U.S. Health Reform—Monitoring and Impact

How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act?

November 2017

By Jane B. Wishner and Rachel A. Burton

Robert Wood Johnson Foundation

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

URBAN INSTITUTE

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 health reform. 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 to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

SUMMARY

Roughly 20 million previously uninsured people have gained health insurance since the enactment of the Affordable Care Act (ACA).[1] To understand how health care providers met the increased demand for services, researchers from the Urban Institute conducted interviews with health care stakeholders in five communities that saw some of the largest percent increases in the number of insured people after the ACA's coverage expansions took effect: Detroit, Michigan; Lexington, Kentucky; Sacramento, California; Spokane, Washington; and Morgantown and nearby northeastern counties in West Virginia (which we refer to collectively as West Virginia). All five communities were in states that expanded Medicaid.

These interviews showed that as the demand for health care services increased, providers responded by expanding their staff, including hiring more advanced practice clinicians (such as nurse practitioners) and care coordinators; opening new or expanding existing health care sites; and/or extending their office hours. The number of urgent care and retail clinics also grew. Telemedicine has not expanded substantially, but respondents said that other payment and delivery reforms increased efficiency and helped providers meet the increased demand.

Despite these changes, gaps in provider capacity persist. Respondents reported that health professional shortages that predated the ACA—including significant shortages of primary care professionals in some communities—were exacerbated by increased demand from newly insured patients. Respondents in all five communities reported that the most significant unmet health care needs were behavioral health services (especially treatment for opioid use disorder), adult dental services, and specialty services (which varied by community).

To increase capacity, providers relied on revenue—particularly Medicaid revenue—from newly insured patients, and many federally qualified health centers (FQHCs) received assistance through ACA-funded grants. But respondents expressed doubts about their ability to maintain infrastructure enhancements and adequate capacity to meet patients' needs if Medicaid funding is scaled back, as was proposed in several congressional efforts to repeal and replace the ACA in 2017 (and is likely to be proposed again). Respondents also identified persistent health care professional workforce shortages as a major ongoing challenge.

BACKGROUND

The ACA expanded Medicaid coverage to nonelderly adults with incomes up to 138 percent of the federal poverty level and provided income-based premium tax credits and cost-sharing reductions to individuals purchasing private health insurance in the new ACA marketplaces. In 2012, the Supreme Court issued a ruling that effectively made the Medicaid expansion optional for states.[2] As of September 2017, 31 states and the District of Columbia had adopted the Medicaid expansion.[3] Roughly 20 million previously uninsured people have gained health insurance coverage since the ACA was passed.[1,4]

To help health care providers handle the anticipated influx of newly insured patients, the ACA included several initiatives designed to increase provider capacity.[5] The ACA included $11 billion to expand the capacity of community health centers, which primarily serve low-income patients and charge fees on a sliding scale based on patients' ability to pay.[6] These ACA funds were available to support ongoing operations; set up new care delivery sites; renovate existing sites; and expand the provision of preventive, behavioral health, and oral health services.[7] The ACA also included initiatives to train and attract new primary care providers to underserved areas of the country (e.g., through scholarships and loan repayment programs)[8] and provided temporary increases to Medicaid and Medicare payment rates for primary care services.[9,10]

Nevertheless, before the major coverage expansions took effect, there was concern that the existing supply of health care providers could not meet the increased demand.[11] Long wait times and difficulties finding new providers were reported anecdotally, especially in states that experienced large gains in the number of people with insurance.[12–15] Patients newly enrolled in Medicaid may have had a hard time finding providers who accepted their coverage because in most states Medicaid offers lower payment rates than Medicare or private insurance;[16] even before the ACA, a sizeable share of providers were unwilling to accept Medicaid.[17,18]

There is evidence that more people have access to health care and have obtained health care services since the ACA's major coverage expansions began in 2014. For example, a 2017 study analyzed four years of annual survey data (2013 to 2016) from three states—Arkansas and Kentucky, which expanded Medicaid, and Texas, which did not expand Medicaid and served as a control state—to assess the impact of Medicaid expansion on health care use and self-reported health among nonelderly low-income adults. Researchers found that Medicaid expansion was associated with "significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health."[19] Another study analyzed national survey data and found that the first two years of the ACA's open enrollment periods (2014 and 2015) were associated with "significantly improved trends" in self-reported access to primary care and medications, affordability, and health among nonelderly adults.[20] The Urban Institute, analyzing data from the Health Reform Monitoring Survey (HRMS),[21] also found statistically significant trends toward increased access to care since the ACA: Between mid-2013 and March 2016, the share of parents receiving routine checkups increased by 3.0 percentage points, and the share of children receiving routine checkups increased by 1.9 percentage points; the share of parents reporting unmet need decreased by 5.7 percentage points; the share of parents reporting problems paying family medical bills decreased by 5.6 percentage points; and the share of parents reporting that they were confident their child could get health care if needed increased by 2.8 percentage points.[22] An analysis of HRMS data through the first quarter of 2017 showed significant declines in the shares of low- and moderate-income adults with problems accessing care since 2013.[23]

