

Access to Primary Care for Virginia's Medicaid Expansion Population

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Disclaimer

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Pledge

On my honor as a student, I have neither given nor received aid on this assignment.

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Executive Summary

There is insufficient access to primary care in Virginia. Across the state there are populations and areas that do not have sufficient access to care. This is demonstrated by the 111 Primary Care Health Care Professional Shortage Areas (Bureau of Health Workforce Health Resources and Services Administration U.S. Department of Health & Human Services, 2018). In addition to the statewide shortages, Medicaid enrollees face additional barriers to access care. Many doctors do not accept Medicaid enrollees as new patients.

In 2018, the Virginia General Assembly voted to expand the eligibility for Medicaid in the state to adults, age 19-64, who earn a family income less than 138% of the Federal Poverty Level (*2018 SPECIAL SESSION I VIRGINIA ACTS OF ASSEMBLY CHAPTER 2*, 2018). Enrollment for this population began in late 2018 and health coverage began on January 1st, 2019. It is expected that 400,000 Virginians will be enrolled in the Medicaid expansion program by the end of 2019. Virginia's Medicaid Program, and the networks of the 6 managed care organizations that comprise of the program, do not have sufficient resources to provide primary care to all new enrollees. The recency of the expansion means that there is not yet data quantify the extent of the problem, however anecdotal evidence and evidence from other expansion states show that there will be insufficient access to primary care for Virginia's Medicaid expansion population and it will not be possible to meet the goals of the Medicaid expansion.

Virginia's Department of Medical Assistive Services (DMAS) is the state agency that administers Medicaid. This report provides DMAS with alternatives that DMAS could implement in order to increase the primary care appointment availability for the Medicaid expansion population. The report analyzes the following three policy alternatives:

1. Let Present Trends Continue, Collect Data, and Reevaluate in 2 Years
2. Raise Reimbursement Rates for Primary Care Providers
3. Work with Free Clinics

These alternatives are evaluated on the criteria of effectiveness at raising appointment availability, cost, equity, political feasibility and administrative feasibility. Upon evaluation, it is recommended that DMAS allow the current program to continue to operate while collecting data to better quantify the problem and plan a reevaluation in 2 years-time. This alternative best balances the urgency of the problem with the importance of low costs and successful implementation of policy.

Problem Statement

There is insufficient access to primary care for the adult population newly enrolled in Medicaid in Virginia in 2019. The stated goals of the Medicaid expansion are better wellness, prevention of diseases, and reduced emergency department usage (Scott, 2018). In order to achieve these goals, the newly enrolled Medicaid recipients need more than just have access to insurance, but access to primary care. If Medicaid enrollees cannot realistically access physicians and medical services, then these goals are not being achieved.

Background

Access to Primary Care in Virginia

Access in General

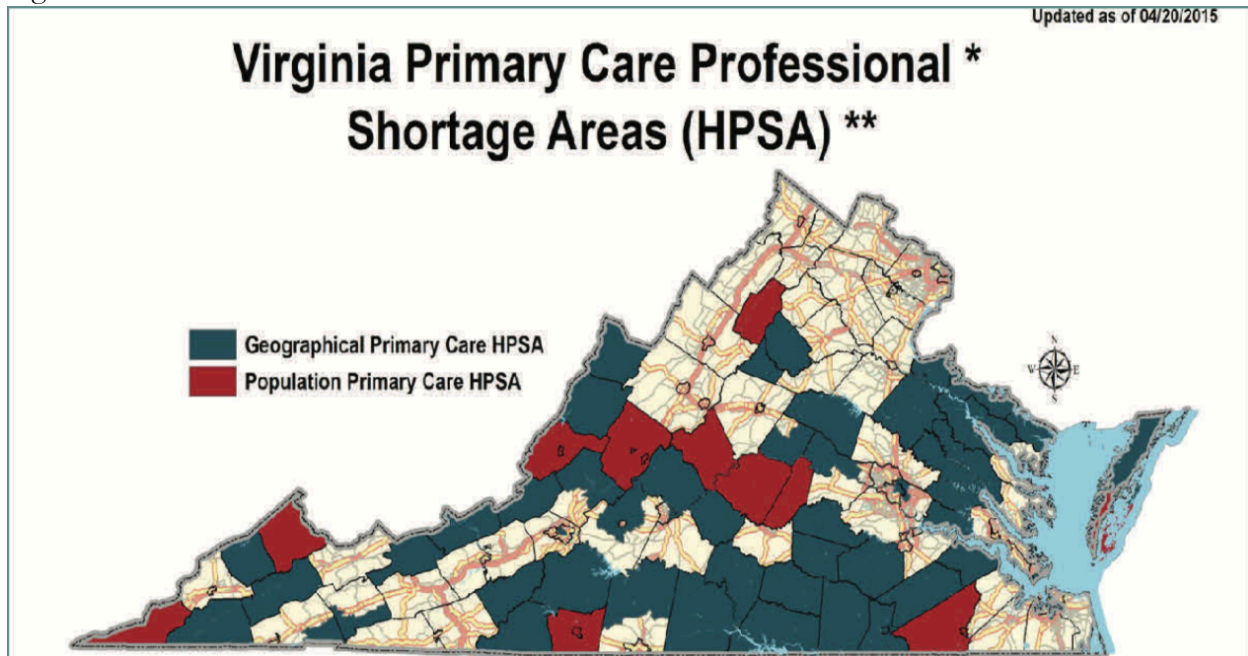
Lack of access to primary care is a serious problem across the state of Virginia. This problem persists not only for Medicaid recipients, but for the uninsured and those with private health insurance as well. This problem also crosses all regions of state, urban and rural divides, and crosses other demographic groups.

One comprehensive measure of lack of access to primary care is the federally designated Health Resource and Service Administration's Health Professional Shortage Areas (HPSAs). This is a designation that indicates health provider shortages in either primary care, dental health, or mental health. The designation can be geographic based, population based, or facility based ("Health Professional Shortage Areas (HPSAs) | Bureau of Health Workforce," 2016). The geographic based designation is calculated based on a shortage of health professionals for the entire population within a specifically defined geographic area, typically a county. A population designation is a shortage of providers for a specific population, such as low-income individuals or migrants. The facility designation means that a specific facility, such as a federally qualified health center, has a shortage of health professionals. The purpose of HPSAs is to facilitate eligibility for a number of federal and state level programs that help to promote quality health care in these areas such as National Health Service Corps, Virginia State Loan Repayment, and Medicare Bonus Payment Program ("Shortage Designations and Maps – Health Equity," n.d.).

