

The Impact of Medicaid Expansion on Community Health Center Staffing

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BACKGROUND

Over the last two decades, community health centers (CHCs) have grown to meet the needs of the uninsured and Medicaid populations. This growth has been accelerated by the Affordable Care Act (ACA), which expanded Medicaid eligibility beginning January 1, 2014 and authorized funds for CHC operations. The 2012 Supreme Court ruling, however, made states' Medicaid expansion optional and created a natural experiment—that is, it allowed researchers to compare outcomes in expansion and non-expansion states before and after expansion. So far, studies have found that Medicaid expansion increased CHC volume and primary care utilization.^{1,2} The impact on CHC staffing, however, is largely unexplored. To address this gap, we isolated the differential effect of Medicaid expansion on the size and composition of CHC staff.

METHODS

Using 2009-2015 data from the Uniform Data System (UDS) and multivariate regression analysis, we compared CHC staffing in expansion and non-expansion states before and after January 1, 2014. We excluded observations from 10 states that expanded Medicaid at different time points and excluded CHCs that did not submit data all seven years. This resulted in a sample of 5,222 observations from 746 grantees in 19 expansion and 21 non-expansion states.

We modelled two staffing outcomes—size (full-time equivalents [FTEs]) and composition (percent FTEs) of personnel in four functional roles (physicians, advanced practice providers (APPs), nurses, other medical staff) and two service categories (clinical, enabling)—and isolated the differential effect of Medicaid expansion on each outcome, separately, using a difference-in-differences (DID) model. Outcomes were drawn from one or more UDS items that report the number of FTEs by staff function and service category. Each regression equation included two binary, independent variables representing the Medicaid expansion status of the state in which the CHC was located, whether the observation was before/after January 1, 2014, and an interaction of these two terms (DID estimator). We incorporated covariates, including county-level practitioner supply, number of patients, state nurse practitioner restrictions, and patient-centered medical home (PCMH) status. We controlled for state fixed effects and clustered standard errors at the state-year level.

KEY FINDINGS

1. During the study period (2009-2015), the number of FTEs in each personnel category increased and was typically higher in expansion states than non-expansion states. The share of clinical staff and total staff were more stable across time and states' expansion status. However, once models were adjusted, there was little evidence to suggest a Medicaid expansion-staffing effect.
2. Predictors—other than Medicaid expansion—were highly correlated with staffing including CHC size, practitioner supply, and uninsurance rates.
3. Additional research that includes vacancy rates is needed to understand whether difficulties in recruitment could be an impediment to increasing staff or modifying provider mix in Medicaid Expansion states. Even if this were the case, however, our findings suggest that CHCs may be using other workforce strategies, such as expanded roles or workflow modifications, to manage increased demand for services.

FINDINGS

Over the seven year study period, CHCs reported a mean of 124.2 total FTEs comprised of 34.7% clinical staff (i.e., physicians, APPs, nurses, other medical personnel) and 9.6% enabling staff. Consistent with prior work by this team, unadjusted, descriptive statistics suggest that the mean number of FTEs by function and service category increased significantly over the study period and were higher in expansion states than non-expansion states (Appendix I). The mean percent of total staff that was clinical was stable across time and states' expansion status. In regression models, when factors that were known to contribute to CHC staffing such as PCMH status were incorporated, the magnitude and statistical significance of Medicaid expansion diminished (Appendix II). In only a few cases were the DID estimators large in magnitude and/or statistically significant. For example, we found that Medicaid expansion increased the mean number of APPs by 0.54 FTEs ($p \leq 0.01$) and nurses by 0.69 FTEs ($p \leq 0.05$); increased the percent of clinical staff that was nurses by 1.42% ($p \leq 0.05$); and decreased the percent of clinical staff that was other medical personnel (e.g., medical assistants, nurse aides, quality assurance/electronic health records staff) by 1.80% ($p \leq 0.01$). Medicaid expansion also increased the number of clinical staff FTEs and the percent of all staff that was clinical by 2.45 FTEs ($p \leq 0.01$) and 0.71% ($p \leq 0.05$), respectively. Partial correlations among these variables suggest that predictors such as CHC size, practitioner supply, and uninsurance were more highly correlated with staffing than Medicaid expansion.

CONCLUSION

Prior studies found that Medicaid expansion increased the demand for CHC care. In this study, although CHCs in states that expanded Medicaid tended to have larger staffs, once we controlled for factors that affected staffing and pre-expansion baseline differences, there was little evidence to suggest that Medicaid expansion alone contributed to significant changes in staff size or composition.

POLICY IMPLICATIONS

Findings, which did not substantiate a Medicaid expansion-staffing effect, do, nevertheless, have important implications. First, given that Medicaid expansion increases demand for CHC care, our findings suggest that CHCs likely employ strategies—other than hiring staff—to contend with increased volume. Indeed, surveys conducted in Washington³ and Iowa⁴ found that CHC directors did not always associate anticipated, excess volume with increased staff workload, and, when they did, they employed diverse strategies—such as workflow changes and role expansion—rather than relying solely on increased staffing. Further exploration of these strategies, their impacts, and the programs and policies that would advance those found to be most promising is warranted. Additionally, it is important to note that while our analysis modeled staffing changes, data limitations prevented us from accounting for high vacancy rates in some personnel categories, which are well documented.^{3,4} Finally, Medicaid expansion aside, we know that states' Medicaid income eligibility limits vary. By dichotomizing states' expansion status, meaningful state-to-state differences in staffing could have been obscured. Additional research that accounts for these differences should be pursued.

References:

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