

Abstract

The passage of the Affordable Care Act presented opportunities and challenges for safety net providers. Significant investments in provider capacity promised much needed expansion of services; and in 2014, the law extended coverage to millions of previously uninsured Americans. However, safety net providers are concerned that changes to financing brought about by changes in the ACA may threaten their ability to provide services to millions more who still lack insurance. This is a preliminary study of changes occurring with maternal and child health services among safety-net providers.

Introduction

The Patient Protection and Affordable Care Act, better known as the Affordable Care Act (ACA) brought important changes to the American health care system. The provisions contained within the ACA promised to elevate the status of health promotion, disease prevention, and population-based services¹. The inclusion of these public health principles were also expected to provide incentives to address problems with the public safety net and the considerable challenges facing safety net providers. The challenges to safety-net providers include the recession, reduced service payments, diminishing tax base, and local health department system realignment². Most local health departments are required by law to provide services to vulnerable populations within their jurisdictions. Local health departments often are "providers of last resort" after community health centers turn patients away because of operational deficits. Often under-recognized, local health departments are major providers of maternity services in the United States³. The purpose of this study is to examine changes in local health department services in conjunction with funding increases or decreases to community health centers.

Methods

We extracted data from the National Profile of Local Health Departments, Collected by the National Association of County and City Health Officials (NACCHO). To examine changes in maternal and child health (MCH) services we used data from the 2008 and the 2013 surveys. The 2008 Profile study consisted of data from all 2794 local health departments in the United States at the time of the survey⁴. The 2013 Profile study included a total of 2532 local health departments⁵.

The measures collected for this study were maternal and child health services offered by many local health departments. They included family planning, prenatal care, obstetrical care, maternal/child health (MCH) home visits, early periodic screening, diagnosis, and treatment (EPSDT), women infants and children services (WIC) and well child clinic.

For our preliminary analyses, we used descriptive statistics to measure changes maternal and child health services between 2008 and 2013. Because of missing location data in the 2013 Profile survey, we were unable to GIS map changes to determine where services increased or decreased.

Results

Figure 1 reports the percentage of MCH direct services provided by LHDs prior to and after the passage of the ACA. The percentage of LHDs providing MCH services decreased for all except WIC services. Figure 2 depicts services provided by other providers in the jurisdiction. Services increased among community providers for well child clinics, prenatal care, and family planning. WIC, EPSDT, MCH home visits and obstetrical services decreased slightly. Figure 3 shows the percentage of LHD jurisdictions where MCH services are not available in the community. Although the percentages are small, many MCH services are less available in LHD jurisdictions. This is especially noticeable among obstetrical care and MCH home visits. Figure 4 shows change in the number of MCH visits provided by community health centers since ACA. Unlike MCH decreases shown by LHDs, community health centers provided an increasing number of services.

