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Primary Care Provider Capacity and the Medicaid Expansion

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The Affordable Care Act (ACA) aims to provide health insurance coverage to 33 million currently uninsured individuals starting in 2014, including up to 17 million new Medicaid beneficiaries.[1] Bringing so many new individuals into coverage represents an extraordinary opportunity to improve access to care, enhance preventive medicine, and take steps towards building a healthier population and a more affordable healthcare system. However, coverage only helps if beneficiaries can access a provider when they need one. In the coming years, normal population growth, significant demographic aging, and to a much lesser extent the ACA coverage expansions will increase demand for primary care services.[2] Provider capacity will have to grow accordingly. The ACA anticipated this concern and included provisions that, coupled with other recent developments in the field, address short and long term needs in primary care provider training and Medicaid participation, especially for medically underserved communities.[3]

Consequently, capacity ***is already increasing*** in anticipation of the 2014 health coverage expansions. Some key developments include:

- **Building primary care supply for medically underserved communities.** The ACA appropriated $12.5 billion to expand capacity at Federally Qualified Health Centers (FQHCs), related community health centers and the National Health Service Corps (NHSC).[4] Additional appropriations will help train new primary care providers.

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[1] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, at 12 (March 2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[2] One study estimates that population growth will account for 64% of anticipated primary care provider shortages by 2025, aging another 19%, and Medicaid and Exchange coverage expansions only 16%. Stephen M. Petterson et al., *Projecting US Primary Care Physician Workforce Needs: 2010-2025*, 10 Annals of Fam. Med. 503, at 507 (Dec. 2012).

[3] The term "medically underserved communities" refers to regions and populations officially designated as Health Professional Shortage Areas (HPSA), Medically Underserved Populations (MUP), or Medically Underserved Areas (MUA). *See Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, Health Resources and Services Administration, http://www.hrsa.gov/shortage/.

[4] 42 U.S.C. § 254b-2 (added by ACA § 10503).

- **Boosting Medicaid primary care payments.** Through the end of 2014, the ACA boosts Medicaid primary care rates to Medicare levels to increase the financial incentive to participate.[5]

- **Increasing efficiency**. The ACA includes measures to promote care coordination that build upon changes in the field such as adoption of electronic health records, the shift away from solo practice and the expanding role of nurses, nurse practitioners, physician's assistants, and dental hygienists.[6]

While primary care provider capacity concerns apply across the health system, this brief focuses on Medicaid, where access to primary care is an ongoing concern.[7] Although full-year Medicaid beneficiaries overall report no more difficulties accessing care than privately insured people, they are more likely to delay care due to lack of transportation, long wait times at providers, and difficulties making timely appointments.[8] Medicaid beneficiaries who do not have a regular primary care provider have more trouble obtaining timely follow-up care.[9] Without the ACA's capacity enhancing provisions, the impact of any general capacity shortage would likely be magnified in Medicaid, especially for beneficiaries in rural or otherwise underserved communities where undersupply is most severe.

In the media din surrounding states' decisions to accept or reject funds for Medicaid expansion, the ACA's provisions to boost primary care capacity have registered barely a whisper. Yet if Congress fully funded health center expansions and training programs for new primary care providers, these ACA measures, together with ongoing developments in the field, would go a long way toward realizing the goal of comprehensive and accessible primary care health care for low-income individuals.

Building Primary Care Supply for Medically Underserved Communities

Robust primary care is the cornerstone of an efficient and effective health care system based on prevention, chronic disease management, and coordinated care. To this end, the ACA appropriated $9.5 billion to supplement operations at FQHCs, rural health clinics and

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[5] 42 U.S.C. § 1396a(a)(13), (jj). The ACA also provides separate 10% bonus payments for certain Medicare primary care services from 2011 to 2015. 42 U.S.C. § 1395l(x) (added by ACA § 5501(a)). However, this will not impact Medicaid primary care services reimbursement since it does not increase the Medicare fee schedule or factor into the Medicaid primary care boost.

[6] The Health Information Technology Economic and Clinical Health (HITECH) Act funds providers to adopt and implement EHRs. Pub. L. No. 111-5, §§ 4101-4104, 4201, 123 Stat. 467-494 (2009).

[7] Gov't Accountability Office, *States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, at 19 (Nov. 2012), http://www.gao.gov/assets/650/649788.pdf. Although beyond this brief's scope, Medicaid beneficiaries' access to specialist services is an ongoing concern. Several studies suggest that Medicaid beneficiaries have more difficulty scheduling specialist appointments than privately insured individuals. *See* Johanna Bisgaier and Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 New Engl. J. Med., 2324 (June 2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[8] Gov't Accountability Office, *supra* note 7, at 26. Working-age adults in Medicaid (including people with disabilities) reported more difficulty obtaining care than comparable privately insured individuals.

