

Study on Improving Access to Pediatric Services

As Required by

2022-23 General Appropriations Act,

Senate Bill 1, 87th Legislature,

Regular Session, 2021

(Article II, HHSC, Rider 29)

Texas Health and Human Services

Commission

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Table of Contents

Executive Summary	1
Introduction and Background	3
Relationship between Reimbursement Rates and Provider Setting	4
Basis for Assumptions Regarding Decreased Hospital Use and the Cost of Care	4
Review of Published Literature.....	5
Rate Implementation and Delayed Savings.....	10
Issues Regarding Provider Participation with Medicaid	11
Some Patients Might Prefer ED Regardless of Other Influencers	13
Results from HHSC Independent Analysis	14
Survey of Managed Care Organizations	14
Results from Independent ACA Research	15
MCO and Fee for Service (FFS) Data Age 0 to 3.....	15
E&M Data: Grouped by Office Physicians and ED Physicians for Clients Ages 0 to 3	17
E&M Data: Ages 0 to 3 in Rural Setting and in 2013 Cohort.....	19
Actuarial Analysis	21
Conclusion and Recommendations	23
List of Acronyms	25
References	26
Appendix A. MCO Survey	A-1

Executive Summary

This Study on Improving Access to Pediatric Services is submitted as required by 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 29(b)).

Rider 29 requires the Health and Human Services Commission (HHSC) to do the following:

- (a) Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall study whether rate increases for services provided in any setting by a physician, including a specialist, to children ages 0 to 3 result in savings to the Medicaid program from reduced emergency room visits, reduced hospital admissions, reduced extended stays in neonatal intensive care units, and any other access to care-related savings identified by HHSC. The study shall examine the feasibility of determining an actuarially sound basis for cost and savings pursuant to federal actuarial soundness requirements. HHSC shall seek public input on the study.*
- (b) HHSC shall report and make recommendations to the Legislative Budget Board and Governor by November 1, 2022, regarding the feasibility of cost-neutral rate increases that could be implemented to improve access and reduce utilization in more expensive settings.*
- (c) If HHSC's recommendations include a possibility that rate increases can be implemented in a cost neutral manner, and is actuarial sound, HHSC may implement the recommendation as a pilot beginning on March 1, 2023.*

To study the impact of rate increases for physicians on utilization of emergency room and emergency department (ED) visits, hospital admission volume, neonatal intensive care unit (NICU) stay length, and other identified savings, HHSC conducted a literature review, analyzed Medicaid data, reviewed information about other programs, and met with stakeholders.

The rider focused HHSC's study on potential savings that might result from a rate increase; the report does not study the impact that a reimbursement rate increase might have on population health and quality of care, economic and job related benefits that could accrue from an investment in physician rates, or comparative studies to other payors, like Medicare or commercial (private) insurers. HHSC does

anticipate that investments in physician reimbursement rates for Well Checks and other office visits could be beneficial to improving the quality of care provided to Medicaid beneficiaries and could be associated with other positive indicators for Texas. Additional information regarding an exceptional item request that was included in HHSC's Legislative Appropriations Request related to physician rates can be provided upon request.

For this study, HHSC identified that there were significant limitations to HHSC's ability to find a direct or singular causal or correlated impact of a rate increase and as a result could not validate that within a biennial period a reimbursement rate increase for physicians would be cost-neutral to the Medicaid program via reduced emergency room visits, reduced hospital admissions, reduced extended stays in NICUs, and any other access to care-related savings.

Introduction and Background

To study the impact of rate increases for physicians on utilization of emergency room and ED visits, hospital admission volume, NICU stay length, and other identified savings, HHSC evaluated the following:

- Literature review of increased payments to physicians and their impact on reduced ED, hospital, and NICU stays;
- Available Texas Medicaid claims data to evaluate potential changes or savings opportunities;
- Affordable Care Act (ACA) rate increase in 2013-2014 to determine if there were savings resulting from the rate increase, increased provider participation due to the rate increase and the results, or both;
- Research of other payors' rate increase programs, including other states' Medicaid strategies to increase rates for physicians to generate cost savings;
- Medicare or private insurance rate increase programs intended to decrease ED use or related programs; and
- Two working sessions with interested external stakeholders were held prior to the completion of the report. HHSC conducted these webinars at the beginning and midpoint of the reporting process to inform the public of the report's status and gather feedback from stakeholders as the report was created.

In Texas, the majority of Medicaid services are delivered via Medicaid managed care. Medicaid managed care organizations (MCOs) have the authority to negotiate different reimbursement rates with providers in their networks, as well as different terms of payments. Beginning in 2012, HHSC incorporated most client risk groups into managed care; as a result, while HHSC has data to determine what the services were that were provided to a beneficiary and what the amount paid for that service was, HHSC does not have details about the contractual terms that resulted in that payment when a service is delivered in the managed care model. This, along with a variety of other factors, makes it difficult for HHSC to identify specific causal factors that might result in a physician choosing to participate in Medicaid and the number of clients that a physician may choose to serve. For this report, HHSC attempted to identify a cohort for comparison of utilization of primary care services to assess the potential cost-neutrality that resulted from a rate increase, but without the specific knowledge of the contractual terms, it is difficult to ascribe a particular factor that might have contributed to utilization (or not).

