV testing family planning services, contraception	Education and counseling
Perinatal and child services	Up to 200% of FPL	Prenatal care or immediate post-partum care.	Health assessments and screening, care planning, tobacco cessation referrals, and post-partum counseling
Medicaid	Adults up 138% of FPL Children and pregnant women up to 200% of FPL	Comprehensive medical and behavioral health services as defined by EHB; full spectrum of women's preventive services, breast feeding supports, supplies and counseling, and all contraceptive methods that are approved by the U.S. Food and Drug Administration, including sterilization[a]	Health assessments and screening, tobacco cessation
Marketplace with federal tax credits	100% to 400% of FPL (0–400% of FPL if legally residing immigrant who does not yet meet residency requirement)	Comprehensive medical and behavioral health services as defined by essential health benefits; full spectrum of women's preventive services, breastfeeding supports supplies and counseling, and all contraceptive methods that are approved by the U.S. Food and Drug Administration, including sterilization	Tobacco cessation covered

Source: Mathematica review of program information provided by ODH, review of the Ohio Medicaid alternative benefit plan, and review of Ohio benchmark plans

[a]Women's Preventive Services Guidelines, http://www.hrsa.gov/womensguidelines. Accessed April 26, 2014.

Note: CFHS = Bureau of Child and Family Health Services; EHB = essential health benefits; FPL = federal poverty level; STD = sexually transmitted disease

CFHS directly serves a relatively small proportion of the low-income women and children who are potentially eligible for the program. In 2012, CFHS directly served approximately 26,000 perinatal women and children. We estimate that CHFS served approximately 8 percent of target children and 5 percent of target perinatal women in 2012. Children and perinatal women with income below 200 percent of FPL constituted 68 percent and 29 percent, respectively, of all those who received direct CFHS services.

Of the population that received direct services in SFY 2012, 77 percent were enrolled in Medicaid, including 80 percent of children and 69 percent of perinatal women. Nearly 19 percent were uninsured. A small proportion, approximately 3 percent of women and 5 percent of children, were enrolled in private insurance but were uninsured for the services they received from CFHS.

The number of Ohioans who rely on CFHS direct services is expected to change very little with implementation of the ACA, largely because Ohio's Medicaid eligibility criteria for children and pregnant and postpartum women did not change. Before 2014, Ohio covered children, pregnant women, and postpartum women up to 200 percent of FPL. Approximately 90 percent of children with income below 250 percent of FPL are expected to be eligible for Medicaid in 2014, the same percentage that was eligible in 2012 (Table II.12). In 2012, 75 percent of children who were estimated to be eligible for Medicaid were enrolled in the program.

Table II.12. CFHS: Estimated number and percentage of low-income children and perinatal women by eligibility for Medicaid or subsidized private insurance, 2012 and projected 2014

	Total (thousands)	Percentage Medicaid eligible	Percentage uninsured	MPE with APTC and reduced cost sharing, but not otherwise insured
2012				
Total	**397.7**	**86.2**	**9.5**	**n.a.**
Children	239.5	90.4	7.0	n.a.
Perinatal women	158.2	79.8	13.4	n.a.
2014				
Total	**398.3**	**88.8**	**—**	**0.7**
Children	239.8	90.4	—	0.4
Perinatal women	158.5	86.3	—	1.3

Source: Mathematica analysis of the 2011 Ohio sample of the American Community Survey.

Notes: — indicates number not estimated. Perinatal women are defined as pregnant or having given birth in the past year.

APTC = advanced premium tax credit; CFHS = Bureau of Child and Family Health Services; MPE = marketplace eligible; n.a. = not applicable.

Similarly, the number of children from low-income families who are privately insured is likely to change very little. We estimate that less than 1 percent of children from low-income families (those who might otherwise be uninsured or ineligible for Medicaid) are eligible for subsidized coverage through the marketplace.

