NC RHRP

Findings Brief
NC Rural Health Research Program

February 2015

Rural Provider Perceptions of the ACA: Case Studies in Four States

Brystana Kaufman, BA; Pam Silberman, JD, DrPH; Mark Holmes, PhD

BACKGROUND

The Affordable Care Act (ACA) is increasing access to health services in the United States. Since the ACA went into effect in January 2013, the uninsured rate in the United States has dropped 4.2 percentage points among adults age 18-64, and the rate has dropped most among low-income Americans.[1] The ACA expanded health insurance coverage to previously uninsured populations by allowing states to expand Medicaid coverage to adults with incomes up to 138% of the federal poverty level (FPL) as well as by creating health insurance marketplaces to subsidize affordable coverage. If all states had expanded Medicaid up to 138% FPL, approximately 8.5 million previously uninsured individuals would have qualified for Medicaid coverage nationally.[2] However, states with a higher number or proportion of rural residents were less likely to expand Medicaid than were more urban states.[3] In addition to those gaining insurance through Medicaid, approximately seven million individuals selected a health insurance plan through the health insurance marketplaces during the initial open enrollment period.[4, 5] Rural residents eligible for insurance coverage through the new health insurance market place were less likely to enroll in coverage compared to eligible urban residents.[6]

KEY FINDINGS

- Respondents in the four states reported an increase in the proportions of patients with insurance coverage, but the numbers in most locations were modest at the time of the interviews.
- Most FQHCs in expansion states described the financial impact of Medicaid expansion and Marketplace enrollment as positive. While hospital administrators were less optimistic about the magnitude of the effect, they agreed that Medicaid expansion would increase revenues by providing a source of reimbursement for some uncompensated care.
- State or local economic conditions were perceived by some to have a larger impact than the ACA in the early months of implementation.
- Non-coverage related ACA provisions such as Patient Centered Medical Homes (PCMHs) and the Community Health Center Fund were perceived to have had a positive effect on primary care capacity and quality.

Expanding health insurance coverage to the uninsured, through both Medicaid and the new health insurance marketplaces, may improve the financial well-being of rural hospitals and Federally Qualified Health Centers (FQHCs) by reducing the provision of uncompensated care. Even a small increase in revenues due to expanded coverage may have a meaningful impact for rural prospective payment system (PPS) hospitals [7] and critical access hospitals (CAHs),[8] which generally have lower median operating margins than do urban hospitals or larger rural referral centers.[9]

In order to inform timely policy development, this study surveyed rural providers' early experiences of the ACA in four states: two that chose to expand Medicaid (Arizona and North Dakota), and two that chose not to expand Medicaid (Georgia and Maine). We interviewed 28 providers and leaders of provider associations regarding the early effects of the ACA, including changes to patient populations, financial health, and capacity for rural hospitals and rural FQHCs.

METHODOLOGY

Through a series of interviews with providers in four states, we conducted case studies of provider perceptions of the ACA's initial impact on rural hospitals and FQHCs. We asked respondents questions about changes their organization

had already experienced in their patient population, services provided, utilization, and finances, as well as their perceptions of the ACA's longer term impacts. We also asked questions about the impact of the sequestration cuts on hospital finances, as well as the anticipated impact of future cuts (e.g., loss of the Community Health Center Fund in 2016). See Table 1 for hospital and FQHC funding changes due to or concurrent with ACA implementation.

We selected two Medicaid expansion states and two non-Medicaid expansion states to study: Arizona and North Dakota (Medicaid expansion states) and Maine and Georgia (non-Medicaid expansion states). Each of these states has a large rural population, ranging from approximately 87,000 in Arizona to more than 600,000 in Georgia.[6] We focused on early impact of the ACA on FQHCs and rural hospitals to capture changes both to primary care and acute care providers. In each state, we first contacted representatives of the State Office of Rural Health (SORH) for an interview as well as to obtain a list of FQHC and hospital contacts in rural communities. Only one SORH was able to participate in the interview, so we conducted interviews of additional state-level respondents, including representatives of either the state Hospital Association or the state Primary Care Association. We emailed the contacts provided by the SORH, which were primarily CAHs rather than PPSs, and proceeded to interview the first three that agreed to participate. Overall, about 80% of the people initially contacted chose to participate in the study. In total, we interviewed 28 providers across the four states between June 24, 2014 and September 9, 2014, including Chief Executive Officers or Chief Financial Officers from three FQHCs and three rural hospitals in each state (of the 12 hospitals interviewed, 11 were CAHs and 1 was a rural PPS).