Discussion

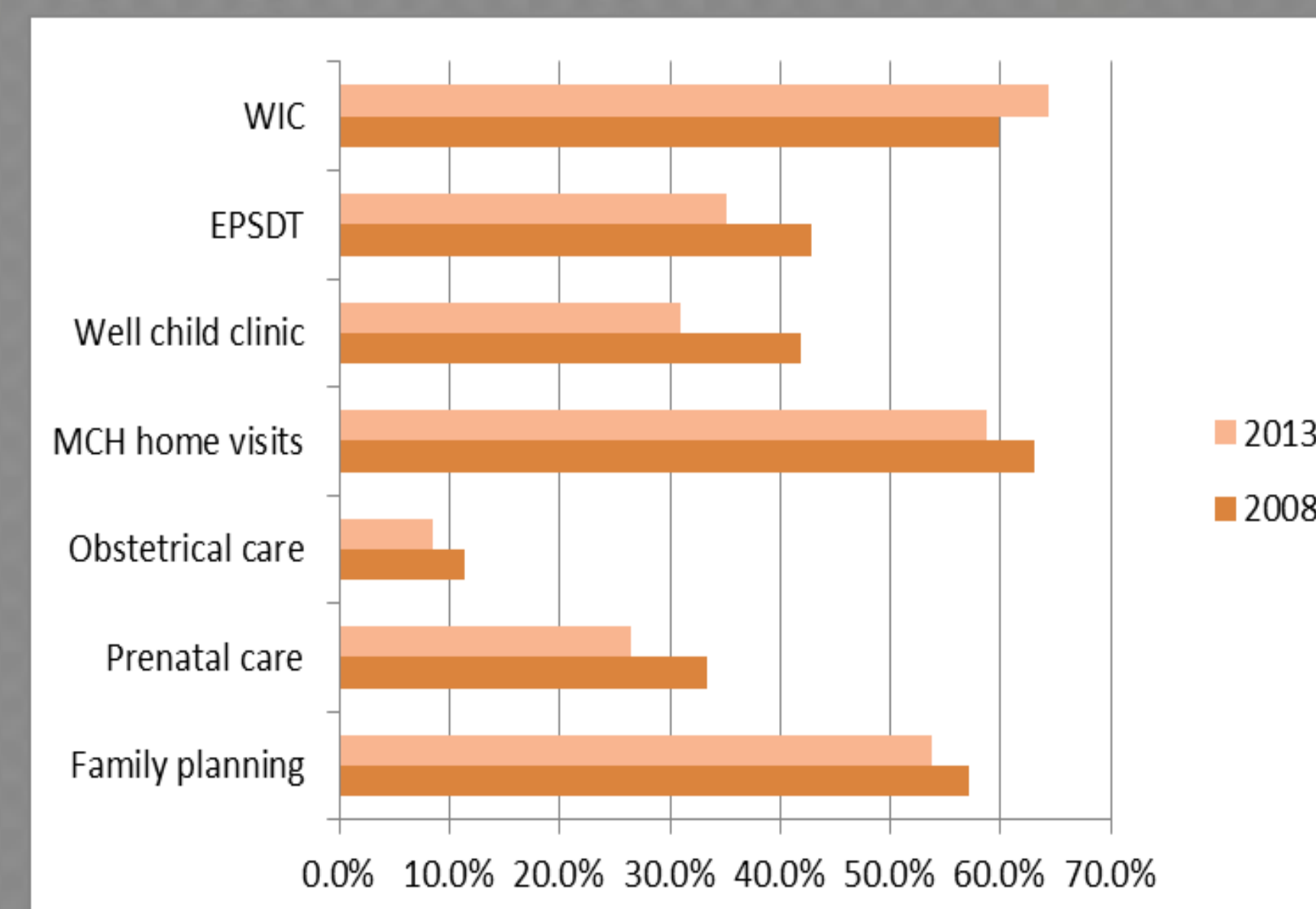
This study gives descriptive results of a preliminary analysis of changes in safety net provided services since the passage of the ACA. In summary, results among the safety-net providers were mixed. While LHDs showed decreasing percentages of LHDs offering MCH services over time, CHCs provided more services. Because the data and analysis is limited, we are unable to say whether the decrease in LHDs offering MCH services is creating a barrier to health care access. Historically, LHDs serve women at the greatest risk for low birth weight and premature births, including the poor, uninsured, and adolescents³. The percent of women who receive prenatal care directly from local health departments varies by state and within states by the availability of resources.

Like other sectors of the economy, safety-net providers have experienced financial and workforce reductions since 2008. And during this same time period demand for services increased. The ACA provided \$11 billion to community health centers to support primary care programs that would support the goal of high-quality, low-cost primary care -- in addition to \$1.5 billion in funds for capital improvements⁶. Moving ahead, the ACA is expected to reduce some of the challenges previously faced by safety-net providers by reducing the rolls of the uninsured, and expanding the community health center infrastructure.