In contrast to the small change in coverage that might be expected among children, more perinatal women might enroll or remain enrolled in Medicaid whether or not they seek CFHS direct services. With the expansion of Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of FPL, 86 percent of low-income perinatal women in Ohio are estimated to be Medicaid eligible in 2014, compared with 80 percent in 2012. In 2012, approximately three-fourths of perinatal women were enrolled in Medicaid when eligible. The percentage of women who are enrolled might increase in 2014 as women who were enrolled in Medicaid during their pregnancy and for childbirth will remain Medicaid eligible beyond two months after giving birth. As with children, the increase in private insurance coverage among perinatal women is expected to be small; approximately 1 percent of women who might otherwise be uninsured and ineligible for Medicaid qualify for subsidized coverage through the marketplace.

In SFY 2013, CFHS provided direct services to approximately 6,783 perinatal women and 15,695 children through the perinatal and child services program. Nearly all of the population that received direct services was in families with income below 200 percent of FPL. Children and perinatal women with income below 200 percent of FPL constituted 68 percent and 29 percent, respectively, of all those who received direct services, and 25 percent of women and 13 percent of children were uninsured. Medicaid and private insurance might assume financing for most or all CFHS direct services (representing about 18 percent of program funds), especially if a larger proportion of eligible children and perinatal women enroll in Medicaid.

Eligibility for Medicaid or subsidized coverage through the marketplace (other than among Ohioans who had been privately insured and are expected to remain insured) is likely to change very little. To estimate the impact of the change in insurance status among children and perinatal women on the ODH budget, we assumed that the proportion of the $2.3 million in state spending on women is equal to their proportion of the total population in the program in SFY 2013, or 30 percent (6,783 divided by the sum of 15,695 and 6,783). We estimate that a larger percentage of uninsured women in the program will acquire insurance than the percentage of uninsured children using the program. As a result, the financial impact of women acquiring insurance is larger. We further assumed that all of the state spending on the program is attributable to uninsured clients and that 86 percent of the uninsured women would acquire insurance in 2014, reducing state spending by $593,400.

F. Impact of the ACA on LHDs and actions taken by other states

1. Recent activity relative to LHDs in Ohio

There is significant interest among LHDs to achieve efficiencies and improve the quality of public health services by consolidating or sharing services, according to the Public Health Futures Report issued in 2012 by the Association of Ohio Health Commissioners and the Health

Policy Institute of Ohio.[36] The Health Futures Project established a minimum package of local public health services that all LHDs should take responsibility for delivering and made recommendations regarding funding, quality, and sustainability of services. The report acknowledged that as more people gain insurance, there is an opportunity to "re-balance public health's role in providing clinical services." This approach is consistent with a recent Institute of Medicine report recommending that, when possible, health departments gradually transfer provision of personal health services to medical providers.[37] A 2013 Ohio law allowing the ODH to require LHDs to gain accreditation from the Public Health Accreditation Board by 2020 to be eligible to receive state public health grants and contracts is also stimulating interest in consolidation and collaboration among LHDs.

2. National landscape

In addition to the changes introduced by the ACA, LHDs are facing several other challenges. Federal budget cuts have caused the CDC to decrease funding for several state block grants that have, in turn, reduced funding to LHDs. The CDC is increasingly focused on evidence-based approaches to prevention for a core group of issues, including preterm births, heart disease, diabetes, and tobacco control. In response to budget cuts and in anticipation of more people gaining insurance, LHDs are improving their ability to bill third parties for medical services they provide but often lack the resources to develop the appropriate infrastructure. Several states and the Robert Wood Johnson Foundation are developing recommendations to define a core set of LHD functions and to achieve sustainable funding, a competent workforce, and the information technology needed to carry out their role.

3. LHD activities and roles under consideration by states

It is well-known that states differ in their approaches to expanding Medicaid eligibility, addressing the needs of low-income individuals, and providing resources for the infrastructure to support transformation of public health programs as health reform progresses. Never the less, among the five states we interviewed, we found some common approaches to refining LHD roles in the changing health care landscape.

Core public health services. The interviewees noted that LHDs need to play an essential role in providing core public health services. Most of the interviewees agreed that, at a minimum, core services include communicable disease control, monitoring environmental standards, ensuring food safety, surveillance and epidemiology, and community engagement and population health. In most states, the duties and responsibilities of the LHDs and therefore the definition of essential services are determined by state law. In some, the state public health department oversees the LHDs' performance of core public health functions.

