STATES IN ACTION: A Bimonthly Look at Innovations in Health Policy

March/April 2010

Published March 18, 2010

States in Action is a newsletter from The Commonwealth Fund. Published bimonthly, the newsletter is part of a Commonwealth Fund initiative on state innovations.

Past issues of *States in Action* are available on The Commonwealth Fund Web site at commonwealthfund.org/statesinaction

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Feature

State and Federal Efforts to Enhance Access to Basic Health Care

Primary and preventive care are important for improving and maintaining health, as well as reducing health care costs in the long term. Having health insurance—whether private or public coverage—is a "ticket" for entering the health care system, but by itself does not ensure access to timely and appropriate care. And the safety net clinics and health centers that serve people without coverage struggle to meet demand.

Hampering access to care is a shortage of primary care physicians, nurses, dentists, and other health personnel, particularly in low-income urban and rural communities. There are inadequate numbers of certain types of practitioners, as well as a maldistribution of practitioners—that is, insufficient numbers living and working in isolated geographic areas and/or willing and appropriately trained to serve culturally diverse low-income Medicaid beneficiaries and uninsured individuals.
This issue of *States in Action* focuses on federal and state efforts to enhance access to basic care. We describe a range of strategies available to states, largely involving efforts to expand and leverage the primary care workforce and to develop and test new models of care delivery.

Workforce Shortages and Other Barriers to Access

Tens of millions of people are living in areas of the U.S. with insufficient basic care, as the nursing and primary care physician shortages grow:[1]

- About 65 million people live in regions without adequate primary care, designated by the federal government as Primary Care Health Professional Shortage Areas (HPSAs). According to the Health Resources and Services Administration (HRSA), 16,643 additional primary care providers—more than a 4 percent increase over the current number—would be required to meet the need in the 6,204 primary care HPSAs, based on a population-to-practitioner ratio of 2,000:1. This need would not be met even if all medical school graduates in 2008 had become primary care providers.
- About 49 million people live in areas with shortages of basic dental care. 9,642 additional dental providers would be required to meet the need in the 4,230 dental HPSAs, based on a population-to-practitioner ratio of 3,000:1. This need is the equivalent of 4.1 percent of the 233,104 dentists practicing nationally in 2008.
- About 80 million people live in areas with shortages of mental health care. 5,338 additional mental health providers would be required to meet the need in 3,201 mental health HPSAs, based on a population-to-practitioner ratio of 10,000:1. This is the equivalent of about five times the number of graduating medical students who were matched to psychiatry programs in 2009.

A report by the National Association of Community Health Centers found that 56 million Americans have inadequate access to a primary care physician and could be considered "medically disenfranchised," out of the even larger number of people who are considered medically underserved because they live in shortage areas or face financial, linguistic, or other challenges to accessing primary care.[2]

Further, there is an estimated shortfall of over 400,000 nurses, projected to grow to 1 million nurses by 2020.[3] Last year, about 50,000 qualified applicants to nursing programs were turned away, primarily due to lack of qualified faculty and clinical training sites. An aging nursing workforce

and attrition also contribute to this shortage.

The number of medical school graduates choosing primary care disciplines such as family practice, internal medicine, and pediatrics has been declining sharply, as the income gap between primary care physicians and specialists—related to wide disparities in reimbursement rates under both public and private coverage—continues to grow. The U.S. physician workforce has a larger proportion of specialists than in many other countries, with 65 to 70 percent of physicians specializing according to some estimates (though some specialists spend part of their time providing primary care). Less than 50 percent of the physicians in Canada, the United Kingdom, and New Zealand are specialists. Cross-national patient surveys find that Americans are less likely than Canadians, Britons, and New Zealanders to have a regular doctor or place of care.[4]

In addition to barriers to access related to workforce shortages, many people face economic, cultural, or language barriers to care. The causes and consequences of such barriers are too complex to address here. To learn about them, see *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook* and *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*.

Federal Efforts to Improve Access to Primary Care

There are many federal programs dedicated to reducing barriers to care. HRSA's Bureau of Health Professions, for example, addresses workforce shortages and insufficient diversity in the health workforce by identifying areas of need and administering a variety of grants and other funding for health professional education and training. HRSA's Bureau of Primary Health Care provides funding and technical assistance to federally qualified health centers, which provide care to uninsured, low-income, and underserved populations. Table 1 lists federal programs that benefit health care workforce shortage areas.

The American Recovery and Reinvestment Act, also known as the stimulus plan, signed into law February 17, 2009, provides significant funds to supplement prior efforts to combat barriers to health care access, generate new health care jobs, and meet the primary care needs of the growing uninsured and Medicaid populations. About $200 million was allocated to help train health care professionals through grants, scholarships, loans, and loan repayments.[5] An additional $300 million was allocated to expand the National Health Service Corps, providing scholarships and loan repayments for students and practitioners who agree to practice primary care in shortage areas. The number of National Health Service Corps practitioners is expected to double to more than 8,000 by 2011.[6]

Table 1. Federal Programs that Benefit Shortage Areas
Health Center Program – administers grants and technical assistance to health centers serving primarily uninsured and low-income, publicly insured patients
Rural Health Clinic Program – provides cost-based reimbursement from Medicare and Medicaid to rural health clinics
Medicare HPSA Bonus Payment – offers extra payments to physicians who serve in primary care HPSAs and to psychiatrists serving in mental health HPSAs
National Health Service Corps Loan Repayment and Scholarship Programs – provide scholarships and educational loan repayment to primary care health professionals and students training to become primary care physicians, dentists, nurse practitioners, certified nurse-midwives, or physician assistants who practice in underserved areas[7]
Indian Health Service Scholarship Program – offers students of American Indian or Alaska Native background scholarships for training in health professions and allied health professions in exchange for service obligations
Exchange Visitor Program – waives the two-year foreign residency requirement for foreign physicians with J-1 visas in exchange for working for three years in a primary care or mental health HPSA
Conrad State 30 Program – allows states 30 J-1 visa waivers for foreign physicians each year in exchange for service in a shortage area

Source: HSRA, http://bhpr.hrsa.gov/shortage/, accessed February 2010.