HPSAs can also provide a measure of the lack of access to primary care in Virginia. For the scope of this project, Primary Care HPSAs in Virginia are of the most concern and are the best measure. There are 111 Primary Care HPSAs in Virginia, including 48 geographic areas, 17 population groups, and 46 facilities. The total population living in Virginia's designated HPSAs is 1,580,206 (Bureau of Health Workforce Health Resources and Services Administration U.S. Department of Health & Human Services, 2018). About 19% of the population of HPSAs in Virginia earn an income below the federal poverty level (FPL), which is higher than the percent of the state population living below the FPL. (Virginia Department of Health, 2016).

Figure 1 shows primary care HPSAs across Virginia by county. This image only shows geographical and population HPSAs, the location of individual facilities that are designated as HPSAs are not shown. As this map shows, HPSAs are spread across nearly all regions of the state, with some of the areas in most need in the Eastern Shore, Southwest Virginia, and Central Virginia. There are more rural areas that are HPSAs, but HPSAs are not exclusive to rural areas.

Figure 1:



Source: Virginia Department of Health, http://www.vdh.virginia.gov/content/uploads/sites/76/2016/05/HPSA_NHSC-Factsheet-2.pdf

Another designation that reflects to lack of access to primary care is Medically Underserved Areas and Populations (MUA/Ps). MUA/Ps are similar to HPSAs but have a more strictly defined definition based on the Index of Medical Underservice and include poverty indicators (“Medically Underserved Areas and Populations (MUA/Ps) | Bureau of Health Workforce,” n.d.). Virginia also has many counties across the state that are designated as MUA/Ps. These designations demonstrate that lack of access to primary care is an issue across Virginia for all populations.

In addition to the federal designation, the Virginia Department of Health has identified access to primary care as an important policy and public health issue in Virginia. The state’s Primary Care Office recently prepared a needs assessment that discusses the lack of access to primary care in the state, the largest barriers to expanding care, and potential solutions (Virginia Department of Health, 2016). This report shows that access to primary care is a significant problem in Virginia for many different groups of Virginians, especially for the low-income population. Many of the barriers to care and potential solutions discussed in this needs assessment require changes and input from stakeholders that have a further reach than is possible for DMAS. As the administrator of Medicaid, there is a limit to the number of options that it is feasible for DMAS to implement. Despite this, it is important to understand the scope of the problem across the state and how Medicaid enrollees and the Medicaid expansion fit in as a part of a much larger problem.

Access for Medicaid Members

In addition to the state-wide access to primary care concerns, the lack of access to primary care providers uniquely affects Virginians covered by Medicaid. Medicaid enrollees face additional barriers to accessing care that many who are privately insured do not.

The full extent of the access problem for the newly enrolled population is not fully known. Due to the recency of the expansion it not possible yet to know how many new enrollees have been able to access appointments with a primary care provider and are receiving better care as a result of Medicaid. Enrollees have only been covered for a short period of time and a full picture of who is actually accesses primary care appointments and receiving care is not possible to create yet. At least a full year of coverage is needed to establish a true baseline that is Virginia specific.

The additional barrier to Medicaid enrollees in finding access to primary care is finding a provider who is willing to accept new patients that are Medicaid enrollees. In Virginia, only 7 out of 10 physicians were accepting any new Medicaid enrolled patients in the end of 2018. With a significant increase in the number of Medicaid enrollees, the demand for available appointments will increase and place a strain on all of the networks and providers. Anecdotal evidence that is beginning to come in says that this finding a provider to accept new patients a problem. New Medicaid enrollees are stating that they have found trouble finding a primary care provider who has appointment availability. This is happening both in rural areas and urban areas, like Richmond (Bilodeau, 2018). Additionally, enrollees have said that even when they are technically able to become enrolled as a patient at a primary care office, they are facing incredibly long wait times for actual appointments. These wait times also construe a lack of access to care, because the patients are not actually receiving care, despite officially having a primary care provider. Based on the anecdotal evidence and assumptions based on the preexisting state of care allow, DMAS can assume that access to primary care is a problem for the problem that uniquely effects the Medicaid expansion population in ways that privately insure individuals do not experience.

One of the population groups used for a population HPSA designation is 'Medicaid Eligible Population HPSA.' This could be an ideal measure of the extent to which of the access problem is greater for the Medicaid eligible population in Virginia. However, there are none of these designations in Virginia (Bureau of Health Workforce Health Resources and Services Administration U.S. Department of Health & Human Services, 2018). Given the recency of Medicaid expansion in Virginia, not enough time has passed to complete proper data collection on this population and determine where this designation should be applied. In the future, Virginia will likely have Medicaid Eligible Population HPSAs. Low income population designations can help to indicate areas where there is likely to be a lack of access, as this includes much of the newly expanded population but are an imperfect measure.

Research in states other than Virginia has focused specifically on accesses to care for the Medicaid expansion population. In order to determine the effectiveness of the expansion, it must be determined if the newly eligible have increased access to care as compared to before expansion. A recent study used a difference in differences model to study access to office-based care for individuals who were ineligible in 2008 and became eligible by 2014, across multiple states. The study found that individuals in expansion states were about 9 percentage points more likely to have had an office based primary care physician visit than similar individuals in non-expansion states

(Biener, Zuvekas, & Hill, 2017). This research shows that Medicaid expansion does increase access to primary care for the newly eligible population as compared to not having insurance, however there is still a large gap in access.

It is also important to consider how the expansion effects access to care in different regions, especially given the rural and urban divide in Virginia's HPSAs. One study has looked at the regional variation in Michigan after Medicaid expansion. The study found that regions with lower baseline acceptance rates of Medicaid enrollees before expansion saw more growth in acceptance rates than higher baseline acceptance regions (Tipirneni et al., 2018). Even with the higher increases, lower baseline acceptance regions still had lower overall rates of Medicaid acceptance. This shows that there are geographic variations in Medicaid acceptance. Medicaid expansion caused increased access to primary care in regions where improvement was most needed, those that had been underserved prior to expansion. The increase in rates wasn't enough to give them equal access. Medicaid expansion alone was not enough to raise acceptance rates in areas that already had a high need for primary care.

Medicaid in Virginia

Medicaid before Expansion

Through 2019 Virginia had only unexpanded, or standard, Medicaid. Standard Medicaid in Virginia covers nearly 1 million people. Enrollees in standard Medicaid are generally children, pregnant women, very low income parents, seniors, and individuals with disabilities (The Commonwealth Institute & Virginia Poverty Law Center, 2018). In 2018, and all prior years, Virginia had strict income eligibility levels for Medicaid. Working parents had to have a household income under 52% of the FPL and childless adults were not eligible. Medicaid in Virginia has generally had lower administrative costs than private insurance and a slower rate of growth.

