

Welcome. You're listening to a UC Davis Center for Poverty Research Conference podcast. I'm the Center's director, Ann Stevens. In November 2013, the center hosted the conference, The Affordable Care Act and Low Income Populations, Lessons from and Challenges for Research. The conference featured top health care experts from across the country to discuss the roll out of the Affordable Care Act and what the new system means for poverty in the United States.

In this presentation, Ian Hill discusses how health care providers will meet the new need created by the Affordable Care Act and how states are planning to cope with the higher demand for care. Hill is a research fellow with the Urban Institute.

>> Thank you very much. I wanna thank The Center for Poverty Research for having me here.

And I also wanna pause just to say that this is really one of the best meetings that I've been to in a long time. It's it's pretty easy to put together a mediocre meeting but it's really hard, and it takes a lot of thought and time to pull together a meeting, I think, where, where the agenda and the speakers and the topics knit together so nicely.

So kudos to Ann and the, the Center for, for this. and, and now that I've said that, I'll do my best to try to to keep the winning streak alive. I'm always happy to be in California. I grew up in LA. I, I'm a UC product as well, studied at Santa Barbara when it was the biggest party school in the system.

>> Folks were tired up in Grass Valley, my brother lives in the San Francisco, and I'll be visiting my daughter who's carrying on the tradition and studying down at Occidental College in, in LA this this year. But even though I'm out here all the time, I realized that I hadn't set foot in Davis for about 25 years.

And, it occurred to me, as I was dodging bicycles on the way, that, that it was when I last rode in the Davis Double Century in about 1990. That's still a big deal here in, in Davis? Yeah? So anyway, it's great, great to be here. And I'm happy to share some of our findings from a Robert Wood Johnson funded study where we're monitoring and evaluating the, the ACA implementation.

I think it's clear to say that once all the web around websites. And people in the individual market losing coverage and, you know, all this nonsense that sort of dominated the headlines in the last month. Once that stuff settles out, and once the enrollment picture starts to become clear, I think it's clear to say that one of the big challenges for the law will be around access to care.

And much of the success of the law, I think, will be judged based on whether or not folks can gain access to care and I think responses to reform by providers, public programs, and peers will all directly affect the access and coverage and, and ultimately sustainability. So my talk today will focus on this thorny issue of, of provider capacity in the ACA and the question of whether there are not, there will be enough providers to meet the new need.

I'm going to divide my talk into about five pieces. I'll give a little bit of an overview of our project. I'll then talk about the many challenges facing the states in terms of demand, new demand for care that's expected among the newly insured. And, in turn, the capacity of provider systems that exist now to respond to that demand.

I wanna review the ACA itself and talk about many of the provisions, the key provisions in the law that were designed to address provider supply and access issues. And then I'll spend the bulk of my time talking about how states are coping with, or at least planning to cope with, this surge in new demand.

And I'm gonna talk about increased reimbursement under Medicaid. I'm gonna talk about efforts to expand the capacity of federally qualified health centers and community health centers. I'll talk about efforts to enhance the primary care workforce and supply. And then I'll finish off by talking about a lot of really interesting activities going on that are consolidating, redesigning, and reforming health systems in an effort to meet complementary goals of lowering cost, improving quality, and improving access.

And then I'll just finish up with a few, few outlooks for the future. Just to tell you a little about this project, again it's funded by the Robert Wood Johnson Foundation. It's called the State Health Reform Assistance Network and it has three parts. Well, the, the, the project is really designed to support and foster successful implementation of the ACA.

So RWJ is a little more activist in, in this particular effort. There is a technical assistance component that's being provided to the states. There's a consumer engagement component that's really trying to raise awareness. And then, there's a pure research component that is looking at both the implementation and the impacts of the ACA.

And that's where we come in. We are leading most of the work in the monitoring and tracking portion of, of SHRAN, as they like to call it. The project involves both qualitative and quantitative research on implementation and impacts, respectively. And I'm helping to lead the qualitative team in our assessment of implementation.

So a lot of you presenting today who've been in, economists, I'm gonna be coming at it from the, the qualitative side of the, of the camp. We've already done in-depth case studies in ten focal states where we sent two teams out into the field simultaneously in each of our states.

