



**Policy Brief**  
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**Ready or Not?**

**The Affordable Care Act and Safety-Net  
Primary Care Clinic Capacity in Iowa**

Prepared for the Commonwealth Fund by:

**Brad Wright\***†  
**Peter C. Damiano\***  
**Suzanne E. Bentler\***

University of Iowa  
Public Policy Center  
209 South Quadrangle  
Iowa City, IA 52242-1192  
319-335-6800 • Fax 319-335-6801  
<http://ppc.uiowa.edu>

The University of Iowa, Public Policy Center\* and College of Public Health†

## Abstract

With the full implementation of the Affordable Care Act (ACA), as many as 25 million individuals are expected to gain insurance coverage over the next five years, creating an increase in demand for health care services. At the same time, as many as 31 million individuals will remain uninsured. Safety-net primary care clinics, including community health centers (CHCs) and rural health clinics (RHCs), are being counted upon to meet the anticipated increase in demand while also continuing to serve the remaining uninsured. While these clinics are afforded new opportunities under the ACA, they also face significant potential challenges. The research described in this issue brief aimed to determine the current capacity of CHCs and RHCs in Iowa and their expected capacity to respond to the opportunities and challenges of the ACA. We utilized an online survey to gather data on current and future needs related to safety-net workforce, service provision, integrated care delivery, and organizational change. We found that both CHCs and RHCs have current staff vacancies that they report difficulty filling and that both report difficulties referring patients for specialty care. We also found that both groups anticipate the demand for their services to increase in the wake of the ACA, and that **both** CHCs and RHCs face resource constraints that may limit their ability to respond to the opportunities and challenges of the ACA.

## About the Authors

- ❖ Brad Wright, PhD, is an Assistant Professor in the Department of Health Management and Policy, College of Public Health and the Public Policy Center at the University of Iowa.
- ❖ Peter C. Damiano, is Director of the University of Iowa Public Policy Center and Professor in the Dept. of Preventive and Community Dentistry.
- ❖ Suzanne E. Bentler, PhD. is an Assistant Research Scientist at the University of Iowa Public Policy Center

## Overview

The implementation of the Affordable Care Act (ACA) and the corresponding expansion in insurance coverage will result in an increased demand for primary care services. Safety net providers will be called upon to provide a significant amount of care to help meet this demand, in addition to caring for those who remain uninsured, Whether they will have the capacity to do so is unknown.

In this brief, we present the results of a study to assess the capacity of two types of safety net providers: community health centers (CHCs) and rural health clinics (RHCs). While these providers are similar in many ways, each is subject to different legal requirements. For instance, CHCs must be located in medically underserved areas (MUAs), must provide comprehensive primary care and enabling services to all patients, regardless of their insurance status or ability to pay, and must operate an income-based sliding fee scale for uninsured patients.<sup>1</sup>

By contrast, RHCs must be located in both a U.S. Census Bureau non-urbanized area and either a primary care health professional shortage area (HPSA), medically underserved area (MUA) or governor-designated shortage area.<sup>2</sup> They receive cost-based reimbursement from Medicaid and Medicare to provide primary care and must employ either a nurse practitioner or a physician assistant on-site at least half of the time that the RHC is open.<sup>3 4 5</sup>

Concerns about the capacity and long-term sustainability of CHCs and RHCs are not new, but the nature of the concerns is changing.<sup>6</sup> Now, the concern is that the number of *insured* persons is

outpacing the ability of the entire health care system—including safety net providers—to care for them.<sup>7</sup> Compounding the problem, recruitment and retention of providers in rural areas is a persistent challenge.<sup>8</sup>

While the ACA presents opportunities for both CHCs and RHCs, including the opportunity to participate in Accountable Care Organizations (ACOs), and the possibility for increased revenue from newly insured patients, it also presents challenges, including concerns about the sufficiency of financial and human resources, the capacity for CHCs and RHCs to integrate effectively into an ACO, and uncertainty about whether newly insured patients will stop going to CHCs and RHCs for their care, leading to a higher proportion of uninsured patients and a loss of revenue.<sup>9</sup>