[9] Brent R. Asplin et al., *Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments*, 294 JAMA 1248, (Sept. 2005).

related community health centers and an additional $1.5 billion to expand capacity. This funding has already increased capacity from 18.8 million patients in 2009 to 22.3 million patients in 2012.[10] Even with only the funding already appropriated by the ACA, FQHC expansion promises to accommodate 16.7 million additional insured patients by 2019, including over 9 million new Medicaid patients.[11] That alone accounts for ***more than half*** the expected 33 million newly insured individuals from ACA coverage expansions. Funding FQHCs up to ACA-authorized levels could increase their capacity by over 31 million new patients annually.[12]

The ACA also appropriated $1.5 billion to expand the NHSC, a program that offers scholarships and loan repayment plans to primary care providers who work in medically underserved communities. In the last four years, the NHSC has ***tripled*** participation, with over 10,000 NHSC health professionals serving 10.4 million patients annually by early 2013.[13] These providers are seven times more likely to stay in primary care even after meeting their service requirements.[14]

Most critically, the FQHC and NHSC expansions focus on improving capacity in low-income and medically underserved communities with documented access issues. Because community health centers offer more inexpensive coordinated care than other delivery systems, bolstering these safety net providers is a sound investment.[15]

To increase provider supply over the longer term, several ACA programs address structural imbalances and increase the number of providers training for primary care careers. For example, ACA funding supports residency programs at 22 Teaching Health

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[10] Press Release, Nat'l Ass'n of Comty. Health Ctrs., *New: Community Health Centers Now Serve over 22 Million People* (Jan. 17, 2013), http://www.nachc.com/pressrelease-detail.cfm?pressreleaseID=795. For the 2009 figure of 18.8 million, *see 2009 National Total Summary Data*, Health Resources and Services Administration, http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/2009/2009nattotsumdata.html.

[11] Leighton Ku et al., George Washington Univ. – Geiger Gibson/RCHN Comty. Health Found. Research Collaborative, *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers through Health Reform, at 7* (2010), http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_895A7FC0-5056-9D20-3DDB8A6567031078.pdf.

[12] *Id.*, at 7. Eight-eight percent of the added capacity will be attributable to new patients with insurance. The ACA authorized up to $34 billion in discretionary funding through 2015 in addition to the $11 billion mandatory appropriation. 42 U.S.C. § 254b(r) (added by ACA § 5601(a)).

[13] Figures based on 2012 NHSC awards. *See National Health Service Corps,* Health Resources and Services Admin., http://www.hrsa.gov/about/organization/bureaus/bcrs/nhscoverview.html.

[14] Robert L. Phillips, Jr. et al., The Robert Graham Center, *Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?*, at 22 (2009), http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2009/rgcmo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf.

[15] Care provided to community health center users is nearly 25% cheaper per capita than care using other delivery systems. Leighton Ku et al., George Washington Univ. – Geiger Gibson/RCHN Comty. Health Foundation Research Collaborative, *Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs*, at 7 (2010), http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_61D685D5-5056-9D20-3DDB6CDE10382393.pdf.

Centers, aimed at training new primary care physicians and dentists in community-based ambulatory care settings.[16] The ACA also appropriated $200 million to train more advanced practice nurses, $200 million to expand school-based health centers and $425 million for health workforce demonstration projects, including the Health Profession Opportunity Grant program that helps low-income individuals train for high demand healthcare careers.[17] Several other ACA-authorized initiatives for new loan repayment programs, additional provider training, and a National Health Care Workforce Commission remain mired in the appropriations process. Meanwhile, states and the private market may pick up some of the slack. Oregon, New Mexico and Colorado offer medical school loan forgiveness programs similar to NHSC.[18] In Connecticut, Quinnipiac University just opened a $100 million medical school designed to promote training primary care physicians.[19]

Boosting Medicaid Primary Care Payments

Healthcare providers who participate in the Medicaid program must take Medicaid payment as payment in full.[20] States typically set Medicaid provider payment rates below – sometimes substantially below – comparable Medicare or private insurance rates, and this discourages provider participation. In tight budget times, states often resort to additional rate cuts, exacerbating the rate disparity and further reducing providers' willingness to take Medicaid.

Increasing provider payment rates can help improve provider participation. The ACA temporarily raised Medicaid payment rates to Medicare levels for primary care services provided by physicians specializing in family, internal or pediatric medicine effective.[21] The resulting rate increase can be significant. It triples Rhode Island's primary care rates and doubles rates in states like California, Florida, New Jersey and Michigan.[22]

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[16] 42 U.S.C. § 256h(g) (added by ACA § 5508). This provision appropriates $230 million over five years to fund operations at these new residency programs. *See* Candice Chen et al., *Teaching Health Centers: A New Paradigm in Graduate Medical Education*, 87 Acad. Med. 1752 (2012), http://journals.lww.com/academicmedicine/Fulltext/2012/12000/Teaching_Health_Centers___A_New_Paradigm_in.28.aspx. For a list of active grants, *see Teaching Health Center Graduate Medical Education*, Health Resources and Services Administration, http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html.