The American Recovery and Reinvestment Act also provided $2 billion for grants to health centers to expand their capacity to provide primary and preventive health services to medically underserved populations, and to meet an increased demand resulting from job losses and other effects of the recession. The Increased Demand for Services initiative (about $340 million), for example, is funding health center efforts to expand access through hiring new providers, extending hours of operation, and increasing the types of services offered. The Facility Investment Program ($515 million) and Capital Improvement Program ($850 million) are funding the costs of health center construction, renovation, and equipment, including information technology such as electronic health records.

The federal government also contributes to health care workforce development through payments to teaching hospitals for costs associated with training physicians in residency programs. These payments from Medicare and Medicaid total about $12 billion per year.

State Strategies to Address Workforce Shortages

Many analysts view the current HRSA and other federal programs to expand and redistribute the primary care workforce as helpful but inadequate. According to one analysis, such efforts are not enough to "counter overwhelming market incentives toward lucrative and highly specialized services—mostly in metropolitan areas."[8] While there are a substantial number of new and planned medical schools, as well as increases in class sizes at some existing schools, these expansions alone are not likely to change the proportion of primary care providers in the physician workforce. Major payment reforms and changes in current federal subsidies in training and education may be necessary. But there are also efforts under way at the state level to improve access to primary and preventive medical and dental care. Indeed, there are many ways in which states can help increase the supply of primary care clinicians or leverage existing providers. States can supplement and build on federal incentive programs, or take the lead and test new approaches, potentially paving the way for expansion at the federal level.

Scope of Practice

Scope of practice laws, which detail the services that health professionals are allowed to offer and the settings in which they can practice, are largely determined by state governments. As a result, there is wide variation among scope of practice laws across states, particularly for mid-level practitioners such as nurse practitioners, physician assistants, emergency medical technicians, and dental health workers. Some states strictly limit the services and settings for these professions, while others allow broad latitude, thereby increasing the pool of practitioners[9] able to provide basic medical and dental services. Training and qualifying mid-level practitioners to conduct some basic services traditionally performed by physicians and dentists—especially in rural and shortage areas and in public programs—can improve access to care and reduce costs.

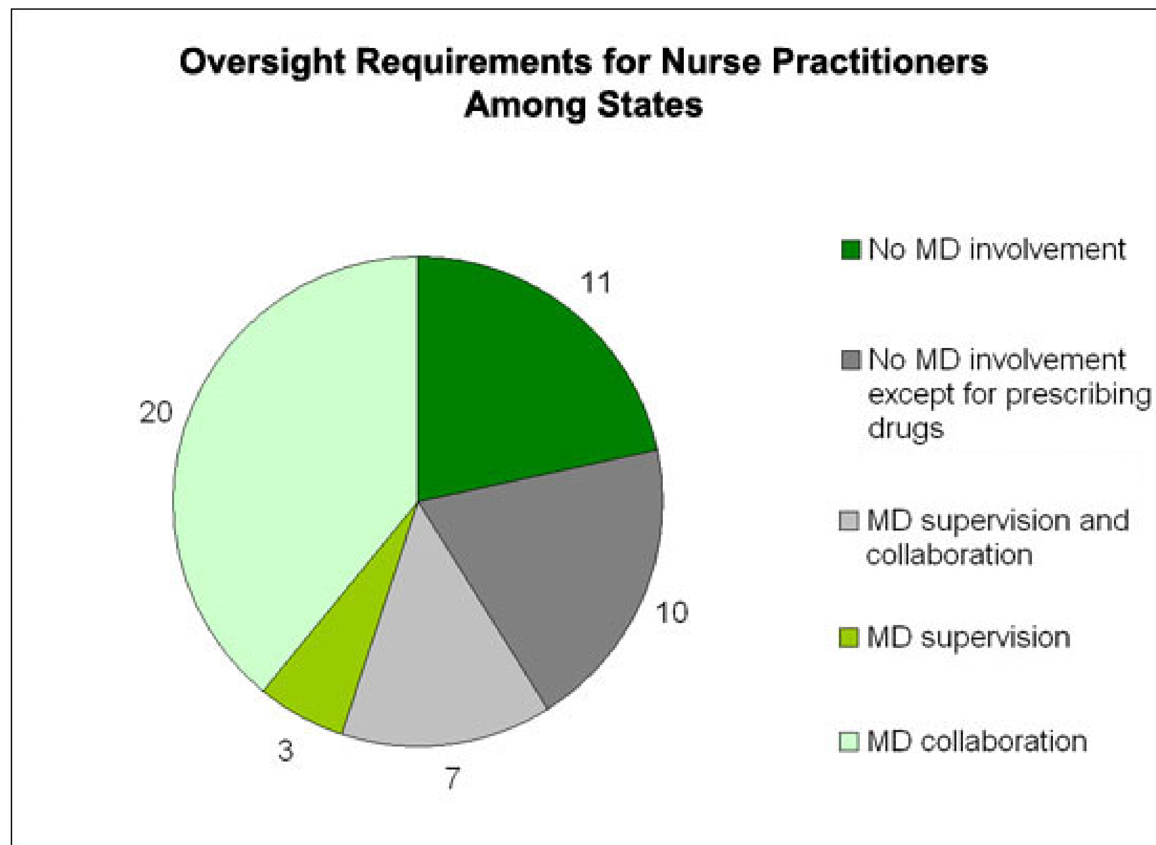
While state legislatures can change scope of practice laws, state nursing and medical boards also have rule-making authority over scope of practice, such as defining training and certification requirements.

Virtually all states have used scope of practice laws to define and/or expand the role of nurse practitioners. About 147,295 nurse practitioners are serving patients in the U.S., with varying capacities in different states (Figure 1).[10] In addition, as described in a Snapshot in this issue, Alaska and Minnesota promote the use of "dental therapists" to help meet basic dental needs in isolated areas, address workforce shortages, and reduce costs.