## About this Study

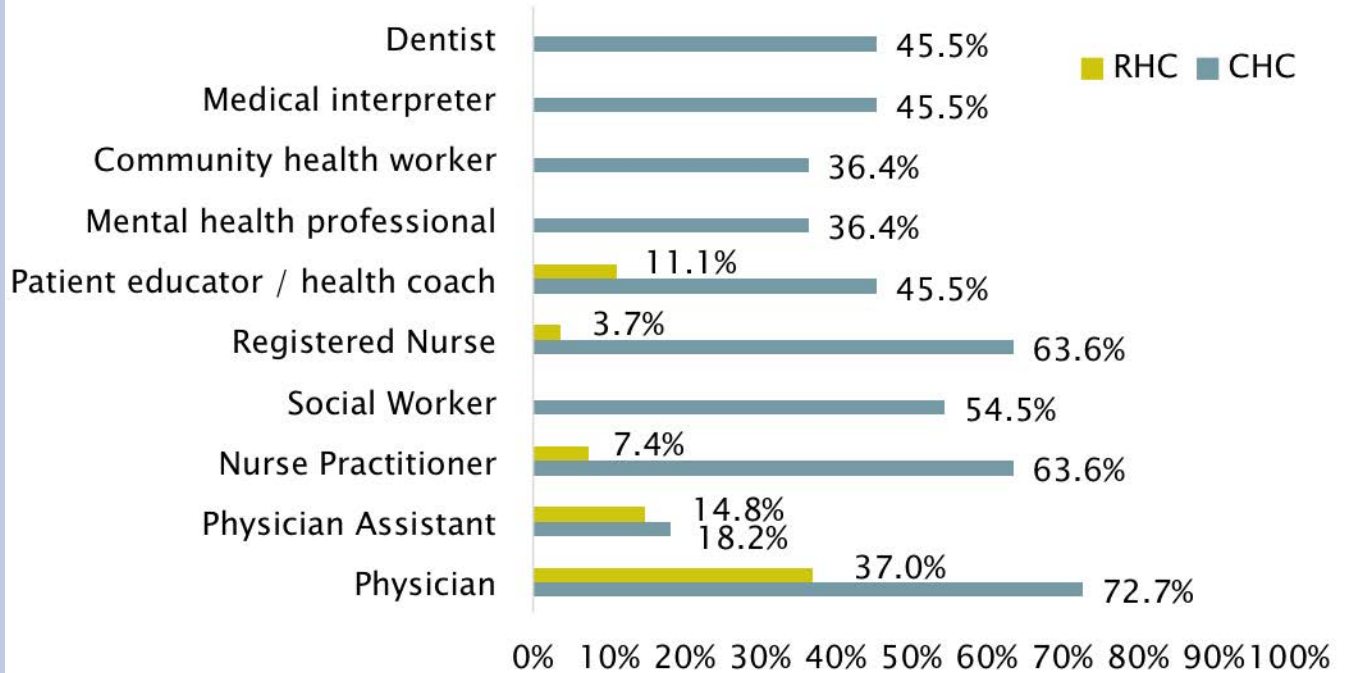
In consultation with members of the Iowa Collaborative Safety Net Provider Network and a national advisory committee, an online survey instrument was used to collect data from the 13 CHCs and 142 RHCs in Iowa. The survey asked about CHCs' and RHCs' current staffing levels, recruitment efforts, and future staffing needs. Survey items also addressed current service provision, the ability to make referrals, and several dimensions of patient-centered primary care. Finally, we asked respondents to predict how ACA implementation may change their patient load. We closed the survey two months after respondents received it, and the response rate was 85% for CHCs and 19% for RHCs.