[17] 42 U.S.C. § 1395ww note (added by ACA § 5509, Advanced Nursing). 42 U.S.C. § 280h–4 (added by ACA § 4101(a), school-based health centers). 42 U.S.C. § 1397g (added by ACA § 5507, Health Workforce Demonstrations).

[18] Ian Hill, Urban Institute, *Cross-Cutting Issues: Will There Be Enough Providers to Meet the Need? Provider Capacity and the ACA*, at 5 (2012), http://www.urban.org/UploadedPDF/412699-Will-There-Be-Enough-Providers-to-Meet-the-Need.pdf.

[19] Jeffrey Cohen, *New Medical School Wants to Build Ranks of Primary Care Doctors* Nat'l Public Radio, (April 2, 2013), http://www.npr.org/blogs/health/2013/04/02/175945921/new-medical-school-wants-to-build-ranks-of-primary-care-doctors.

[20] 42 C.F.R. § 447.15. The Medicaid program does allow limited cost sharing based on standards at 42 U.S.C. §§ 1396o, 1396o-1.

[21] 42 U.S.C. § 1396a(a)(13)(C) (added by ACA § 1202(a)). The PCP boost is not available for services provided by FQHCs or rural health clinics, which are paid under a different reimbursement system.

[22] *Medicaid-to-Medicare Fee Index,* Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/. At this writing, all states have submitted applications to

Unfortunately, the primary care payment boost alone will not solve Medicaid capacity problems. One study estimates an 11% bump in provider participation, with considerable state-to-state variation.[23] Furthermore, many states facing the largest provider shortages already pay Medicaid providers near or above Medicare rates and consequently will see little benefit.[24] Finally, Congress limited the primary care payment boost to calendar years 2013 and 2014, which may discourage provider uptake. Many hope Congress will extend the increase, as it has repeatedly done for scheduled Medicare physician rate cuts, but absent legislation the boost will sunset after 2014.[25]

Increasing Efficiency: An Alternative to Adding Providers

In addition to increasing supply, reducing per capita demand for services and increasing provider productivity can accomplish the same goal of getting people access to care when and where they need it.

Per capita demand is dynamic. When Kaiser Permanente instituted an EHR system for its 225,000 customers in Hawaii, it found a 25% ***decrease*** in primary care office visits over four years, with a corresponding increase in more cost- and time-efficient telephone and email consultations.[26] The Health Information Technology Economic and Clinical Health (HITECH) Act includes strong financial incentives to help providers implement interoperable EHR systems.[27] To date, CMS has paid out $12.7 billion to hospitals and individual Medicaid and Medicare providers to install and improve EHR data systems.[28]

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implement the payment boost, which will apply retroactive to January 1, 2013 upon CMS approval. *See* Phil Galewitz, *Most Doctors Still Waiting on Medicaid Pay Raise*, Kaiser Health News, http://capsules.kaiserhealthnews.org/index.php/2013/05/most-doctors-still-waiting-on-medicaid-pay-raise/ (May 14, 2013).

[23] Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 Health Affairs 1673, 1676 (2012).

[24] This applies to many states in the South and interior West. Peter J. Cunningham, Ctr. for Studying Health Sys. Change, *State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions* (2011), http://www.hschange.com/CONTENT/1192.

[25] Since 1997, Congress has enacted temporary fixes to delay Medicare provider cuts due to the Sustainable Growth Rate (SGR) index. 42 U.S.C. § 1395w-4(f).

[26] Chen, Catherine et al. *The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care*, 28 Health Affairs 322 (2009), http://content.healthaffairs.org/content/28/2/323.full.html.

[27] Pub. L. No. 111-5, §§ 4101-4104, 4201, 123 Stat. 467-494 (2009). For more information on health IT and HITECH incentive payments, *see* Deborah Reid, National Health Law Program, *Q & A: What Advocates Should Know About Health Information Technology and Electronic Health Records* (June 24, 2013), http://www.healthlaw.org/images/stories/2013_06_QA_HIT_EHR_final.pdf.

[28] Ctrs. For Medicare & Medicaid Services (CMS), *EHR Payment and Registration Summary Report*, at 4 (February 2013), http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Feb_EHRIncentiveProgramsPaymentsReg_SummaryReport.pdf. States can get 100% federal match for programs that incentivize Medicaid providers to implement or enhance EHR and a 90% federal match for related administrative expenses. CMS, *Dear State Medicaid Director* (Aug. 17, 2010), http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf (outlining federal funding for Medicaid health information technology activities).