METHODOLOGY

To better understand how providers are handling the increased demand for health care services under the ACA, we conducted interviews in five communities with leaders of different types of health care organizations in 2017. We selected communities that experienced some of the largest drops in uninsurance between 2013 and 2016, included both urban and rural areas, and varied in their geographic region and health care provider landscape.[24] The study communities saw 69 to 72 percent reductions in their number of uninsured and 12 to 20 percent increases in their number of insured people (see Table 1). Each community had a median income lower than that of its state and was in a state that expanded Medicaid in 2014, although we did not select for these criteria.

We interviewed leaders of community health centers, health care systems (which operated both acute care hospitals and ambulatory care practices), provider associations, and an urgent care association, as well as some state Medicaid officials. Our main research questions were as follows:

- To what degree are health care providers experiencing an influx of newly insured patients in these communities?
- How well have providers met any new demand for care, and are there areas of unmet need?
- What changes, if any, have providers made to their delivery of care to accommodate these new patients? For example, are they hiring new or different kinds of staff, opening new practice sites, or increasing their use of telemedicine?
- What public or private programs, market developments, or contextual factors have made it easier (or harder) for providers to handle the influx of new patients seeking care?

Table 1: Study Areas

Geographic area[a]	Number of uninsured people		Percent decrease in number of uninsured people	Number of insured people		Percent increase in number of insured people
	2013	2016		2013	2016	
Outlying suburbs of Lexington, Ky. *(12 counties surrounding Fayette County)*	48,185	14,794	-69%	309,896	347,697	+12%
Northeastern and central Detroit, Mich. *(southwestern corner of Macomb County and northern part of Wayne County)*	43,705	13,724	-69%	229,147	262,532	+15%
Northern half of city of Spokane, Wash. *(middle of Spokane County)*	18,528	5,684	-69%	110,054	124,507	+13%
Northwestern part of city of Sacramento, Calif. *(northwestern corner of Sacramento County)*	20,374	5,634	-72%	90,736	108,767	+20%
Northeastern corner of West Virginia *(7 counties)*	45,938	14,198	-69%	255,247	289,183	+13%

[a] These are public use microdata areas (PUMAs), geographically contiguous areas containing at least 100,000 people that are defined for the dissemination of U.S. Census Bureau data. Calculations are based on the following PUMAs: Lexington area (PUMAs 2000, 2200, 2300); Detroit (PUMAs 3006, 3209); Spokane (PUMA 10501); Sacramento (PUMA 6705); and West Virginia area (PUMAs 300, 400). See endnote 24 for further details on these calculations. Other parts of these cities and areas also saw large reductions in the number of uninsured, although not as large as those in the selected PUMAs.

Because most of our interviews took place when Congress was actively considering repeal and replacement of the ACA, we also asked respondents how providers in their communities would be affected by retrenchment or elimination of the ACA's coverage expansions.

Interviews were transcribed and analyzed to identify findings, including observations common across multiple communities and observations that were less common.

OBSERVATIONS FROM THE FIVE STUDY COMMUNITIES

Changes in Demand for Services

Demand for health care services increased substantially.

Unsurprisingly, respondents reported that demand for services increased after the ACA's coverage expansions. This was true for all types of primary and specialty care and for community health centers and large health systems. Several primary care providers reported that people who only used the health care system for acute care before the ACA now came in more frequently and received preventive services and treatment for chronic conditions. Several respondents reported an increase in the number of patients with more complex health care needs and comorbidities. For example, respondents in multiple communities reported that demand for diabetes services increased significantly as more people were screened for and diagnosed with the disease. Some also noted that the coverage expansions brought a new challenge: the need to educate patients on how to appropriately use the health care system, including not using the emergency room to obtain primary care services.

For safety-net providers, the change in payer mix was more significant than the overall increase in the number of patients served.

Representatives of several safety-net providers reported that although the total number of patients increased, the bigger change for their organizations was the shift in payer mix to fewer uninsured patients and many more Medicaid-covered

patients; these respondents did not report a significant increase in privately insured patients. One FQHC respondent reported that the Medicaid expansion "flipped the payer mix upside down." This new source of revenue helped provider organizations increase their capacity to meet the increased demand.

Changes in Care Delivery

Health care systems and community health centers hired new staff, including advanced practice clinicians.