References

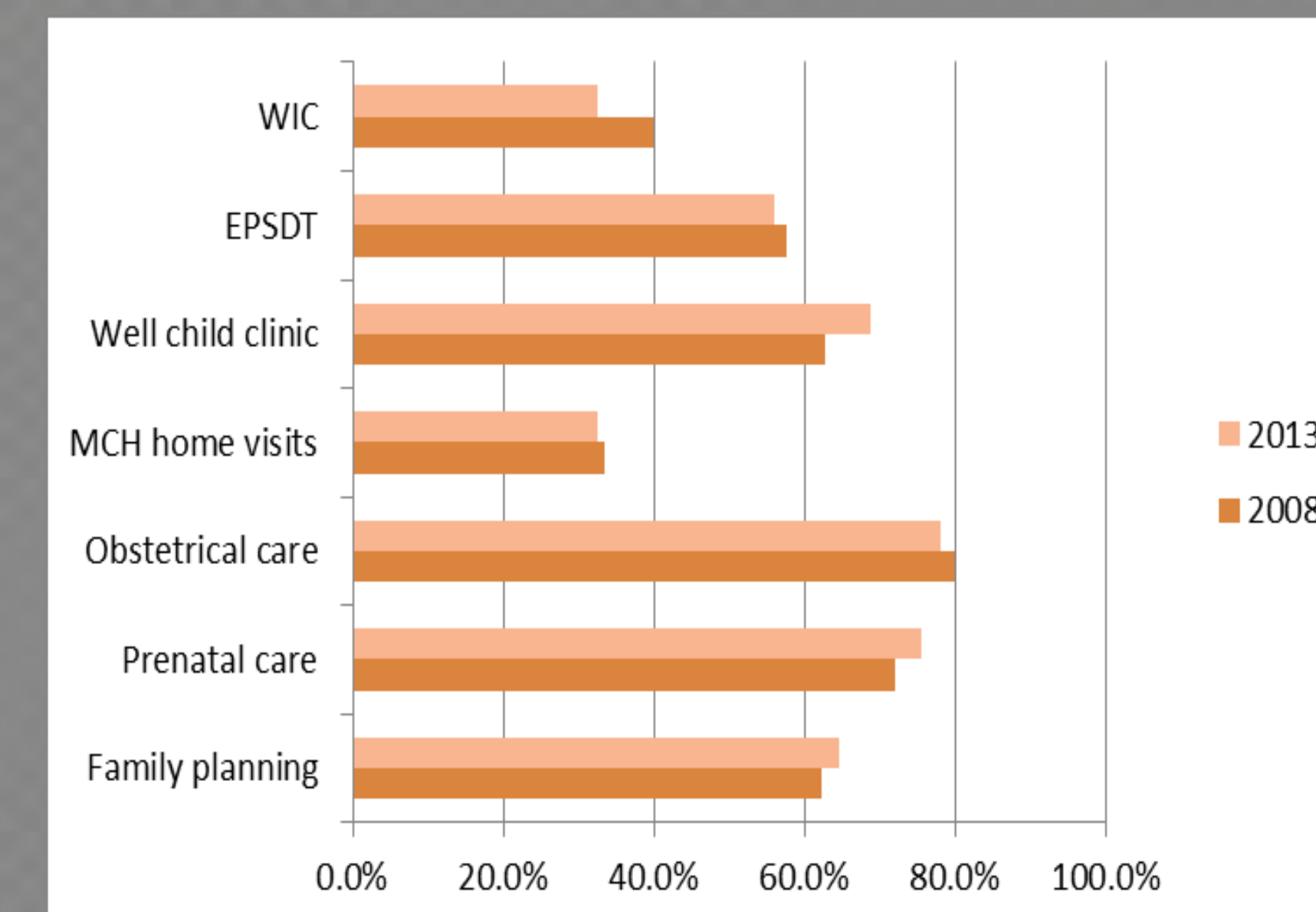
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Figure 1