Oversight Requirements

States use scope of practice laws to expand the use of allied health workers as well as more highly trained health professionals. Lay community health workers, for example, can fill roles such as counselors and educators, patient advocates, or members of clinical teams. Community health workers usually share a racial or ethnic background and/or a primary language with the community members they serve, helping to build bridges between the health care system and populations who face financial, language, or cultural barriers to care. The Bureau of Labor Statistics

Figure 1. Nurse Practitioner Scopes of Practice



Note: Totals sum to 51 (50 states and the District of Columbia). States use varying definitions of collaboration and supervision, but supervision generally involves direct or indirect physician oversight of the services provided by nurse practitioners, while collaboration means that nurses and physicians plan and practice together in an interdependent way.[11]

Source: S. Christian and C. Dower, *Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners* (Oakland, CA: California HealthCare Foundation, January 2008).

estimated that there were approximately 121,206 community health workers nationwide in 2005, an increase of 41 percent from 85,879 in 2000.[12]

Expanding the pool of health care providers through scope of practice changes has been controversial. Often, physicians and dentists are concerned about the ability of mid-level trained professionals to provide high-quality care and treat complex cases; some also fear increased competition for their services. Advocates for broadening the scope of practice point out that doing so expands access to much-needed services, helps leverage the expertise of physicians and dentists by freeing them to treat more complex or critically ill patients, and reduces costs for many basic services. States have addressed some quality control concerns through careful delineation of authorized responsibilities, stringent educational and certification requirements, and requirements for physician/dentist supervision. States also can fund analyses of the likely impact of scope of practice changes, and then monitor and evaluate expansions. While some research has suggested that nurse practitioners can provide primary care that is comparable in quality to that provided by primary care physicians, this issue continues to generate debate and research.[13]

Primary Care Reimbursement

Another critical lever that states control is third-party reimbursement. State insurance departments and Medicaid programs determine whether various practitioners qualify for reimbursement by private insurers and Medicaid, respectively.[14] States may also use their leverage as health care purchasers to attempt to reduce provider workforce shortages by setting competitive Medicaid reimbursement rates for primary care services and for new models of care, such as medical homes and community care teams that emphasize primary and preventive care.

There are significant disparities in Medicaid rates across states for services overall and for primary care specifically. While higher payment rates do not guarantee access to care, they do increase the probability that providers will accept Medicaid patients.[15] Among pediatricians in private practice, there is evidence that Medicaid fee levels, in addition to the payment models and administrative requirements, influence provider acceptance rates.[16] As of 2008, five states had Medicaid primary care reimbursement rates that were comparable to or higher than the rates paid by Medicare.

Some states are offering enhanced Medicaid payments (and/or encouraging additional private insurance payments) to practitioners for becoming "medical homes," a patient-centered approach to providing comprehensive primary care. This has the potential to improve access to care by encouraging practitioners to serve Medicaid beneficiaries and take an active role in prevention. In some cases, the payments are sufficient to cover the cost of care teams, including care coordinators and health educators.

Several states, including Vermont, North Carolina, and Rhode Island, are using Community Health Teams to coordinate primary care and other services in order to prevent and manage chronic disease, creating both a new care coordination structure and new payment strategies to support it. West Virginia and Pennsylvania are also planning to implement this model. Community health teams include a variety of providers, from care coordinators and nurse practitioners to nutritionists, social workers, behavioral health providers, and other community health workers. The model is also part of the national, multi-payer "Advanced Primary Care" demonstration projects being conducted in Medicaid and Medicare. Vermont is integrating the medical home and community health team models as part of its Blueprint for Health public–private initiative to reduce the toll of chronic diseases, an effort highlighted in the June/July 2009 issue of *States in Action*. The state divides the responsibility for funding the salaries of community health team staff among private insurers, the state Medicaid program, and Medicare.

Colorado's Medicaid program is offering enhanced payments for certain preventive services to practitioners who meet medical home certification. Working with the state, the Colorado Children's Health Access Program provides support services to pediatric practices—including a centralized care coordination/resource hotline, assistance with Medicaid enrollment and claims, and help with quality improvement projects—that qualify the practices for the additional reimbursement. This effort has helped to increase the portion of private pediatric practices serving children in public programs from about 20 percent in 1996 to more than 90 percent today.

Telemedicine

Telemedicine involves the use of conference calls as well as videoconferencing and other Web-based technologies for consultations, medical procedures, or examinations. Telemedicine can enhance access to care for patients in isolated rural areas or other areas where they face challenges in accessing care. Telemedicine is most often thought of as a strategy for increasing access to specialists for patients in remote areas, but it also can be used to expand access to primary care.

While telemedicine may produce savings by reducing travel time and expenses, it may require investments in sophisticated, and expensive, equipment. In addition, state physician licensing requirements may present challenges to the use of telemedicine across state borders, though 10 states have some version of a portable special-purpose license that covers telemedicine interactions.

As part of their efforts to improve access to primary care, states can cover telemedicine services in their Medicaid programs and require private insurers to reimburse for them. Estimates of the number of states that cover telemedicine in Medicaid vary from 19 to 34, with states taking different approaches and covering different services.[17] Maine and New Hampshire recently enacted requirements for private insurers to pay for telemedicine, joining 10 other states with similar laws.

Table 2: States Requiring Private Insurance Coverage for Telemedicine	
▪ California	▪ Louisiana
▪ Colorado	▪ Maine
▪ Georgia	▪ New Hampshire
▪ Hawaii	▪ Oklahoma
▪ Kansas	▪ Oregon
▪ Kentucky	▪ Texas

Source: M. Edwards, Background on Maine and New Hampshire's Enactment of Laws Mandating Private Insurance Reimbursement for Telemedicine, Maine Telemedicine Service News, September 2009.

Training and Placement Incentives

As described above, the federal government provides financial and other incentives to promote training of primary care physicians and nurses and encourage them to practice in underserved areas. States can supplement these efforts through tuition discounts, loans, and/or scholarships to students pursuing primary care degrees; loan forgiveness and affordable housing to graduates agreeing to practice in underserved areas for a specified period of time; and creation of medical school slots and incentives for students to specialize in primary care.