## Research Findings

### Staffing, Vacancies and Recruitment

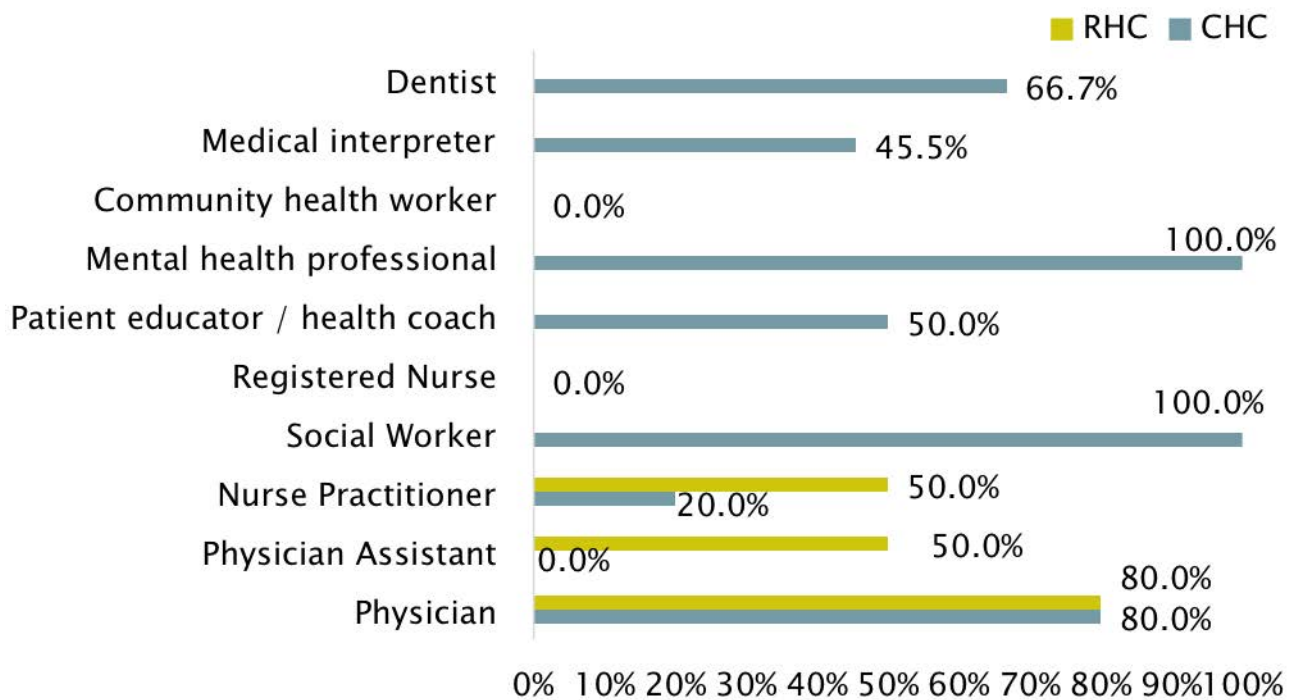
Neither CHCs or RHCs in Iowa reported being fully staffed prior to the ACA insurance expansion (Figure 1). CHCs had greater vacancies, with physicians (72.7%), nurse practitioners, and registered nurses (both 63.6%) the providers most in need. Among RHCs, the most common positions with a shortage were physicians (37%), physician assistants (14.8%), and patient educators (11.1%).

**Figure 1. Proportion of Clinics Reporting a Provider Vacancy, by Type**



CHCs indicated difficulty recruiting mental health professionals, social workers, physicians and dentists-primarily because of salaries and funding and the rural location of Iowa CHCs. RHCs had the most difficulty recruiting for physicians, nurse practitioners and physician assistants,, primarily because of the need for RHC physicians to provide obstetric and emergency care, the rural location, and issues around inadequate salaries and the lack of loan forgiveness for newly licensed physicians. These existing vacancies and recruiting challenges are noteworthy, given that respondents anticipate their provider needs to increase either somewhat or substantially (100% for CHCs; 70.4% for RHCs) following ACA implementation.