We've conduct, used structured interview protocols to interview about 30, 35 key informants in each state. Medicaid officials, health exchange officials, providers, health plans consumer advocates, a broad swath of, of key informants. This paper's based on site visits that occurred in the late 2011, early 2012, which seems like a long time ago.

But we also did a series of phone calls phone interviews that update the information. You've heard me talk about our ten focal states. Here they are. And you can see that it does not include California, which is probably good because I'm sure all of you can tell me more about California than I can tell you.

But you will note that these represent kind of a skewed sample of states. Mostly, these are states that have embraced health care reform that have invested huge amounts of effort, like California, in planning for and implementing the ACA and really trying to get it off to a good start.

There are states that have set up their own state based marketplaces or, or exchanges. And they've expanded Medicaid, typically. So those, those seven states are New York and Mar, Maryland, Rhode Island, Minnesota, Colorado, New Mexico, and Oregon. But we do have in our sample some of the, the lagging states, if you want to call them that Michigan, which is going to rely on a partnership exchange where the federal government is mostly running their, their exchange.

And they've only just finally, recently decided to expand Medicaid. We've also got Alabama and Virginia, which are states that have shunned Obamacare and are not expanding Medicaid at least for the time being. So that's our study pool and everything I'm gonna talk about from this point, at least, as far as results go, are from those ten states.

So let's talk a little bit about the challenge and, and paint that picture. again, estimates are that upwards of 25 million folks will gain coverage under the ACA, either through Medicaid expansions or through subsidized coverage through health insurance marketplaces. The size of increases varies considerably across the states where states like New York, because of generous past Medicaid thresholds, are gonna, gonna see a relatively smaller percentage-wise increase in coverage.

Whereas, states like Alabama, at least in theory, if they go ahead and implement a Medicaid expansion, which I think they've, ultimately will, should expect huge increase because, for the opposite reason, because of their very, very poor history of coverage. Regardless of the variation though, most states that we talked to were very concerned about provider capacity and the ability to serve the newly insured.

And while the focus is maybe, mainly on primary care, there's also a lot of concern about specialty care and behavioral health and other gaps in the, in the, in capacity. I think it is pretty interesting to note that there's actually a lot of disagreement about the extent of the problem.

Most people, the common belief is that we just don't have enough providers. The Annals of Family Medicine

published their most recent number that they project a shortfall of 52,000 primary care docs by 2025. The Health, Health Resources and Services Administration says we need 16,000 more docs now. But most studies of, of, of supply focus on docs and not other members of the primary care workforce, like nurse practitioners and physician's assistants which make up about a quarter of the primary care workforce.

And the pace of growth in those professions is actually growth, faster than, than population growth. And Robert Johnson did a really nice synthesis of the literature that suggest that the sheer numbers of primary care providers may be sufficient. But it's the way we deploy those resources that is the problem, inefficiently and not taking full advantage of, of, of the range of skills.

That if we did a better job with existing resources, better practice models, coordination that we could meet the demand. regardless, everyone agree, agrees that the supply is maldistributed. That there are more providers in urban, suburban areas, lower numbers in rural and frontier areas, lower in communities with high ethnic minorities and low income populations.

Among our study states New Mexico is one where there were 32 out of 33 counties were health professional shortage areas in medically underserved areas. Al, in Alabama, 65 of 67 counties show some pretty, pretty severe needs,. Let me talk a little bit about the ACA. And I think it's fair to say that the law refocused very important renewed attention on the importance of primary care, that it is important to the health of the nation and that primary care should be bolstered in our emerging and reformed health care systems especially if we want to lower costs, and improve quality, expand access.

There were a huge number of provisions in the ACA, in that law that supposedly nobody read that that address primary care, systems of care, work force. And I picked out a few here that that, that I'll highlight. Some focus on payment and specifically the increase of Medicaid reimbursement for primary care procedures to 100% of Medicare rates that Dr. Katz mentioned that this morning.