Hospital systems and community health centers in all five study communities responded to the increased demand for services by hiring more staff, including physicians, advanced practice clinicians (such as nurse practitioners and physician assistants), care coordinators, and administrative and health information technology staff. Hospital system respondents also reported hiring more specialists. Some health centers added or increased behavioral health services after the ACA expansions. Respondents reported that increased revenue from newly insured patients helped cover the cost of additional staff.

Many respondents reported hiring proportionately more advanced practice clinicians than physicians in primary care settings after the ACA expansions. In some cases, this was a response to physician shortages and challenges recruiting and retaining physicians. Most nurse practitioners work in the primary care environment, but some respondents reported hiring advanced practice clinicians to provide behavioral health services or to provide follow-up care for specialty services. Some practice sites, especially FQHCs, had already increased their reliance on advanced practice clinicians before the ACA, as part of a move toward patient-centered medical homes and a team-based approach to patient care. Advanced practice clinicians were also used in smaller sites, including school-based health centers and satellite sites in rural communities.

Respondents emphasized that increased hiring included administrative and health information technology staff to help manage the increased demand for services, shift to new billing models, and growing reliance on electronic health records. Some respondents reported that community health centers hired more staff who could serve as care coordinators, including registered nurses, social workers, medical assistants, and community health workers. In Sacramento, some health care providers employ health navigators to help patients use their new coverage, understand how to navigate the health care system, and avoid inappropriate use of emergency departments.

Providers opened new care delivery sites, expanded existing sites, and extended their operating hours.

Respondents reported more primary care sites in their communities after the ACA expansions, but more often they described expansions and upgrades to existing facilities to accommodate increased demand. The ACA provided substantial funding for FQHCs to support these capital investments. Some health system respondents reported an expansion in specialty care clinics, but this was not universal.

Health system and community health center respondents reported extending their hours to make care available outside the normal workday, including evening and weekend hours. Some FQHC respondents said that this trend started before the ACA and was tied to their adoption of the patient-centered medical home model. A state Medicaid official also reported that under Michigan's Primary Care Transformation demonstration project, which predated the state's Medicaid expansion, the patient-centered medical home model already required expanded hours, and that Michigan's 2016 Medicaid managed care contracts promote use of alternative hours to improve access for enrollees. In contrast, a Washington hospital respondent reported that offering extended hours was a direct response to the coverage expansions, particularly the Medicaid expansion, both because of increased demand for care and because many of the newly eligible Medicaid enrollees worked in jobs that did not offer flexibility during the workday to see a health care provider.

The number of urgent care centers and retail clinics increased.

Respondents reported an increase in the number of urgent care centers and, except in West Virginia, an increase in the number of retail clinics in pharmacies and/or retail outlets in their communities. Large health systems were most likely to open or expand urgent care sites after the ACA expansions. One health system respondent said that opening additional urgent care centers helped to "decompress" the emergency department. A respondent from another community explained, "As demand for hospitalization has gone down, hospitals are trying to expand their nets to capture more admissions. It's really an explosion of urgent care centers." The reported growth in urgent care sites is consistent with survey data published by the Urgent Care Association of America, which found that 96 percent of urgent care centers saw more patients in 2015 than in 2014, and that the total number of urgent care centers in the United States increased to 7,357 in 2016, a 10 percent increase over 2015.[25]

Respondents from FQHCs reported that they met some urgent care needs by offering extended hours and same-day appointments. They emphasized that freestanding urgent care clinics are not compatible with their practice model, which provides comprehensive primary care to patients, including tracking care and checking the status of preventive care screenings; this responsibility is tied to the federal funding they receive from the Health Resources and Services Administration. In contrast, many patients of urgent care clinics seek episodic care or treatment only for the condition that brought them to the clinic, rather than an ongoing primary care relationship with the provider.

Persistent Gaps in Provider Capacity

Health professional workforce shortages that predated the ACA's coverage expansions were exacerbated by the increased demand for care.

Many communities across the country have health care professional workforce shortages, including shortages of primary care physicians and shortages of providers in rural communities.[26] Although different communities had different kinds of shortages, respondents in all the study communities observed that increased demand for services intensified pre-ACA provider shortages. Respondents in Lexington, Spokane, and Sacramento said that the coverage expansions placed particular stress on primary care providers, which were reportedly in short supply before the ACA. West Virginia respondents said that they still struggle to recruit and retain providers of all types in rural communities. Of the five study communities, Detroit seemed to have been most successful in meeting the increased demand for primary care, perhaps because it was the largest city we studied and had several medical schools in the area; but pre-existing specialty shortages continued there even after the ACA expansions.

Several FQHC respondents reported significant challenges in recruiting and retaining primary care physicians, who could receive better pay, benefits, and administrative support in larger health systems. Respondents noted that many medical school students graduate with significant debt and seek better-paying jobs, including higher-paying specialties.

