ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:

Will There Be Enough Providers to Meet the Need? Provider Capacity and the ACA

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Much of the success of Affordable Care Act (ACA) will hinge on issues surrounding access to care. Furthermore, the responses to health care reform by providers, public programs, and payors will directly affect access, coverage and, ultimately, the sustainability of reform. The potential entry of millions of newly insured individuals into health insurance coverage will undoubtedly strain the capacity of provider systems, and critical questions surround the extent to which these systems will be able to respond to the expected new demand by providing timely access to appropriate care. This brief will explore this complex issue primarily drawing on information gathered from 10 states[1] participating in the Robert Wood Johnson Foundation's health reform implementation monitoring and tracking project. Discussion is divided into four sections:

- Background information on the challenge facing the nation—in terms of expected demand for care among newly insured, the capacity of provider systems to respond to this demand, the supply and distribution of providers, and how all these factors vary state to state—is presented first.
- Second, the brief reviews and summarizes key provisions contained in the ACA designed to address provider supply and access to care issues.
- Third, it presents new information on how states are coping with (or planning to address) the challenge and describes strategies to increase provider reimbursement, expand the capacity of community health centers, enhance the primary care workforce, and consolidate, redesign, and reform health delivery systems in an effort to meet complementary goals of controlling costs, improving quality, and improving access to care.
- The brief concludes by examining the outlook for the future.

THE CHALLENGE FACING THE STATES

Prior to the Supreme Court's ruling on the constitutionality of the ACA—and before the Medicaid expansion component of reform was ruled optional for the states—estimates were that upwards of 30 million individuals would gain coverage under the reform law, either through Medicaid or subsidized coverage in health

insurance exchanges.[2] The size of coverage increases under Medicaid, however, vary considerably by state. For instance, states like New York, with a history of generous Medicaid eligibility, anticipate that there will be only about a 15 percent increase on top of current enrollment. In contrast, Alabama, Colorado and Virginia—states with historically restrictive income eligibility rules—could see their programs grow by up to 48 percent.[3] Other provisions of the law will also add to coverage; for example, Alabama will see a 63 percent reduction in the number of uninsured when all sources of new coverage are considered.

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Regardless of this variation, most stakeholders with whom we spoke during our site visits were very concerned about provider capacity to serve the newly insured. The focus of this concern was mainly on primary care, but shortages of specialists and behavioral health providers were also frequently mentioned.

Interestingly, however, there is considerable disagreement among health policy researchers and provider organizations on the extent of the problem. The common belief is that there are simply not enough providers across the country to serve the population; for example, the American Association of Medical Colleges projects that the United States will face a shortage of 45,000 primary care physicians in the next decade.[4] But most studies of provider capacity focus on doctors and not other types of primary care providers, such as nurse practitioners and physician assistants—which currently make up one-quarter of the primary care workforce—and data show that the pace of growth in these professions has outpaced population growth in recent years.[5] Of note, a recent synthesis of the literature suggested that the sheer numbers of providers may be adequate, but that it is the manner in which they are deployed that is insufficient. That is, if health systems did a better job of utilizing existing resources through more efficient practice models and better coordination, they could better meet patients' needs.[6]

Debates on sufficiency aside, most analysts agree that the current supply of providers is mal-distributed. Research has shown that physician shortages are more likely in rural and frontier areas than urban/suburban areas, in low-income communities, and in communities with higher proportion of minority populations.[7] Among our study states, for example, New Mexico has 32 of its 33 counties designated as either Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs);[8] in Alabama, this is true in 60 of the state's 67 counties.[9]

There are also new data that suggest that problems of mal-distribution will get worse before they get better. According to the Center for Studying Health System Change, states currently with the smallest number of primary care providers per capita (in the South and Mountain West) are projected to have the largest increases in Medicaid enrollment as a result of the ACA.[10] Meanwhile, those states with the largest number of primary care providers per capita (in the Northeast) will see only modest Medicaid enrollment increases.[11]

ACA PROVISIONS OF RELEVANCE

It is fair to say that the ACA focused considerable renewed attention on primary care, emphasizing that it is critically important to individuals' health, and that it should be supported and strengthened in the U.S. reformed health care systems if we are to achieve the goals of lower cost, improved quality, and expanded access. Indeed, a great many provisions in the law were designed to promote primary care and bolster the primary care workforce.