Medicaid Expansion

As a part of the 2010 passage of the Affordable Care Act in the US Congress, a provision was passed to expand Medicaid. States were given the option to expand Medicaid eligibility to adults whose household income is less than 138% of the FPL. This expansion includes cost sharing, where the federal government pays the majority of the costs for the newly eligible population, with states paying no more than 10%.

In May 2018, the Virginia General Assembly passed a Biannual budget for FY2019-FY2020 that authorized DMAS to expand Medicaid (*2018 SPECIAL SESSION I VIRGINIA ACTS OF ASSEMBLY CHAPTER 2*, 2018). The Medicaid expansion provides full benefit coverage to adults aged 19-64 who have a family income less than 138% FPL.

The enrollment period for newly eligible adults began in November 2018 and coverage began on January 1st, 2019. As of the week of April 19th, there are 266,592 adults newly enrolled in Medicaid (DMAS, 2019). Of these adults, 192,447 or about 72% of new enrollees have a family income below 100% of the FPL. The remaining 67,286 have a family income between 100% and 138% of the FPL. The majority of enrollees (61%) are female. 45% of the enrollees are between 19 and 34 years old,

39% between 35-54, and 16% over 55. It is estimated that the number of enrollees will continue to rise throughout the year and should reach about 400,000 individuals by January 2020.¹

Virginia's Medicaid Program

The majority of Medicaid enrollees in Virginia, including adults in the newly expanded population, are enrolled in a health insurance plan through a Managed Care Organization (MCO). Virginia currently has two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus. DMAS runs contracts, or a Managed Care Services Agreement, through these programs with 6 different MCOs: Aetna, Anthem, Magellan, Optima, United Healthcare, and Virginia Premier. Each MCO offers a health insurance plan specifically for Medicaid expansion enrollees that provides insurance coverage statewide. The majority of the expansion population are relatively healthy adults and will enroll in the Medallion 4.0 program. CCC plus provides services for “medically complex” individuals. The first Medallion 4.0 contract began in 2018, after the end of the previous managed care program, Medallion 3.0. All providers have contracted with DMAS to provide basic benefits to all enrollees and can also choose to offer added benefits. Some individuals will initially enroll in a fee-for-service program for about 15-45 days as they await enrollment in an MCO (Lee, 2018).

DMAS contract with the MCOs does require certain access to care standards. MCOs are required by the contract to have a 1 full time equivalent Primary Care Provider for every 1,500 Medicaid members (Commonwealth of Virginia Department of Medical Assistance Services, 2018). As well as this ratio there are travel time and distance standards that contractually must be met as part of NCQA's network adequacy standards. In urban areas there should be 2 primary care providers within 30 minutes or 15 miles from every member and in rural areas there should be 2 primary care providers within 60 minutes or 30 miles from every member. Providers are able to apply for exemptions to these standards where there is a provider shortage and the provider provides an action plan for network improvement. These minimum standards are currently set at the federal level. The Center for Medicaid and Medicare Services has proposed a rule change that would eliminate these specific requirements and allow states to set their own (Hinton, 2019). Additionally, MCOs are contractually required to assign each enrollee to a primary care provider upon enrollment. However, as discussed, assignment to a primary care provider does constitute actual appointment availability. With a ratio of 1 provider to 1500 members, assignment and appointment availability are not the same thing. Minimum standards for access to care are set in place, but these standards do not constitute full access to appointments and services for all Medicaid members.

The contract also states that the providers “shall develop a provider network development project plan that describes in detail the Contractor's recruitment strategy to enroll and credential primary care providers, large and small physician groups, providers...who do not participate in the Virginia Medicaid program” (Commonwealth of Virginia Department of Medical Assistance Services, 2018). These plans are specifically for the purpose of expanded access to care for the Medicaid expansion

¹ When passing the Medicaid expansion, the General Assembly took a two-step process to simultaneously authorize Medicaid expansion while also applying for a Section 1115 waiver to amend the Medicaid expansion to include work requirement. A waiver request was filed in November 2018 (Antonisse & Rudowitz, 2019). As these work requirements have not been approved nor implemented, this analysis does not consider them or the effect they may have on enrollment or availability of care.

population. Each MCO is to report to DMAS monthly on their progress in network development plan.

Virginia's new Medicaid Expansion program is now in place and in its first year of coverage and operation. The Medicaid network meets minimum standards set at the federal level for network adequacy and access to care. There is not yet a calculated baseline to determine true levels of access for the expansion population. However, multiple factors across the state of Virginia show that a lack of access to primary care services is a key issue and studies from other states and anecdotal evidence demonstrates that it is an issue for the Medicaid expansion population. There is significant room for DMAS and MCOs to improve and to increase access to primary care for Virginia's newly eligible Medicaid population.

Alternatives

As demonstrated by the background information, lack of access to primary care is significant issue facing Virginia's Medicaid expansion population. Federal minimum network adequacy requirements are not enough to ensure that all Medicaid enrollees have access to actual care. In order to improve the quality of Virginia's Medicaid system and meet the goals of the system, DMAS should consider policy alternatives to address this problem. The following alternatives are based on research and actions that are popularly considered in Virginia and across the country. The alternatives are framed within the reality of DMAS's lack of administrative ability to address the access to care issue as it effects the entire state. The effectiveness of each alternative is limited by the lack of access to care in general. However, alternatives that work to address the overall issue are generally beyond DMAS's power. These alternatives specifically address the additional barriers that Medicaid enrollees face in accessing care. Three alternatives that DMAS could take to address the lack of access to primary care for Medicaid expansion enrollees are proposed and will be evaluated. These alternatives are as follows and will be explained in further detail below:

- 1. Let Present Trends Continue, Collect Data, and Reevaluate in 2 Years*
- 2. Raise Reimbursement Rates for Primary Care Providers*
- 3. Work with Free Clinics*

Alternative 1: Let Present Trends Continue, Collect Data, and Reevaluate in 2 Years

This alternative entails letting the current Medicaid program remain in place for 2 additional years, during which time DMAS will engage in qualitative and quantitative data collection to better define the problem and prepare for reevaluation at the end of this 2-year period.

As discussed, Virginia's Medicaid Managed Care program, Medallion 4.0, currently meets the minimum federal requirements for network adequacy and access to care. There is a strong assumption based on other states and initial anecdotal evidence the federal minimum will not provide a sufficient level of access to care to meet the goals of the Medicaid expansion. However, the recency of the expansion and the lack of data means that DMAS is currently unable quantify the full extent of network adequacy or access to primary care. DMAS could continue to let the current program operate as is for 2 years and collect the necessary data in order to properly quantify the problem and understand the effect of potential solutions before taking more extensive action. During this time DMAS will ensure that each contracted MCO continues to meet the federal minimums for provider to member ratios, travel distance and time standards, and provider assignment.