Effective care coordination is another innovation that, while not directly related to provider capacity, should increase efficiency. The ACA promotes care coordination through delivery models like patient-centered medical homes. One aspect of care coordination aims to prevent wasteful duplication of services. Another potential improvement arises from the efficient delegation of tasks such that nurse practitioners (NPs), physician assistants (PAs) and registered nurses (RNs) consistently work "at the top of their license," leaving physicians more time to focus on complicated cases.[29]

Finally, broader changes in employment structure – namely physicians' shift away from solo practice towards small groups with pooled administration – may also boost physician productivity and flexibility in scheduling. This shift, while independent of the ACA, will likely decrease wait times for appointments. A 2013 *Health Affairs* study found that changes in office structure, record keeping and team-oriented care could effectively eliminate the projected nationwide primary care shortfall while maintaining timely access to care for patients simply by increasing productivity.[30]

Implications for Medicaid

As states consider whether to accept federal funds to expand Medicaid, some opponents argue that current provider capacity cannot handle more beneficiaries. They maintain that expanding Medicaid coverage would require a too expensive boost in Medicaid provider rates to attain adequate provider participation. This argument has several flaws. First, raising provider rates is only one of many possible strategies for increasing primary care access. For example, expanding the community health center network builds capacity while containing or even reducing service costs.[31] Second, although it varies across states, population growth and aging account for 83% of the projected increase in primary care demand.[32] Thus, states will need to increase Medicaid primary care capacity regardless of whether they expand Medicaid enrollment. Third, the alternative – rejecting federal funds for expanding Medicaid enrollment – simply maintains the status quo of high uncompensated care costs, delayed care, and ever larger gaps in the healthcare safety net as millions remain uninsured. One final possibility – covering low-income adults through the private insurance market with Medicaid funds – is considerably *more*

[29] Currently 18 states allow NPs to diagnose, treat and prescribe medicine independently. *See* Amanda Cassidy, *Health Policy Brief: Nurse Practitioners and Primary Care*, Health Affairs (Oct. 25, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402293. Other groups are working to ensure Medicaid and Medicare recognize NPs as primary care providers. *See* Tracy Yee et al., Nat'l Inst. for Health Care Reform, *Research Brief #13: Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies* (Feb. 2013), http://www.nihcr.org/PCP-Workforce-NPs.

[30] Projected national shortfalls would disappear if physicians worked in groups of three and 20% of primary care visits get diverted to telephone, email or lower level healthcare professionals. Linda V. Green et al., *Primary Care Physician Shortages Could Be Eliminated through Use of Teams, Nonphysicians, and Electronic Communication*, 32 Health Affairs 11, 16 (Jan. 2013).

[31] Leighton Ku, *supra* note 15, at 7.

[32] Stephen M. Petterson et al., *supra* note 2, at 507.

expensive than standard Medicaid.[33] Both administrative costs and provider rates in Medicaid are almost always substantially lower than comparable private coverage and would remain so even if a state boosted its Medicaid provider rates.[34] Clearly, the more reasonable approach would expand Medicaid coverage using multiple strategies to address provider capacity, such as adequately funding primary care and safety net providers, training more primary care providers and expanding loan assistance programs like NHSC.

Conclusion

The ACA prioritized expanding primary care capacity to build a health system – including Medicaid – that promotes accessibility, care coordination and preventive health care. Payment boosts for primary care, capacity building at community health centers, expansions in the National Health Service Corps and shifts towards more efficient care delivery models are already contributing towards expanding primary care capacity for the regions and populations that need better access. While these ACA provisions alone will not address all the capacity concerns on the horizon, other measures to train more primary care providers await Congressional appropriations. Outside the ACA, additional changes in the structure of care delivery, such as the use of EHRs, physician pooling and team-based care promise to increase the productivity of primary care providers over the longer term. In short, the ACA takes important steps to expand access and creates a policy structure to do even more.

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[33] The CBO projects that covering beneficiaries in private health plans through Exchanges will cost 50% more than Medicaid. Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, at 4 (July 24, 2012), http://www.cbo.gov/publication/43472.

[34] National Academy of Public Administration and the National Academy of Social Insurance, *Administrative Solutions in Health Reform*, at 45-47 (July 2009), http://www.napawash.org/wp-content/uploads/2009/09-14.pdf. Note also that ACA eligibility system reforms should lower per capita Medicaid administrative expenses. In most cases provider rates in private insurance substantially exceed Medicare rates, which are, in turn, usually higher than Medicaid. *See, e.g.*, Jeff Stensland and Cori E. Uccello, Am. Acad. of Actuaries, *The Relationship between Medicare and Private Insurance Provider Rates*, at 6 (Feb. 21, 2013), http://www.actuary.org/files/February_2013_Medicare_webinar_final_slides.pdf.