Some components of the law were focused on payments to providers, with the goal of creating incentives to promote increased participation in public programs among existing providers. Insufficient provider participation in Medicaid—a problem in many, if not most states—is often attributed to low reimbursement rates; indeed in 2008, a study found that Medicaid payments for primary care services were 66 percent of Medicare rates.[12] In response, the ACA increased Medicaid payments for primary care services provided by

physicians in family medicine, general internal medicine, pediatric medicine, and subspecialties who provide primary care services, to 100 percent of Medicare rates.[13] This rate bump, however, only lasts for two years—2013 and 2014.[14] Despite its short duration, some have estimated that the number of physicians willing to accept new Medicaid patients could increase by up to 11 percent as a result of this ACA provision.[15]

Other parts of the ACA provide increased funding to safety net providers that traditionally serve low income individuals and families. For example, the reform law provides $11 billion for Federally Qualified Health Centers (FQHCs) over the five year period from 2011 to 2015.[16,17]

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The ACA also addresses primary care workforce and supply issues, specifically by increasing funding for the National Health Service Corps (NHSC) by $1.5 billion over five years. The goal is to assist an additional 15,000 providers—including primary care physicians, nurse practitioners and physician assistants—by 2015 with medical school loan repayment, in return for providers' commitments to practice in underserved areas for a given period of time.[18] Moreover, the law includes funding for a variety of workforce training and development initiatives for doctors, nurses, and other health professionals. In particular, the Prevention and Public Health Fund allocates $5 billion between 2010 and 2015, and an additional $2 billion each year after 2015, to increase the number of primary care residency positions, support physician assistant and nurse practitioner training in primary care, and establish nurse-managed health clinics that would assist with the training of new nurse practitioners.[19]

Finally, there are many ACA provisions that, while not directly focused on provider reimbursement, supply, or training, do promote reforms in the way health care services are delivered. For many of these, the goal is to emphasize the efficient and effective provision of primary and preventive care by supporting grants and demonstration projects for Accountable Care Organizations, Collaborative Care Networks, and Patient Centered Medical Homes, among others.[20]

The following section follows the above-mentioned framework to describe how the study states were planning for and responding to provisions in the ACA related to primary care provider reimbursement, investments in FQHCs, bolstering the primary care workforce, and working to reform and improve health care delivery systems.

STRATEGIES TO ADDRESS PROVIDER SUPPLY AND ACCESS

During our interviews in the 10 study states, we asked state officials, policy-makers, providers, insurers, and other stakeholders about the access to care situation in their states, their perceptions of potential effects of the ACA's provisions designed to bolster provider participation and supply, and any strategies states were implementing in response to the law to improve access to care and health system performance. Insights we gained are summarized below.

1. Increasing primary care reimbursement

When we spoke with state officials about whether they had increased Medicaid provider reimbursement in recent years or were planning to in response to the ACA, they were quick to point out that, due to the Great Recession and resulting severe budget pressures, most states had been cutting reimbursement rates not increasing them. Maintenance of effort rules embedded in the ACA and the American Recovery and Reinvestment

Act (ARRA) took eligibility cuts off the table, in terms of cost containment strategies, leaving payment policies as one of the few levers left available for program savings. Even Maryland, which had passed state rules to bring its Medicaid rates to parity with those of Medicare, had postponed implementation of the fee increases due to budget deficits.[21]

To be sure, virtually all the stakeholders with whom we spoke welcomed the ACA's primary care fee increase and, in particular, the 100 percent federal funding provided for the increase. But none were committed to extending these higher fees beyond 2014, nor were many very optimistic that a temporary fee hike would have much effect on provider participation in Medicaid, much less the supply of providers in the state. At best, most informants believed that the rate increase would help to maintain providers' participation in the program or stem departures from the program.

2. Increasing funding to Community Health Centers

Further expanding the capacity of community health centers was viewed as a more promising, long-term solution to access pressures, according to state officials and other stakeholders with whom we spoke. The past decade has been kind to FQHCs, as annual federal funding grew from about $1.2 billion in 2001 to $2.2 billion in 2010 (prior to passage of the ACA).[22] Once again, the ACA expanded funding by another $11 billion over five years, roughly doubling annual funding levels.

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Across the board, FQHC representatives, state primary care associations, and other health system stakeholders opined that the ACA was a clear "win" for these safety net providers. More broadly, they saw FQHCs as very well-positioned to play a key role in meeting new demand for services among individuals and families gaining coverage under health reform. Health center administrators in Colorado, for example, said they expected to double their capacity in the next few years, not only due to increases in federal grants, but also because 40 percent of their clients are now uninsured and many will likely to qualify for expanded Medicaid. With Medicaid coverage, these clients would carry with them advantageous cost-related prospective payment reimbursement.[23] FQHCs are also strong examples of the primary care medical home model, and many we spoke with are busy enhancing that model, building care coordination capacity in anticipation of serving new populations.