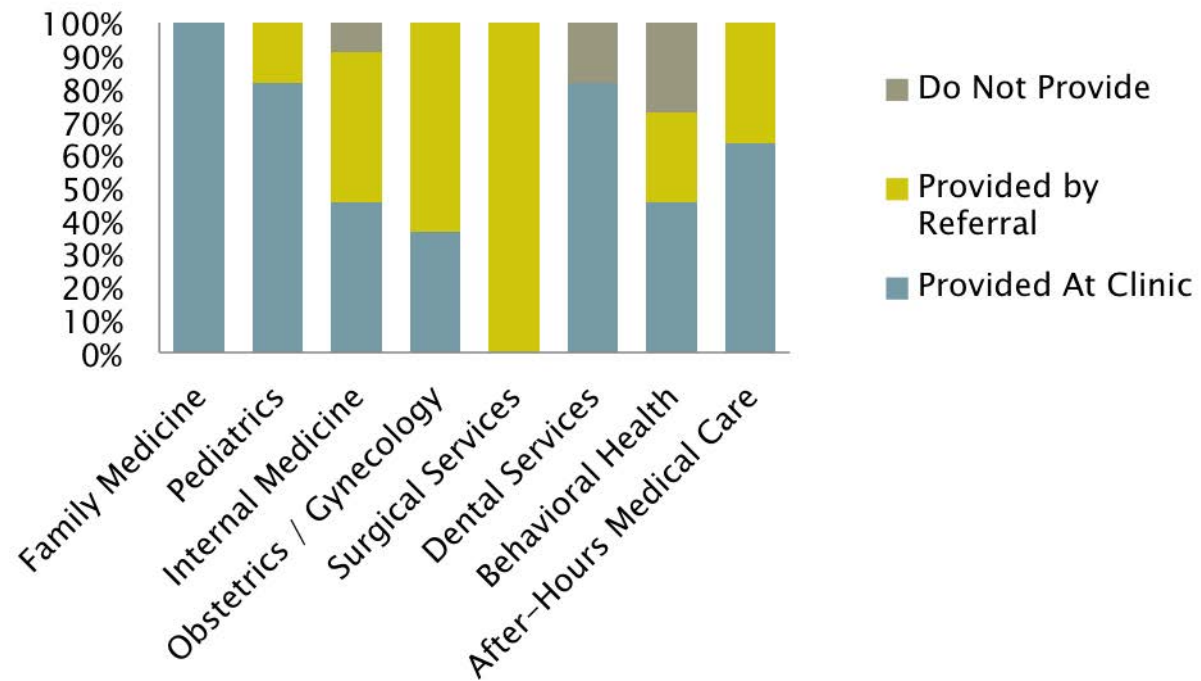
**Figure 2. Proportion of Clinics Actively Recruiting to Fill a Provider Vacancy that Report Difficulty Doing So, by Type**