Relationship between Reimbursement Rates and Provider Setting

Basis for Assumptions Regarding Decreased Hospital Use and the Cost of Care

At a minimum, payments to providers moderately affect patient interactions with the health care system. Surveys show that low rates are the primary reason physicians do not participate in Medicaid (Cunningham & Nichols, 2005). Furthermore, the same surveys show that higher rates result in greater willingness to see Medicaid patients. Therefore, increased payments to health care providers may change the number of patients a provider is willing to see on a given day, who they are willing to see based on reimbursement options, and the overall availability they offer during the week. Ultimately, this may lead to increased accessibility for patients and greater potential for care.

However, caregivers of pediatric patients might be inclined to seek care in EDs if:

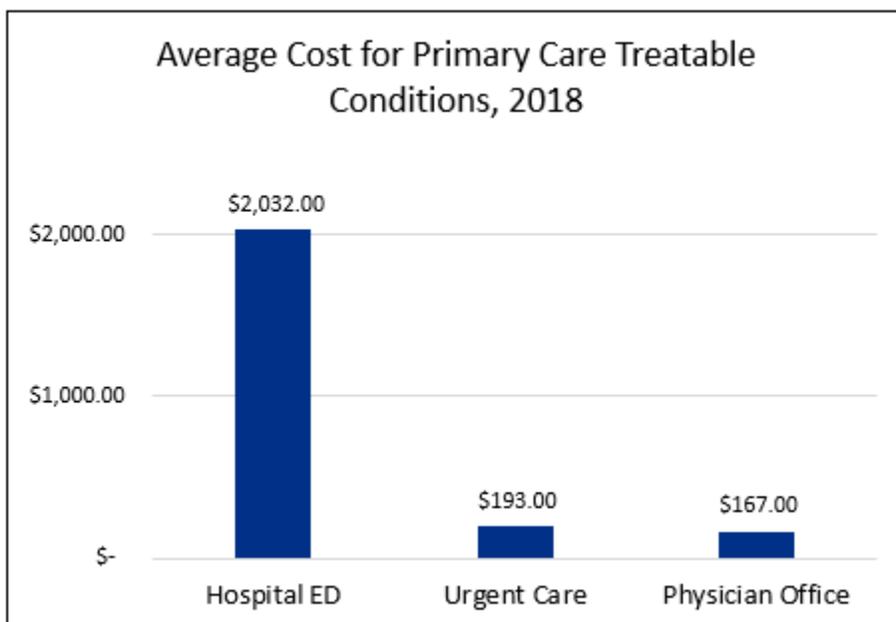
- They have medical concerns outside of their regular health care providers' availability;
- Their regular health care providers do not have enough availability during regular hours; or
- They have difficulties finding providers based on insurance coverage.

This is problematic for patients and health care insurers since ED visits are significantly more expensive than primary care provider(PCP) visits (Wier et al., 2010; Davis et al., 2018). Therefore, any decrease in ED usage (especially when the ED usage could be prevented by other means) provides an opportunity for cost savings.

Increased health care availability is critical in pediatrics because children typically require more preventative care than adults (National Research Council and Institute of Medicine Board on Children, Youth, and Families, 1996). Furthermore, provider availability is critical to pediatric care since caregivers tend to work during the same hours most general health care offices are open. Also, availability is a more significant issue for pediatric patients covered by Medicaid and CHIP. Low-income beneficiaries covered by public health insurance (Medicare and Medicaid) display

worse health outcomes and have less access to care than their counterparts (Bricklin-Smal & Thorsness, 2012; Weir et al., 2013; Davis et al., 2018; Cabral et al., 2022). Furthermore, children on Medicaid use the ED more than other children. According to the Center for Disease Control and Prevention’s 2013 National Center for Health Statistics Report, 25 percent of children on Medicaid had utilized the ED at least once in the previous year, compared to 16 percent of uninsured children and 13 percent of privately insured children.

Figure 1. Average Cost for 10 Common Primary Care Treatable Conditions Frequently Treated at EDs.



Conditions include bronchitis, cough, dizziness, flu, headache, low back pain, nausea, sore throat, strep throat, and upper respiratory infection. Data retrieved from <https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html>.

Review of Published Literature

The relationship between Medicaid payments and patient health care usage is important for developing policy, but little published research was found that evaluates how Medicaid payments and patient health care usage interact or impact one another. During the review of published literature for this report, HHSC found even less available information regarding this relationship in pediatric medicine. Therefore, some sources in this report use statistics for adult Medicaid patients.

Generally, increased payments to providers result in increased access and willingness in physicians to see Medicaid patients (Li et al., 2019; Patterson et al., 2014). However, the evidence is mixed. Decker (1993, 2007) has previously estimated small effects, while Coburn et al. (1999) and Zuckerman et al. (2004) have estimated no effect at all.