Table 1: Current Policy Changes in Hospital and Health Center Reimbursements

Hospital Reimbursement Changes as a Result of the ACA or Concurrent with ACA Implementation	
Medicare and Medicaid Disproportionate Hospital Share (DSH) Payments	Medicare DSH hospitals will receive 25% of their traditional DSH funding. The remaining 75% was cut by approximately $500 million in FY 2014 and will be reduced further as the percentage of uninsured declines. The remaining Medicare DSH funds are distributed based on the proportion of uncompensated care the hospitals provide. The scheduled Medicaid DSH funding cuts will be delayed until Federal Fiscal year (FFY) 2016, at which time the total amount of funding will be reduced by $1.2 billion.
Other Changes to Medicare Reimbursement	The ACA included provisions that aim to reward hospitals based, in part, on the efficiency and quality of care provided. This includes value based purchasing and penalties for excess readmissions. These provisions currently apply to PPS hospitals, but may apply to CAHs in the future.
American Recovery and Reinvestment Act (ARRA)	Authorizes incentive payments beginning in FFY 2011 for eligible hospitals (including eligible small, rural hospitals) and CAHs that adopt a certified Electronic Health Record (EHR) system and are meaningful users of certified EHR technology.
Medicare Payments	Under the Budget Control Act of 2011, a sequestration process resulted in a 2% reduction to Medicare reimbursements beginning in January, 2013.
FQHC Funding Changes as a Result of the ACA or Concurrent with ACA Implementation[10, 11]	
Community Health Center Fund (CHCF)	$9.5 billion was appropriated over 5 years for FQHC general operations. CHCF currently makes up more than half of all federal grant funding for the Health Centers. In 2016, the CHCF will end unless it is reauthorized.
Health Center Outreach and Enrollment Assistance Supplemental Funding	As a part of the CHCF, in December 2013, HRSA awarded approximately $58 million to support outreach and enrollment activities nationwide, and $150 million in July 2014.
Health Center Construction and Renovation	In addition to the CHCF, $1.5 billion was appropriated from FY 2011 through FY 2015 for health center construction and renovation.
Health Center Discretionary Budget Appropriation Funding	The Budget Control Act of 2011 cut base funding for FQHCs by $600 million and capped cuts for FY 2013 at 8% for discretionary appropriation, 2% for Health Center Fund, and 7% for funds for homeless and public-housing health centers—a combined total of $167 million.

RESULTS

Summarized Perceptions from FQHCs

Generally, FQHC administrators expected a larger positive financial effect from Medicaid expansion than hospital administrators because a larger proportion of health center patients had Medicaid coverage (or were potentially Medicaid eligible). Compared to hospitals, FQHCs received higher Medicaid reimbursements relative to costs. FQHCs in all four states saw an increase in proportions of insured patients even though providers in the expansion states reported greater increases in coverage than those in non-Medicaid expansion states. Nearly all FQHC respondents we interviewed were pursuing PCMH certification and utilizing Community Health Center Fund grants to expand services. Respondents in both expansion and non-Medicaid expansion states discussed challenges meeting the needs for education, outreach, and marketplace enrollment assistance in their communities.

Patient population

While some of the FQHCs in the four states saw an increase in their insured population, those in the states that had expanded Medicaid typically experienced a greater increase. In addition, several of the FQHCs noted that many of the people who gained coverage in the health insurance marketplace were still eligible for the health center's sliding-fee schedule because of high deductibles.

Financial Impact

Most health centers in expansion states described the financial impact of the ACA as positive, including Medicaid expansion and the Marketplace enrollment. While one respondent noted that the expansion was "*a complete win*" for health centers and patients, other providers expressed concerns that expanded Medicaid coverage did not cover all the same services as traditional Medicaid. Most of the FQHC respondents reported that Medicaid expansion would be better for them financially than the expansion of coverage in the health insurance marketplace because Medicaid payment generally covers more of their costs (including enabling services) than the commercial insurers. Providers reported that many patients who purchased plans on the marketplace faced deductibles so high "*it's like they are uninsured*." A few respondents in non-expansion states noted that the ACA enrollment efforts could have a negative financial impact because patients who fell into the Medicaid coverage gap would often return for services, thereby increasing the numbers of uninsured patients the clinic served.

Respondents generally believed that the reduction in Community Health Center funding in federal fiscal year 2016 (see Table 1) would be damaging, and that the increased revenue from Medicaid expansion would not be enough to offset the projected cuts. Even in expansion states, respondents noted that 25%-50% of the population they served remained uninsured, primarily due to ineligibility for coverage, inability to pay the premium, or lack of understanding of the options and process. Almost every health center indicated that the scheduled reduction in federal funding in 2016 would force the center to increase copays, reduce services, and/or reduce the number of providers.