Respondents talked about two countervailing forces affecting newly insured patients' access to specialists. Some reported that it was easier to make referrals because their patients were no longer uninsured, but others reported longer wait times to see specialists now that more people were trying to access them. In all five communities, pre-existing shortages of psychiatrists and other physicians providing treatment for mental health (MH) and substance use disorder (SUD) were exacerbated by increased demand from newly insured people.

Increased demand has placed significant strains on primary care providers.

Respondents reported that primary care providers in their communities generally have been able to take in newly insured patients, but the increased demand has placed significant stress on many providers. Several respondents said that the increased availability of insurance coverage meant that many consumers accessed nonacute primary care and preventive services for the first time, which initially placed strains on primary care providers; many newly covered patients needed treatment for complex chronic conditions that had not been treated previously. Many FQHCs are moving toward a patient-centered medical home model—a trend that began before the ACA—and FQHC respondents reported that the model's team approach to care helped improve efficiency and alleviate the increased demand on physicians. But some respondents expressed concerns about physician burnout in the primary care setting, especially associated with the need to see more patients during each work day.

Behavioral health was the single most significant unmet need reported in all five communities.

The most consistent unmet need reported in all five communities was behavioral health. Respondents from all the study communities reported significant increased demand for MH/SUD treatment, particularly treatment of opioid use disorder. This increased demand for opioid use disorder treatment was attributed to an increase in the number of people who had coverage for MH/SUD treatment, as well as to an increase in the number of people with opioid use disorder. The increased demand for behavioral health services resulted in part from the ACA's requirement that newly insured Medicaid and marketplace plan enrollees have coverage including MH/SUD benefits. In Lexington and Morgantown, respondents said that the opioid epidemic created a huge need that existing providers could not meet. One West Virginia respondent said this problem was statewide, explaining, "The single largest health issue in [coal country] is behavioral health, over and even above diabetes and heart disease."

Access to certain specialty services remains limited.

The five study communities had shortages of different specialty services. Pre-existing health care professional shortages and the ACA's coverage requirements contributed to these areas of unmet need. Many patients who gained access to preventive services and primary care for the first time were diagnosed with diseases, including hepatitis C and diabetes, that they may have had for a while; this reportedly caused significant delays in seeing specialists such as endocrinologists and gastroenterologists.[19,27] Some respondents said that demand for

gastroenterologists also increased because many people were receiving referrals to specialists for colon cancer screenings, one of the covered preventive services under the ACA.

Respondents in Detroit, Lexington, and Spokane reported significant increased demand—and unmet needs—for adult dental services. These communities are in states that included adult dental benefits in their Medicaid benefits packages.[28]

Other Changes in Provider Practices

Use of telemedicine is increasing slowly but has not significantly enhanced provider capacity.

Respondents reported that telemedicine use increased modestly in their states and communities since 2013, but the move toward telemedicine has been gradual and may not be a direct response to ACA coverage expansions. Several respondents expressed interest in using telemedicine more, and many emphasized that in their states, telemedicine was used most often to provide care in rural communities. Respondents in Detroit, Lexington, and Morgantown said that their communities have many specialists, so they may not need telemedicine as much as rural areas do.

Respondents discussed two different types of telemedicine: (1) connecting a provider with a patient through a video connection; and (2) connecting a primary care provider in a remote location with a specialist located elsewhere. Sometimes care can be provided through a combination of both, for example, in a dermatology consultation with a specialist. Respondents said that academic medical centers and other large health systems provide and use telemedicine most frequently, and FQHCs use it minimally if at all. In West Virginia and Spokane, local academic medical centers were participating in Project ECHO,[29] an initiative that connects rural physicians to specialists to help treat complex patients.

Respondents said that telemedicine was used most commonly for telepsychiatry, to enable patients located in remote areas to interact directly with a psychiatrist. In Washington state, nonphysician behavioral health providers (e.g., counselors) use telepsychiatry to consult with psychiatrists. But one West Virginia respondent reported that the ACA's coverage expansions seemed to have reduced the use of telepsychiatry because "it's hard to get psychiatrists to do telemedicine clinics when there is a line [of patients] out the door of the physical office they're sitting in." According to respondents, dermatology was the next most common specialty accessed through telemedicine; it allows a primary care provider in a remote location to share images of a patient's skin with a specialist to assess whether the patient needs treatment or testing.

Web portals were used increasingly for direct communication between patients and their providers, but most respondents did not view such communications as a substitute for face-to-face appointments; instead, they said that a patient web portal promotes better, more efficient communication and allows patients to make online appointments.