LHDs as wellness and prevention sites. Some of the state interviewees described opportunities to transform LHDs to focus more on wellness and prevention activities. For example, in Arkansas, more than 100,000 people use LHD-run specialized clinics (such as sexually transmitted disease or family planning clinics) and do not participate in any other form

[36] http://www.healthpolicyohio.org/wp-content/uploads/2013/12/PHF_ExecutiveSummary_FINAL_Revised06262012.ashx_.pdf.

[37] Institute of Medicine. "*For the Public's Health: Investing in a Healthier Future*." Washington, DC: The National Academies Press, 2012.

of care. The LHDs are considering requiring all specialized clinic visits to include preventive services (such as checking blood pressure, cholesterol, and glucose) using advanced practice nurses and billing for the services. LHDs would refer people who need follow-up to local providers. In some states, LHDs in rural areas are the only providers of these services and they are exploring ways to work more collaboratively with Medicaid as Medicaid providers.

Collaborate with other providers to deliver integrated care. The level of interest among primary care providers and hospitals to collaborate with LHDs varies by geography, with less interest in urban areas (where providers described LHDs as competitors) and more interest in rural areas where there is less competition. For example, LHDs in Iowa are very involved in providing home health services in collaboration with hospital and other providers. Several states are investigating ways to coordinate their public health maternal and child health services with clinical services provided by local hospitals and obstetric providers to improve care for vulnerable, high-risk pregnant and parenting women. In Kansas, LHDs bill the managed care plans for the population health services they provide for Medicaid beneficiaries. Also in Kansas, LHDs are exploring ways to support the six core functions required of Medicaid health homes for populations with chronic diseases.[38] To increase their capacity to bill Medicaid, Medicare, and private insurance for preventive and other services, several LHDs are using the NACCHO toolkits that provide guidance about which providers can bill for services, proper coding, and how to implement a required process.[39] In other states, several LHDs are participating in pilot programs in which they jointly contracted with a third party for billing services.

Continuing role of LHDs to provide vaccinations. Immunization represents a unique challenge. Although more state residents will have access to vaccinations without incurring any out-of-pocket costs, many community providers find it too expensive to stock and store vaccines. Many community providers refer children and adults to LHDs for vaccinations. Thus, several state interviewees reported that LHDs are seeing increasing numbers of people seeking immunization, including those with insurance. Several studies suggest that the public health sector is more effective than the individual provider in delivering influenza vaccines to communities.[40] The five states are weighing these factors as they consider the future role of LHDs in ensuring access to immunizations. Missouri LHDs are participating in a pilot program using five different models for immunization billing. Some LHDs are contracting with private companies that stock and track vaccines to improve their efficiency and quality control.

State public health departments supporting LHD transformation. State public health departments are providing technical assistance to LHDs, convening LHDs to support their efforts in strategic plan development, and reviewing state statutes to identify areas where statutory changes are necessary to support the future roles of LHDs. States are also fostering collaborations by convening state public health leaders, state hospital associations, and medical

[38] The six core functions of health homes are comprehensive care management, care coordination, health promotion, comprehensive transitional care follow-up, patient and family support, and referral to community and social supports. See http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Medicaid-Health-Homes-Overview.pdf.

[39] Accessed at http://www.naccho.org/topics/HPDP/billing/.

[40] Schwartz, Benjamin, and Pascale M. Wortley. "Mass Vaccination for Annual and Pandemic Influenza." *Current Topics in Microbiology and Immunology*, vol. 304, 2006, pp. 132–150.

associations to discuss collaboration and integration of services and conducting and responding to nonprofit hospital community health assessment procedures the ACA requires. Some states and LHDs are successfully partnering with universities to support data collection. For example, the Indiana University Business Research Center and Indiana Hospital Association worked with the state to build a website that contains a core set of indicators that hospitals can use in their community assessments and that LHDs can use in their work to become accredited.

