ACA Medicaid Primary Care Fee Bump: Context and Impact

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ACA Medicaid ‘Fee Bump’ Policy

- ACA provision providing full federal funding for a required increase in Medicaid fees in 2013 and 2014 for qualified primary care services to Medicare rates
  - Funding was based on the difference between a state’s Medicaid fees on July 1, 2009 and Medicare fees
  - Applies to providers in both FFS Medicaid and Medicaid managed care
  - For qualified providers only: Board certified in family medicine, general internal medicine, pediatrics, or certain subspecialties (or at least 60% of billing in primary care)
    - Includes NP/PAs only under supervision of a qualified physician
Medicaid Fees Below Medicare Fees for Years

Index of Medicaid Fees Relative to Medicare, 1998-2012

Source: Urban Institute Surveys of Medicaid Physician Fees
Medicaid Access Problems Exist Even for Those with Full-year coverage

<table>
<thead>
<tr>
<th>Low-Income Full-Year Insured Adults</th>
<th>Medicaid</th>
<th>ESI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any provider access problem</td>
<td>14.4</td>
<td>8.3</td>
</tr>
<tr>
<td>Difficulty finding provider or delayed care because health care coverage not accepted</td>
<td>6.8</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Has a usual source of care:

| Doctors office or HMO Clinic or health center | 53.8 | 75.4 |
| 42.0 | 22.0 |
Medicaid Access Often No Worse than for Those with Full-year Employer coverage – Sometimes Better

<table>
<thead>
<tr>
<th>Low-Income Full-Year Insured Adults</th>
<th>Medicaid</th>
<th>ESI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Physician Office Visit</strong></td>
<td>85.6</td>
<td>82.7</td>
</tr>
<tr>
<td><strong>Any Unmet Health Care Needs Due to Affordability Concerns</strong></td>
<td>11.0</td>
<td>11.6</td>
</tr>
<tr>
<td><strong>Any Delayed Medical Care Due to Affordability Concerns</strong></td>
<td>6.9</td>
<td>9.3</td>
</tr>
</tbody>
</table>

Putting Wisconsin Medicaid Access in Perspective

• In 2014, overall WI Medicaid fees were 71% of Medicare fees
  • The national average was 66%

• Prior to the Fee Bump, WI Medicaid primary care fees were 56% of Medicare
  • The national average was 58%

• The Primary Care Fee Bump between 2012 and 2013 in WI was 78%
  • Nationally, the Fee Bump averaged 73%

• In WI in 2011, 93% of physicians were accepting new Medicaid patients
  • Nationally, only 69% were accepting new Medicaid patients

• In 2011, 64% of WI Medicaid beneficiaries were in managed care plans, mostly risk-based plans as opposed to PCCM
  • Nationally, 74% were in Medicaid managed care, but 1 in 5 were in PCCM
Average Medicaid Fee Increases for ACA Primary Care Services in 2013, by State

2013 increase in Medicaid fees for primary care, US overall = 73%

2013 increase in Medicaid PCP fees
- 100-200% (6 states)
- 50-99% (12 states)
- 25-49% (20 states + DC)
- 0-24% (11 states)

Note: TN has no Medicaid FFS program.
SOURCE: 2012 Medicaid Physician Fee Survey, Zuckerman S.
Implementing and Studying the Medicaid ‘Fee Bump’

• Delays in Implementation
  ▪ Medicaid Managed Care fees were unknown
    ▪ Hard to assure “fee bump” would actually occur
    ▪ Medicaid and Medicare fee rules were hard to align (esp. geography)
  ▪ Temporary policy that was delayed over 6 months in all states

• Policy ended January 1, 2015
  ▪ Cuts will average 43%, but will vary by state
  ▪ 16 states and DC, have indicated they will continue with higher rates
    ▪ Smaller states with small fee bumps
    ▪ Both Medicaid expansion and non-Medicaid expansion states
Reduction in Medicaid Primary Care Fees for Eligible Physicians in 2015 by State Intention to Continue the Fee Bump

<table>
<thead>
<tr>
<th>Category</th>
<th>Reduction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All states</td>
<td>-42.8%</td>
</tr>
<tr>
<td>States that do not plan to extend the fee increase</td>
<td>-47.4%</td>
</tr>
<tr>
<td>States that are undecided on fee increase extension</td>
<td>-31.7%</td>
</tr>
<tr>
<td>States that plan to extend the fee increase</td>
<td>-31.0%</td>
</tr>
</tbody>
</table>