Several respondents said that they had expected telemedicine to be more important in providing care after the ACA, but barriers to telemedicine remain, including reimbursement issues. FQHC respondents said that the low reimbursement rate for providing the video connection was a barrier to using telemedicine in their practices. In addition, if an FQHC has a psychiatrist on staff at its main clinic who sees a patient "virtually" in a satellite clinic, the FQHC cannot collect a telemedicine fee, but it could collect the telemedicine fee if the psychiatrist were not on staff. A respondent whose health system uses telemedicine and is trying to expand its use noted that private insurers do not consistently cover telemedicine services.

Health systems are buying up primary and specialty care practices, but this is not directly related to the ACA's coverage expansions.

Respondents reported that solo and small group practices in their communities are being bought up by larger health systems. The trend seemed particularly significant in Morgantown, West Virginia, where hospital systems have been acquiring primary and specialty care practices and smaller hospitals in the surrounding area. Respondents consistently said that such consolidation was part of a national trend, and none attributed the acquisitions to the ACA coverage expansions. Providers in independent practices were either close to retirement or seeking affiliation with a larger system to address changes in electronic health records, gain a stronger bargaining position for negotiations with insurers, and reduce the administrative burden of practicing medicine in a rapidly changing environment.

Impact of Government Policies on Provider Capacity

The ACA's coverage expansions generated more demand and more revenue for many providers, which increased their capacity to serve more patients. FQHCs also benefited from significant additional funding under the ACA. Respondents described other federal and state policies that may have had an impact on provider capacity.

The ACA's temporary fee bump for primary care providers in Medicaid may have helped meet increased demand, but Medicaid reimbursement rates are low and some providers remain unwilling to accept Medicaid patients.

The ACA required state Medicaid programs (both fee-for-service and managed care) to offer a temporary fee bump for primary care physicians, bringing their payment rates up to Medicare levels in 2013 and 2014. The federal government paid for the increase in those two years. States that wanted to continue the fee bump after 2014 were required to use state funds and conventional Medicaid matching rates. FQHCs are reimbursed by Medicaid under a prospective payment system, so the fee bump did not directly affect them. Respondents believed that the fee bump increased the number of providers willing to take Medicaid patients, but reported that many providers still do not. Respondents in multiple communities said that reimbursement rates in public insurance programs still cannot attract enough providers to participate. As of July 2016, Medicaid programs in California, Kentucky, Washington, and West Virginia had not continued any part of the Medicaid fee bump, and Michigan had partially continued the fee bump.[16]

Respondents from two states noted specific state Medicaid policies that promote provider participation. In Michigan, the state Medicaid program reimburses medical school faculty at higher rates than other providers. In California, a recent change in state Medicaid policies allows FQHCs to bill Medicaid for marriage and family therapists (before, they could only bill for psychiatrists, psychologists, and licensed clinical social workers); this helped meet the increased demand for behavioral health services.

State scope-of-practice laws can increase provider capacity by authorizing advanced practice clinicians to work independently of physicians.

Advanced practice clinicians, including physician assistants and nurse practitioners, are subject to licensing and scope-of-practice laws and regulations that vary by state. These rules set parameters on how much advanced practice clinicians could help meet the increased demand for care in the study communities.[30] Washington was the only state in our study that gives nurse practitioners authority to practice independently of a physician up to the full scope of their license.[31] Respondents in all study communities reported that nurse practitioners generally are allowed to practice with less direct supervision from physicians than physician assistants are; this creates incentives to hire more nurse practitioners than physician assistants. Washington state recently changed its scope-of-practice policies to authorize physicians to oversee five physician assistants (increased from three), which has made it easier to hire physician assistants to help meet increased demand. Washington also allows pharmacists to monitor chronic conditions and adjust medications and run anticoagulant and hypertension clinics. A Medicaid official in Washington explained, "[T]here's a recognition that we're not always having everyone work at the top of their license and that we need to fully take advantage of existing rules, regulations, and laws that allow broader scopes of practice for these other practitioners, particularly in team-based models."

Health care payment and delivery reforms helped increase provider capacity in some communities.

The ACA provided funding for payment and care delivery reforms, which coincided with increased demand for care among newly covered patients. These initiatives included efforts to increase efficiency, quality, and workforce capacity; many were funded by the ACA-created Center for Medicare and Medicaid Innovation. Respondents in Spokane and West Virginia said that the State Innovation Models (SIM) initiative helped meet increased demand. For example, the West Virginia SIM project includes a workforce development program. In addition to these large federally funded initiatives, a shift from fee-for-service payment to value-based purchasing reportedly helped increase efficiency. Several respondents said that the move to patient-centered medical home models improved efficiency and enabled health care organizations to coordinate care and use nonphysicians more effectively.

States and communities still struggle to rectify health professional workforce shortages.