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III. CONCLUSIONS

There are significant opportunities for ODH to plan how to provide services for low-income uninsured or previously uninsured populations. The greatest opportunity comes from the increased access to insurance for low-income adults through Medicaid eligibility expansion and the marketplace plans supported by federal subsidies to make them affordable. The ODH programs we reviewed provide both medical services commonly covered by Medicaid and private insurance as well as nonmedical services that other payers do not typically cover. In those cases in which participants have private insurance, the ODH programs serve as a payer of last resort for services that are not otherwise covered. The Medicaid ABP and the state benchmark plan provide comprehensive coverage for the majority of medical services that are currently supported by ODH programs. Thus, the ODH may find significant opportunity to redesign certain programs to account for the populations that will likely become insured under the ACA and no longer need access to medical care through ODH programs. At the same time, the ODH can find ways to provide access to services that insurance does not cover but that enhance clients' engagement in effective prevention or treatment programs.

Maximizing access to insurance coverage for populations served by ODH programs. ODH should consider standardizing the collection and reporting of a core set of data related to eligibility and enrollment, service utilization, and costs for all ODH programs that provide direct medical services and medical care management. ODH could establish a minimum set of required data for all clients using ODH programs to ensure that individuals who may be eligible for insurance coverage are identified and referred for appropriate counseling about their coverage options. ODH may continue to provide services to much of the population that is eligible for coverage, but it can ensure it is the payer of last resort and maximize benefits for the population served by leveraging the more comprehensive coverage provided by the Medicaid ABP and the FFM plans. Ensuring that the information it collects is consistent with information required by other state programs that serve low-income populations and meet federal data requirements will promote efficiencies across programs. ODH may also be able to take advantage of administrative processes that have been implemented as part of the Ohio Integrated Eligibility System initiative. As ODH considers the impact of the ACA on programs, it is imperative that the department coordinate with other agencies to track the impact on users who transition to other services and on the populations that ODH continues to serve as the provider of last resort.

In addition, ODH should continue to ensure that the hardest-to-reach populations receive necessary preventive and medical services. We estimate that in some circumstances ODH programs served a relatively small percentage of the potentially eligible population. According to program reports, some programs serve as the option of last resort for populations in rural areas or with unique social circumstances. For example, we estimate that CFHS served approximately 8 percent of target children and 5 percent of target perinatal women in 2012 due to their unique needs or geographic location. Ensuring these populations are educated about and assisted in gaining insurance is an important role for the ODH, and future planning for these programs should consider the uniqueness of ODH's role. However, women of reproductive age will have access to continuous coverage through Medicaid or marketplace plans, independent of their pregnancy status. Continuous coverage with access to women's preventive services and

contraception remove significant barriers to improving women's health problems such as unintended pregnancy, depression and other mental illness, and chronic medical conditions.

Integrating public health care coordination and care management with the medical system. The Medicaid program offers a vehicle for coordinating and integrating care for ODH populations through collaboration with the providers and staff who provide case management services, home visiting, outreach, and enrollment services for ODH clients. An array of providers participates in ODH programs. These providers have extensive experience with outreach, care coordination, case management of chronic medical conditions, patient education and counseling, and other skills that are important for maximizing the impact of integrated delivery systems to improve care and lower costs. As reforms to integrate and coordinate care progress, there is an opportunity to leverage the experience of these ODH providers. ODH program staff also demonstrate expertise in outreach, care coordination, care management of chronic medical conditions, patient education and counseling, and other skills across an array of populations and settings. Their skills also should also be leveraged to promote integrated services and care in both the public health and health care systems.

As ODH reviews the impact of more prevalent and comprehensive insurance coverage on clients' needs and considers a redesign of ODH programs, it may be possible to gain efficiencies in the delivery of services by identifying common administrative and management approaches, identifying common needs, cataloging unique population needs, and tracking a core set of outcomes related to coordination of care and case management. Care coordination, case management, and social supports are increasingly recognized as a means for maximizing the effects of insurance coverage, improving access to care, and improving health outcomes for vulnerable populations.[41] Building on past experience, the department should explore ways it can support the provision of these services.