### Health Center Service Provision and Specialty Referrals

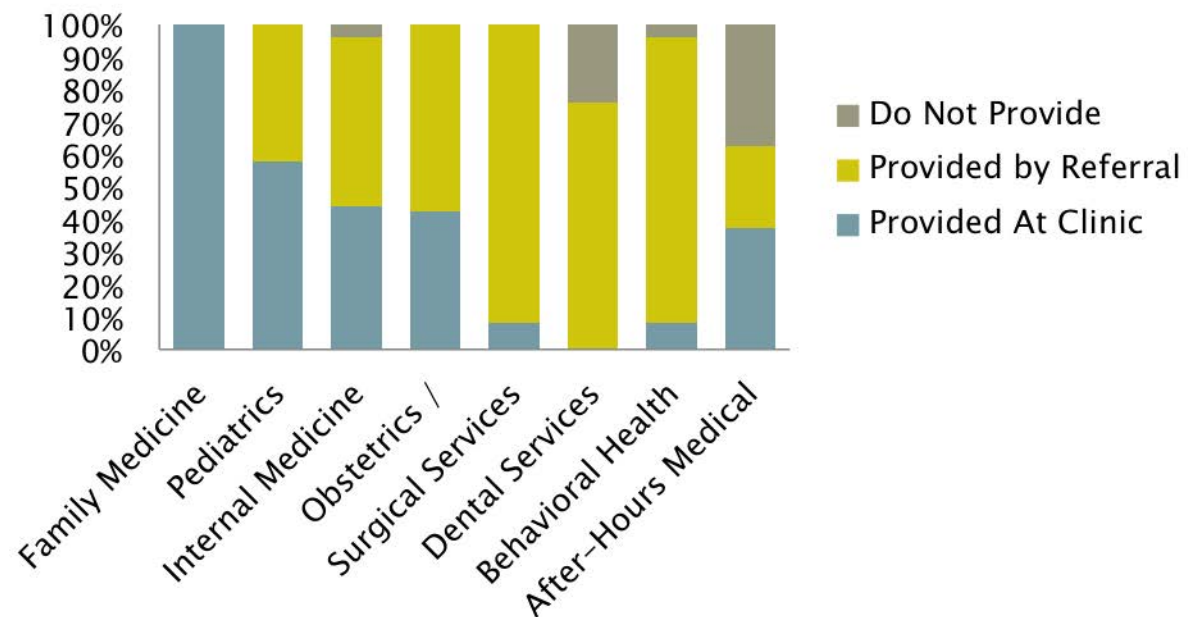
Figures 3 and 4 depict the variety of services Iowa CHCs and RHCs provide directly or by referral. However, adequacy of service provision is a concern. For example, only 73% consider their ability to provide family medicine services adequate. More than one-third of CHCs consider their ability to provide surgical services, which they do by referral only, less than adequate. Only 37.5% of Iowa CHCs consider their ability to provide or refer for behavioral health to be adequate, and only 55.6% consider their ability to provide or refer for dental services to be adequate.

Figure 3. CHC Service Provision, by Location



Only 29.2% of RHCs in Iowa consider their ability to provide or refer for behavioral health to be adequate, and only 63.2% consider their ability to provide or refer for dental services to be adequate. After hours medical care is not provided at all by over one-third (37.5%) of respondents.

