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LDI ResearchBRIEF

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DECLINING MEDICAID FEES AND PRIMARY CARE APPOINTMENT AVAILABILITY FOR NEW MEDICAID PATIENTS

Molly Candon, Stephen Zuckerman, Douglas Wissoker, Brendan Saloner, Genevieve M. Kenney, Karin Rhodes, Daniel Polsky

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KEY**FINDINGS**

Primary care appointment availability for new Medicaid patients declined when Medicaid fees for providers decreased after the ACA-mandated "fee bump" expired.

THE QUESTION

Medicaid reimburses physicians at a lower rate and fewer physicians participate in Medicaid when compared to other insurance types. To encourage provider participation in Medicaid, the Affordable Care Act (ACA) increased Medicaid fees to Medicare levels for primary care providers in 2013 and 2014. As expected, the bump in fees resulted in an increase in primary care appointment availability for new Medicaid patients, with larger increases occurring in states with larger increases in fees. Despite the improvements in access, most states returned to lower reimbursement rates in 2015. The question is: did the gains in access in Medicaid erode once fees declined?

We conducted a study in which callers simulated new patients with Medicaid and requested appointments from thousands of randomly-sampled primary care physicians across ten states before the fee bump was fully introduced (2012 and early 2013) and again during its implementation (2014) and after the Medicaid fee bump expired (2016). We assessed the appointment availability rate, i.e., the percent of requests that resulted in a scheduled appointment. We used state-level Medicaid fees to primary care providers for a level 3 new patient office visit, then measured the changes in fees and changes in appointment availability between 2012 and 2014 to estimate the effect of the increase in fees. We repeated the analyses between 2014 and 2016 to estimate the effect of the fee bump's removal, partial removal, or retention.

THE FINDINGS

The average Medicaid fee for a new patient office visit increased from $68.58 in 2012 to $107.38 in 2014 and decreased to $75.67 in 2016. Similarly, the appointment availability rate increased from 56.2 percent to 65.5 percent, then fell to 61.5 percent. Except for Iowa and Oregon, each state followed a similar pattern. Overall, we found that a $10 decrease in payments was associated with a 1.7 percentage point decline in appointment availability (95% CI, 1.2 to 2.1; $P < .001$). Providers' responses to the initial increase in fees did not differ significantly from their response to the eventual decrease in fees.

Since these results may be driven by other changes during this period, we also looked at appointment availability for the privately insured, which is unlikely to be driven by Medicaid reimbursement rates. Indeed, there was no relationship between changes in Medicaid fees and changes in appointment availability for patients with private coverage.

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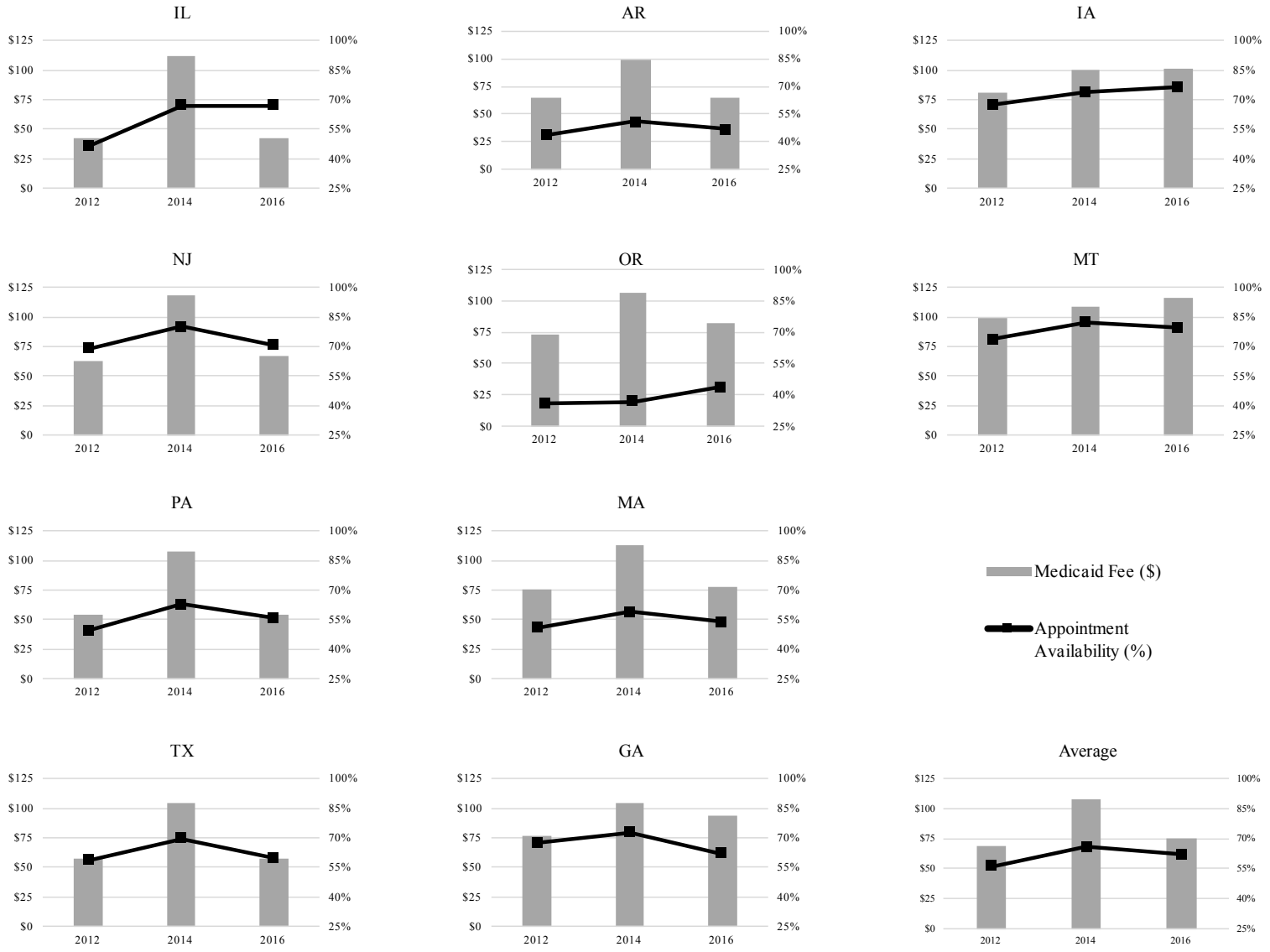
MEDICAID NEW PATIENT VISIT FEES AND PRIMARY CARE APPOINTMENT AVAILABILITY, BY STATE