Opportunities for enhancing care for persons with HIV/AIDS. Insurance will not cover some important HIV/AIDS services but federal programs will continue to cover these nonmedical services. For example, supportive services, such as early intervention services for newly diagnosed HIV-positive individuals, case management, and medication adherence counseling services covered by the RWHAP are not covered by insurance but they are important to maintaining the health of those living with HIV/AIDS.[42] The RWHAP will continue to fill insurance coverage gaps, particularly for plans that place HIV drugs on higher tiers and charge significant coinsurance or that limit access to HIV providers. This program will also pay for services such as treatment adherence and case management that may be covered by Medicaid but are not typically covered by health insurance.[43] Given the high concentration of HIV-positive

[41] Bachrach, D., H. Pfister, K. Wallis, and M. Lipson. "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." Commonwealth Fund, May 2014. Available at http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs. Accessed July 15, 2014.

[42] Mugavero, Michael J., Wynne E. Norton., and Michael S. Saag. "Health Care System and Policy Factors Influencing Engagement in HIV Medical Care: Piecing Together the Fragments of a Fractured Delivery System." *Clinical Infectious Diseases,* vol. 52, no. S2, 2011, pp. S238–S246.

[43] Kates, Jennifer. "Implications of the Affordable Care Act for People with HIV Infection and the Ryan White HIV/AIDS Program: What Does the Future Hold?" The Kaiser Family Foundation, 2013. Available at http://kff.org/hivaids/issue-brief/implications-of-the-affordable-care-act-for-people-with-hiv-infection-and-the-ryan-white-hivaids-program-what-does-the-future-hold/. Accessed July 31, 2014.

individuals who will qualify for Medicaid, ODH should work with the Medicaid program to develop a delivery model that supports high quality, effective care for HIV populations. The ODH should explore models that will allow using Medicaid funds and RWHAP funds to support medical and nonmedical needs of HIV-positive individuals and build on integrated models of care, such as patient-centered medical homes and on the payment innovations supported by the Ohio transformation effort.[44]

Conclusion

Populations that have used and benefited from several ODH programs will gain insurance that will cover many of the medical services the ODH programs have provided with state and federal funds. ODH may find significant opportunities to redirect public health funds from covering medical services to nonmedical and population health services as more people who use public health programs gain insurance. ODH may find significant opportunity to redesign certain programs to account for the populations that will likely become insured under the ACA and no longer need access to medical care through ODH programs. At the same time, the ODH can find ways to provide access to services that insurance does not cover but that enhance clients' engagement in effective prevention or treatment programs. In addition, ODH should explore the need for continuing programs that serve as the option of last resort for a relatively small populations living in rural areas or in other communities where services are limited. The challenge of serving rural communities or socially isolated communities also presents an opportunity for local health departments to better integrate services among the few providers in those communities.

[44] http://www.healthtransformation.ohio.gov/CurrentInitiatives/PayforValue.aspx

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APPENDIX A

OHIO OFFICIALS INTERVIEWED

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Senior ODH Staff	• Anne Harnish, Assistant Director of Programs • Rebecca Maust, Chief of Division of Quality • Jay Carey, Stakeholder Liaison • Karen Hughes, Chief of Division of Family and Community Services • Lisa Heinbach, Program Administrator • Anthony Perry, Budget Chief • Steve Wagner, Chief, Division of Prevention • Will McHugh, Assistant Director of Administration
Help Me Grow	• Lea Blair, Chief of Bureau for Children with Developmental and Special Health Needs • Jeff Winnick, Home Visiting Program Manager • Wendy Grove, Part C Coordinator • Jessica Foster, Physician Administrator, Title 5 • Karen Hughes, Chief of Division of Family and Community Services • Anthony Perry, Budget Chief
Medicaid program	• Anne Harnish, Assistant Director of Programs • Jay Carey, Stakeholder Liaison • Patrick Beatty, Ohio Department of Medicaid Deputy Director
Ryan White HIV/AIDS Program (RWHAP)	• Jamie Blair, Chief of Bureau of HIV/AIDS, STD, and TB • Katherine Shumate, Ohio Ryan White Part B Administrator • Jay Carey, Stakeholder Liaison
Immunization program	• Siestke de Fijter, Chief, Bureau of Infectious Diseases • Steve Wagner, Division of Prevention: oversees Ryan White, Tobacco • Dave Feltz, Vaccines for Children Program Manager • Anthony Perry, Budget Chief
Local Health Departments, Tobacco Use Prevention and Cessation Program, and federally qualified health centers	• Mandy Burkett, Chief of Tobacco and Indoor Environments Section • Heather Reed, Chief of Bureau of Community Health Services and Patient-Centered Primary Care (Division of Family) • Gene Phillips Chief of Bureau for Environmental Health • Joe Mazzola, Local Health Department Liaison
Bureau for Children with Medical Handicaps (BCMH)	• Karen Hughes, Chief of the Division of Family and Community Services • Jessica Foster, MD, Physician Administrator • Patrick Londergan, Health Planning Administrator • Anna Starr, Genetics Section Administrator • Sam Chapman, Chief Nursing Administrator • Anthony Perry, Budget Chief • Pam Leimbach • Kimberly Weimer • Lea Blair, Chief of Bureau for Children with Developmental and Special Health Needs
Breast and Cervical Cancer Project	• Roberta Slocum, BCCP Data Analyst • Mary Lynn, BCCP Researcher • Nicole Brennan, BCCP Program Director • Steve Wagner, Chief, Division of Prevention