Furthermore, as demonstrated by Piehl et al. (2021) and others (e.g., Davis et al., 2018), increased access to health care reduces ED visits in pediatric populations. Therefore, it would make sense that increased Medicaid rates lead to decreased hospitalizations. Decker et al. (2009) showed that reductions in office-based Medicaid provider fees correlate with reduced health care visits and a shift from physician offices to hospital EDs. Likewise, Reschovsky et al. (2012) ran a simulation model where a 10 percent increase in ambulatory Evaluation and Management (E&M) services resulted in a 1.9 percent decrease in overall annual costs per beneficiary after 10 years. This simulation indicates savings in the long-term but not in the short-term. Therefore, according to these findings, increasing rates would not result in a cost neutral change or savings for many years and is a small percentage saving even at that time. Additional research shows that this relation is perhaps more complex than it first appears, as presented in subsequent sections of this report.

Physician Payments Relating to Hospital and ED Stays

Much of the literature examining the relationship between payments to providers and subsequent outcomes are based on the temporary provider payment increases for E&M services provided by the ACA between 2013 and 2014. This increase is the most notable change to Medicaid physician reimbursement in the last decade in Texas. During this time, the federal government funded a temporary increase to Medicaid payments for E&M services to equal 100 percent of the Medicare fee for the same service when provided by certain qualified health care providers, including pediatricians.

The outcomes of these increased payments are mixed. Decker et al. (2018) determined in a survey of 1,500 physicians that the primary rate increases of the ACA did not affect Medicaid acceptance by physicians. Likewise, Patterson et al. (2014) found that in the state of Washington, 60 percent of PCPs reported that the ACA did not affect their willingness to accept new Medicaid patients or continue providing care for current ones. Additionally, Mulcahy et al. (2018) found no association between the ACA rate increases and office visits by Medicaid beneficiaries. However, according to data from The Commonwealth Fund, the overall rate for uninsured adults dropped from 20 percent to 16 percent between

2010 and 2014 (Collins et al., 2015). Though, according to the opinions of some physicians and researchers, this outcome is underwhelming (Shah & Brumberg, 2016).

The National Bureau for Economic Research (NBER) is currently writing several working papers that add to the ongoing debate on how physician reimbursement affects health care use (Alexander & Schnell, 2019; Cabral, Carey & Miller, 2022). However, these findings are still in the working stages and have yet to undergo peer review. After evaluating a random sample of administrative claims data from both Medicare and Medicaid, Cabral, Carey, & Miller (2021) concluded that those dually eligible for both Medicaid and Medicare experienced the most profound effect of the ACA payment increases. These dually eligible individuals account for 15 percent of Medicaid participants and 20 percent of Medicare participants in the US. They also account for roughly a third of the spending in both programs. Low-income dually eligible individuals face lower cost-sharing (i.e., out-of-pocket) obligations compared to higher-income counterparts, so providers generally receive lower payments from this population. However, reducing the provider payment inequality after the implementation of the ACA increased established patient visits, though there was no observable change in new patient visits. Overall, there was a 6.3 percent increase in targeted services to dual-eligible beneficiaries.

In another paper from the NBER, Alexander & Schnell (2019) examined the ACA rate increases from the provider's perspective. Building off previous research suggesting greater payment levels allow providers to do more for a patient (Clemens, Jeffrey & Joshua, 2014), researchers sought to reveal other ways payments might alter provider relationships with clients. They found that large increases in Medicaid reimbursement rates reduced the likelihood that a provider would turn away Medicaid beneficiaries. Historically, office-based physicians have been less likely to accept new patients covered by Medicaid than those covered by private insurance (Decker, 2012). Alexander & Schnell estimate that a \$10 increase in Medicaid payments among children in the U.S. would lead to a 25 percent decrease in parents who report difficulty finding a doctor for their children.

These findings indicate there is likely a link between an increase in payments and access to office-based physicians. However, a clear and consistent correlation between increased access and an overall financial cost saving was not outlined in the research identified for this report.

Physician Payments Relating to NICU Stays

Our research found it difficult to connect the length of NICU stays to provider reimbursement. Data from the Health Resources and Services Administration claims that roughly 85 percent of women receive at least adequate prenatal care. Adequate prenatal care is defined as receiving 80 percent or more of expected visits, given the timing of prenatal care entry and gestational age at delivery (2014 data). Therefore, some have claimed that ensuring the last 15 percent have adequate prenatal health care would result in diminishing returns (Shah & Brumberg, 2016). However, Li et al. (2019) found that the ACA increased prenatal utilization for African American and white women. Collins et al. (2015) also found that the ACA led to increased Medicaid enrollment for Hispanic and African American women, which historically have higher incidences of pre-term births.

In addition, NICU stays are difficult to relate to provider reimbursement because days spent in the NICU or NICU readmissions are problematic quality measures. According to Shah and Brumberg (2016), many NICU patients are discharged “early” and then electively readmitted later to reduce the initial in-patient stay, thereby reducing costs by decreasing in-patient hospitalization. Therefore, rather than NICU stays and readmissions being an indicator of the quality of NICU or prenatal care, these factors might instead indicate a carefully orchestrated treatment plan for a complex infant.

It is also worth mentioning that greater NICU stays have historically been associated with decreased infant mortality. This trend was seen during Medicaid eligibility expansions between 1975 and 1995, leading to increased spending and usage (Shah & Brumberg, 2016). Therefore, decreasing NICU stays may be an unproductive endeavor.