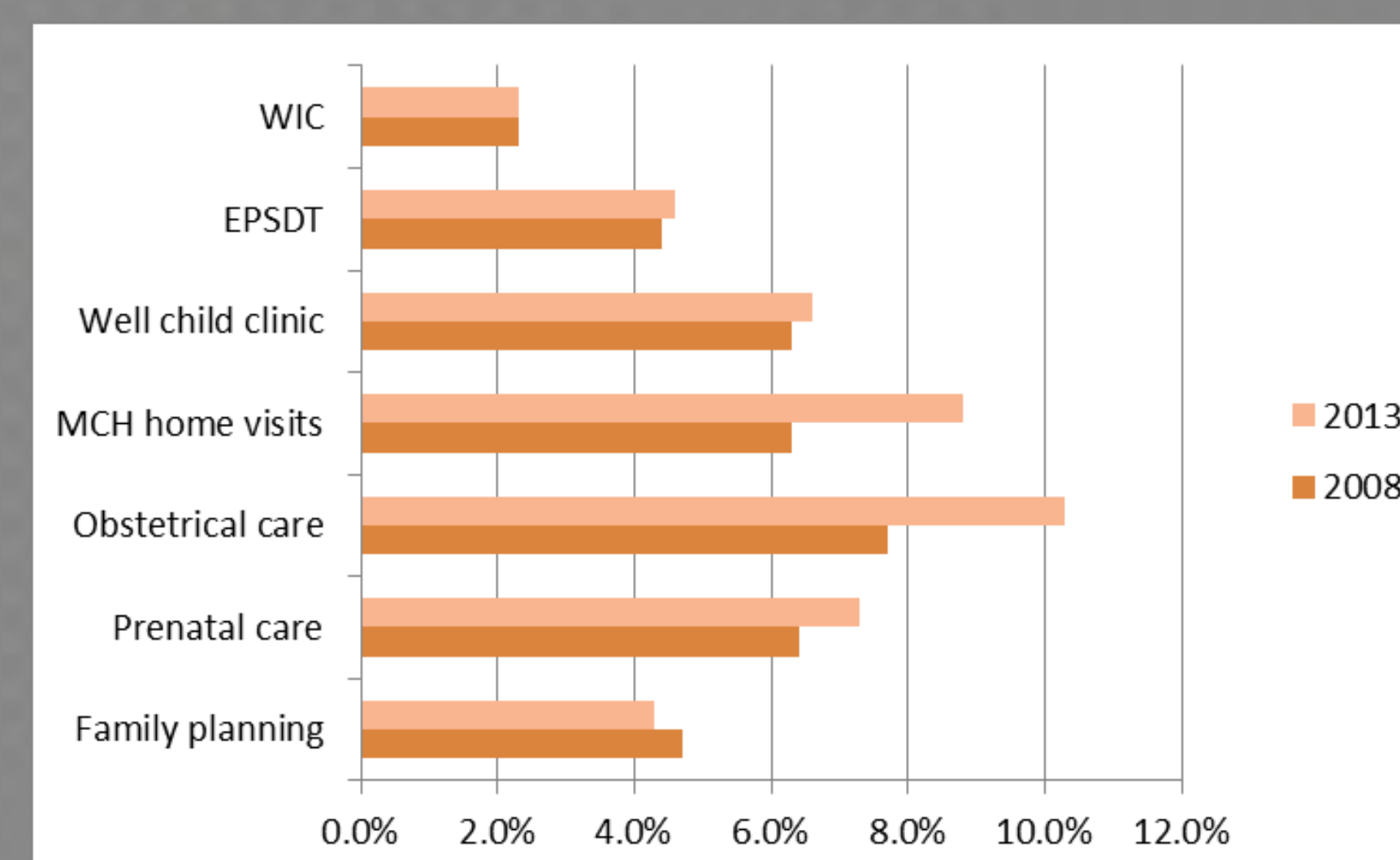
MCH Services Performed by LHDs

Figure 2



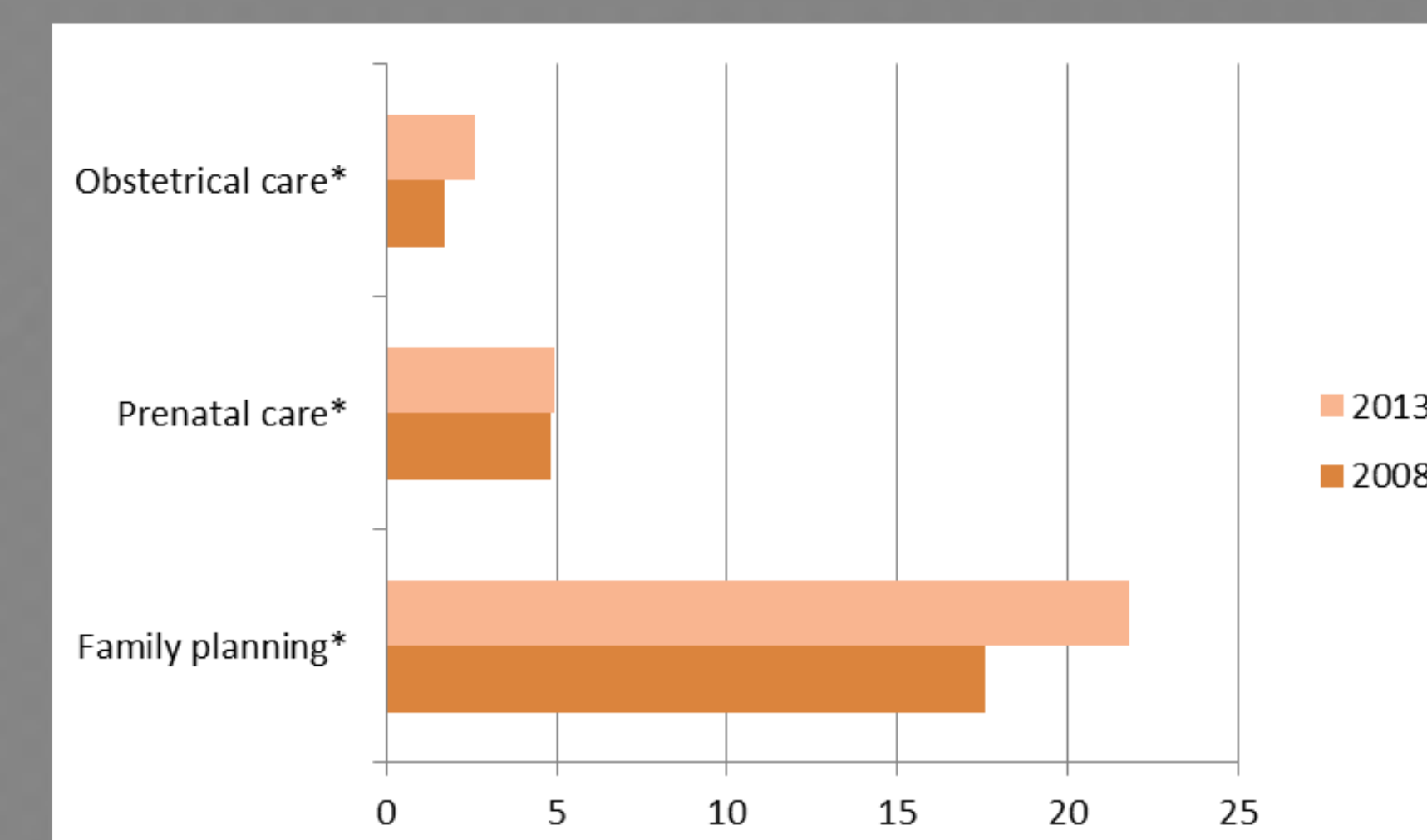
MCH Services Performed by Other Community Agencies

Figure 3



MCH Services Not Available in the Community

Figure 4



*Numbers represent 100,000 visits

MCH Services Provided by CHCs

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