CFHS and Reproductive Health Program	• Karen Hughes, Chief, Division of Family and Community Services • Jo Bouchard, Chief, Bureau of CFHS • Lori Deacon, Assistant Chief, Bureau of CFHS • Dyane Gogan Turner, Supervisor, Bureau of CFHS • Amy Davis, Supervisor, Assessment and Planning, Bureau of CFHS • Anthony Perry, Budget Chief • Amanda Waldrup, Reproductive Health & Wellness Program Administrator • Michelle Clark • Jay Carey, Stakeholder Liaison • Lisa Wolfe

APPENDIX B

METHODS FOR ATTRIBUTING OHIO RESIDENTS TO PROGRAM ELIGIBILITY

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The analytic method to attribute Ohio residents to program eligibility relied on the Ohio sample of the 2011 American Community Survey Public Use Microdata Sample (ACS PUMS). The ACS is a national survey that the Census Bureau has conducted annually since 2000. The ACS includes the basic "short-form" questions as asked in the decennial census, as well as detailed demographic questions and questions about household income, marital status, and work status.[1] In each state, the ACS sample is drawn by housing unit; individuals residing in group quarters (such as such as college dormitories, nursing homes, and prisons) are sampled separately.

The 2011 ACS sampled 129,699 households in Ohio obtaining full interview data from 89,255 sampled households (Table B.1).[2, 3] In addition, 7,662 Ohioans in group quarters were sampled, with 5,900 interviews completed successfully. The Census Bureau weights each successful interview (considering age, gender, race/ethnicity, and other characteristics) to represent the total population in the survey year. To represent Ohio's population in 2014, Mathematica adjusted the census-produced 2011 population weights proportionately. Specifically, the 2011 census weight for each individual was multiplied by a factor calculated to produce a total population estimate (within five-year age groups) equal to the census projection of Ohio's population in 2014.

To develop estimates of the population eligible for each program, we first identified the key characteristics that defined eligibility and were identifiable in the ACS. Such characteristics included items that were directly reported in the ACS (such as age, gender, and Native American or Alaskan Native ethnicity). They also included family poverty level, which is not directly reported. To calculate family income as a percentage of the federal poverty level (FPL) for each individual, we used the Modified Adjusted Gross Income (MAGI) rules that became

ESTIMATING MAGI AND MEDICAID ELIGIBILITY

The MAGI rules generally follow tax dependency principles, with some exceptions for non-filers. Because household composition and size can vary for adults and children living in the same household, it was necessary to calculate MAGI separately for each individual. Starting with all the individuals reported by the ACS respondent as living in the household at the time of the survey, families and family sizes were constructed for each individual as follows:

- **Married adults.** All married adults and parents of children younger than 19 were grouped with the spouse and their or their spouse's biological children, adopted children, or stepchildren.
- **Unmarried adults.** Unmarried adults, if parents, were grouped with their biological or adopted children younger than 19 if no unmarried partner lived in the household, or if the unmarried partner in the household had a lower income—in effect, assuming the higher-income adult would claim the children as dependents for tax purposes, creating a tax-filing unit that would be treated as a separate family under MAGI rules. Unmarried adults in households without children younger than 19 were considered households of one.
- **Children.** Children's households included any parents (married or unmarried) and siblings in the same household. If neither parent was present, the child was grouped with any siblings plus the nearest adult relative (such as a grandparent) living in the household.

