

ACA Implementation—Monitoring and Tracking

**The Launch of the  
Affordable Care Act in Selected States:  
The Problem of Provider Capacity**

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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, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers 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. Cross-cutting reports and state-specific reports on case study states can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://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](http://www.rwjf.org/coverage).

## INTRODUCTION

This brief is one in a series examining what selected states are likely to accomplish in terms of expanding health insurance coverage, increasing transparency and competition in private insurance markets, providing consumer protections in the purchase of coverage, and addressing issues related to provider supply constraints. We compare eight states: five that have chosen to aggressively participate in all aspects of the Affordable Care Act (ACA)—Colorado, Maryland, Minnesota, New York, and Oregon—and three that have taken only a limited or no participation approach—Alabama, Michigan, and Virginia. This brief focuses on how states are addressing provider capacity issues in response to the anticipation of increased demand for health care services.

In this series of analyses, the study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides to states in-kind technical support to assist them with implementing the reform components each state has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. RWJF selected these states based on their governments' interest in exploring the options related to state involvement in ACA implementation. Some states pursued implementation aggressively, but in others varying degrees of political opposition to the law

prevented full involvement. The result is that the variation in state commitment to health reform among the RWJF states reflects the variation across the country.

Once again, five of the states have been actively pro-reform. Not only were these states quick to adopt the ACA, they also actively engaged stakeholders and invested in consumer outreach and education. They contracted with information technology vendors to develop eligibility and enrollment systems, though not all of them experienced a smooth rollout of their websites. Finally, these states have created State-Based Marketplaces (SBMs) and have adopted the Medicaid expansion.

In the other three states, at least in some quarters, there has been strong opposition to ACA implementation. Because of their current circumstances (e.g., lower rates of employer-sponsored coverage and higher uninsurance rates), they have more to gain from health reform than do the other five states. All three rely on the federal government to develop and run their Marketplaces, known as Federally Facilitated Marketplaces (FFMs), although Michigan and Virginia have taken on the Marketplace responsibilities associated with plan management. Two of the three—Alabama and Virginia—have not adopted the Medicaid expansion.

# THE PROBLEM OF ACCESS TO CARE

Much of the success of the ACA will ultimately hinge on issues surrounding access to care. The potential for millions of Americans to gain new coverage—through either expanded Medicaid or federal and state health insurance Marketplaces—will likely strain the capacity of some provider systems. How much they are strained depends on the extent of the coverage expansion, which depends, in part, on the current uninsurance rate, whether a state adopts the Medicaid expansion, and existing capacity. Critical questions surround the extent to which existing capacity will be able to respond—not only for primary care but also for specialty and behavioral health care.

Interestingly, however, there is considerable disagreement on the extent of the problem. The common belief is that there are simply not enough providers nationwide to serve the population; for example, the *Annals of Family Medicine* recently projected a need for 52,000 primary care physicians by 2025.<sup>1</sup> However, most studies focus solely on doctors and not on other types of primary care providers, such as nurse practitioners and physician assistants, who make up one-quarter of the primary care workforce.<sup>2</sup> One recent synthesis of the literature suggests that the number of providers may be adequate, but that it is the manner in which they are deployed that is insufficient. In other words, 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.<sup>3</sup> David Auerbach and colleagues recently published research showing that the expansion of primary care medical homes and nurse-managed health centers could dramatically reduce the shortage of primary care physicians.<sup>4</sup>

Debates on sufficiency aside, most agree that the current provider supply is poorly distributed: shortages are more prevalent in rural and frontier areas, and in low-income and minority communities, than in urban and suburban areas.<sup>5</sup> All states find these distribution problems increasingly difficult to address.

The ACA focused considerable attention on primary care, emphasizing that it should be supported and strengthened in America's reformed health care systems. Several provisions in the law were designed to promote primary care and expand the workforce. Some focused on payments to providers in Medicaid; others increased funding to safety-net providers that traditionally serve low-income individuals and families, and expanded support for a broad range of workforce development initiatives for health professionals; and, finally, many ACA provisions promoted reforms in the way health services are delivered, supporting innovations that improve the efficient and effective delivery of primary and preventive care.