Community Health Center/Clinic Capacity

In 2008, community health centers provided care for more than 17 million patients, including 3.1 million who received dental services and nearly 700,000 who received mental health care.[18] Through financing, reimbursement, and technical assistance for community health centers, rural health centers, and state-run clinics, states can increase the number and capacity of health centers that provide primary and preventive care to low-income and uninsured residents. A recent study found that increasing grant funding for federally qualified health centers between 1996 and 2006 increased the services available to patients, including uncompensated care.[19] There is also evidence to suggest that by providing a regular source of care, health centers can reduce disparities in access to care related to race/ethnicity, income, and insurance status.[20]

Recent experience in New Orleans demonstrates the potential for community clinics to provide care for high-need populations. Since the city's major safety net hospitals were devastated by Hurricane Katrina, a network of independent primary care and behavioral health clinics has emerged to meet the population's substantial needs. A Commonwealth Fund study of patient experiences in these clinics in 2009 found that most patients reported having easy access to care, as well as good management of their chronic conditions.

For more information

See:

Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Improving Incentives in the Medicare Program, June 2009.

Health Workforce Information Center

M. M. Doty, M. K. Abrams, S. Mika et al., *Coming Out of Crisis: Patient Experiences in Primary Care in New Orleans, Four Years Post-Katrina*—Findings from The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans. (New York: The Commonwealth Fund, January 2010).

C. Schoen, R. Osborn, M. M. Doty et al., A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences. *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.

The Johns Hopkins Primary Care Policy Center

Notes

1 Estimates as of September 30, 2009. Health Resources and Services Administration, U.S. Department of Health and Human Services, http://bhpr.hrsa.gov/shortage/, accessed February 2010.

2 *Access Denied: A Look at America's Medically Disenfranchised* (Washington, D.C.: National Association of Community Health Centers, March, 2007).

[3] D. J. Derksen. and E.-M. Whelen, *Closing the Health Care Workforce Gap* (Washington, D.C.: Center for American Progress, December 2009).

[4] Schoen, R. Osborn, P. T. Huynh et al., "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive, October 28 2004:W4-487–503.

[5] Programs funded by the American Recovery and Reinvestment Act include: Scholarships for Disadvantaged Health Professions Students; the Centers for Excellence program; the Nursing Workforce Diversity program; the Health Careers Opportunity program; and the Equipment to Enhance Training of Health Professionals program.

[6] Key Facts About the National Health Service Corps, U.S. Department of Health and Human Services, http://www.hhs.gov/recovery/programs/nhsc/nhscfactsheet.html, Accessed February 2010.

[7] Loan repayment of up to $50,000 in student loans is also available to dental hygienists and mental health providers in exchange for two years of service at an approved site in a HPSA.

[8] D. J. Derksen and E.-M. Whelen, *Closing the Health Care Workforce Gap* (Washington, D.C.: Center for American Progress, December 2009), p. 10.

[9] There is a federal requirement that nurse practitioners must complete at least a three-month specialized training program.

[10] Total Nurse Practitioners, 2009, Statehealthfacts.org, http://www.statehealthfacts.org/comparemaptable.jsp?ind=773&cat=8, Accessed February 2010.

[11] For a more detailed discussion of these distinctions and the wide range of state definitions of these terms, see: *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*. (Dallas, TX: Federation of State Medical Boards, 2005), http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf.

[12] Community Health Worker National Workforce Study (Washington, D.C.: U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Professions, 2007).

[13] M. O. Mundinger, R. L. Kane, E. R. Lenz et al., "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association*, 2000 283:59–68.

[14] S. Christian and C. Dower, Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners (Oakland, CA: California HealthCare Foundation, January 2008). http://www.chcf.org/documents/policy/ScopeOfPracticeLawsNursePractitionersIB.pdf

[15] P. J. Cunningham and L. M. Nichols, "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective," *Medical Care Research and Review*, 2000 62(6):676–96.

[16] S. Berman, J. Dolins, S. Tang et al., "Factors that Influence the Willingness of Private Primary Care Physicians to Accept More Medicaid Patients," *Pediatrics*, 2002 110(2): 239–48.

[17] N. A. Brown, State Medicaid and Private Payer Reimbursement for Telemedicine: An Overview, Journal of Telemedicine and Telecare, 2006 12(Suppl. 2):S32–9 and J. P. Marcin, J. Trujano, C. Sadorra et al., "Telemedicine in Rural Pediatric Care: the Fundamentals," *Pediatric Annals*, 2009 38(4): 224–26.

[18] Providing Access to Health Care in the Nation's Most Needy Communities, http://bphc.hrsa.gov/.

[19] A. T. Lo Sasso and G. R. Byck, "Funding Growth Drives Community Health Center Services," *Health Affairs*, 2010 29(2): 289–96.

[20] R. M. Politzer, "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care," *Medical Care Research and Review*, June 2001 58(2):234–48.

Ask the Expert

In this States in Action*, we talk with Fitzhugh Mullan, M.D. Dr. Mullan is a professor of medicine and health policy at the George Washington University School of Public Health and Health Services, where he directs a program focusing on the influence of medicine and medical education on health care and public health. Previously, Dr. Mullen directed the Health Resources and Services Administration's Bureau of Health Professions, the National Health Service Corps, and other workforce programs.*

Q: What would you say are the key drivers behind the shortage and maldistribution of primary care practitioners in this country?

First, "pay parity" is lacking for primary care. They make less and this is both a financial and "signal" problem—lower pay sends the message that primary care is less important. Second, mission setting by medical schools that tend to promote specialism and demean generalism. Virtually every family physician in the U.S. has a story from medical school of a faculty member who told him/her, "You're too smart to be a family doctor."

Q: To what degree does this shortage and maldistribution affect access to care?

Access to primary care is stretched thin everywhere. Worse, any kind of cost and/or quality-conscious change to the system will have to amplify the role of primary care, and the providers won't be there. For example, the state of Massachusetts experienced an acute shortage of primary care providers after they expanded coverage in their 2006 health reform.