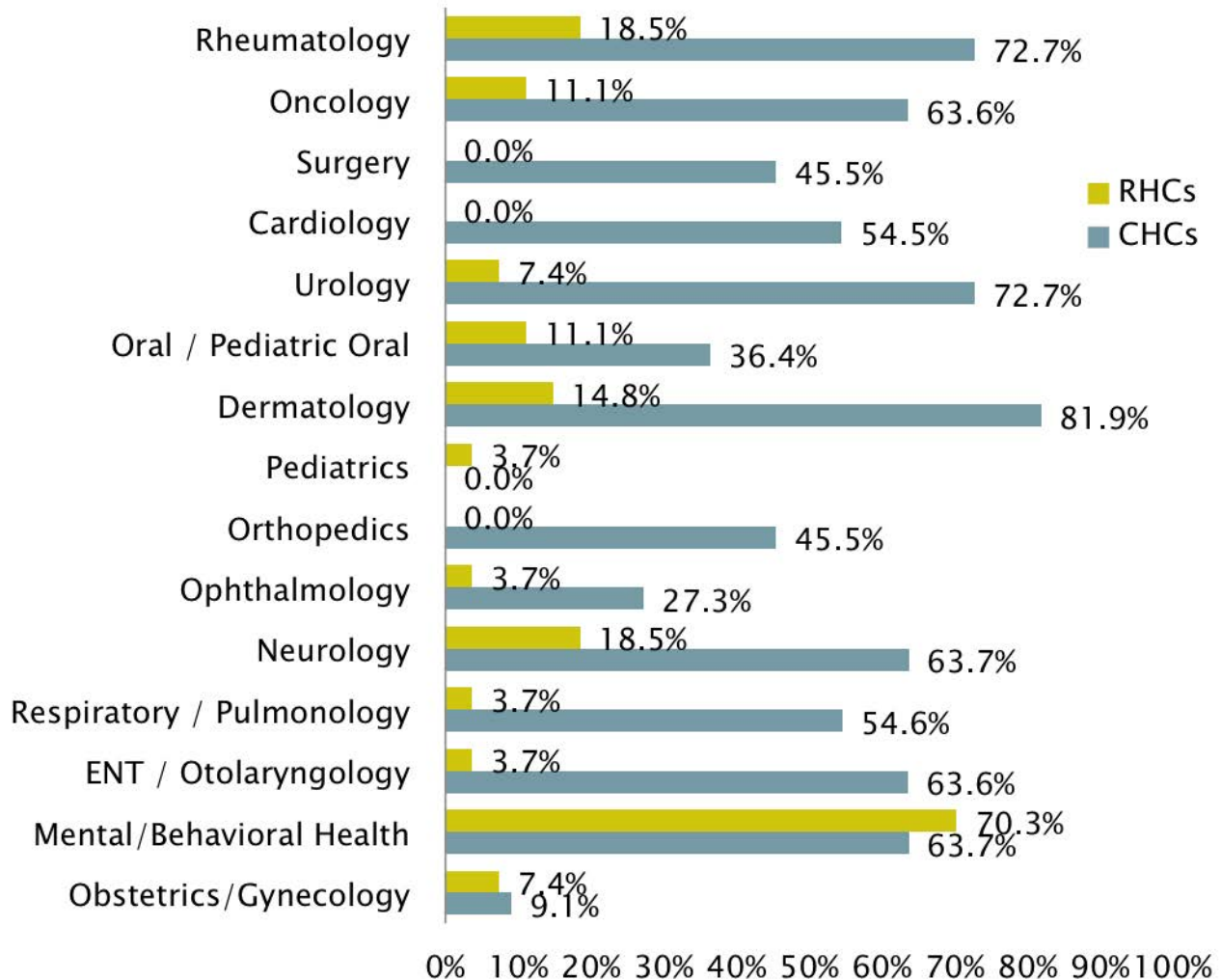
Figure 4. RHC Service Provision, by Location



It is well established that CHCs can encounter obstacles in referring their patients for needed specialty care.<sup>10</sup> This is particularly true of their uninsured patients, although Medicaid patients also encounter barriers.<sup>11</sup> As Figure 5 shows, the majority of CHCs reported that it was “somewhat difficult” or “very difficult” for them to refer their patients for mental health, otolaryngology, pulmonology, neurology,

dermatology, urology, cardiology, oncology, and rheumatology services. However, with the exception of mental health services, RHCs report relatively few barriers in referring their patients for specialty care.