For all three groups (married adults, unmarried adults, and children), pregnant women were counted as two individuals for the purposes of determining household size and, subsequently, Medicaid eligibility.

[1] See: U. S. Census Bureau, "American Community Survey: Information Guide." Available at http://www.census.gov/acs/www/about_the_survey/acs_information_guide/flipbook/files/inc/d6425564bc.pdf, accessed October 16, 2014.

[2] See: U.S. Census Bureau. "American Community Survey Sample Size and Data Quality." Available at http://www.census.gov/acs/www/methodology/sample_size_data/index.php, accessed October 16, 2014.

[3] Sampled addresses are first contacted by mail, then telephone. Households associated with surveys that were not completed or addresses with post office box mail delivery are sampled and visited for an in-person interview. Persons People living in group quarters also are interviewed in person. See: U.S. Census Bureau, "American Community Survey: Information Guide. How ACS Data Are Collected." Available at http://www.census.gov/acs/www/about_the_survey/acs_information_guide/flipbook/files/inc/d6425564bc.pdf accessed October 16, 2014.

effective in January 2014 for determining Medicaid eligibility (see text box).

This estimation necessarily involves some error, perhaps especially due to members of tax filing units who do not live at the same address. For example, to the extent that we undercount the number of dependents associated with the income of a parent residing in Ohio, we over-estimate the parent's actual FPL and, in turn, under-estimate the parent's eligibility for Medicaid or subsidized coverage in Ohio's health insurance exchange. Conversely, a tax-dependent living in Ohio, whether or not his parent or spouse resides in Ohio, might appear to be a tax unit of one. Because the ACS does not observe the true tax filing unit, this person's calculated FPL might be lower than is accurate and his eligibility for Medicaid or subsidized coverage in Ohio's exchange would be over-estimated. For any one household (and therefore for all households together) it is impossible to discern the magnitude or direction of this potential error.

All adults enrolled in Medicaid in 2011 were assumed to remain enrolled when the population was reweighted to 2014, producing a slight increase in the estimated number of Ohioans enrolled in Medicaid but no change in that number as a percentage of the population within five-year age groups. Individuals were flagged as eligible for Medicaid in 2014 if (1) they reported that they were enrolled in the program; or (2) their age and MAGI-determined FPL indicated they would be eligible although they were not currently enrolled.

The unweighted 2011 ACS sample of Ohioans included more than 111,000 individuals, including nearly 92,000 individuals younger than 65. These tabulations of the 2011 ACS sample, together with tabulations of various subpopulations relevant to our estimates of individuals in each program who are Medicaid-eligible in 2014 or eligible for subsidies if enrolled in coverage in the FFM, are presented in Table B.1. Most population cells include substantial numbers of unweighted observations—typically more than 1,000 and often more than 10,000, but with some exceptions. Most notably, the Vaccines for Children program, which includes Native American and Alaskan Native children at any income, relies on a very small unweighted count of those children. However, even when census-weighted and then proportionately re-weighted to 2014, those numbers did not materially affect our estimates of total children eligible for the program.

For each program, estimates of eligibility were calculated directly from the weighted population estimates. The only exception was the Ryan White HIV/AIDS Program (RWHAP), for which it was necessary to estimate the number of Ohioans living with HIV/AIDS in demographic subcategories to approximate their age and income distribution (and therefore Medicaid eligibility). The approximate number of Ohioans younger than 65 were living with HIV/AIDS in 2014 (20,500) was projected as the reported number in 2011, increased by 1,500 people per year.[4] We developed an incidence matrix to allocate Ohioans living with HIV/AIDS across the population, benchmarked to the Ohio population, using national prevalence estimates by age and race/ethnicity, published in the CDC's HIV Surveillance Report, benchmarked to the Ohio population (Table B.2). This incidence matrix was applied to the 2014 weighted population