Q: How effective are tuition assistance, loan forgiveness, and other incentive programs (e.g., National Health Services Corp) for getting the right health care providers to practice where they are needed most?

These programs are very efficient and socially responsible. We need more of such incentives including applying the same principles to other shortage areas—primary care in general, public health, prison health care, global health service, etc.

Q: How else can we steer students and practitioners toward primary care, given the "big money" is in other medical specialties?

The real fix is a big fix. A closed system that requires us—or some portion of us—to live off the same health care budget will immediately put primary care at the center of things since primary care represents the best shot at prudent, evidenced-based, organized delivery. This, of course, would raise the salaries and heft of primary care providers, and the workforce would, in time, re-balance itself. We have examples of that in capitated systems such as Kaiser Permanente and the Veterans Administration.

Q: To meet primary care needs, do we need to change the traditional model of care delivery? If so, how?

Medical homes and accountable care organizations are good partial solutions that will take more advantage of the capabilities of primary care. As long as they remain islands in a sea of fee-for-service, however, their influence will be good but limited to the population of their "island."

Q: What role can and should states play to promote access to primary care?

States can do a number of things: 1) use Medicaid to promote the use of primary care in organized delivery systems; 2) review the performance of state-sponsored medical schools in regard to primary care output; and 3) review any state GME/Medicaid monies in regard to the institutional performance of the hospital-based training programs in regard to primary care output. Reviews of state training support should include consideration of conditioning funding on performance in regard to primary care.

Q: How can states and the federal government support and complement each other in this effort?

States and the federal government can collaborate on workforce research. Data collection and analysis would better equip us to engage the primary care and other workforce issues. A national workforce commission to examine and make policy recommendations in this area, as proposed in the Senate reform bill, would be very helpful.

Snapshots

Overview

The diversity of state efforts to enhance access to basic care reflects not only different areas of unmet need, but also different political and health sector dynamics as well as the wide range of available strategies. The following Snapshots represent only a small sample of current state activities.

Massachusetts: Comprehensive Approach to Expanding Access

After Massachusetts expanded health care coverage as part of comprehensive health reform in 2006, it faced increased pressures on its primary care system. In response, the state included a set of provisions to improve access to health care services in a cost-containment bill (MA S 2863) passed in 2008 (Table 3).

Table 3. Massachusetts' Access Provisions, MA S 2863, passed 2008.
• Establishes a new Health Care Workforce Center within the Department of Public Health to improve access to health care services in the Commonwealth, with a particular emphasis on primary care. The Center will develop short-term and long-term policies to address workforce shortages.
• Creates a new loan forgiveness program for doctors and nurses who commit to practicing certain specialties in medically underserved areas, administered by the Health Care Workforce Center.
• Expands enrollment at the University of Massachusetts Medical School for students committed to primary care specialties.
• Creates an enhanced "learning contract" for University of Massachusetts Medical students who commit to working four years in primary care in Massachusetts , providing a greater tuition incentive for those who participate but also including a tougher penalty for students who don't complete their commitment.
• Creates an affordable housing model for health care professionals committed to providing care in underserved regions.
• Requires health insurers to recognize and reimburse nurse practitioners as primary care providers.
• In medically underserved areas, expands the number of physician assistants that a physician may supervise from two to four.
• Establishes a Nursing and Allied Health Workforce Development Trust Fund to increase the nursing workforce and creates a loan forgiveness/incentive program for nursing graduates who commit to serve as nursing faculty for a specified number of years.
• Directs the MassHealth Payment Policy Advisory Board to study methods of improving reimbursement or bonuses for primary care providers.

Source: National Conference of State Legislatures, Summary of MA S 2863.

These primary care provisions were implemented relatively recently, and it may be too soon to evaluate their impact. They may take years to grow to a scale that will substantially affect the primary care workforce, and current budgetary constraints are likely to slow this process. For example, the Health Care Workforce Center's taskforce on primary care and other issues has had its ability to function limited by budget cuts. "This is a good idea, but so far it has been underfunded," said Dennis Dimitri, M.D., president of the Massachusetts Academy of Family Physicians and vice chair of clinical services in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School.

The state will track how medical students and providers respond to new incentive programs. The planned increase in class size at the University of Massachusetts Medical School, for example, was envisioned as a complement to other incentives to specialize in primary care, with the goal that

together they would attract a greater number of students. In another initiative intended to increase the number of physicians from underrepresented ethnic and socioeconomic backgrounds, the University of Massachusetts Medical School is launching a program that would allow high school students to be admitted simultaneously to college and subsequent medical school training.

Massachusetts is also involved in a public–private partnership to repay loans for primary care physicians and nurse practitioners working at community health centers. The partnership is run by the Massachusetts League of Community Health Centers and funded by the state, Bank of America, and a number of health plans and other health care organizations. Between June 2007 and January 2009, the program repaid loans for 57 physicians and 25 nurse practitioners. The state had previously made a variety of investments to increase health center capacity, including grants to help expand health center hours and further promote access.

Dr. Dimitri noted one initiative that is moving ahead quickly: an all-payer, patient-centered medical home pilot run through the executive office of the Massachusetts Department of Health and Human Services. Over the next two to three years, this program will create medical homes in many different types of medical practices, from community health centers to academic health centers to larger group practices with primary care physicians. "The pilot has moved ahead with everyone at the table, including the insurers, the state, physician organizations, primary care providers, and academic medical practice representatives," he said. "Our hope is that it will be very helpful in improving the delivery of primary care, which is critical to attracting providers to the field and expanding access to their services."

For more information

See: Summary of MA S 2863, National Conference of State Legislatures, http://www.ncsl.org/Portals/1/documents/magazine/ma_s2863.pdf and Primary Care Provider Initiatives, MA League of Community Health Centers, http://www.massleague.org/Programs/PrimaryCareProviderInitiatives/LoanRepaymentProgram-CHC.php

Alaska and Minnesota: Increasing Access to Dental Care

Since 2003, the Alaska Dental Health Aide Therapist Program has trained a new type of mid-level dental provider to perform routine dental services in remote rural areas of the state, with a focus on increasing access to preventive and basic dental care for the Alaska Native population. This past year, Minnesota approved a more limited dental therapist role to help enhance access to basic dental care.