In contrast to ED and hospital care, many in-patient stays could not have been prevented with additional preventative care and reducing stays would not significantly benefit health care providers or patient wellbeing. Shah & Brumberg (2016) further these conclusions in a commentary published in *The Journal of Perinatology*, “No data yet demonstrate rates of overall NICU admission have changed significantly since ACA passage” (p. 588). However, targeted prenatal interventions for disadvantaged populations would likely be the most effective strategy if prenatal care is to be a target for cost savings and improvements to birth outcomes (Roman et al., 2014; Arima et al., 2009).

Physician Payments in Conjunction with Other Strategies

While increased utilization and better care strategies have been shown to decrease hospital and ED stays, increased payments to providers are not usually used to increase utilization and better care. For example, in recent years, Mosquera et al. (2014; 2020; 2021) have conducted multiple studies with the University of Texas Health Science Center at Houston using creative health care strategies to give children with medical complexity better access to quality care.

In 2014, they showed that enhanced medical homes (i.e., collaborative health care teams for treatment of a complex patient) emphasizing comprehensive care reduced serious illness and costs. They demonstrated in 2020 that a hospital consultation service reduced total hospital days, hospitalizations, pediatric intensive care unit days, other outcomes, and health system costs. In 2021, Mosquera and colleagues demonstrated the effectiveness of telehealth, showing that when used in conjunction with comprehensive care, telemedicine likely reduced care days outside the home, serious illnesses, and health care costs for medically complex children. Similar efforts have been very effective.

Perhaps the most successful strategies involve rate increases in conjunction with additional strategies to maximize effectiveness. This strategy is supported by the Center for Health Care Strategies Inc. (Briklin-Small & Thorsness, 2012), with support from The Commonwealth Fund and the New York State Health Foundation. Together they outlined strategies states could use to employ rate increases, particularly rate increases related to additional payments received under the ACA, to sustain or improve primary care access. Their guidance aimed to help states:

- Engage PCPs around the rate increase;
- Target efforts to areas where Medicaid has struggled with primary care access;
- Address PCPs' reluctance to participate in Medicaid beyond issues associated with reimbursement rates; and
- Measure the impact of the rate increase on primary care access.

In short, they recommend identifying key stakeholders, developing an effective outreach strategy, targeting outreach efforts to areas where providers have historically not contracted with Medicaid, and streamlining Medicaid reimbursement and enrollment to increase provider convenience. Recommendations for measuring the rate increase impact were to identify access-related metrics, establish a pre-

ACA baseline, track measures through the end of the ACA, and continue tracking after ACA.

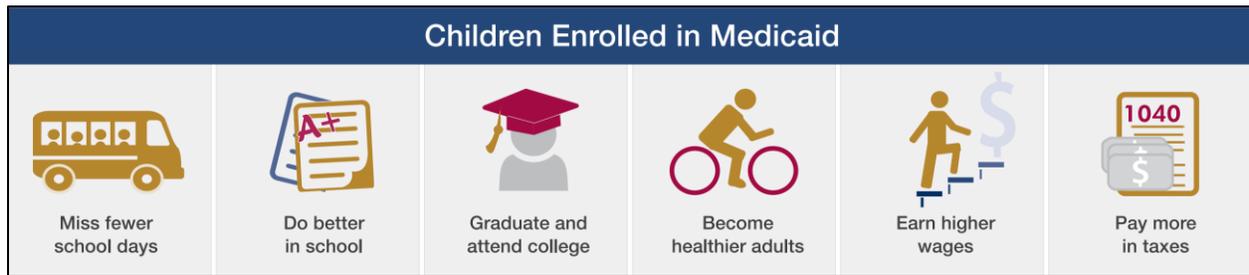
Rate Implementation and Delayed Savings

When evaluating how provider reimbursement relates to patient utilization, a key consideration is a delay between new rate implementation and patient and provider habit changes, improved health care outcomes, or both. In the case of physician engagement with the Medicaid system, the first challenge is ensuring currently enrolled physicians are aware of the rate increases. When the ACA rate increase was implemented, some physicians were unaware of the details relating to the program until after the increases were effective. For example, around 40 percent of primary care physicians in the state of Washington were not immediately aware that Medicaid payments were made equal to Medicare payments, as illustrated in Figure 3 (Patterson et al., 2014).

Once currently enrolled physicians become aware of these changes, the next task was to encourage new providers to begin engaging with Medicaid. After a provider has decided to enroll in the system, the enrollment process for a new provider may take months. Afterward, Medicaid beneficiaries must become aware of any potential changes to their preventative health care access and engage with their improved health care ecosystem. This process can delay potential Medicaid cost savings as benefits roll over from physicians to patients.

While there is some debate over the amount of preventative care increases because of increased physician reimbursement, there is some certainty that having greater access to Medicaid produces long-term savings opportunities. Children who qualify for and actively use Medicaid become healthier adults; healthier adults cost the health care system less. Furthermore, access to Medicaid in childhood leads to economic returns in adulthood; each year of eligibility from birth to age 18 increases cumulative tax payments by \$186 (Wagnerman, Chester, & Alker, 2017).