Respondents emphasized the importance of loan repayment programs and other incentives to attract students to medical school and incentivize recent graduates to pursue primary care (as opposed to better-paying specialties) and seek residencies and jobs in community health centers, safety-net hospitals, and communities with underserved residents. State initiatives, such as scholarship programs and loan forgiveness programs, can supplement federal programs, but respondents said that funding for these efforts was insufficient to make a significant dent in the professional shortages.

Looking Forward: What Hinders Providers' Ability to Meet the Health Care Needs of Their Communities?

Respondents said that proposals to eliminate or cut back the Medicaid expansion and scale back the Medicaid program threaten care delivery.

We conducted most of our interviews during the first few months of 2017, a period of great uncertainty over congressional repeal and replacement of the ACA. The

legislation under debate at the time included a phaseout or elimination of the Medicaid expansion, significant changes in Medicaid financing that would reduce federal Medicaid funding in future years from funding levels under current law, and cuts in subsidies for consumers in the individual health insurance market.[32] Most respondents expressed concern and/or alarm over the potential impact of these proposals—particularly elimination of the ACA's Medicaid expansion. Respondents said these changes would have a negative impact on the clients they serve, leading people to forgo preventive and primary care and treatment for chronic conditions; overburdening local emergency departments, as some who lose insurance seek nonemergency care at hospitals; and reducing their organizations' capacity to provide care to people, as they begin to treat a higher percentage of uninsured patients. Some respondents raised concerns about FQHCs' ability to sustain the office expansions and new hires that had enabled them to serve more patients, if fewer people have insurance and health centers receive less revenue.

In West Virginia and Kentucky, respondents raised concerns about the potential loss of coverage for mental health and substance use disorder services, especially because it could reduce treatment for opioid addiction. A West Virginia FQHC respondent said of the statewide Medicaid program, "Of the expanded Medicaid population, there are 50,000 individuals in need of substance abuse treatment, and we do not have the resources to handle that on our own. If we lose the capacity to provide services to the population, it's just going to be a death spiral for those individuals." A Lexington respondent said that repeal of the Medicaid expansion would reduce behavioral health services; the respondent noted that after the coverage expansions, there was an "onslaught" of new patients with complex mental health and substance abuse issues that needed both behavioral health services and medical care.

Addressing persistent physician workforce shortages remains a challenge.

Respondents in all five communities identified behavioral health as the area with the most significant unmet need, even after the ACA's coverage expansions. Respondents also raised concerns about the health care workforce generally and the need for more policies to encourage people to become physicians, provide primary care, and serve rural and other underserved communities. Respondents mentioned several policies that they believed might encourage more professionals to work in rural and other underserved communities, including retaining cost-based payment systems for FQHCs in Medicaid, increasing residency program partnerships with community health centers, expanding loan repayment programs for physicians, and increasing incentives to draw medical students into primary care instead of higher-paying specialties.

Recent efforts to integrate behavioral health into primary care and to pursue payment and service delivery reforms help communities meet health care needs.

Several provider respondents discussed the importance of integrating behavioral health services into primary care and of reforming payment and care delivery to increase efficiency and improve outcomes. Several respondents reported that payment and delivery reforms—for example, adopting the patient-centered medical home model, which focuses on care coordination—make care delivery more efficient and thereby help meet patients' health care needs. One representative of an association of safety-net providers explained, "The real hard part, right now, is the ACA started a process of trying to build a value-based health care delivery system. And to do that, you have to build an infrastructure. Are we going to continue that? If not, are we going to go back to the old concept of 'treat 'em and street 'em'?"

CONCLUSION

Our interviews suggest that health care providers have adapted to the increased demand for services caused by the ACA. Providers responded by hiring more staff, relying more on advanced practice clinicians, and expanding facilities and hours. More urgent care centers and retail clinics opened. In contrast, telemedicine and increased reliance on electronic communications between patients and providers have not contributed significantly to meeting the increased demand. Despite increases in provider capacity, there are still areas of unmet need, particularly in behavioral health and other specialty services, and persistent professional workforce shortages that were exacerbated by the ACA's coverage expansions. Although health care delivery reforms, including greater care coordination, helped to increase efficiency among providers, many respondents reported that the increased demand for services placed significant stress on primary care providers. With the backdrop of congressional efforts to repeal and replace the ACA, most respondents also were bracing for coverage losses, which they expected to hurt patients' health as well as their organizations' finances and ability to serve their communities.