Dental therapists in Alaska work under the general supervision of a dentist and are part of a team of providers, but they can provide care without being in the physical presence of a dentist. "The ability to use general supervision allows dental therapists to get to areas where dentists have not traditionally been, and to bring people into the oral health and dental care system who would not

otherwise have access," says Dental Health Aide Program Director Mary Williard, D.D.S, of the Alaska Native Tribal Health Consortium.

The Alaska Native population experiences oral health disparities and a lack of access to dental care compared with the state and nation overall, largely due to geographic isolation and dental workforce shortages. Eighty-five thousand of the 120,000 Alaska Natives in the state live in 200 rural villages, many of which are accessible only by airplane or boat, with the nearest dentist sometimes hundreds of miles away. Alaska Native adults have disproportionately high rates of tooth decay, and the rate of tooth decay among children is more than twice the national average. The Indian Health Service and the tribes have had trouble recruiting adequate numbers of dentists, including clinicians of Alaska Native ethnicity. In Alaska, tribal programs have historically had a vacancy rate of 25 percent for dentists, and annual turnover rates are as high as 30 percent.

The first phase of the program, initiated by the nonprofit Alaska Native Tribal Health Consortium with outside grant funding, built on other countries' extensive experience training similar providers. Forty-two countries use some version of a dental therapist to address workforce shortages or maldistributions and increase access to care. An initial group of six Alaskan students began training as dental therapists in 2003 at the University of Otago in New Zealand, where dental therapists have been providing comprehensive primary dental care since 1921.

In Alaska, dental health aide therapists are part of an integrated team of dental care providers, and are able to provide preventive oral health services, including nutrition and tobacco cessation counseling, as well as basic dental services such as tooth cleanings (above the gums), filling cavities, primary tooth and nerve treatment, primary tooth preformed crowns, and simple extractions.

In 2007, the Alaska Native Tribal Health Consortium and the University of Washington School of Medicine Physician Assistant Training Program, MEDEX Northwest, launched a collaborative Alaska-based training program, the DENTEX Dental Health Aide Therapist Program. In addition to 10 New Zealand-trained dental therapists who are now practicing, nine have graduated from the DENTEX training program and are either working in the field or undergoing a mandatory certification process. The training program is funded mainly with foundation grants, with additional federal funding from the Indian Health Service and the Health Resources and Services Administration. Students are sponsored by tribal health organizations for two years of training, and then owe four years of service to that entity as salaried employees.

The dental therapist model helps address recruitment challenges. "It is very hard to recruit dentists to serve Medicaid populations when reimbursement is low—but dental therapists' salaries are about half that of dentists, so the financing becomes workable," said Williard. Further, Alaska's Medicaid program recently shifted to paying the same amount for a dental visit, regardless of whether a more expensive treatment or a less costly preventive service is provided. Dr. Williard hopes this change "will tip the scales even more toward primary prevention, and motivate people to train and get out into the villages, where this care can make a big difference."

Two independent evaluations have found that Alaskan dental therapists provide high-quality, appropriate care that is within their scope of practice, and another comprehensive evaluation

is under way. There is no official estimate of how many people are currently served by dental therapists, but according to Williard the numbers are growing and the integration of these new providers into the communities they serve has been successful. They live in the villages where they work, and in some cases may be the first dental providers to be permanent residents in the area.

In Minnesota, a law enacted in May 2009 created two new dental therapist roles with a more limited scope of practice than in Alaska, requiring the new providers to practice with a dentist present in the same office. There was extensive debate in Minnesota, with the Minnesota and American Dental Associations successfully arguing for narrower scope of practice than the Alaska program allows. Minnesota established its own training requirements for its dental therapists, with the University of Minnesota's dental school offering its first classes in the fall of 2009 for a four-year Bachelor of Science in Dental Therapy degree and a two-year Master of Dental Therapy degree. In Alaska, students can enter the dental therapist training program after completing four years of high school.

Minnesota's experience illustrates the challenges that efforts to implement the Alaska dental therapist model in other states (or outside the tribal health system) would likely face. The Alaskan program reached an agreement with the American Dental Association that its model would not be extended outside the tribal health system, and that it would support proposed language to be included in the Indian Health Care Improvement Act that would limit the model to Alaska, even within the tribal health system. The U.S. House and Senate passed that Act as part of their health reform bills, but its ultimate enactment depends on further action on health reform. If the legislation passes, Alaska and Minnesota's programs would continue unchanged, but any new programs in the rest of the country would require changes in state law similar to the process Minnesota went through.

"The Minnesota model is important not only because it will certainly improve access to care for many people in the state, but because it really changed the playing field for the rest of the country outside Alaska," says Dr. Williard. "For a state to change their practice is a major development."

For more information

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Oklahoma: Enhancing Access Through Medicaid Rate Increases and Medical Homes

Over the past five years, Oklahoma has used a combination of rate increases, outreach, administrative simplification, and a medical home initiative to enhance access to care in SoonerCare, the state's Medicaid program.

In 2005, Oklahoma increased its Medicaid reimbursement to 100 percent of Medicare rates—a substantial increase from rates that were 28 percent below Medicare levels in 2003. The Oklahoma legislature appropriated additional funds specifically for a rate increase. This change occurred during a period when Medicaid rates across the country were growing more slowly than inflation. From 2003 to 2008, Medicaid fees increased an average of 15.1 percent nationally, but because their overall growth was below the rate of inflation this actually amounted to a decrease in their real value.