Figure 2. Benefits of Children Enrolled in Medicaid.

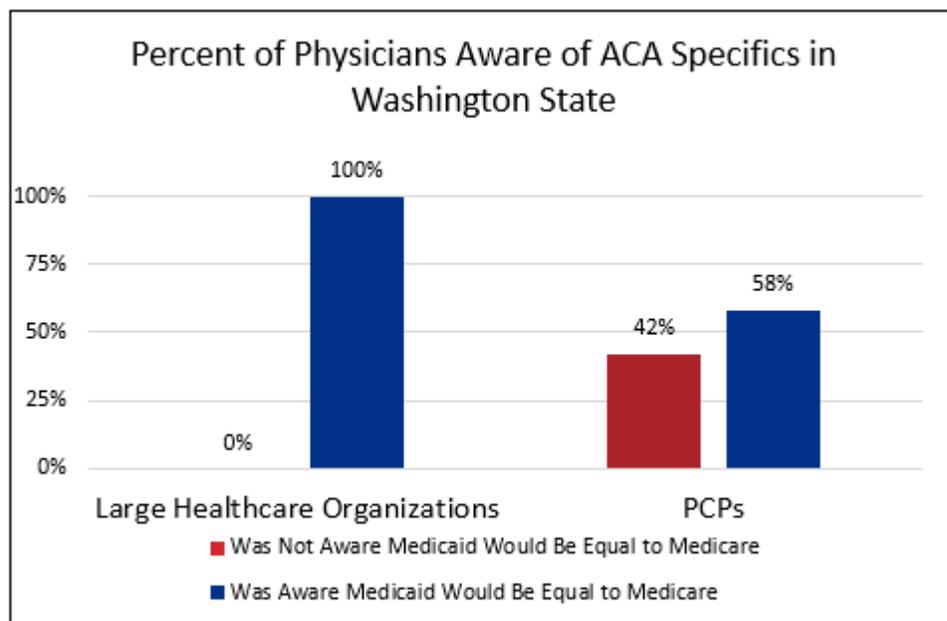


Retrieved from <https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf>.

Issues Regarding Provider Participation with Medicaid

Another issue relevant to the current discussion is the reluctance of some physicians to enroll in Medicaid. Some physicians and physician groups disregard the Medicaid system and any future updates associated with it, potentially hindering programs to increase Medicaid enrollment. Furthermore, research has shown that Medicaid acceptance rates among physicians are more likely to improve health care access than fee levels (Cunningham & Nichols, 2005).

Figure 3. Physicians Aware that Medicaid Payments Would Be Made Equal to Medicare Payments in Washington State.



From Patterson et al., 2014

As previously stated, some physicians are unaware of fee updates, even notable updates such as the ACA increase. Data from Patterson et al.'s (2014) survey of physicians in Washington state revealed surprising results beyond those previously mentioned and illustrated in Figure 3:

- More than a third of primary care physicians did not know or were not sure if they or their practices received increased Medicaid payments resulting from the ACA.
- Among those primary care physicians in smaller practices who played a part in making the decision, 34.2 percent indicated the payment increase increased their willingness to accept new Medicaid patients somewhat or greatly, 60.3 percent indicated the increase in payment had no effect, and 5.5 percent reported decreased willingness.
- Additionally, 40.5 percent of primary care physicians reported that the payments increased their willingness to continue providing care for current Medicaid patients somewhat or greatly. 52.5 percent indicated it had no effect, and 7.0 percent reported decreased willingness.

While some physicians might be unaware of changes and updates, others may simply be uninterested in the system because of previous experiences or expectations. The Center for Health Care Strategies has detailed multiple reasons physicians might not be interested in Medicaid beyond lower reimbursement rates (Briklin-Small & Thorsness, 2012). Many physicians cite payment delays as a barrier to accepting Medicaid (regardless of improvements many states have made over the past decade). Others cite administrative barriers and complexity. Still, others say Medicaid provider credentialing, eligibility verification, claims processing, billing, prior authorization, and preferred drug list programs make Medicaid an intimidating system. In addition, many cite significant difficulties finding specialists for referrals or communication issues as barriers to seeing Medicaid beneficiaries. The difficulty in finding specialists to refer Medicaid beneficiaries to was echoed during the workgroup meetings as a continued challenge for pediatricians. Of particular concern was trying to refer NICU graduates to needed specialists after they had been discharged home. Physicians cited this as a frustrating challenge in many cases.

Some Patients Might Prefer ED Regardless of Other Influencers

When trying to change or alter a patient's utilization habits, it is important to realize that some patients might be resistant to such attempts because of preferences and beliefs surrounding health care. In truth, there may be instances of ED, hospital, and NICU visits that are inevitable. An example of this would be a perceived emergency occurring late at night or early in the morning when no health care office besides the ED or urgent care was available. Additionally, Medicaid beneficiaries with higher financial struggles might have difficulties bringing children to primary care visits because of work, childcare issues, and other social stressors.