Additionally, during this time, DMAS will engage in data collection efforts on access to care and network adequacy in order to better understand the extent of the problem. This data includes standard data such as enrollment and total and per-enrollee spending on primary care. The plan and administrative infrastructure to collect this data is already in place. DMAS will also continue and

complete its current survey of physicians. This survey, conducted together with Virginia Commonwealth University, will assess primary care providers' ability to serve the Medicaid expansion population (Times-Dispatch, 2018). Qualitative analysis of the results of this survey would be completed to understand the largest barriers to physician participation. DMAS would engage in a similar survey for Medicaid members to further understand the extent of the problem from the patient prospective. DMAS would also use the MCO network development plans as a data source. The month to month goals and outcomes of these plans would be tracked in order to determine the effectiveness of MCO actions on access to care.

All of this would be collected over 2 years. This time frame will allow DMAS to gain a complete picture of the success of the program. The Medicaid expansion was a large change so the system will need a period to adjust. A 2-year time span will give a better picture of the true problem than just initial year data, while still valuing the urgency of the problem. This time frame will also some initial trends to begin to emerge.

This data would then be used to reevaluate the problem and possible alternatives to address it. The data would be analyzed and evaluated to determine the full extent of the problem, and areas that are of the most concern. DMAS would reevaluate the alternatives discussed in this analysis as well as any additional ones that become logical based on the data evaluated. Further action can be taken after evaluation based on stronger data.

Alternative 2: *Raise Reimbursement Rates for Primary Care Providers*

This alternative entails raising the reimbursement rates that are paid from DMAS through the MCOs to individual providers for providing primary care in order to increase physician participation in Medicaid.

Reimbursement rates refer to the amount that the state or individual insurance company pays physicians for services. In general, Medicaid plans pay physicians less than a private insurer would pay. It is a common argument that largest barrier to Medicaid enrollees is from low rates leading to fewer physicians accepting Medicaid.

There is open debate surrounding the relationship between reimbursement rates and access to primary care. This topic has been studied over the past 30 years and the results from both academic and policy literature are inconclusive. Studies done throughout the 1990s and early 2000's find some positive but weak links between payments and access (Coburn, Long, & Marquis, 1999; Shen & Zuckerman, 2005). Many studies that show a positive link are based on cases with incredibly specific circumstances, such as extremely low base rates or pediatric care providers (Berman, Dolins, Tang, & Yudkowsky, 2002; Zuckerman, McFeeters, Cunningham, & Nichols, 2004). Research on physicians in North Carolina, found that physicians restricting access was much more common in cities but there was only a weak relationship between reimbursement rates and physician acceptance of Medicaid (Margolis et al., 1992). This study emphasized that attitudes, norms, and informational aspects of Medicaid payments were important to improving access, not just the amount of the reimbursement rates themselves. A weakness of early studies is a focus on fee-for service Medicaid beneficiaries. In the time since these articles were published there has been a significant growth in

the proportion of Medicaid beneficiaries who are in a managed care system. In the US, a majority of Medicaid enrollees are in MCOS and In Virginia, nearly all Medicaid enrollees are in MCOs.

Since the passage of the Affordable Care Act (ACA) in 2010, the nature of Medicaid has changed. The ACA allowed states to expand Medicaid and expansion has led to a large increase in the number of Medicaid enrollees. It has also changed the demographics of the Medicaid enrolled population, as more relatively healthy adults are enrolled. As more individuals have become eligible for Medicaid under recent expansions, research has begun to focus on access to primary care for this new population and Reimbursement rates remains an important area of focus.

When the Affordable Care Act was passed initially it included what was known as “Medicaid Primary Care Pay Parity Program” which required states expanding Medicaid to raise reimbursement rates in order to attract more primary care physicians. This rate increase was paid for by the federal government and lasted from January 2013 until it expired in December 2014. The rate increase was enacted as there was a growing concern that there would not be an adequate number of physicians to meet the needs of newly eligible population (MACPAC, 2013). . It was cited by many at the time that rate increases could alleviate some of the problem by creating incentives for more physicians to accept Medicaid (Cunningham & May, 2006; Decker, 2012).

When the federal funding for the fee bump expired 19 states chose to at least partially keep the fee bump in place (Zuckerman, Skopec, & Epstein, 2017) Since the mandated fee increase’s expiration multiple groups have studied its effectiveness at improving access to primary care physicians. A consensus has not been reached, partially due to the recency of the policy changes (Crawford & McGinnis, 2014; Laff, n.d.; Tollen, 2015; Zuckerman et al., 2017). Some research has suggested that it led to a significant increase in availability in states with managed care systems (Polsky et al., 2015). The policy also does not bring cause physicians that did not previously accept Medicaid to begin accepting it. Surveys done by MACPAC, a non-partisan legislative branch agency that studies Medicaid, in 2015 found that in 8 surveyed states there was no increase in provider participation (MACPAC, 2015). MCOs that were surveyed directly also reported no noticeable change in provider rates. The American College of Physicians openly supports fee increases and links the increases to access to primary care (Crawford & McGinnis, 2014) (American College of Physicians, 2014). In general, this policy has not led to conclusive evidence on the role of reimbursement rates in access and there is still open debate on the issue.

Despite the lack of conclusive evidence in support of the effectiveness of this alternative, the option is still commonly considered and supported by stakeholders. Due to its popularity and reputation as a ‘common sense’ solution, it is important for DMAS to consider. For this alternative, DMAS would raise reimbursements to MCOs to match Medicare reimbursement rates in Virginia, which are recalculated annual as a part of complex forecasting system.

Alternative 3: *Work with Free Clinics*

This alternative entails requiring MCOs to work with free clinics in Virginia to reduce the administrative burden of becoming a Medicaid provider and requesting funding to clinics to reduce administrative costs of billing.

Free clinics in Virginia serve as a safety net for those who do not have access to health care through any other means. Free clinics typically operate with volunteer staff and provide medical and health services for free or at incredibly reduced prices to those who would otherwise not be able to afford these services. Free clinics typically have income eligibility restrictions in order to receive these services.

Virginia currently has more than 70 free clinics across the state (“Find a Free Clinic in Virginia | Medical, Dental, Pharmacy,” n.d.). Free clinics serve individuals who are in a ‘coverage-gap’ between Medicaid eligibility and being able to afford adequate private insurance. Before Medicaid expansion, the majority of the population that is now newly eligible fell into this coverage-gap and free clinics provided medical services many of them. About 49,000 patients who received medical services from free clinics in 2018 have now become Medicaid eligible (Wilkinson, 2018).