There were, however, some concerns expressed that FQHCs should not, as a side effect of the ACA, lose focus of their role as a safety net provider for the uninsured. FQHC managers and advocates for the poor in many states reminded us that 20 million or more individuals will not get coverage under the ACA and FQHCs will need to maintain their ability to serve these most vulnerable groups. Indeed, serving persons with incomes up to 400 percent of the poverty level may not be consistent with the mission of a safety net system.

3. Expanding the primary care workforce

We did not see an abundance of activity in the study states aimed at expanding the supply of primary care providers. Still, there were interesting and promising efforts in some states. In Michigan, for example, the emphasis was on long-term strategic planning. There, Governor Snyder tasked the state Department of Community Health to develop a new State Healthcare Workforce Plan.[24] In three of the study states—Colorado, New Mexico and Oregon—we learned of state programs that essentially mirror the federally-funded. These programs all offer medical school loan forgiveness in return for commitments to practice in underserved areas. Interestingly, they do so not only for physicians, but also for nurse practitioners, physician assistants, and nurses. Colorado's program is noteworthy due to its funding base—which is primarily philanthropic rather than state-funded—as well as for its size—the program provides loan repayment for 200 health professionals, matching the size of the federally-funded NHSC program that also supports 200 primary care providers in Colorado.[25]

Efforts to expand "scope of practice" laws—that broaden the scope of services non-physician providers can provide independent of physicians—were often stymied by the medical professions, according to key informants in most of our study states. Still, in Virginia, legislation was passed in the 2012 session that will allow nurse practitioners to practice in separate locations from their

team physician, such as free clinics, community health centers, and nursing homes.[26] Minnesota policy-makers created a new certification level for Emergence Medical Technicians, called Community Paramedicine, which will allow these providers to render certain treatments to chronically ill individuals in their homes to avoid costly ambulance and emergency room (ER) services. Minnesota also became only the second state to certify the practice of Dental Therapists, who are mid-level practitioners working under the supervision of licensed dentists.[27]

Finally, we observed a few examples of what might be called "feeder" programs designed to orient students and young people to possible careers in primary care medicine. In Alabama, a state with large underserved rural areas, there are two small but interesting efforts. First, the Rural Health Scholars program offers summer school sessions for high school students featuring coursework on health careers in rural areas. Second, the Minority Rural Health Pipeline program targets undergraduate college students from underrepresented communities and provides academic financial assistance to these students as they complete their pre-med requirements.[28]

4. Improving efficiency, quality and access through health system reforms

Perhaps the most exciting set of strategies about which we learned were those designed to reform health delivery systems in ways that offer promise to improve access by enhancing the efficiency, coordination, and quality of service delivery.

In the private sector, we consistently heard of increasing consolidation among physician practices, with solo providers and small groups merging with larger groups. We also heard of the growing trend of hospital employment of physicians—with such arrangements established for up to 50 percent of all physicians in states like Oregon and Virginia.[29] For doctors, the explanation for this trend had more to do with a desire to "get out of the business side" of health care, avoid having to individually shoulder the burden of adopting electronic health records, benefit from hospitals' market strength in negotiating reimbursement rates, and seeing a "safer" and more stable future in the employ of hospitals. For hospitals, though, we learned that the aim was to become larger, with more primary care capacity to provide a steady base for referrals.

Beyond this, whether driven by the ACA or a more fundamental desire to become more integrated, hospitals described how greater primary care capacity would enable them to develop medical home capacity, use a mixture of physician and non-physician providers (like nurse practitioners, physician assistants, and care coordinators) to more efficiently provide care, and better compete in reforming health systems. These hospital

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providers, by virtue of their scale and large resources, were relatively better equipped (compared to physicians) to adopt such structural changes. Already integrated systems—like Kaiser Permanente and Denver Health in Colorado—told us how they are increasingly using telemedicine to serve rural and remote populations and text messaging as a tool for prevention, reminding patients to take their medicines, come in for physical exams, and keep their appointments. Providers in these systems even hold "e-visits" with their patients, meeting via Skype to discuss needs and progress when a face-to-face visit is either impossible or not required.[30] Similarly, the larger health systems in Virginia, such as Sentara and VCU, are developing telemedicine and transport services to compensate for provider shortages and increase their capacity to serve rural areas.[31]

In the public sector, we witnessed considerable activity in Medicaid programs, where statewide initiatives were playing out at the regional and local levels with the complementary goals of containing costs, improving quality, and increasing access to care. For example, two of our study states—Colorado and Oregon—are implementing Accountable Care Organization-type initiatives. In addition, Alabama is developing a patient centered medical home initiative, while Maryland is establishing a consumer-operated and oriented plan (CO-OP).