Utilization and Capacity

FQHCs in the four states reported increased capacity due to the CHCF (See Table 1). Most noted that they had used the new funding to add new sites, expand behavioral health services, expand adult primary care services, or seek PCMH certification. All three Arizona health centers reported increases in adult well visits and preventive services that they attributed to the increased coverage of adults through Medicaid. Perceived challenges meeting the health needs in the community included the lack of capacity in dental care as well as behavioral health. Respondents in both expansion and non-expansion states discussed challenges meeting the need for education, outreach, and enrollment assistance in their communities, partially due to large geographic service areas. Compared to health centers in non-Medicaid expansion states, those in Medicaid expansion states were generally more optimistic about their ability to maintain or increase capacity over the next few years.

Summarized Perceptions from Hospitals

Hospital participants had mixed responses as to whether the ACA had already changed their patient populations, although most expected that their insured population would increase over the next few years. Most respondents—in expansion and non-expansion states—thought that Medicaid expansion would be financially positive for the facility, though increases in health insurance marketplace coverage would be more profitable. As with the FQHC respondents, hospital administrators noted that there was a need for more outreach and enrollment staff in their rural area.

Patient population

Hospital participants had mixed responses as to whether the ACA had changed their patient populations. Some in Medicaid expansion and non-Medicaid expansion states had seen a small uptake in people covered with private insurance through the health insurance marketplace, and some of the respondents in expansion states reported an

increase in the number of patients served by Medicaid. While several hospital respondents noted low participation in the health insurance marketplace, most thought that enrollment was likely to grow in the next few years as public awareness increased and the individual mandate was strengthened. One administrator expressed that "*there will be increased demand due to word-of-mouth because people have been generally satisfied with what they found*."

Financial

While at the time of the interviews, none of the hospitals experienced a noticeable financial impact due to an increase in the number of people with insurance, most respondents in expansion and non-expansion states expected a positive future impact: "*Getting paid something rather than nothing is going to have a positive impact on our bottom line*." On the other hand, respondents also noted that the overall impact of Medicaid expansion would be limited because their state's Medicaid reimbursements did not cover the cost of care, and Medicaid was a small portion of their overall business. As one respondent stated: "*Expansion might lead to a small shift, but … our overall profitability is more affected by changes in Medicare policies*." While some providers expected the increase in health insurance marketplace coverage to be more profitable than Medicaid coverage, there were also concerns that high deductible policies would increase bad debt. Rural hospitals typically have higher bad debt than their urban counterparts,[12] and as one provider expressed: "*Bad debt is not going away*."

Some hospital respondents thought that the financial impact of the health insurance marketplace was limited by the low enrollment rates, and they expected increased impact in the future as more people gained coverage. Respondents also noted concerns about the financial impact of policy changes concurrent with the implementation of the ACA, including the cut in Medicare Disproportionate Share Hospital (DSH) payment, the 2% reduction in Medicare payments, and the expense of implementing meaningful use requirements (see Table 1) in addition to state level changes.[13] One participant described their situation: "*Tough to know what the future does hold… we are on a very thin line, one mistake could sink the whole boat*."

Utilization and Capacity

Aside from the efforts to seek PCMH certification for rural health clinics connected to their hospitals, hospital administrators did not generally attribute other changes in services or utilization to the ACA. Some CAH administrators reported shifting more resources to primary and outpatient care, while others were trying to increase diversification with specialists and telemedicine strategies. Rural areas have historically faced challenges with recruiting and retaining specialty providers, and this was a concern among participants though it was not cited as a reason for dropping services. Respondents noted that there was a need for more outreach and enrollment staff to help people enroll into the Marketplace and Medicaid (in states that expanded Medicaid). They also discussed challenges in reaching Native American or immigrant populations due to remote geography, unreliable contact information, and cultural barriers. A couple of hospitals obtained funding or otherwise dedicated resources to train staff as in-person assisters, but most hospital respondents noted that they referred enrollment questions to outreach staff in FQHCs or other organizations who had received grant support for enrollment services or insurance agents or brokers.

DISCUSSION

In these four states, most providers expected that expanded health insurance coverage through Medicaid expansion and the health insurance marketplace would reduce uncompensated care costs over the next few years and result in a positive financial impact for rural health providers. In general, Medicaid expansion may not be as helpful to hospitals as it is to health centers in states where Medicaid payments do not cover full costs in hospitals (as they do for FQHCs).