The following sections describe how the eight states are responding to these ACA provisions and working to bolster the capacity of their provider systems. It is important to note that while provider capacity is an issue everywhere, in some of the study states with strong opposition to the ACA, these issues are less of a concern because there has been no Medicaid expansion, and outreach and application assistance are underfunded. As such, these states will likely see a smaller growth in enrollment and less pressure on the provider system.<sup>6</sup> Nonetheless, in all states we find examples of efforts to expand provider capacity.

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## MEDICAID PRIMARY CARE FEE INCREASE

The ACA requires states to increase Medicaid payments for certain primary care procedures—rendered by family and general practitioners, pediatricians, and other subspecialists who provide primary care—to 100 percent of Medicare rates. This is not insignificant. On average, Medicaid primary care fees will increase by 73 percent over 2012 levels (although the magnitude of the increase varies considerably by state).<sup>7,8</sup> However, this rate hike—paid for entirely with federal dollars—lasts only for the two-year period of 2013 through 2014.<sup>9</sup>

Because the rate hike is temporary, stakeholders were not optimistic that it would improve provider participation in Medicaid. What's more, state officials were not confident that they would be able to afford to keep the increases in place beyond 2014.<sup>10</sup> This dire picture only worsened over the past year. Federal rules on this provision were not released until November 2012,<sup>11</sup> making it difficult for states to comply with the January 2013 start date. Indeed, by May, only three states, including Michigan, had implemented the pay raise.<sup>12</sup> Reasons for further delays included the complexity of

**Table 1: Average Primary Care Fee Increase, by State, 2013–14**

State	Average Primary Care Fee Increase
<b>United States</b>	<b>73%</b>
<b>SBM Study States</b>	
Colorado	32%
Maryland	45%
Minnesota	36%
New York <sup>13</sup>	156%
Oregon	39%
<b>FFM Study States</b>	
Alabama	47%
Michigan	125%
Virginia	36%

*Source: Zuckerman, Stephen, and Dana Goin. 2012. How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Washington, DC: The Urban Institute.*

figuring out how to pass fee increases through to primary care providers operating under prepaid managed-care arrangements.<sup>14</sup> Nearly all states—including all of our study states—had finally implemented the increase by September 2013, and most committed to paying providers the higher rates retroactive to January 2013.<sup>15</sup> As illustrated in Table 1, average primary care fee increases for 2013 ranged from a low of 32 percent in

Colorado to a high of 156 percent in New York (due to an independent increase in Medicaid rates subsequent to the survey, it is not clear how much of the increase can be attributed to the ACA). Despite the skepticism, these rate increases are substantial, and states could face political pressures from physicians and hospitals to sustain them, in which case they could markedly affect capacity.

## EXPANSION OF COMMUNITY HEALTH CENTERS

The ACA provides \$11 billion for Federally Qualified Health Centers (FQHCs) over the five-year period from 2011 to 2015,<sup>16,17</sup> with the goal of helping these providers roughly double the number of patients they can serve by 2015. This significant increase builds on the previous decade that also saw federal funding for FQHCs grow, from \$1.2 billion in FY 2001 to \$2.2 billion in FY 2010.<sup>18</sup>

Across the board, stakeholders viewed the ACA as a clear “win” for FQHCs, and many saw health centers well-positioned to play a key role in meeting some of the new demand for primary care expected after ACA implementation.<sup>19</sup> Many community health centers are expected to double their capacity in the coming years due to both increased federal funding and the entry

of a high proportion of their currently uninsured clients into Medicaid, which will bring a valuable revenue source to support operations. Colorado, for example, expects its health centers to double their capacity in the coming years, not only because of increases in federal grants but also because 40 percent of their clients, who were previously uninsured, would likely qualify for expanded Medicaid. Other reasons for optimism, beyond increased funding, include the fact that FQHCs already broadly participate in Medicaid managed-care networks, receive advantageous cost-related prospective payment under Medicaid, and represent strong examples of primary care “medical homes.” But advocates point out that more than 20 million people will remain uninsured after full ACA implementation, and FQHCs will need to continue to serve these individuals.