Free clinics are free to independently choose how to adapt to Medicaid expansion. Some have chosen to accept Medicaid, others have chosen to expand eligibility to a higher income level as they believe Medicaid enrollees will shift to other providers, and many others have taken unique or hybrid approach (Wilkinson, 2018). Free clinics that want to accept Medicaid must become a Medicaid provider with one of the MCOs and must go through the process of registering and becoming official, and negotiating a contract in order to begin billing Medicaid (Bortz, 2013). DMAS currently encourages MCOs to consider free clinics and include plans to work with them in the MCO network development plans (Commonwealth of Virginia Department of Medical Assistance Services, 2018).

For this alternative DMAS would require, rather than encourage, all MCOs to engage with free clinics and create a process to facilitate free clinic enrollment as a Medicaid provider. The process to become a provider would be simplified and the burden to enroll free clinics as providers will fall to MCOs. Additionally, DMAS would request that funding be designated from the General Assembly to assist free clinics with the costs of the billing process. This would allow free clinics to provide continuous patients to clients that they have been serving and quickly receive payment for these service from the MCOs.

Evaluative Criteria

In order to evaluate alternatives to improve access to primary care, this analysis will use five different criteria: effectiveness, cost, costs, and feasibility, both administrative and political.

Criterion 1: Effectiveness

The alternatives are designed to increase the availability of appointments with primary care providers for the Medicaid adult expansion population. The effectiveness measure will estimate the percentage increase in appointment availability due to the implementation of each alternative. This will be evaluated quantitatively.

Criterion 2: Cost

The cost to implement each alternative will be calculated and analyzed. The costs that will be considered will be costs to the Commonwealth of Virginia. The total net present value of the implementation of each alternative over the next five years will be calculated. This analysis will provide the net present value of the total cost to implement each alternative for the next 5 years. A cost effectiveness measure, or the cost per percent change in appointment availability, will also be calculated.

Criterion 3: Equity

Each alternative is designed to impact a specific population, the newly enrolled adult Medicaid population. It is still important to consider equity within this group across income, race, age, area (rural vs. urban), and other characteristics. As well, alternatives may cause a change in equity between the expansion population and other groups. This criterion will analyze the equity of the outcomes of each alternative. Alternatives will be judged in terms of a change in equity from the current state. This will be qualitatively analyzed and given a rating of high, medium, or low. A rating of high would mean that the alternative creates a more equitable Medicaid system and low would mean the system has little change from the current equity.

Criterion 4: Political Feasibility

This criterion will measure the likelihood that an alternative will be able to implemented due to political factors. Many polices will require direct approval from the General Assembly in order for DMAS to implement them. Even if direct support is not necessary, assumed support still must be analyzed as the General Assembly and the Governor influence and control DMAS through the budget. The political feasibility of each alternative will be quantitatively analyzed and given a rating of high, medium or low.

Criterion 5: Administrative Feasibility

This criterion will measure the ability of DMAS to effectively implement an alternative. It is incredibly important that the chosen alternative is implemented correctly in order to achieve the full effectiveness. The process through which Medicaid members access a primary care provider can be complex and involves multiple different actors. DMAS does not have direct control over all of the actors in this situation and all stakeholders must be considered. This criterion will quantitatively analyze the ability of DMAS to successfully implement each alternative in order to achieve the desired outcome and will be given a rating of high, medium, or low.

Evaluation of Alternatives

Alternative 1: Let Present Trends Continue, Collect Data, and Reevaluate in 2 years

Effectiveness:

The implementation of this alternative will cause **no change** in effectiveness. There will be no change in the availability of appointments for Medicaid enrollees from the current baseline as this alternative allows specifically allows that baseline to continue.

It is incredibly difficult to estimate a current baseline of appointment availability for primary care services for the expansion population. Medicaid coverage for the expansion population began less than 6 months ago. Therefore, there is not currently data on the actual medical services utilized by this population. A 2018 study estimated that in Virginia in 2015, about 63% of the population below 138% of the FPL had regular access to care (Choi, Lee, & Matejkowski, 2017). The average percent in states that had expanded Medicaid was about 3 percentage points higher. From, this availability for 66% of the Medicaid expansion population can be used as a very rough estimate of the baseline. There is a large amount of uncertain in this estimate. Another best estimate of coverage is the minimum physician requirement, 1 for every 1500 members. However, this method only provides an estimate of physician numbers, and not actual appointment availability or use. While this alternative will not lead to a change in effectiveness, the further data collection that will come from this alternative will allow DMAS to prepare a precise estimate of the baseline of actual coverage and care received in order to be used in future evaluation.

Cost:

The implementation of this alternative will cause **no additional costs** over the next 5 years.

The cost of the Medicaid expansion to the state over the next 5 years is not set in stone, as the state budget is proposed or amended each year. This alternative does ensure that there will be no additional costs due to its implementation.

Equity:

The change in equity due to the implementation of this alternative is **low**.

Equity problems will continue to exist in the current model if present trends are allowed to continue. There is not a current measure of equity within the expansion population. There largest possible sources of inequity that should be of concern are between rural and urban populations, income level within the group, and race. There are no trends to predict that current trends will cause a change in equity to occur. Further data collection will allow a better understanding of what groups are most easily able to access care and what are the largest equity concerns for DMAS.

Administrative Feasibility:

The administrative feasibility of implementing this alternative is **high**.

No significant administrative changes will need to take place in order to implement this alternative. The managed care system in Virginia does currently meet federal standards for access to care, so no changes do not need to occur in order to continue the current system. The contract between MCOs and DMAS can continue through their terms. The administrative process for implementation of data collection and the process of continuing reevaluation is also already in place, or the process for the future is set in place. There will not be any significant administrative burden to implement this alternative.

Political Feasibility:

The political feasibility of this implementing this alternative is **medium**.

The main goal of any policy changes to the Medicaid expansion program is that the expansion be considered successful. Different stakeholders have different definitions of what success looks like for this program. Access to care is an important part of success, as well as the costs of the program and ensuring that it is sustainable.

DMAS has acknowledged that access to care for the expansion population is an important concern and there is political will within the agency to address and solve this problem. There is also significant political pressure to not overspend on the implementation of any alternative. The expansion of Medicaid itself was contentious in the General Assembly, mainly due to cost concerns. Additionally, an increase in DMAS expenses, unrelated to the expansion, has caused contention in the General Assembly (Times-Dispatch, 2019). These factors mean that there is real political pressure to not spend a large amount of additional money on the Medicaid expansion at this time. This is especially true if it is on a policy change that is not quantitatively proven to improve access to care. This means that is politically feasible to implement an alternative that does not spend additional money and allows the current system to stay in place.