**Figure 5. Clinics Reporting Difficulty Referring Patients for Specialty Care**

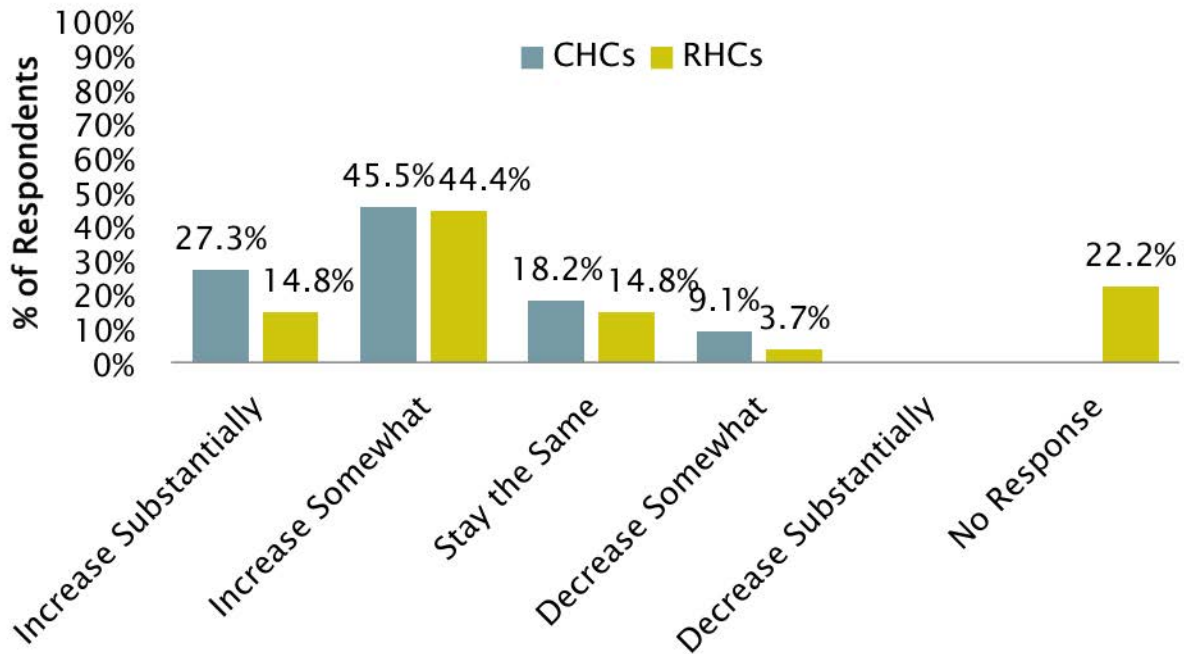


### Anticipated Changes in Demand and Organizational Readiness for Change

A key consideration of ACA implementation for CHCs and RHCs is what happens to their current patient load. How many will gain coverage, and of those who do, how many will continue to seek care at the CHC or RHC? On average, CHCs expected that 48.8% of the uninsured they serve will gain coverage, with responses ranging from 10% to 95%, while RHC respondents expected that 50.9% of the uninsured they serve will gain coverage. However, there is significant variation, with responses ranging from 2% to 100%.

As shown in Figure 7, nearly 73% of CHCs anticipate an increase in their patient population as a result of ACA implementation, with 27.3% expecting a substantial increase. By comparison, 59.2% of RHCs anticipate an increase in the size of their patient population, with 14.8% expecting a substantial increase.