According to Medicaid Director Lynn Mitchell, M.D., the board of the Oklahoma Health Care Authority (OHCA), which administers Medicaid, had for years recognized the need to keep provider payment rates fair and competitive, and accordingly made this a top priority in several years of strategic planning. As the Medicaid program grew and increasingly became a line of business for a wider range of providers, the need for this type of accountability continued to increase. "A great deal of effort was focused on the rate increase, both in terms of a potential legislative agenda, and in working with our partners in the state medical, osteopathic, and hospital associations," Dr. Mitchell said.

The Medicaid program also sought to promote access to care through expanded outreach efforts and improve its relationships with providers by reducing their administrative burdens. As a result, it has not been possible to isolate the impact of the rate increase on access to care, though Dr. Mitchell noted that providers' response to the increase has been very positive.

As in many states, Oklahoma has struggled to preserve its Medicaid rates in the current economic environment. After extensive efforts to avoid a rate cut, the OHCA took action to make a 3.25 percent reduction in provider rates starting April 2010, though Dr. Mitchell noted that the situation could change before it takes effect. Oklahoma still views the rate increase as a successful effort, noting that OHCA's board continues to focus on preserving rates and rebounding from any cuts as soon as economic conditions allow.

In the past few years, the Medicaid program's efforts to establish and promote medical homes have become a major policy priority. Interest from the provider community has led OHCA, in collaboration with providers, to develop an enhanced payment model for medical homes in the existing SoonerCare Choice program (in which most Medicaid members are enrolled). The new model was implemented in January 2009 under a Section 1115a waiver. The change shifted the program away from a partially capitated managed care model to a monthly payment for care coordination and case management, in combination with a fee-for-service component for office visits. The care coordination fee is set based on characteristics of the practice and populations that providers serve, and also on the practice's sophistication as a medical home, ranking its capabilities in three tiers from "entry level" to "optimal."

The model also includes a pay-for-performance bonus program. Advanced registered nurse practitioners and physician assistants can qualify as medical home providers, and the state has a wide variety of practice sites participating. OHCA Provider Services Director Melody Anthony said the transition has been successful so far. "The provider community has been very supportive,

and a large percentage of providers are qualifying for bonus payments under the new SoonerExcel pay-for-performance program," she says.

Oklahoma's Medicaid leaders have learned that rate increases alone are not sufficient to address access to care and provider participation. It has been crucial for the state to work with partners and make the improvements explicit priorities. "It took a lot of outside help to move these efforts forward from the standpoint of legislative progress and dollars," Dr. Mitchell said. "And we did not look to just one area to be the answer."

For more information
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Maine: Requiring Private Insurers to Reimburse for Telemedicine

In January 2010, Maine joined 11 other states in requiring private insurers to reimburse services provided via telemedicine. The new Maine law defines telemedicine as "the use of interactive audio, video, or other electronic media" for "diagnosis, consultation or treatment," excluding e-mail and telephone communication. It specifies that an insurance carrier must cover services that would be reimbursed if they were provided in person, and that patient cost-sharing for telemedicine services cannot be higher than it would be for the same service in person.

Maine's Medicaid program, MaineCare, has covered telemedicine services delivered via interactive video sessions for over a decade, but as of 2008 only one of four major insurers in the state had a policy for reimbursement of some telemedicine services. There are varying perspectives within the state on the role of telemedicine and how this change might affect its use and patients' access to care.

"The focus of this effort was really expanding the accessibility of care. Because Maine is so rural and the distances involved in getting to care can be so great, there are often significant challenges in accessing many different types of providers," said Representative Anne Perry, sponsor of the bill and a nurse practitioner. Indeed, past state efforts to expand rural health services have highlighted telehealth reimbursement as a barrier to its broader adoption, according to Michael Edwards, Ph.D., a project evaluator with the Regional Medical Center at Lubec and its division Maine Telemedicine Services. "It will take a few years to see whether private insurance coverage increases utilization," he said.

Charles Dwyer, director of Maine's Office of Rural Health and Primary Care, said Maine looked at the experience of other states in developing its approach. "The issue of reimbursement needed to be addressed, and we 'leapfrogged' by looking at other states with similar mandates," he said. "It was a welcome surprise to see such strong support for the bill."

Maine hospitals, some of which already have telemedicine programs, strongly supported the new law. Insurers opposed the change, arguing that evidence on the effectiveness of telemedicine and the need to expand its use in Maine was not sufficient to justify reimbursement requirements. The Maine Telehealth Advisory Committee, which Dwyer coordinates, will be studying the effects of the new law on utilization of telemedicine.

Also, Maine will be closely monitoring other states' coverage of home "telehealth" services, which its Medicaid program currently does not cover. This would include, for example, home blood pressure or glucose monitoring equipment with a telecommunications connection to a provider, which would enable diabetic patients to transmit information needed for care management to a remote location. Maine will "need to look both nationally and locally at emerging evidence showing decreases in hospital and emergency room use with in-home telehealth calls, especially for congestive heart failure and diabetes," said Perry. "Moving forward, especially given budget issues, we must focus on how to be more effective and cost-effective with services, and reduce the use of high-cost services as much as possible."

Though telemedicine is often considered to be most useful in increasing access to specialty care, it can also be useful in expanding access to primary care. "We're very rural, and as the primary care situation just gets worse across the nation, in terms of retirements and where medical students are going, the need for strategies such as telemedicine to address it will continue to grow," said Dwyer.

MaineCare's existing coverage of telemedicine services was part of the discussion of the new policy, but it did not drive the change. Use of telemedicine in MaineCare has been limited to date. According to MaineCare Medical Director Roderick Prior, M.D., early experience in the provider community suggests that certain factors are critical to making telemedicine work: a committed technology vendor to set up the infrastructure and make it user-friendly for providers and practices on both the "sending" and "receiving" ends, and providers who are committed to building telemedicine into their practices. "If these conditions are not met, interest may wane—in the past, providers have found that they were less productive via telehealth than face to face, which was a barrier," he said.

Improvements in telemedicine technology, coupled with providers' expanding information technology capacity, may encourage broader use of telemedicine for both primary and specialty care as states move forward with technology infrastructure investments.

For more information

See: http://tie.telemed.org/news/#item1771.