Additionally, there is no strong or unified lobbying force from patients, MCOs, or care providers themselves that is pushing the General Assembly or DMAS to make large changes this early on in the Medicaid expansion.

Alternative 2: Raise Reimbursement Rates for Primary Care Providers

Effectiveness:

The implementation of this alternative will cause about a **4% increase in appointment availability**.

This estimate is based on studies conducted in other states across the country where Medicaid reimbursement rates have been raised. As discussed, there is no conclusive evidence and studies have found that there is a range in the effect that raising rates has had on both physician

participation in Medicaid and actual appointment availability. This range includes no significant effect (0% change) to about an 8% increase in appointment availability (MACPAC, 2015; Polsky et al., 2015). Based on this range and the applicability of these studies to the situation in Virginia, it is estimated that the increase in appointment availability in Virginia due to the rate raise will be about 4%. This estimate however is uncertain and the real possible outcomes could vary within the range mentioned (0-8%).

Cost:

The total cost to implement this alternative for 5 years in Virginia has a net present value of **\$108,236,916.77**

This total cost is based off an annual cost of \$25 million dollars. The cost increase will carry across each year that rates are raised. A discount rate of costs in future years of 5% is assumed.

These cost will come in the form of increased payments from DMAS to each MCO. Then each MCO will use this money to make increased payments directly to physicians who bill Medicaid through the MCO. See Appendix A for further discussion of assumptions and costing.

The cost effectiveness of this alternative, or the total cost per percent increase in appointment availability over 5 years is \$6,250,000.

Equity:

The change in equity due to the implementation of this alternative is **low**.

The main reason that there is not an increase in equity due to this alternative is due to the locations that new appointments are likely to become available. Research in other states where Medicaid reimbursement rates have been raised show that when there is an increase in appointment availability this is usually due to physicians that already accepted Medicaid increasing their appointment availability, not due to new physicians being brought on to the Medicaid system (Polsky et al., 2015). This means that this alternative will not bring appointments to any new areas, or populations that are currently underserved.

This alternative also does not address healthcare professional shortage areas at all, as the reimbursement increase to Medicaid is not enough to bring new physicians into rural areas, even if they have a high Medicaid population.

Administrative Feasibility:

The administrative feasibility of implementing this alternative is **high**.

The administrative changes that would need to occur in order to effectively implement this alternative are relatively each to complete. The main changes would come in the form of the rates that are set through the contract between DMAS and each of the six MCOs. These rates are often reset and the rate increase could be easily implemented at the next rate change. Rate calculation

work will not be significantly impacted by raising rates, as recalculation is completed regularly. Additionally, the administrative process that occurs between individual physicians and the MCOs that they bill to will not be affected.

Political Feasibility:

The political feasibility of this alternative is **medium**.

The policy of raising reimbursement rates is a popularly considered alternative, across the country and in Virginia. This alternative has support from many with DMAS, the General Assembly, and within other advocate group in Virginia. It is often seen as a common-sense alternative. There is support for this alternative within the agency to raise reimbursement rates, as this has repeatedly been proposed in annual budget discussions.

There is also hesitancy to implement this alternative from other stakeholders. As discussed, there is not a large amount of political will to spend large amounts of money on the Medicaid expansion. The relatively low-cost effectiveness of this alternative as well as the uncertainty of the outcomes means that there is not support for it among those who view financial stability of Medicaid as one of the key factors to its success.

Alternative 3: Require Managed Care Organizations to work with Free Clinics

Effectiveness:

The implementation of this alternative will cause about a **6.3% increase in appointment availability**. See Appendix B for further discussion calculations.

In 2018, free clinics in Virginia served about 75,000 individuals. From this population about 70%, or 49,000 individuals, have since become Medicaid eligible in 2019. Ideally, many of these patients will transition to other providers when available. However, many do not have a choice of another provider to go to.

Based on conversations with leaders of free clinics in Virginia and the Virginia Association of Free and Charitable Clinics, I believe that about 20 free clinics would begin to bill Medicaid and provide appointments to Medicaid eligible patients if this alternative was implemented. A few clinics have begun to bill Medicaid even without the this alternative and others have stated that their main barriers to billing Medicaid include things like administrative cost, which is addressed in this alternative. Some clinics will choose not to utilize the offerings of this alternative due to the availability of appointments elsewhere, the clinic's mission, or other individual reasons. Based on the concertation of Medicaid eligible patients in certain clinics, about one third of the Medicaid eligible population who was previously seen in a free clinic could continue to be seen there if this alternative was implemented. This would mean **17,000 patients** would be able to see a primary care provider. This is about 4% of the total expected expansion population. This outcome has reasonably certain based on the number of patients and where they are currently being served. There is some uncertain associated with the number of clinics who have interest in billing Medicaid versus the number of clinics that would follow through with the implementation of this alternative. There is

also uncertainty in the percent change in appointment availability, as it is calculated from an uncertain baseline.

Cost:

The total cost to implement this alternative for 5 years in 25 free clinics in Virginia would be **\$6,941,174**.

The main sources of these costs are wages to cover time for administrative costs of initial enrollment and salary for billing specialists needed annually at each clinic. A full breakdown of costs and assumptions can be seen in Appendix B.

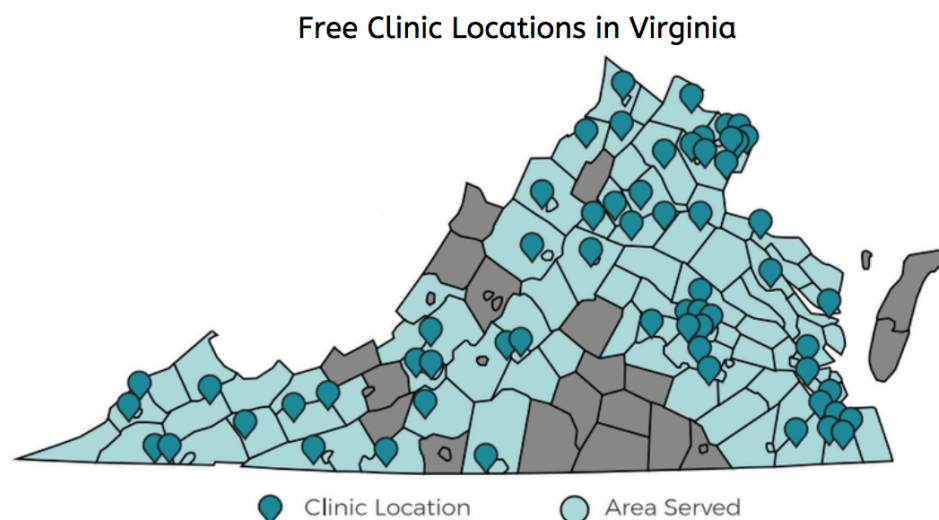
The cost effectiveness of this alternative, or the total cost per percent increase in appointment availability over 5 years is \$214,960.