[4] See: Honeck, Jon and Tara Dolansky. "The Ryan White HIV Drug Assistance Program: A Vital Part of Ohio's Public Health Infrastructure." *State Budget Matters*, Vol. 7, no. 8, October 2011. Available at http://www.communitysolutions.com/assets/docs/State_Budgeting_Matters/sbmv7n8ryanwhitereport100711.pdf, accessed October 16, 2014.

in Ohio with income under 300 percent of FPL by age and race/ethnicity to derive projections of the total number of Ohioans eligible for services under the RWHAP in 2014.[5]

Table B.1. Unweighted counts of Ohioans in the 2011 ACS by selected characteristics

				Not Medicaid eligible		
	Total population	Medicaid eligible	Medicaid enrolled	0 – 249% of FPL	250%– 400% of FPL	More than 400% of FPL
Total population	111,047	44,641	17,642	12,605	19,017	22,997
Population younger than 65	91,622	36,498	15,537	12,543	18,945	22,868
Breast and Cervical Cancer Project						
Total women age 40 or older	32,290	3,223	3,112	3,719	4,475	5,318
Total women ≤ 200% of FPL or eligible for Medicaid	31,401	12,378	9,917	3,165	--	--
Bureau of Child and Family Health Services						
Total < 250% of FPL or enrolled in Medicaid	62,915	44,633	17,642	12,605	--	--
Pregnant or perinatal women	1,331	1,131	749	360	--	--
Infants ages birth to < 1 year	683	622	440	61	--	--
Children ages 1 and 2	1,514	1,358	968	155	--	--
Bureau of Children with Medical Handicaps						
Children younger than 21						
< 185% of FPL	12,990	12,897	7,726	93	--	--
≥ 185% of FPL	14,611	1,990	1,243	1,720	5,231	5,657
Adults ages 21 to 45						
< 185% of FPL	14,001	11,510	3,918	2,452	--	--
≥ 185% of FPL	17,517	379	352	3,300	6,887	6,898
Adults ages 46 to 64						
< 185% of FPL	11,941	9,626	2,202	2,108	--	--
≥ 185% of FPL	20,562	96	96	2,870	6,827	10,313
Ryan White HIV/AIDS Program						
Younger than 65, and 0 – 300% of FPL or enrolled in Medicaid	68,516	36,497	15,537	12,543	18,825	--
Vaccines for Children						
Children younger than 1	1,242	701	509	63	232	245
American Indian or Alaskan native	7	4	4	0	1	2
Children ages 1 to 18	24,004	12,022	8,080	1,598	4,967	5,406
American Indian or Alaskan native	203	147	114	16	8	32
Children < 300% of FPL						
Children younger than 1	835	686	494	63	86	--
American Indian or Alaskan native	5	4	4	0	1	--
Children ages 1 to 18	15,126	11,626	7,689	1,598	1,895	--
American Indian or Alaskan native	170	146	113	16	8	--

Source: Mathematica tabulations of the American Community Survey Public Use Microdata Sample.
ACS = American Community Survey; FPL = federal poverty level.

[5] The Ohio Department of Health (ODH) HIV/AIDS Surveillance Program recently released 2013 estimates of HIV/AIDS prevalence in Ohio. Our incidence estimates and projections are similar to ODH's 2013 estimates but not identical. See: "Guidance for Users of Ohio HIV/AIDS Surveillance Data.," available at http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.ashx, accessed October 19, 20146.

Table B.2. Projected incidence of HIV-AIDS in Ohio as a percentage of the population by age, gender, and race/ethnicity, 2014

Age	Black Male	Black Female	White Male	White Female	Latino Male	Latino Female	Other Male	Other Female
0 to 18	0.19	0.06	0.06	0.02	0.06	0.02	0.03	0.01
19 to 39	2.65	0.68	0.53	0.17	0.78	0.26	0.59	0.17
40 to 64	2.01	0.50	0.42	0.10	1.42	0.36	0.67	0.16

Source: Mathematica estimates derived from Centers for Disease Control and Prevention: "HIV Surveillance Report, 2011. Vol. 23," February 2013. Available at http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf#Page=17, accessed October 16, 2014.

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