# EXPANDING PRIMARY CARE WORKFORCE

The ACA also addresses primary care workforce supply challenges by increasing funding for the National Health Service Corps (NHSC) by \$1.5 billion over five years, with the goal of assisting an additional 15,000 primary care providers (both physician and nonphysician) by 2015 with medical school loan repayments in return for providers' commitments to practice in underserved areas.<sup>20</sup> Moreover, the law included funding for a variety of workforce training and development initiatives for doctors, nurses, and other health professionals. Many observers argue, however, that resistance at the state level to liberalizing scope-of-practice laws will limit the expansion of primary care capacity.<sup>21</sup>

All of our states bolster the NHSC by funding medical school loan repayment programs that reflect the federal program. Colorado's example is noteworthy because of its size—it has provided \$14 million in support of loan repayment for 200 health professionals over a five-year period, matching the size of the federally funded program—and for its funding base, which is largely from philanthropic donations.<sup>22</sup> *Doctors Across New York* is another state-funded program that is providing \$1.7 million in 2012–13 to support loan repayment, and another \$4.3 million to provide smaller grants to doctors who commit to serving for two years in underserved areas.<sup>23</sup>

In the study states, there was not an abundance of activity aimed at expanding nonphysician providers' scope-of-practice; efforts to do so were typically stymied

by the medical professions, according to stakeholders. Still, Minnesota officials created for emergency medical technicians a new certification level called Community Paramedicine, which allows these providers to render certain treatments to chronically ill individuals in their homes to avoid costly ambulance and emergency room services. The state also became only the second in the nation to certify the practice of Dental Therapists, who are mid-level practitioners working under the supervision of licensed dentists.<sup>24</sup>

In 2012 Virginia policy-makers passed legislation that will allow nurse practitioners to practice in separate locations from their team physicians, such as in free clinics, community health centers, and nursing homes.<sup>25</sup> In Alabama, there were interesting “feeder” programs designed to orient students and young people to possible careers in primary care medicine. For example, the Rural Health Scholars program offers high school students summer school sessions featuring coursework on health careers in rural areas. And the Minority Rural Health Pipeline program targets undergraduate college students from underrepresented communities and provides them with academic financial assistance as they complete their pre-med requirements.<sup>26</sup> Another source of primary care capacity, at least for convenient low-intensity care, are retail clinics. There are now more than 1,200 retail clinics throughout the nation and outcomes are generally positive, though their efficiency depends on scope-of-practice regulations or the activities of nurse practitioners.<sup>27</sup>

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## DELIVERY SYSTEM REFORMS

Numerous provisions in the ACA provide grants and incentives for reforming health delivery systems in ways that promise to improve access by enhancing the efficiency, coordination, and quality of service delivery, including such strategies as Accountable Care Organizations (ACOs), Collaborative Care Networks, and Patient-Centered Medical Homes.

In the private sector, important developments include increased consolidation among physician practices and the growth of hospital employment of physicians. In several states (e.g., Oregon and Virginia), up to 50 percent of all physicians in the state are employed by hospitals. For doctors, this is often explained by a desire

to “get out of the business side” of health care, avoid having to 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, the goal was to become larger, with more primary care capacity to provide a steady base for referrals. Although hospital officials often did not attribute this directly to the ACA, they described their desire to become more integrated and saw how greater primary care capacity would enable them to develop medical home capacity, use a mixture of physician and nonphysician providers to render care more efficiently, and better compete in reformed health systems. Increasingly, integrated health systems—like Denver Health and Kaiser Permanente in Colorado—are using

telemedicine to serve rural and remote populations. Providers in these systems even hold e-visits with their patients via Skype when face-to-face visits are either impossible or unnecessary.<sup>28</sup> In Minnesota, such systems as the Mayo Clinic, Avera, and Accenture Health are engaged in tele-ICU, tele-dermatology, and even tele-psychiatry to expand access. In Virginia, for example, large health systems like Sentara and VCU are developing telemedicine and transport services to compensate for provider shortages and to increase their capacity to serve rural areas.<sup>29</sup>

At the same time, insurance providers and managed care companies are incentivizing the adoption of medical homes through increased payments. For instance, in Maryland, CareFirst—the Blue Cross Blue Shield (BCBS) Patient-Centered Medical Home initiative—offers provider groups strong incentives to reduce hospital use and has shown promising results, according to recent BCBS analysis. Indeed, they estimate cost savings of 2.7 percent of total projected 2012 health care costs for its 1 million members (totaling \$98 million) and increased reimbursements for 66 percent of participating primary care panels.<sup>30</sup>

In the public sector, several states saw significant system reforms in the form of Accountable Care Organization-type initiatives under Medicaid, each designed to achieve the complementary goals of containing costs, improving quality, and increasing access to care.