Large Change in Fees (>$40) | Medium Change in Fees ($20-$40) | Small Change in Fees (<$20)



NOTES: Data collection in 2012 extended into 2013. Federally qualified health centers are excluded. Analyses are weighted at the county level to ensure the distribution of calls by insurance type matched the distribution of individuals by insurance type. Weights are scaled so that each state contributes equally to cross-state averages.

THE IMPLICATIONS

These results suggest that many of the gains in appointment availability for new Medicaid patients associated with higher Medicaid fees were lost when the fee bump expired. Despite the end of the fee bump, appointment availability in Medicaid was 5.4 percentage points higher in 2016 than in 2012, suggesting that other changes to primary care delivery had a positive influence on physician participation in Medicaid. For instance, Illinois and Iowa shifted to capitated Medicaid managed care for non-disabled beneficiaries, while the ACA promoted patient-centered medical homes in Medicaid. A growing trend toward team-based practices may have allowed physicians to care for more patients by relying on other health care personnel, while other trends such as increased data sharing and retail clinics may have further expanded capacity.

Yet a large gap in access to primary care between Medicaid patients and the privately insured remains. With the possibility of a restructured Medicaid program on the horizon, some are anticipating a reduction of federal funding for Medicaid. If the financial burden faced by states worsens, it will likely place additional downward pressure on Medicaid fees. Unfortunately, our findings suggest that an erosion of access to primary care in Medicaid would follow.

THE STUDY

In the audit study, we measured appointment availability at primary care practices in Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas in three time periods: before the fee bump (late 2012 and early 2013), during its implementation (2014), and after its expiration in most states (2016). Scripted staff posed as new patients with Medicaid and called in-network primary care practices with at least one physician who served working-age adults. A pre-audit survey and provider directories identified insurance carriers for Medicaid calls, as plan names vary across carriers participating in Medicaid managed care. The practices receiving calls were representative of primary care offices serving working-age adults.

Callers were trained staff with voices that varied by age, sex, race, and ethnicity. They were also randomly assigned to a routine check-up or newly-diagnosed untreated hypertension. Callers requested the earliest appointment available with a randomly selected physician within the practice, but would accept an appointment with other providers, including nurse practitioners and physician assistants. A successful appointment required a specific date and time, even if the caller was told that the appointment could be scheduled pending additional information. All appointments were cancelled at the end of the call or immediately thereafter. If the appointment process could not be completed, often because scheduling software required an insurance number, the calls were excluded from the analysis.

We face some limitations. Since this audit was restricted to in-network offices, we were unable to document changes in the size of Medicaid networks, nor could we assess whether changes in Medicaid fees affected access for established patients, the elderly, or children. Some data collection in the first wave occurred in early 2013 when the fee bump was first implemented, which may attenuate results. Finally, we only include 10 states and 27% of the national nonelderly population; while states were selected to provide geographic, demographic, and health care-related variation, our results may not be generalizable to other states.

CITATIONS

Polsky D, Candon M, Saloner B, Wissoker D, Hempstead K, Kenney GM, Rhodes K. Changes in Primary Care Access between 2012 and 2016 for New Patients with Medicaid and Private Coverage. *JAMA Internal Medicine*. 2017, 177(4). DOI: 10.1001/jamainternmed.2017.6302

Polsky D, Richards M, Basseyn S, Wissoker D, Kenney GM, Zuckerman S, Rhodes KV. Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*. 2015, 373. DOI: 10.1056/NEJMsa1413299

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ABOUT LDI

Since 1967, the Leonard Davis Institute of Health Economics (LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation's health and health care. Originally founded to bridge the gap between scholars in business (Wharton) and medicine at the University of Pennsylvania, LDI now connects all of Penn's schools and the Children's Hospital of Philadelphia through its more than 250 Senior Fellows.

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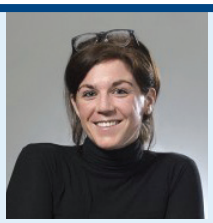

LEAD AUTHOR

MOLLY CANDON, PhD

Molly Candon, PhD is a postdoctoral fellow at the Leonard Davis Institute of Health Economics and Center for Mental Health Policy and Services Research and a lecturer of Health Care Management at the University of Pennsylvania. Her research is focused on access to primary and mental health care and the implementation of evidence-based prescribing.