Some of the provisions focus on money going to the safety net and in particular, an increase of funding of \$11 billion to federally qualified health centers over the course of five years. Some focus directly on work force and supply. There's increased funding for the national health service corps that forgives medical student loans if, if folks commit to serve in, serving in underserved areas 1.5 billion over five years with a goal of increasing supply by 15,000 suppliers by 2015.

And then many provisions that focus on this health system reform that I mentioned earlier. Incentives, grants, demonstrations for accountable care organizations, collaborative care networks, patient center, medical homes and the like. So, given this framework, what did we find in our ten states? When we spoke to key informants about the prospects for improving supply based on Medicaid reimbursement enhancements.

They were quick to point out that, that due to the great recession, we're coming from a base where rates have really been cut. Because of maintenance of effort rules around the eligibility states really didn't have much way of controlling their Medicaid budgets except by reimbursements. So we're already starting behind the eight ball.

Even in states like Maryland, which had passed laws to raise Medicaid rates to medicare levels. They hadn't been able to implement those because of the recession and, and budget pressures. To be sure, across the board states were excited and welcomed the 100% federal dollars to raise Medicaid rates for primary care.

These were not insignificant rates. Some work by my colleague Steve Zuckerman showed that Medicaid rates on average only about 66% of Medicare. And so, we're looking at rate increases of 50 to 70% in, in a lot of cases. But none of the informants we talked about were really optimistic that this temporary fee hike, especially because of its temporary nature, would have much effect on provider participation, much less supply.

None were really committed to carrying it on beyond 2014. Though, though some states were in in a wait and see mode. And the situation has only gotten worse, actually, since we did a lot of these interviews because of this excruciatingly slow implementation of the fee increase. The federal rules weren't released until November of 2012, one

month before it was supposed to take effect.

By June, I think, there were only five states that were actually paying the enhanced rate. According to what I've, the homework I did, it looks like just about everyone's paying it now with the possible exception of California. I'm not sure if you guys have done it yet mainly because of the huge cost implications of raising rates that much in such a large state.

So again, this was not much of a bright spur, spot in terms of meeting the challenge. When you turn to increasing funding for community health centers though the, the picture, I think, is, is quite a bit brighter. As many of you know, the last decade has been really good for FQHCs.

Strong federal, federal funding has been flowing in to the centers for about a decade. Annual federal funding grew from \$1.2 billion in 2001 to about \$2.2 billion in 2010, prior to the ACA. And then, as I mentioned, the ACA is gonna pump another 11 billion into centers, over the next five years roughly doubling their capacity, at least in theory.

Across the board, FQHC representatives that we spoke with, primary care associations, and other officials saw the ACA as a huge win And for, for this part of the div the provider system. And really thought that FQHCs were pretty well positioned to absorb at least a good portion of the load.

In states like Colorado health centers thought they we gonna be able to double their capacity cuz about 40% of their current clients were uninsured and were gonna be gaining coverage through Medicaid expansions. FQHCs typically participate broadly in Medicaid Managed Care networks So, again, they're plugged into the system.

They already enjoy advantageous reimbursement from Medicaid cost-based reimbursement. So, again, FQHS are, are in a good place and they represent a medical medical home model in many ways. And we talked to folks who are really working hard to further enhance the medical home model, specifically, by building care coordination capacity.

But you know the issue of mission and mission creep has come up a few times today, and I think that was something else we heard. Centers were excited that all these new revenue potential and excited at broadening and, and expanding. But they were also worried about, what about the 20 or 30 million who's, who will remain uninsured.

And, and can we, how do we make sure we don't abandon our, our traditional mission even as we grow? Expanding the primary care workforce gets us back into an area that was less, less promising. Didn't see an abundance of activity going on in the states but some interesting efforts in Michigan.

The governor appointed his department of community health to define a new strategic plan for work force development. We saw many programs, quite a few programs, where states mirror the national health service corps in Oregon Colorado, New Mexico, New York. to, to bolster the money, federal monies coming in to, again, forgive medical loans for students that serve in underserved areas.

Efforts to expand scope of practice of non-physician providers we're mostly being stymied by the medical professions. We heard a few promising things going on in, in Virginia where legislation was passed a year ago to expand the scope of nurse practitioners. In Minnesota where they created a new, new category of provider called community paramedics that give EMTs more flexibility to treat chronic illness in the home and avoid hospitalizations.