Equity:

The change in equity due to the implementation of this alternative is ***low***.

The existing locations of free clinics limits the equity of this alternative. While free clinics are spread across the state, there are concentrated in urban areas of the state large gaps of areas that are not served. The following map shows the locations across the state, and the lack of clinics in Southside Virginia, the Eastern Shore, and other parts of the state. Many of areas which lack free clinics are the same areas that are HPSAs.

Figure 2: Free Clinic Locations in Virginia



Source: Virginia Association of Free and Charitable Clinics, <https://www.vafreeclinics.org/free-charitable-clinics>

Working with free clinics will not do anything to address existing health care shortages and the rural urban divide within the Medicaid expansion population.

Another potential equity concern of this alternative is the effect on the non-Medicaid population. In light of Medicaid expansion many free clinics have chosen to expand eligibility by increasing the maximum income threshold the individuals can earn and remain eligible for services. Patients who are Medicaid eligible could take resources away from other who are not eligible but still fall into the coverage gap and need services from free clinics. The income generated from accepting Medicaid may eventually allow free clinics to expand eligibility requirements. However, clinics will not do this in the initial years as income is uncertain. Additionally, Medicaid will not likely not cover full costs so it will not allow for a full increase in coverage as if Medicaid eligible patients were not being accepted

Administrative Feasibility:

The administrative feasibility of implementing this alternative is **medium**.

The administrative burden of implementation of the free clinic arrangement would be spread across three main stakeholder groups: DMAS, the Managed Care Organizations that provide Medicaid, and the Free Clinics themselves. DMAS is a single organization that can implement changes fairly easily. This changed would be implemented through the contracts that DMAS has with the MCOS. The MCOs and free clinics are all individual organizations with their own interests and administrative processes. This number of individual organizations complicates the administrative process and contributes to decreased feasibility.

The main administrative burden of this alternative comes from the need for each individual clinic negotiating a contract with each MCO with which it works with. In order for this alternative to be effective, these contracts would need to be negotiated quickly and efficiently. DMAS has limited ability to intervene in the contract negotiation process, which hurts the administrative feasibility of this alternative.

Political Feasibility:

The political feasibility of this alternative is **low**.

The stakeholders that must be considered for the political feasibility of this alternative are DMAS, the MCOs, free clinics, and the patients that they serve. For DMAS this option is highly feasible. It addresses the important issue in a manner that does not create a large burden for the agency itself. MCOs will view this alternative less favorably. This alternative creates an additional burden for them and is not a position that they will support. The support of free clinics varies. There are many free clinics that are strongly in support of this alternative, while some clinics which would not bill Medicaid even if this alternative is implemented. The Virginia Association of Free and Charitable Clinics does not have a position on accepting Medicaid, and leaves support up to individual clinics. This means that free clinics are not a unified political force for or against this alternative. The largest political barrier to this alternative is the fact the state funds many free clinics as well as funding Medicaid and to many legislators this may seem like unnecessary double funding.

Outcomes Matrix

Criteria:	Effectiveness	Cost	Equity	Administrative Feasibility	Political Feasibility
	Percent increase in appointment availability	Net Present Value, 2019 Dollars	High, Medium, Low		
Alternative 1: <i>Let Present Trends Continue</i>	0%	0	Low	High	Medium
Alternative 2: <i>Increase Reimbursement Rates</i>	4%	\$108,236,917	Low	Medium	Medium
Alternative 3: <i>Work with Free Clinics</i>	6.3%	\$5,863,181.67	Low	Medium	Low

Recommendation

Alternative 1: Let Present Trends Continue, Collect Data, and Reevaluate in 2 years

Based on analysis of the chosen criteria, I recommend Alternative 1. DMAS should let present Medicaid program continue to operate, while collecting important data, and creating a plan to use this data to reevaluate these and other potential alternatives in 2 years' time. This alternative is the best balance of the important criterion of cost with the short- and long-term success of the Medicaid expansion.

While this alternative does not cause a change in effectiveness it is the best alternative for the long-term success of the Medicaid expansion in Virginia, including in terms of access to primary care. A tradeoff exists between small and expensive changes that can be made immediately and larger more cost-effective policies in the long term. The recommendation of this alternative chooses to place more importance on the long-term goals. Given the recency of the expansion there is little data that exists to establish a baseline of what coverage and access to primary care currently looks like. The implementation of this alternative will allow DMAS to develop this baseline, as well as gather other important information, to create a policy that is targeted and has more certainty in effectiveness.

Cost is the most important criterion for this recommendation. This alternative has no costs over the time of implementation, as the structure to collect data and plan for reevaluation is already in place. Keeping costs low, and certain, are key to successfully providing a robust Medicaid program in the long term. This low cost is the most important factor in this recommendation.

Additionally, this alternative has high administrative feasibility and medium political making easier to implement successfully than the other alternatives. There is a high certainty that data collection will be carried out correctly and that this problem will be addressed again in a revaluation. Successful implementation of the recommended alternative is key to success, which is one reason why this alternative is recommended over the less feasible Alternative 3. This alternative does not currently address equity concerns. However, all alternatives fail to causes a meaningful change to equity. It does allow for a better long-term consideration of them. The data collected will allow DMAS to gain a better understand of the demographics of access to care and what the largest areas of inequity are.

Implementation

There are two key elements that must be emphasized while implementing this alternative in order to ensure future success for the Medicaid expansion and in address to access to primary care problem.

Firstly, it is important to establish knowledge of this problem and support for further study. DMAS must communicate to all stakeholders that inaction now does not mean that DMAS does not view this as a problem. Collecting data and the evaluation of that data must not be considered inaction. Rather, the implementation of this alternative must be framed as an important step towards establishing a cost effective and robust solution, as it is. Framing the implementation as such will allow DMAS further success when reevaluation is carried out and higher likelihood of further action once there is a further recommendation in the future.

Secondly, it is important to ensure that DMAS is gathering the proper data to successfully carry out analysis and evaluation in 2 years. This includes patient surveys, physician surveys, cost data, and other information like MCO's plans. DMAS has already identified all of these data needs. Where action plans for the collection of this data is already in place, such as with the physician survey, DMAS must ensure that these projects are completed and that the information is made available to key stakeholders and in way that is best suited for further analysis. For data that is not yet available, DMAS must create concrete plans for data collection and analysis in the next 2 years to ensure that all relevant information is utilized in future analysis and recommendations.