Note: For comparability, this figure presents average fee reductions in 2015 as if no state except Maryland was continuing the fee bump. For example, in the states that plan to extend the fee bump, fees would fall an average of 31.0 percent in 2015 if the fee bump were not extended. Since 2013, Maryland has used state funds to provide the primary care fee increase to all providers, not just the provider types specified by the Centers for Medicare and Medicaid Services. Given this unique situation, we assume Maryland will continue paying all providers at the increased rate in 2015 and beyond.
Medicaid Enrollment in 2015 by State Intention to Continue the Fee Bump

- States that do not plan to extend the fee increase
- States that are undecided on fee increase extension
- States that plan to extend the fee increase

71.3%  13.1%  15.6%

Sources: Enrollment data from the FY 2010 Medicaid Statistical Information System; state decisions from Snyder, Paradise, and Rudowitz (2014).
Reduction in Medicaid Primary Care Fees for Eligible Physicians in 2015 by Medicaid Expansion Status

Expanding Medicaid: -46.2%
Not expanding Medicaid: -36.8%

Note: For comparability, this figure presents average fee reductions in 2015 as if no state except Maryland was continuing the fee bump. Since 2013, Maryland has used state funds to provide the primary care fee increase to all providers, not just the provider types specified by the Centers for Medicare and Medicaid Services. Given this unique situation, we assume Maryland will continue paying all providers at the increased rate in 2015 and beyond.
What Was the Effect of The Medicaid Fee Bump?


• Was the Medicaid fee bump associated with greater *primary care appointment availability* for Medicaid beneficiaries?

• Economics says that a large bump in fees should increase provider participation
  - But mitigating factors created uncertainty
    - Medicaid expansion increased demand
    - Medicaid managed care was an unknown fee baseline
    - Temporary policy limited incentives for physicians to change
    - Implementation delays provided further discouragement
    - Anecdotal reports of few additional physicians signing up for Medicaid managed care plans
Simulated Patient (Audit) Study

- Time Period
  - 2012/13: November-March
  - 2014: May-June

- Scripted field workers made 15,000 calls asking for new patient primary care visits (regular visit or ‘urgent’ concern)
- Randomized to private or Medicaid insurance status
- Called primary care physician offices in insurance networks
- Study was conducted in 10 states
Account for 28% and 26% of the non-elderly private and Medicaid populations nationwide; variation in Medicaid-to-Medicare fee ratios
Key Design Details for Collecting Audit Data

• Sample frame: physician offices with primary care physician seeing adult patients. Source: SK&A

• Offices not refreshed in 2014 – but managed care networks are refreshed (from 64% to 69% of eligible offices)

• Dropped 12.7% (2012) and 11.4% (2014) of sample due to bureaucratic blocks or “vague” appointments

• A qualifying new appointment could be with any provider in the office (including NP/PA).

• When asked about insurance, callers provided the name of the carrier (only in-network physician offices included)
Analysis Issues

• Exclusions
  
  • Used stable sample – offices eligible for audit calls in both waves – to isolate changes over time that are independent of a changing mix of physician offices
    
    • Exclude wave one offices that become ineligible and wave 2 offices new to Medicaid managed care
    
    • Excluded FQHCs because fee bump did not apply to these facilities.
  
• Primary outcome: appointment availability for new patients (by state, insurance type, and audit wave)
  
  • Secondary outcome: median wait time

• Weights: proportion of population with insurance type in county where office is located.
### Table 2. Availability of Appointments for New Patients, According to the State, Insurance Type, and Time Period.*