Furthermore, many researchers and physicians are beginning to realize that the utilization behaviors of disadvantaged populations are resistant to outside influences. For instance, though readmissions have historically been used as a metric for quality of care, this is now questioned by agencies such as the Medicare Payment Advisory Commission, who originally helped devise readmission penalties in 2008. They have determined that using hospital readmissions as a quality metric is perhaps unfair to hospitals caring for populations of lower socioeconomic status. Therefore, they have reevaluated the impact of readmission penalties and acknowledged that socioeconomic status could affect readmission rates beyond what a hospital can control (June 2013: Report to the Congress: Medicare and the Health Care Delivery System, 2013).

Still, other factors besides preventative care, provider availability, or socioeconomic status play into whether patients seek unnecessary or preventable care at EDs and hospitals. To some, the ED has a greater level of perceived security and certainty in care. This is especially true among the highest users of the ED. One survey showed that some high utilizers believe that between the two options, the ED provided better same-day access than a related clinic during regular daytime hours, 8:00 a.m. to 5:00 p.m., Monday through Friday (Davis et al., 2018).

Furthermore, many of these high utilizers are defined as "medically complex," and while children with medical complexity account for only 0.4 percent of children in the United States, they account for roughly 15-33 percent of health care spending for children, and approximately 40 percent of pediatric hospital charges for children covered by Medicaid are medically complex patients (Berry et al., 2014). These children are inherently more likely to have higher ED use and readmissions, and the perceived security and accessibility of the ED might be more attractive, given their circumstances.

Results from HHSC Independent Analysis

Survey of Managed Care Organizations

In addition to the other research covered in this report, HHSC sent out a survey to MCOs to collect insight from their perspective on the questions posed in this rider. Managed care is a system in which a single-payer organization oversees a patient's overall care to improve quality and control costs. HHSC works alongside MCOs to provide better access to health care for Texas Medicaid beneficiaries, and each MCO has its own practices and policies, which are used to provide the best care possible while reducing costs and maintaining fiscal responsibility.

The survey was distributed through the HHSC TexConnect computer portal system and was open for three weeks. The survey was sent to over one hundred individuals from Texas' 16 MCOs. During the survey period, HHSC received 14 completed responses. These responses were deidentified to maintain anonymity. The survey content focused on whether Texas' MCOs had a past or current program that used payment rate increases for primary care or specialty physician services to reduce usage and costs.

Of those that completed the survey, 50 percent said they did not have a current or past program. Five respondents had programs that targeted ED visits, hospital admissions, NICU stays, or a combination. Two respondents said their program targeted something besides ED admissions, NICU stays, or hospital admissions. When asked to describe their programs, MCOs provided a wide variety of responses. The features highlighted in those programs included: increased payments for E&M codes, enhanced after-hour or weekend rates, alternative payment models, care management/coordination, and value-based contracts which promote wellness visits.

Several MCOs who responded to the survey indicated their plan had employed other strategies to reduce preventable ED visits, hospital admissions, or NICU stays. Two indicated that they had not developed alternative strategies. The features highlighted in MCO programs included: client outreach and education, case management, monitoring potentially preventable events, early identification of at-risk mothers, community health care workers, and health care hotlines.

HHSC asked a series of questions to understand better how Texas' MCOs handle reducing ED, hospital, and NICU stays and how they use physician reimbursements

to accomplish that goal. The results from the survey are presented in Table 1 within Appendix A (Respondents could skip questions, and some questions allowed for multiple responses.; therefore, all totals do not add up to the number of those surveyed).

Results from Independent ACA Research

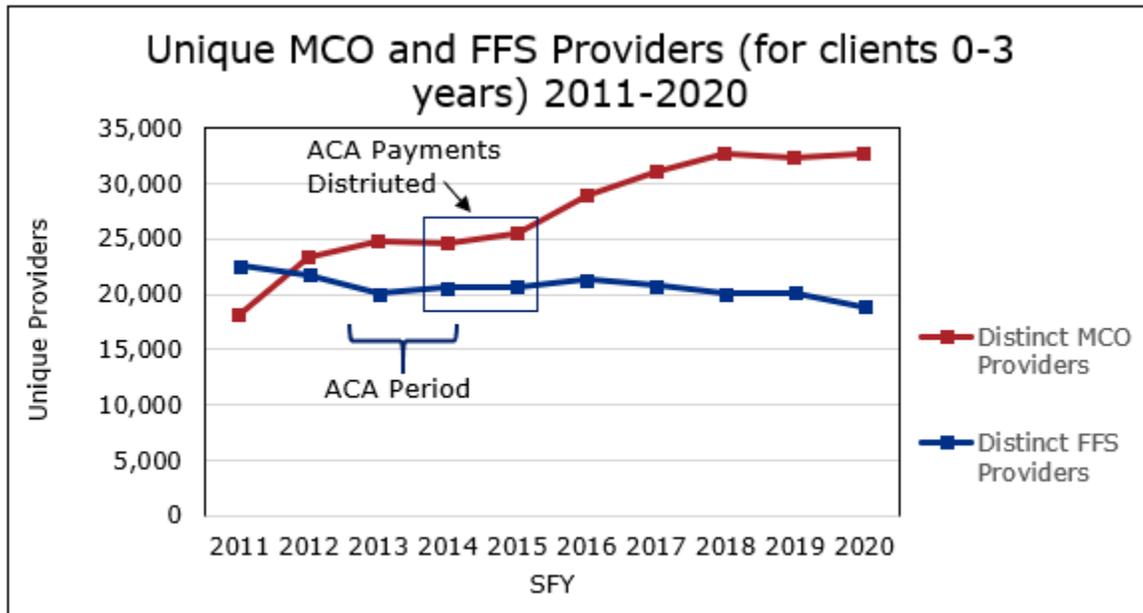
MCO and Fee for Service (FFS) Data Age 0 to 3