Minnesota was also certifying dental therapists to work under the supervision of a dentist and, and do more work at lower cost. I guess California had a number of initiatives like this that were looked like they were getting steam had a steam going but mostly got caught up in committee nurse practitioner bills and optometrist bills.

But I think the bill to expand the scope of pharmacists did, it passes. Does anybody know? And based on what Doctor Katz was saying, that could be really important in terms of expanding the amount of prescription authority they have and, and ability to give clinical guidance. So then, finally, I think some of the most interesting stuff we heard was about these health system reform efforts.

And again, the idea of improving access by making better use of existing resources. In the private sector, we heard over and over about the consolidation of physician practices that's going on from smaller to larger. We, there's a definite trend of hospital employment of physicians as many as 50% of all docs in states like Oregon and Virginia now are in, in the employ of, of, of hospitals.

Not always in responses to the ACA, but rather, docs kinda wanting to get out of the business of, of, of, pri, private practice. Not wanting to shoulder the burden of transitions to EA Chars all by themselves, seeing the more safe and stable future in the employ of hospitals.

We heard, generally about the aim of hospital systems to grow, t grow their primary care capacity to develop medical home capacity to use a better mix of physician and non-physician resources. And we heard about how systems that were already integrated, like Kaiser Permanente, like Denver Health and Hospitals, Rocky Mountain Health Plans.

We're doing a lot of really interesting stuff with telemedicine to serve populations in rural areas. Text messaging, as a tool for prevention, reminding folks about their meds, coming in for exams, and e-visits, where doctors would use internet technologies, like Skype, to conduct business at a lower cost. And then on the public sector side a lot of neat stuff going on, at least in our sample states with regard to Medicaid initiatives that essentially like what we, we heard of several ACO-type initiatives going on in Oregon and Colorado and Minnesota.

One of the things we talked about Oregon a lot today but I don't think we've talked about their coordinative care organizations or CCOs. Where health plans, hospitals, physicians and county governments, as well as community-based groups, are working together on a regional basis, dividing up the state into regions to set goals and plan for their community's health to take on the full responsibility for primary dental, behavioral needs of their patients working under payment and incentives to, to, to share savings.

Pretty exciting stuff. Colorado's version of that is called accountable care collaboratives. It's a quasi-managed care system. They've divided the, the state into seven regions where there are regional care collaborative organizations, again, similarly kind of organizing health systems. There's primary care providers who are receiving enhanced PMPMs to, to manage care.

And there's a statewide data repository that's being used to support measurement of, of, of quality. Minnesota's another state where there's lots of ACO and Medicaid ACOs going on. And then even down in Alabama, we saw some really interesting stuff going on with, with medical home initiatives. The patient care networks is a model they're putting together that's de, designed to emulate what's goin' on in North Carolina for years where, where primary care docs in a given region are supported by a non-profit organization that has care coordinators.

And makes the practice of, of primary care more coordinated and more organized. So that was, that was an interesting one. So, I guess in conclusion what we've learned is that, again, we know that the success of reform is gonna depend on, on access to care. But we still don't know really how it's gonna play out.

We did not come across any silver bullets, not surprisingly. Medicaid reimbursement didn't look too promising, work force expansion efforts didn't seem like they were gonna be necessarily enough, but they were important ingredients, pieces of the puzzle. FQHCs will be in a good position to, to absorb some of the load.

And maybe this reorganization of health systems, Dr. Katz started off by making the distinction between insurance and health care delivery and services. Maybe that's the place where we can really depend or hope that, that, that some of the solutions will, will lie. How it all will come together remains to be seen, but at least it was promising to see so much activity in the states that we visited So, thank you very much.

>> I'm Ann Stevens, the director of The Center for Poverty Research at UC Davis, and I want to thank you for listening. The Center is one of three federally designated poverty research centers in the United States. Our mission is to facilitate non-partisan academic research on domestic poverty, to disseminate this research and to train the next generation of poverty scholars.

Core funding comes from the US Department of Health and Human Services. For more information about the Center, visit us online at poverty.ucdavis.edu.