- Colorado's Accountable Care Collaboratives (ACCs). Launched in 2011, Colorado's ACCs represent a quasi-managed care model aligned with ACO principles. Seven Regional Care Collaborative organizations have been established across the state, each working with a team of Primary Care Medical Providers within their region, all supported

by a Statewide Data Repository that collects utilization and cost data and monitors quality. Each of these three entities receives a per-member, per-month (PMPM) payment from Medicaid, while providers also receive fee-for-service reimbursement tied to incentives for reducing ER visits, imaging, and hospital readmissions. The state will introduce gains-sharing and a hold-back next year, and hopes to introduce global payments to further promote efficiency and effectiveness in years to come.[32]

- Oregon's Coordinated Care Organizations (CCOs). In Oregon, health plans, hospitals, physician groups, and counties will merge at the regional level to form CCOs that share responsibility and risk for the full medical, dental, and behavioral health needs of patients. CCOs are being designed to work under global payment arrangements and will be held accountable for outcomes based on performance benchmarks. The state hopes that CCOs will alleviate the impact of sharp increases in Medicaid enrollment on primary care capacity by streamlining and improving the efficiency of the health care system. Implementation of the CCO model is slated for the end of 2012.[33]

- Alabama's Patient Care Networks (PCNs). Modeled after the PCN initiative in North Carolina, Alabama's PCN was launched in 2011 and is now present in three regions of the state. Networks of primary care physicians are supported by regional not-for-profit organizations that assist practices in becoming comprehensive medical homes, in providing care coordination and other supports to high-need patients, and in improving quality. Doctors receive enhanced PMPM coordination fees plus shared savings based on their performance. While a nascent initiative at this time, Alabama hopes to emulate the experience of North Carolina—where 95 percent of all primary care physicians in the state now participate in its Medicaid PCN—by expanding the program statewide by 2014.[34]

- Maryland's Consumer-Operated and Oriented Plan (CO-OP). The Evergreen Project in Maryland relies on medical homes, payment reform, and the use of evidence-based protocols to make insurance more affordable for working class families. At the foundation of the CO-OP are networks of salaried providers or "teamlets," made up of a primary care doctor, family nurse practitioner, care coordinator, health coach, mental health/substance abuse social worker, and local office staff person situated in storefronts in moderate-income neighborhoods. In addition, salaried high-volume specialists and contracted low-volume "Super Specialists" will be available at regional specialist centers. Although the CO-OP is currently only underway in Baltimore, officials hope to slowly expand the initiative statewide within the next five years.[35]

OUTLOOK FOR THE FUTURE

In summary, a broad range of health system stakeholders—across the 10 states and representing both private and public sector interests—agree that the success of health care reform will hinge on the degree to which health systems will be able to provide good access to quality care. Critically, these stakeholders also fear that these systems will be greatly challenged in being able to provide such access. Not surprisingly, we learned of no "silver bullets" to solve provider supply problems. ACA provisions to boost primary care reimbursement provide welcome, short-term relief, but do not seem designed to provide a long-term solution to provider participation shortfalls. Increased funding for the NHSC, coupled with state-level initiatives of similar design, hold promise to bolster the supply of primary care providers long-term, but will not address shortfalls in the immediate term after implementation of the ACA. FQHCs are certainly well positioned to absorb much of the demand for primary care of the newly insured, but are not plentiful enough to address all of it. Finally, new service delivery reforms in Medicaid and the private sector hold great promise to improve access through more coordinated use of resources—both physician and non-physician—to improve quality while controlling cost and, over time, even improve provider participation in Medicaid. But the promise of such initiatives will need time to be fully realized.

How well these various efforts come together to support strong access to care remains to be seen. But the level of focus, attention and activity surrounding access issues that we observed in the 10 study states is encouraging.

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ENDNOTES

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14. The law also provides a 10 percent reimbursement bonus to Medicare physicians who provide high volumes of primary care services; to qualify for this increased reimbursement, primary care services must account for 60 percent of a physician's charges. This provision, too, is limited in duration and is only effective through 2015.

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