<table>
<thead>
<tr>
<th>State</th>
<th>Appointment Availability in Medicaid Group</th>
<th>Appointment Availability in Private-Insurance Group</th>
<th>Increase in Medicaid Reimbursement†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Period 1</td>
<td>Period 2</td>
<td>Period 1</td>
</tr>
<tr>
<td>All 10 states</td>
<td>58.7</td>
<td>66.4</td>
<td>86.1</td>
</tr>
<tr>
<td>States with larger increases in payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>70.6</td>
<td>81.5</td>
<td>92.7</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>50.8</td>
<td>63.6</td>
<td>79.0</td>
</tr>
<tr>
<td>Illinois</td>
<td>47.4</td>
<td>65.7</td>
<td>90.7</td>
</tr>
<tr>
<td>Texas</td>
<td>63.5</td>
<td>75.4</td>
<td>90.4</td>
</tr>
<tr>
<td>States with smaller increases in payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>73.3</td>
<td>77.2</td>
<td>89.4</td>
</tr>
<tr>
<td>Arkansas</td>
<td>46.4</td>
<td>51.8</td>
<td>89.2</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>55.0</td>
<td>59.2</td>
<td>69.0</td>
</tr>
<tr>
<td>Oregon</td>
<td>37.7</td>
<td>34.9</td>
<td>77.4</td>
</tr>
<tr>
<td>Iowa</td>
<td>67.9</td>
<td>73.8</td>
<td>89.2</td>
</tr>
<tr>
<td>Montana</td>
<td>74.5</td>
<td>81.3</td>
<td>93.7</td>
</tr>
</tbody>
</table>

* States are ordered according to the amount of the increase in Medicaid reimbursement.
† The increase in Medicaid reimbursement is the average percentage increase in Medicaid reimbursement for the affected primary care services that was required to achieve parity with Medicare fees from 2012 through 2013. These estimates were based on a sample of the affected primary care services.
## Percentage Point Differences in Primary Care Appointment Availability for New Patients by Insurance Status

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Diff</th>
<th>Private Diff</th>
<th>Diff-in-Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Bump</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NJ</td>
<td>10.8***</td>
<td>-4.7**</td>
<td>15.5***</td>
</tr>
<tr>
<td>PA</td>
<td>12.8***</td>
<td>7.2***</td>
<td>5.6</td>
</tr>
<tr>
<td>IL</td>
<td>18.3***</td>
<td>-0.9</td>
<td>19.2***</td>
</tr>
<tr>
<td>TX</td>
<td>12.0***</td>
<td>-2.8</td>
<td>14.8***</td>
</tr>
<tr>
<td><strong>Low Bump</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA</td>
<td>3.9</td>
<td>1.5</td>
<td>2.4</td>
</tr>
<tr>
<td>AR</td>
<td>5.5</td>
<td>-5.9***</td>
<td>11.4**</td>
</tr>
<tr>
<td>MA</td>
<td>4.2</td>
<td>8.6***</td>
<td>-4.4</td>
</tr>
<tr>
<td>OR</td>
<td>-2.9</td>
<td>-8.4</td>
<td>5.5</td>
</tr>
<tr>
<td>IA</td>
<td>5.9</td>
<td>1.2</td>
<td>4.7</td>
</tr>
<tr>
<td>MT</td>
<td>6.8***</td>
<td>-1.7</td>
<td>8.5***</td>
</tr>
<tr>
<td><strong>10 State</strong></td>
<td>7.7***</td>
<td>-0.6</td>
<td>8.3***</td>
</tr>
<tr>
<td><strong>High Bump Composite</strong></td>
<td>13.5***</td>
<td>-0.3</td>
<td>13.8***</td>
</tr>
</tbody>
</table>
States with Higher Bump Had Greater Gains in Appointment Availability

![Graph showing the relationship between Medicaid reimbursement increase and difference in appointment availability.](image-url)
No Pattern for Private Insurance

A Medicaid Group

B Private-Insurance Group
Limitations

• Focused on availability and did not consider changes in the numbers of provider participating in Medicaid networks

• Used a stable cohort of physicians instead of a representative sample of Medicaid providers in each period

• Data collection timing was not ideal
  • Half of the base period was during the first three months of 2013, when the policy should have been in effect but really wasn’t
  • Could have underestimated to effect if providers were already responding in anticipation of higher fees

• Focused on new adults patients and did not consider changes for established patients or children

• 10 states provide geographic and health system diversity but only represent 27% of the nonelderly population; not necessarily nationally representative
Conclusion

• Primary care appointment availability for Medicaid beneficiaries seeking new patient appointments jumped 7.7 percentage points between 2012 and 2014 (from 58.7 to 66.4%)
  • With no corresponding change in appointment availability among the privately insured

• This change was associated with the size of the Medicaid pay bump which averaged over 50% in these 10 states
  • We see a strong dose-response. Large jump in appointments in states with large pay bump. Small jump in states with a smaller pay bump

• No observable pattern related to Medicaid expansion

• Beyond appointment availability, it will also be important to consider other measures of access (e.g., provider participation, specialty care, usual source of care, unmet needs)