ENDNOTES

1. Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016*. Washington: National Center for Health Statistics; 2017. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf. Published May 2017.
2. National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).
3. For a list of states that expanded their Medicaid programs after the ACA, see: Status of state action on the Medicaid expansion decision. Kaiser Family Foundation website. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Accessed October 22, 2017.
4. The ACA also requires insurers to allow adult children to stay on their parents' health plans up to the age of 26. As of October 2013, before the major coverage expansions of the ACA started, about 2.3 million young adults between the ages of 19 and 25 gained coverage under that requirement. See: Uberoi N, Finegold K, Gee E. Health insurance coverage and the Affordable Care Act, 2010–2016. Washington: Office of the Assistant Secretary for Planning and Evaluation; 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf. Published March 3, 2016.
5. Hill I, Wilkinson M, Holahan J. *The Launch of the Affordable Care Act in Selected States: The Problem of Provider Capacity*. Washington: Urban Institute; 2014. http://www.urban.org/research/publication/launch-affordable-care-act-eight-states-problem-provider-capacity. Published March 5, 2014.
6. What is a health center? Health Resources and Services Administration website. https://bphc.hrsa.gov/about/what-is-a-health-center/index.html.
7. Health Resources and Services Administration. *The Affordable Care Act and Health Centers*. Washington: Health Resources and Services Administration. https://www.hrsa.gov/about/news/2012tables/healthcentersacafactsheet.pdf.
8. About the Affordable Care Act. US Department of Health and Human Services website. https://www.hhs.gov/healthcare/facts-and-features/fact-sheets/creating-health-care-jobs-by-addressing-primary-care-workforce-needs/index.html. Accessed December 29, 2016.
9. Medicaid and CHIP Payment and Access Commission (MACPAC). An update on the Medicaid primary care payment increase. In: *March 2015 Report to Congress on Medicaid and CHIP*. Washington: MACPAC; 2015. https://www.macpac.gov/wp-content/uploads/2015/03/An-Update-on-the-Medicaid-Primary-Care-Payment-Increase.pdf. Published March 2015.
10. Centers for Medicare & Medicaid Services. Summary information regarding Medicare's primary care incentive payment program (PCIP). *MLN Matters*. 2014;SE1109. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1109.pdf. Published March 22, 2011. Updated April 30, 2014.
11. See, for example: Christensen J. Doctor shortage, increased demand could crash health care system. *CNN*. October 2, 2013. http://www.cnn.com/2013/10/02/health/obamacare-doctor-shortage/. Pipes S. Thanks to Obamacare, a 20,000 doctor shortage is set to quintuple. *Forbes*. June 10, 2013. http://www.forbes.com/sites/sallypipes/2013/06/10/thanks-to-obamacare-a-20000-doctor-shortage-is-set-to-quintuple. Lowrey A, Pear R. Doctor shortage likely to worsen with health law. *New York Times*. July 28, 2012. http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html. Christie B. Doctor shortage likely to get worse in Arizona. *Arizona Daily Star*. June 23, 2013. http://tucson.com/news/science/health-med-fit/doctor-shortage-likely-to-get-worse-in-arizona/article_84fa995d-282d-513a-9093-9c009445f839.html.
12. Luhby T. Got Obamacare, can't find doctors. *CNN*. March 19, 2014. http://money.cnn.com/2014/03/19/news/economy/obamacare-doctors/index.html.
13. Terhune C. Californians gripe about Obamacare enrollment snags, lack of doctors. *Los Angeles Times*. May 23, 2014. http://www.latimes.com/business/healthcare/la-fi-obamacare-california-exchange-complaints-20140522-story.html.
14. Galewitz P. Fears of doctor shortages under new health law may have been overblown. *Kaiser Health News*. May 12, 2014. http://www.pbs.org/newshour/rundown/primary-care-doctors-handling-new-influx-insured-patients-problems/.
15. Dorner SC, Jacobs DB, Sommers BD. Adequacy of outpatient specialty care access in marketplace plans under the Affordable Care Act. *JAMA*. 2015;314(16):1749–1750. http://jamanetwork.com/journals/jama/fullarticle/2466113. Published October 27, 2015.
16. Zuckerman S, Skopec L, Epstein M. *Medicaid Physician Fees after the ACA Primary Care Fee Bump*. Washington: Urban Institute; 2017. http://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump. Published March 5, 2017.
17. National Center for Health Statistics. Health insurance and access to care. Washington: National Center for Health Statistics; 2017. https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf. Published February 2017.
18. Decker SL. In 2011, nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. *Health Aff*. 2012;31(8):1673–1679.
19. Sommers BD, Maylone B, Blendon RJ, Orav EJ, Epstein AM. Three-year impacts of the Affordable Care Act: improved medical care and health among low-income adults. *Health Aff*. 2017;36(6):1119–1128. http://content.healthaffairs.org/content/early/2017/05/15/hlthaff.2017.0293. Published May 2017. Arkansas and Kentucky expanded Medicaid; Texas, which did not expand Medicaid, served as a comparison state.
20. Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. *JAMA*. 2015;314(4):366–374.
21. The Health Reform Monitoring Survey is a survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available.
22. Karpman M, Kenney GM, McMorrow S, Gates JA. *Health Care Coverage, Access, and Affordability for Children and Parents: New Estimates from March 2016*. Washington: Urban Institute; 2016. http://hrms.urban.org/briefs/health-care-coverage-access-affordability-children-parents-march-2016.html. Published September 14, 2016.
23. Long SK, Bart L, Karpman M, Shartzer A, Zuckerman S. Sustained gains in coverage, access, and affordability under the ACA: a 2017 update. *Health Aff*. 2017;36(9):1656–1662. http://content.healthaffairs.org/content/36/9/1656.
24. Researchers at the Urban Institute identified the top 20 public use microdata areas (PUMAs) with the largest reductions in the uninsured rate, using the Urban Institute's Health Insurance Policy Simulation Model, and combined similar contiguous PUMAs together. (PUMAs are geographically contiguous areas containing at least 100,000 people; they are defined for the dissemination of census data. See: Public use microdata areas (PUMAs). US Census Bureau website. https://www.census.gov/geo/reference/puma.html.) We then selected five substate areas that varied in their urbanity, their region of the country, and their health care provider landscape. Information on the Urban Institute's Health Insurance Policy Simulation Model can be found at http://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm.
25. UCAOA 2016 benchmarking report shows wait times of 30 minutes or less at 92 percent of centers [news release]. Naperville, Ill.: Urgent Care Association of America; January 17, 2017. http://www.prweb.com/releases/2017/01/prweb13987046.htm.
26. The Health Resources and Services Administration at the Department of Health and Human Services publishes data on health professional shortages: https://bhw.hrsa.gov/shortage-designation/hpsas. A recent discussion of shortages in primary care and in rural communities is found at: US Government Accountability Office. *Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs*. GAO-17-411. Washington, DC: US Government Accountability Office; 2017. https://www.gao.gov/products/GAO-17-411. Published May 25, 2017.
27. A recent study of annual survey data from Kentucky showed that in 2016, there was an "increased rate of difficulty" obtaining appointments with specialists. See note 19.
28. California, Michigan, and Washington cover adult dental services. Kentucky has covered some adult dental services but is planning to eliminate that benefit. West Virginia only covers certain dental procedures relating to fractures, pain, and infection.
29. Project ECHO is an initiative led by the University of New Mexico School of Medicine that connects patients needing specialty care in rural and/or underserved areas to teams of specialists who use multipoint videoconferencing to conduct virtual clinics with community providers. See: Project ECHO. The University of New Mexico School of Medicine website. http://echo.unm.edu/. Accessed July 7, 2017.
30. The American Association of Nurse Practitioners publishes a map showing the status of state laws and regulations addressing licensing and practice laws for nurse practitioners. See: State practice environment. American Association of Nurse Practitioners website. https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment.