Although the ACA is expected to reduce the cost of uncompensated care, these case studies also suggest the extent of the financial gain for rural health providers varies substantially based on the remaining uninsured population and other changes in state Medicaid policies. For example, despite high health insurance marketplace enrollment in Maine, some providers saw an increase in uninsured populations due to the lingering effects of the recession and reductions in Medicaid eligibility for traditional populations. Providers in North Dakota experienced increases in total patient volume and uncompensated care due to the influx of oil industry employees. FQHCs in North Dakota anticipated reduced revenue from dental services because dental services were not included in the expanded Medicaid health plan in North Dakota, though they had been covered under the existing plan.

Despite these concerns, many providers interviewed were optimistic about the long term impact of the ACA. While in most communities the current gains in coverage due to the ACA were modest, providers generally anticipated greater participation in the health insurance marketplaces and greater impact in the coming years.

LIMITATIONS

Due to the small sample size, these findings may not reflect the experiences of providers in other areas of the country. In addition, this study was conducted very early in the implementation of the ACA, and it may have been too early to capture the effect of Medicaid expansion and the new health insurance marketplace enrollment on patient population and utilization due to the delay between the initiation of coverage and the use of services. The political polarization around the ACA may have led to biased results due to self-selection of the participants. Finally, only one hospital participant was currently paid as a PPS hospital, so these results are not likely to adequately capture the PPS perspective. Future research should continue to monitor the combined impact of the ACA and concurrent policy changes on the viability of rural providers.

REFERENCES AND NOTES

1. Gallup-Healthways Well-Being Index. Quarter 1 2008-Quarter 4 2014. Available at: http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx.
2. Kaiser Family Foundation. How Will the Uninsured Fare Under the Affordable Care Act? April 2014. Available at: http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/.
3. Thompson K, Kaufman B, Holmes M. How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations? NC Rural Health Research Program. Findings Brief. July 2014. Available at: http://www.shepscenter.unc.edu/wp-content/uploads/2014/07/MedicaidCoverageJuly2014.pdf.
4. Assistant Secretary for Planning and Evaluation. How many individuals might have marketplace coverage after the 2015 open enrollment period? November 10, 2014. Available at: http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf. Accessed November 20, 2014.
5. Open enrollment was October 1, 2013 through April 19, 2014.
6. Holmes GM, Silberman P, Thompson K, Freeman V, Randolph RK. Geographic Variation in Plan Uptake in the Federally Facilitated Marketplace. NC Rural Health Research Program. Findings Brief. October 2014. Available at: http://www.shepscenter.unc.edu/wp-content/uploads/2014/09/EnrollmentFFMSeptember_rvOct2014.pdf.
7. Standard PPS refers to hospitals paid under the traditional Medicare PPS payment rates. PPS hospitals are eligible for value-based reimbursement mechanisms driven by the ACA. PPS hospitals represent 15% of rural hospitals.
8. To qualify for the CAH designation, a hospital must have 25 or fewer beds, be located at least 15 miles by secondary road and 35 miles by primary road from the nearest hospital, or be declared a "necessary provider" by the state. Under the original legislation, CAHs received 101% of their costs but, under current law, Medicare pays 99% due to payment reductions imposed by a budget sequester on Medicare payments and changes to the share of hospital bad debt payments reimbursable by Medicare. CAHs represent more than half of rural hospitals.
9. Pink GH, Freeman V, Randolph R, Holmes GM. Profitability of Rural Hospitals. NC Rural Health Research Program. Findings Brief. August 2013. Available at: http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/Profitability-Findings-Brief-Final_August-2013.pdf.
10. Redhead, SC. Congressional Research Service. Appropriations and Fund Transfers in the Affordable Care Act. October 10, 2014. Available at: http://fas.org/sgp/crs/misc/R41301.pdf. Accessed November 12, 2014.
11. Taylor, J. Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market. Issue Brief #848. December 18, 2012. Available at: http://www.nhpf.org/library/details.cfm/2914. Accessed November 14, 2014.
12. American Hospital Association. Assistance to Low-Income Medicare Beneficiaries (Bad Debt). Factsheet. 2013. Available at: www.aha.org/content/12/fs-bad-debt.pdf.
13. A.R.S. § 36-2901.08 authorizes an assessment on hospital revenues, discharges or bed days for funding a portion of the nonfederal share of the costs associated with the Arizona Medicaid program beginning January 1, 2014.

This study was funded through Cooperative Agreement # U1CRH03714 with the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration, U.S. Department of Health and Human Services. The conclusions and opinions expressed in this brief are the authors alone; no endorsement by the University of North Carolina, FORHP, or other sources of information is intended or should be inferred.

NC RHRP | UNC THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

North Carolina Rural Health Research Program
Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill
725 Martin Luther King Jr. Blvd. | Chapel Hill, NC 27599
919-966-5011 | www.shepscenter.unc.edu/programs-projects/rural-health