The ACA provided a temporary rate increase for certain primary care providers and services from January 1, 2013, through December 31, 2014. Texas, like most states, was unable to begin making these payments on January 1 because of the late release of federal guidance, which led to a delay in receipt of payment by providers. This delay in receipt of the reimbursement rate increase makes it difficult to confidently assert that the full benefit or impact of the rate increase can be assessed, though it is the best potential data available to examine such an impact.

To examine the effect of the rate increase on physician participation and services provided, HHSC examined unique (i.e., distinct individuals) claims data from the previous decade for distinct providers and for distinct Medicaid members in Texas aged 0 to 3 years to evaluate how claims data changed before and after the temporary ACA rate increases. This period was overlapped by a significant shift in the Texas Medicaid program from an FFS model to a managed care model, which may have affected results somewhat.

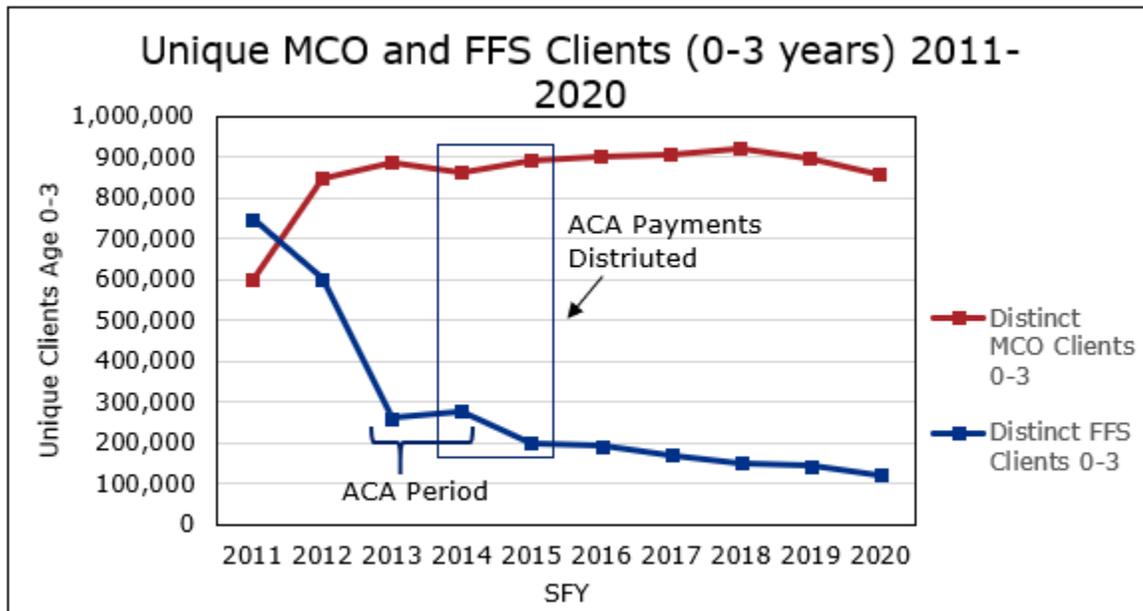
In the previous decade, the total number of distinct Medicaid managed care beneficiaries aged 0 to 3, as identified by patient control numbers, has generally increased. Likewise, Medicaid managed care providers who have submitted claims for clients aged 0 to 3 as identified by national provider identifiers have also increased. At the same time, the Medicaid FFS metrics for ages 0 to 3 have been on the decline due to managed care expansion, more so with clients than with providers (Figures 4 & 5).

Figure 4. Unique MCO and FFS Providers (Ages 0-3).



*Data based on Texas Medicaid & Healthcare Partnership (TMHP) Business Objects FFS/MCO data pull from 2011-2020 set on Physician’s Taxonomies and Targeted ACA Procedure Codes.

Figure 5. Unique MCO and FFS Clients (Ages 0-3).



*Data based on TMHP Business Objects FFS/MCO data pull from 2011-2020 set on Physician’s Taxonomies and Targeted ACA Procedure Codes.

