

Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients

Under the Affordable Care Act (ACA), Medicaid fees for primary care physicians were raised to Medicare levels in 2013 and 2014. The size of the federally funded increase varied widely, as Medicaid fees were close to Medicare levels in some states and Medicaid paid less than half for the same services in other states.¹ A previous study found that higher Medicaid fees in 2014 were associated with increased primary care appointment availability for new Medicaid patients.² Now that most states have returned to lower fee levels, it is time to examine whether declining Medicaid fees are associated with decreased primary care appointment availability for new Medicaid patients.

Methods | Appointment availability was measured with an audit study (described fully elsewhere³), in which trained staff simulated new patients and requested the earliest appointment available from randomly selected primary care physicians in 10 states: Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas. The sample frame (from the SK&A Office-Based Physician Database) included any practice with at least 1 primary care physician serving working-aged adults (≥ 18 years) and was refreshed in 2016. Scripted callers referred to a Medicaid plan accepted by that practice, which was determined with a pre-audit survey. With some exceptions, callers were different across waves, although they underwent the same training and used identical scripts. Some, but not all, practices were called in multiple waves. The study was conducted before the ACA Medicaid fee increase was fully enacted (2012) and then repeated during its implementation (2014) and after its expiration (2016). Some practices were called in early 2013 when the ACA Medicaid fee increase was theoretically in place, which

may attenuate study findings. This study was approved by the University of Pennsylvania Institutional Review Board. Written informed consent was exempted by the University of Chicago Social Science Institutional Review Board because the study collected data in the course of “business as usual” and protects the identities of individuals and practices in the sample frame.

In total, 12 092 calls were made to eligible practices. Excluded were 854 calls to federally qualified health centers because they were not affected by the ACA Medicaid fee increase and another 1605 calls in which appointments could not be confirmed, often due to schedulers asking for an insurance number. Scheduled appointments required a specified date and time and were immediately cancelled.

Data on Medicaid fees for level-3, new-patient primary care office visits (Current Procedural Terminology code 99203) by state and year were used to capture state-level changes.^{1,4} Some states vary Medicaid fees by geography, age, or physician specialty, in which case the mean of the fees was calculated. States were categorized by the size of the mean change in Medicaid fees: large (more than \$40), medium (between \$20 and \$40), and small (less than \$20).

Changes in appointment availability by state between 2012 and 2014 as well as between 2014 and 2016 were tested for statistical significance using 2-tailed tests and county-clustered SEs. The slope of a fitted line across state-level changes in appointment availability and state-level changes in Medicaid fees was estimated using 2-tailed tests and state-clustered SEs.

Results | Across the 10 states, the mean Medicaid fee for a level-3, new-patient office visit was \$68.58 in 2012, \$107.38 in 2014, and \$75.67 in 2016 (Table). Appointment availability for new Medicaid patients followed a similar pattern: 56.2% in 2012, 65.5% in 2014, and 61.5% in 2016. The four states with large

Table. Medicaid Fees for a Level-3, New-Patient Office Visit and Differences in Primary Care Appointment Availability for New Medicaid Patients^a

Change in Fees by State	Medicaid Fee, \$			Appointment Availability, %			Difference in Appointment Availability, Percentage Points	
	2012	2014	2016	2012	2014	2016	2012-2014	2014-2016
Large (>\$40)								
Illinois	42.90	111.53	42.58	46.6	67.1	67.1	20.5 ^b	0.0
New Jersey	62.49	118.56	66.79	68.9	80.0	70.9	11.1 ^c	-9.1 ^c
Pennsylvania	54.25	107.25	54.25	49.5	62.9	55.9	13.4 ^c	-7.0
Texas	57.37	104.65	57.37	58.7	69.6	59.5	10.9 ^c	-10.1 ^c
Medium (\$20-\$40)								
Arkansas	64.90	98.76	64.90	43.7	51.1	47.0	7.4	-4.2
Georgia	76.53	104.82	93.42	67.2	72.7	61.7	5.4	-10.9 ^c
Massachusetts	75.00	112.87	77.94	50.8	59.1	53.7	8.3	-5.4
Oregon	72.93	106.37	82.29	35.8	36.8	43.8	1.0	7.0
Small (<\$20)								
Iowa	80.57	100.05	100.73	67.4	73.8	76.3	6.3	2.5
Montana	98.89	108.95	116.47	73.6	82.5	79.5	8.9 ^d	-2.9
10-State mean	68.58	107.38	75.67	56.2	65.5	61.5	9.3 ^b	-4.1 ^c

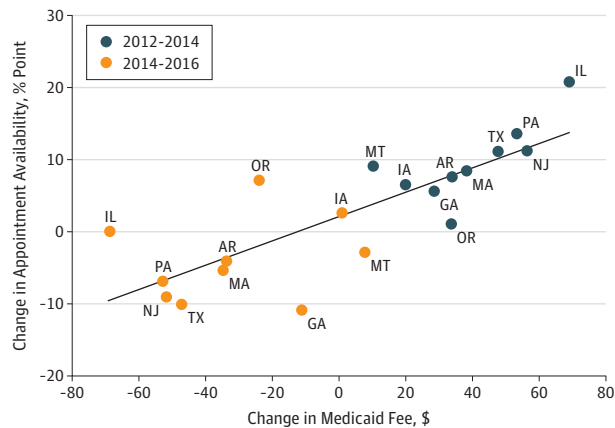
^a Data from Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

^b $P < .001$.

^c $P < .01$.

^d $P < .05$.

Figure. Association Between Changes in Medicaid Fees and Changes in Primary Care Appointment Availability for New Medicaid Patients by State From 2012 to 2014 and 2014 to 2016



Federally qualified health centers and calls in which appointment availability could not be confirmed (18.2% in 2012, 21.5% in 2014, and 22.1% in 2016) were excluded from the analyses. County-level weights were used on the basis of the portion of the population with each insurance type; weights were scaled so that states contributed equally to the 10-state mean. Standard errors were clustered at the state level.

changes in Medicaid fees—Illinois, New Jersey, Pennsylvania, and Texas—all experienced substantial increases in appointment availability when Medicaid fees increased; New Jersey and Texas also experienced substantial decreases in appointment availability when Medicaid fees decreased.

Overall, a \$10 change in Medicaid fees was estimated to be associated with a 1.7 percentage point (95% CI, 1.2 to 2.1; $P < .001$) change in appointment availability for new Medicaid patients (Figure). There was no evidence that the response to increasing fees differed from the response to decreasing fees.

In contrast, 11 071 calls made by privately insured simulated patients in the audit study were analyzed. No association between Medicaid fees and appointment availability was detected (95% CI, -0.4 to 1.1; $P = .28$). This finding suggests that changes in physician access in Medicaid were driven by Medicaid fees rather than potentially confounding changes to primary care.

Discussion | The association between Medicaid fees and primary care appointment availability for new Medicaid patients is robust and not dependent on whether fees increase or decrease. Historically, reductions in Medicaid funding have led to states lowering their Medicaid fees.⁵ These findings indicate that reductions in Medicaid funding would affect the breadth of primary care physician participation in Medicaid and may compromise access to primary care for new Medicaid patients.

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The Evidence Basis for the American College of Rheumatology Practice Guidelines

The American College of Rheumatology (ACR) places a high priority on developing methodologically rigorous, evidence-based Clinical Practice Guidelines (CPGs).¹ To assess the