31. The Policy Surveillance Program at Temple University provides searchable datasets on state scope-of-practice laws. The data on nurse practitioner scope-of-practice laws are located at http://lawatlas.org/datasets/nurse-practitioner-scope-of-practice-1460402165.
32. At the time of our interviews, the Senate did not have a draft bill to repeal and replace the ACA. Researchers at the Urban Institute estimated the coverage effects of the American Health Care Act, passed by the House of Representatives in May 2017, and the Better Care Reconciliation Act, the version of the Senate bill released in June 2017. See: Blumberg LJ, Buettgens M, Holahan J, Garrett B, Wang R. *State-by-State Coverage and Government Spending Implications of the American Health Care Act*. Washington: Urban Institute; 2017. https://www.urban.org/research/publication/state-state-coverage-and-government-spending-implications-american-health-care-act. Blumberg LJ, Buettgens M, Holahan J, Garrett B, Wang R. *State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act*. Washington: Urban Institute; 2017. https://www.urban.org/research/publication/state-state-coverage-and-government-spending-implications-better-care-reconciliation-act.

About the Authors and Acknowledgements

Jane Wishner and Rachel Burton are senior research associates in the Urban Institute's Health Policy Center.

The authors gratefully acknowledge the expertise provided by the respondents with whom we spoke. We also thank Jeremy Marks and Patricia Solleveld for their research assistance, Vicky Gan for her copyediting, Matthew Buettgens for his analysis of areas that experienced the largest coverage gains, Robert Berenson for his input on the study design, John Holahan and Stephen Zuckerman for their thoughtful comments and suggestions, and the Robert Wood Johnson Foundation for its generous support of this project.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit **www.rwjf.org**. Follow the Foundation on Twitter at **www.rwjf.org/twitter** or on Facebook at **www.rwjf.org/facebook.**

About the Urban Institute

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information, visit **www.urban.org**. Follow the Urban Institute on **Twitter** or **Facebook**. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at **www.healthpolicycentver.org**.