Additional Resources

Commonwealth Fund Publications

M. M. Doty, M. K. Abrams, S. Mika et al., *Coming Out of Crisis: Patient Experiences in Primary Care in New Orleans, Four Years Post-Katrina*—Findings from The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans, The Commonwealth Fund, January 2010.

J. Gabel, *Does the Congressional Budget Office Underestimate Savings from Reform? A Review of the Historical Record*, The Commonwealth Fund, January 2010.

D. McCarthy and K. Mueller, *Scott & White Healthcare: Opening Up and Embracing Change to Improve Performance*, The Commonwealth Fund, January 2010.

A. Osei-Anto, M. Joshi, A-M. Audet et al., Health Care Leader Action Guide to Reduce Avoidable Readmissions, Health Research & Educational Trust, The Commonwealth Fund, and the John A. Hartford Foundation, January 2010.

S. Silow-Carroll, *Rhode Island's Pediatric Practice Enhancement Project: Parents Helping Parents and Practitioners*, The Commonwealth Fund, January 2010.

A. Robinow, The Potential of Global Payment: Insights from the Field, The Commonwealth Fund, February 2010.

Related Resources

State of the States 2010: The State We're In, AcademyHealth and Robert Wood Johnson Foundation, January 2010.

L. Blumberg, *The Biggest Losers, Health Edition: Who Would Be Hurt the Most by a Failure to Enact Comprehensive Reforms?*, Urban Institute, February 2010.

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J. Cantor, A. Monheit, M. Beloff et al., Dependent Coverage Expansions: Estimating the Impact of Current State Policies, Robert Wood Johnson Foundation and State Health Access Data Assistance Center, January 2010.

R. Carey, Preparing for Health Reform: The Role of the Health Insurance Exchange, AcademyHealth and Robert Wood Johnson Foundation, January 2010.

J. Holahan and L. Blumberg, *How Would States Be Affected by Health Reform?*, Urban Institute, January 2010.

G. Kenney and A. Cook, *Potential Impacts of Alternative Health Care Reform Proposals for Children with Medicaid and CHIP Coverage* (Updated 1/8), Urban Institute, January 2010.

C. Marks, Issue Brief: Maternal and Child Health Statistics, FY 2008, National Governors Association Center for Best Practices, January 2010.

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R. Berenson, P. Ginsburg, and N. Kemper, Unchecked Provider Clout in California Foreshadows Challenges to Health Care Reform, *Health Affairs* Web Exclusive, February 25, 2010.

J. Buxbaum and M. Takach, State Multi-Payer Medical Home Initiatives and Medicare's Advanced Primary Care Demonstration, National Academy for State Health Policy, February 2010.

J. Edwards, L. Duchon, and E. Ellis et al., *Maximizing Enrollment for Kids Diagnostic Assessment Reports*, National Academy for State Health Policy and Robert Wood Johnson Foundation, February 2010.

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C. Hanlon, *Reimbursing Medical Providers for Preventive Oral Health Services: State Policy Options*, National Academy for State Health Policy and The Pew Center on the States, February 2010.

S. Long, A Comment on "The Massachusetts Health Plan – Much Pain, Little Gain," Urban Institute, February 2010.

J. May and N. Kaye, *State Innovations in EPSDT, National Academy for State Health Policy*, February 2010.

S. Perry et al., *Improving Language Access: CHIPRA Provides Increased Funding For Language Services*, Families USA, February 2010.

E. Miller, A. Trivedi, S. Kuo et al., Rhode Island's HEALTHpact Plan: Lessons for Small-Group Reform, Robert Wood Johnson Foundation and State Health Access Data Assistance Center, March 2010.

G. Volk and A. Jacobs, *The Impact of Health Care Reform on State Operations*, AcademyHealth and Robert Wood Johnson Foundation, March 2010

Upcoming Meetings

National Conference of State Legislatures Spring Forum 2010
Washington, DC
April 8–10, 2010
http://www.ncsl.org/Default.aspx?TabID=714&tabs=2638,122,921#921

World Congress Leadership Summit on Accountable Care Organizations
Washington, DC
May 24–5, 2010
http://www.worldcongress.com/events/HL10017/index.cfm

Fifth National Medicaid Congress
Washington, DC
June 7–9, 2010
http://www.medicaidcongress.com/

National Accountable Care Organization Summit
Washington, DC
June 7–9, 2010
http://www.acosummit.com/

2010 National Association of Public Hospitals and Health Systems Annual Conference
Denver, CO
June 23–5, 2010
http://www.naph.org/2010-NAPH-Annual-Conference.aspx

AcademyHealth Annual Research Meeting
Boston, MA
June 27–9, 2010
http://www.academyhealth.org/events/content.cfm?ItemNumber=882&navItemNumber=529

Multimedia and Interactive Resources

Podcast: Health Reform in Massachusetts: Lessons for the Nation, The Commonwealth Fund, December 2009.

E-Forum: Health Insurance Exchanges: House or Senate Style?, The Commonwealth Fund, January 2010.

Webcast: Child and Mental Health, National Governors Association Center for Best Practices, January 2010.

Webinar: Policy Strategies for Advancing Interstate HIT: Using Legal Mechanisms to Address Differences in Laws around Privacy, Security and Other Key Issues, National Governors Association Center for Best Practices, January 2010.

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Podcast: Rebuilding Primary Care in New Orleans, The Commonwealth Fund, February 2010.

Webcast and Podcast: From Crunch to Crisis: State Budgets, Medicaid and the Economy, Alliance for Health Reform, February 2010.

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Webinar and Podcast: Using Income Tax Information to Target Medicaid and CHIP Outreach, State Health Access Data Assistance Center, February 2010.

About the Newsletter

The *States in Action* bimonthly newsletter describes innovative state health programs from across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a Commonwealth Fund program on state high performance health systems. For more information, contact Ed Schor, Vice President, State High Performance Health Systems, at els@cmwf.org. We welcome those involved in state efforts to expand coverage and improve care and efficiency to send an e-mail about their efforts to statesinaction@cmwf.org.

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