Figure 7. Anticipated Changes in Patient Population Following ACA Implementation

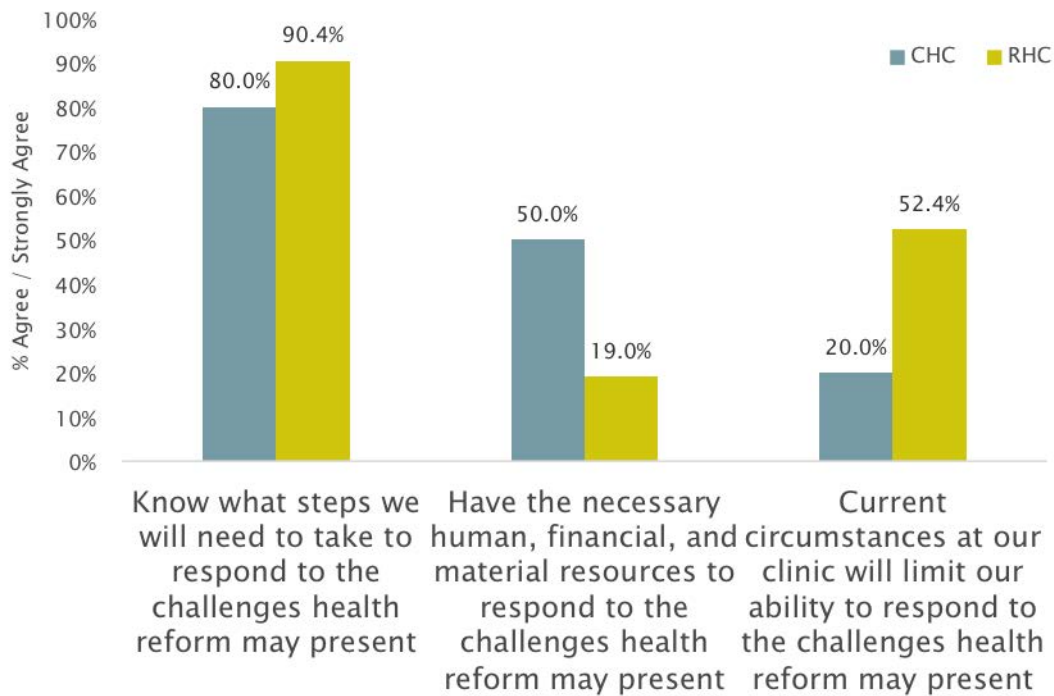


Finally, as CHCs and RHCs adapt to the ACA, we must consider organizational readiness for change, which is the product of both change commitment and change efficacy.<sup>12</sup> Strikingly, the vast majority (90.9%) of CHCs indicated that they “wanted to change” in response to health reform, suggesting a high degree of change commitment but only 29.6% of RHCs indicated the same, suggesting only a low to moderate degree of change commitment.

Change efficacy is a product of task demands, resource availability, and situational factors.<sup>13</sup> Figure 8 shows limited change efficacy among both CHCs and RHCs. While CHCs and RHCs generally report knowing what steps they must take to respond to the challenges of health reform, only 50% of CHCs and 19% of RHCs agree that they have the human, financial, and material resources necessary to respond to those challenges. Moreover, 20% of CHCs and 52.4% of RHCs report that current circumstances will limit their ability to respond to the challenges of health reform.



**Figure 8. Elements of Organizational Readiness for Change**



## DISCUSSION/CONCLUSION

Our study provides evidence that both CHCs and RHCs may be underprepared to respond adequately to the increase in demand for primary care services expected with the ACA-related expansion in insurance.<sup>14</sup> This is partly because the ACA does little to address the non-financial barriers to access that will persist even after individuals gain insurance coverage, especially in rural areas where RHCs—and many CHCs—operate. The problem is likely to be compounded in states opting out of the Medicaid expansion and in cases where the newly insured discontinue receiving care at CHCs and/or RHCs.

One of the biggest concerns for both CHCs and RHCs is ensuring an adequate supply of providers to meet the projected increase in demand. Our findings indicate that CHCs and, to a lesser extent, RHCs are currently understaffed for any future patient growth, and that they expect needing to hire more staff in the future. Thus, regardless of current capacity, diminished future capacity can be expected as the ACA is implemented unless recruiting difficulties and resource constraints are overcome. While our study was restricted to Iowa CHCs and RHCs, evidence suggests that other states appear to face more significant primary care capacity constraints than Iowa.<sup>15</sup>

Perhaps even more important than responding to the changing insurance landscape is the ability of CHCs and RHCs to participate in ACA-related delivery system changes, such as ACO development. Both CHCs and RHCs have long used midlevel providers to deliver patient-centered, team-based care, but they may be unprepared for ACO participation. For example, recent research finds that RHCs are generally not knowledgeable about ACOs, and may be deterred from ACO participation because of various limited resources.<sup>16</sup>

In Iowa, CHCs and RHCs are embracing the ACA's opportunities and are willing to meet the ACA's challenges, but resource constraints may limit their ability to do so. As seen following the insurance expansion in Massachusetts, the need for safety net providers is only going to increase, thus their

ability to meet the increased demand for primary care services will be critical for access to care for these vulnerable populations.

## Endnotes

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