- In Oregon, Coordinated Care Organizations (CCOs) represent regional mergers of health plans, hospitals, physician groups, and county health departments that share responsibility and risk (under global payments) for the full medical, dental, and behavioral health needs of patients. Fifteen CCOs have taken shape since August 2013. Ninety percent of Oregon Health Plan members are enrolled, and early evidence suggests that the model is slowing the growth of spending, decreasing emergency department use, decreasing rates of hospitalizations for chronic conditions, and decreasing hospital readmissions, all while increasing use of primary care.<sup>31</sup>
- Colorado's Accountable Care Collaboratives (ACCs) also embrace system coordination at the regional level for Medicaid—seven Regional Care Collaborative organizations have been formed across the state, each working with a team of Primary Care Medical Providers and all supported by a Statewide Data Repository that collects utilization and costs data and monitors quality. Each of these three entities receives a per-

member, per-month payment from Medicaid, while providers also receive fee-for-service reimbursement tied to incentives for reducing emergency department visits, imaging, and hospital readmissions. So far, the program has enrolled over one-third of the state's Medicaid enrollees into ACCs.<sup>32</sup> While the state has slowly transitioned to global payments in one of the regions, and plans to expand global payments and introduce gain-sharing in the future, the program already appears to be saving money—\$20 million in 2012, its first year of operation.<sup>33</sup>

- In Minnesota, the federal State Innovation Model (SIM) demonstration is supporting the formation of six Medicaid ACOs—many relying heavily on safety-net providers—that will serve about 100,000 of the state's Medicaid enrollees.<sup>34</sup>
- New York also received a SIM Pre-Testing State Grant for \$1 million. The funding will help further develop the Health Care Innovation Plan, which includes support for care transitions, community-based care management, ACOs, regional quality improvement collaboratives, and health information technology improvements.<sup>35</sup>
- Michigan received a Model Design SIM Grant for \$1.7 million to support patient- and family-centered health homes, coordination and accountability in medical neighborhoods, care bridges from behavioral health and long-term care, and the integration of health care and community resources.

Significant system reforms also taking place in the public sector are occurring in the form of enhanced Patient-Centered Medical Home Models. Alabama's Patient Care Networks were launched in 2011 and now operate in four 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 per-member, per-month payment coordination fees, plus shared savings based on their performance. Legislation passed in 2013, based on recommendations of a multistakeholder Medicaid Advisory Commission, aims to expand this model statewide and transition it to a risk-bearing Regional Care Organizations (RCOs) model that will manage the full continuum of health care services for Medicaid beneficiaries under a single capitated rate.<sup>36</sup> In Virginia, private-sector efforts are driving delivery system reform. For instance, Cigna—a large health plan in the state—is sponsoring medical home initiatives in several counties.

# CONCLUSION

There is considerable agreement that health care reform's success will significantly hinge on whether systems will be able to provide good access to high quality care, and there is considerable fear that these systems will be greatly challenged in their ability to provide such access. States are basically in three kinds of situations. Some, such as Minnesota and New York, will have a relatively small coverage expansion under the ACA because of low uninsurance rates today and, thus, access problems will not dramatically increase. Others, such as Alabama and Virginia, will not have large coverage expansions because they are not expanding Medicaid coverage; these states will also not

see a significant worsening of access issues. However, the final set of states, such as Colorado and Oregon, will see major coverage expansions, and provider capacity issues could become very real. All states face issues with distribution of medical resources, which are often limited in geographic areas where coverage expansions are greatest. Between the Medicaid fee increase, hospitals employing more physicians, expanding primary care capacity and telemedicine capabilities, and growing community health center capacity and delivery system reforms that can lead to more efficient use of existing personnel, there are more reasons to believe access gaps can be addressed.

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