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Appendices

Appendix A: Cost Effectives for Alternative 2: Raise Reimbursement Rates

Cost Assumptions:

DMAS has officially estimated that total cost to raise reimbursement rates in fiscal year 2019 will be 25 million dollars. This cost will come in the form of increased payments to each of the 6 Managed Care Organizations. The additional cost will be incurred every year. 2019 will serve as Year 0. Year 1 of this analysis is FY 2020 as this is the earliest that rate increases could be implemented.

General Assumptions:

Discount Rate: 5%

Percent Increase in Appointment Availability: 4

Cost Assumptions:

Annual Cost: \$25,000,000

Costs

	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Year	0	1	2	3	4	5
Annual cost		\$23,809,524	\$ 22,675,737	\$ 21,595,940	\$ 20,567,562	\$ 19,588,154

Total Net Present Value: \$ 108,236,916.77

Outcome

Percent Increase in Appointment Availability	3.81	3.63	3.46	3.29	3.13
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Total Net Present Value: 17.32

Cost Effectiveness

Total Net Present Value of Costs	Total Net Present Value of Percent Increase in Appointment Availability	Cost per Percent increase in Appointment Availability
\$ 108,236,917	17.32	\$ 6,250,000

Sensitivity Analysis:

One source of uncertainty in this analysis is the discount rate. A 5% rate is used for this calculation. However, if the true discount rate is lower, such as 2%, the net present value of the cost could rise to about \$118,000,000. If the true discount rate is higher, such as 7%, the net present value decreases to about \$102,000,000.

Another source of uncertainty is the effectiveness. As discussed in the evaluation of this alternative, there is a fairly large amount of uncertainty in the percent change in appointment availability due to this alternative within the range of 0-8%. The assumption of 4% effected the cost effectiveness of this alternative. If the true effectiveness is 1%, then the cost per percent increase in appointment availability is \$25,000,000. If the true effectiveness is 8%, the cost per percent increase is only \$3,125,00. The sensitivity of these outcomes is important to recognize when judging the importance of the cost criterion.

Appendix B: Cost Effectiveness for Alternative 3: Work with Free Clinics

Calculating Effectiveness:

It is assumed that this alternative will provide appointments to 17,000 Medicaid enrollees.

The percent increase in appointment availability can be calculated using the baseline assumption from alternative one, of 67% of the Medicaid expansion population having access to care.

Based on the expected eventual Medicaid population of 400,000, this would mean that 268,000 individuals have access to care without this alternative. The addition of the 17,000 individual that will gain access due to this alternative is a 6.3% increase in appointment availability.

Cost Assumptions:

The process that clinics must go through in order to bill Medicaid has many steps and costs associated with it. First Clinics must get a National Provider Identification Number. Next clinics must credential all of the providers who plan to bill Medicaid in the clinic. The providers must complete separate credentialing forms for the MCOs and for DMAS. It is possible that this step can be avoided by clinics if the providers are already credentialed for billing Medicaid in their own practice. Next the clinic itself needs to complete the Virginia Enrollment package through DMAS. After completing these steps, the clinic must ensure that the credentialing process is approved by each health plan they plan to work with. The Virginia Health Care Foundation (VHCF) estimated in 2013 that the time to complete the enrollment and credentialing process is 135-175 minutes per provider enrolled an additional 3 hours for clinic enrollment (Bortz, 2013). This analysis will use the assumption of 4 providers per clinic that will be enrolled meaning a total time of 12- 14.6 hours. The median of 13 hours will be used for this analysis. The enrollment process can be completed by volunteer administrative staff. The average hourly wage for office and administrative support staff in Virginia in 2018 of will \$18.77 will be used to value this time ("Virginia - May 2018 OES State Occupational Employment and Wage Estimates," 2018). These enrollment costs will only occur in

the initial year. To calculate these costs the total time it takes for one clinic to enroll, 13 hours, is multiplied by the wage, \$18.77, to get the cost per clinic. This is multiplied by the number of clinics.

Even after completing the process of becoming a credentialed provider, there is the significant task of actively billing to the MCOs. This is the major cost that will be occurred. Clinics must keep proper documentation and code all billing. Due to the complicated nature of Medicaid Billing, VFCH recommends that free clinics hire 2 billing specialists to complete this task. At least one specialist would need to have experience with Medicaid or insurance billing and VHCF suggest that the average annual salary of someone with the necessary experience is \$36,000 in 2014, adjusted to \$38,656.00 in 2019. The second specialist could have less experience, so a lower salary of \$29,000 is assumed. The cost of the salaries of these billing specialists would occur annually for the entire 5-year duration of the analysis.

General Assumptions:

Discount Rate: 5%
 Number of Clinics Participating: 20
 Percent Increase in Appointment Availability: 6.3

Enrollment Assumptions:

Hours Needed to Enroll per Clinic: 13
 Hourly Wage for Administrative Staff: \$18.77

Yearly Billing Assumptions:

Annual Salary for Primary Billing Specialist: \$38,656
 Annual Salary for Secondary Billing Specialist: \$29,000

Costs						
	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Year	0	1	2	3	4	5
Enrollment Costs						
<i>Administrative</i>						
<i>Cost</i>	\$ 4,880					
Billing Costs						
<i>Salary for</i>						
<i>Primary</i>						
<i>Specialists</i>		\$736,305	\$701,243	\$667,850	\$636,048	\$605,760
<i>Salary for</i>						
<i>Secondary</i>						
<i>Specialists</i>		\$552,381	\$526,077	\$501,026	\$477,167	\$454,445
Total Net Present Value: \$5,863,181.67						

Outcome

Percent Increase in Appointment Availability	6.00	5.71	5.44	5.18	4.94
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Total Net Present Value:	27.28
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Cost Effectiveness

Total Net Present Value of Costs	Total Net Present Value of Percent Increase in Appointment Availability	Cost per Percent increase in Appointment Availability
\$ 5,863,182	27.28	\$214,960

Sensitivity Analysis

One source of uncertainty in this analysis is the discount rate. A 5% rate is used for this calculation. However, if the true discount rate is lower, such as 2%, the net present value of the cost could rise to about \$6,400,000. If the true discount rate is higher, such as 7%, the net present value decreases to about \$5,550,000.

Another source of uncertainty is the percent change. While the number of patients that will be served can be estimated with a fair amount of accuracy, the percent change is calculated based on an estimate baseline effectiveness that is relatively uncertain. It is important to consider the usefulness of the cost effectiveness analysis when the effectiveness measure has such uncertainty.