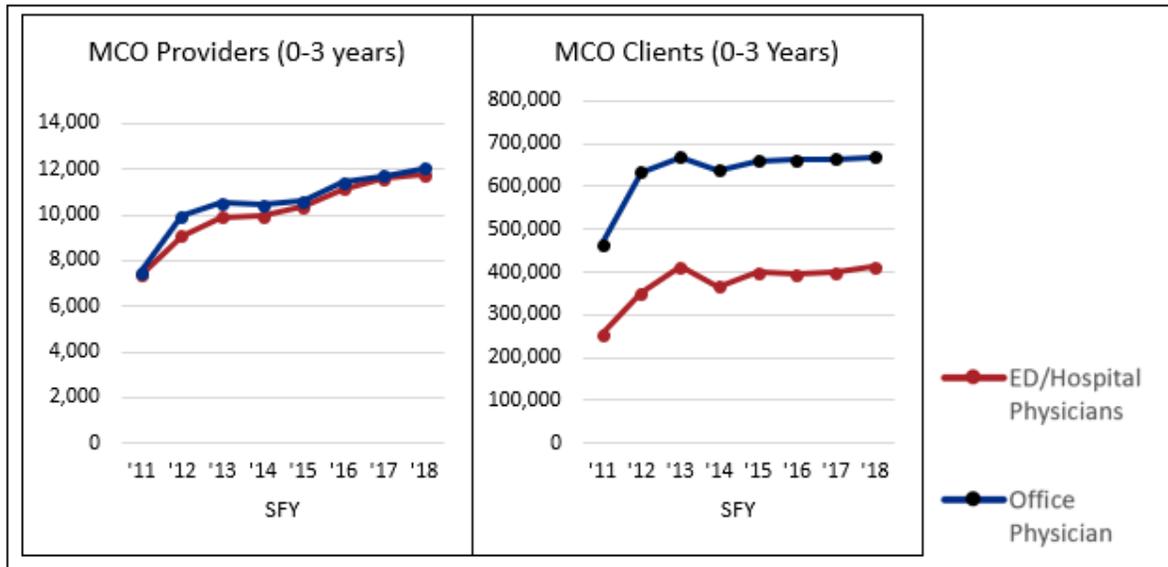
E&M Data: Grouped by Office Physicians and ED Physicians for Clients Ages 0 to 3

HHSC categorized claim and encounter data into two major groups based on whether the claim was for E&M procedure codes or non-E&M procedure codes. The E&M group was then separated into three more groups based on targeted procedure codes which indicate whether it was billed by an ED physician, a hospital physician, or an office-based physician. The targeted procedure codes used to differentiate these groups were established by HHSC staff who have extensive clinical experience.

During a workgroup meeting, stakeholders suggested that HHSC separate the E&M data based on MCO and FFS claims (Figures 6 & 7). External stakeholders also suggested removing providers that had billed very few services each year from the data to not skew results. HHSC investigated this prospect but found that 62.3 percent of claims data for patients age 0 to 3 were submitted by providers who had a median of less than 50 claims per year between 2011 and 2020. Ultimately, HHSC opted to keep this data within the final analysis.

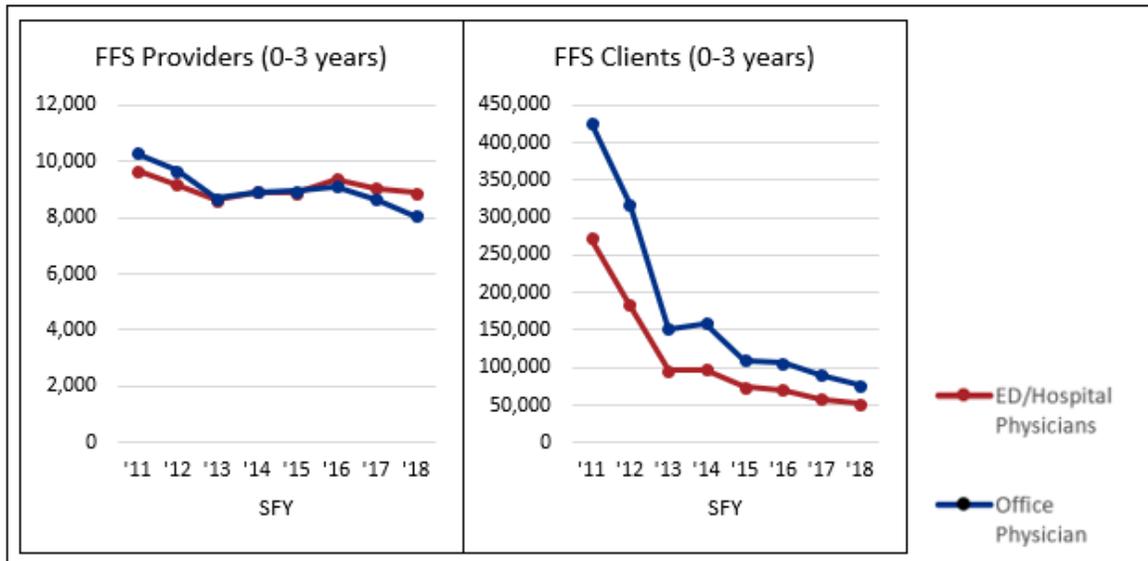
Within the E&M MCO data, there was a steady increase in provider and client billing for ages 0 to 3 for ED and hospital physicians and office-based physicians (Figure 6). ED and hospital based physician services were billed far less than office-based physician services in the client claims data, but there was less of a distinct difference in provider claims. On the FFS side of E&M claims, provider activity was on a decline in 2011-12 before giving way to slight increases in 2013-16 (Figure 7). FFS client engagement drastically decreased between 2011 and 2013, though there was a slight bump in activity in state fiscal year 2014 before returning to its previous trend of decline in 2015-18.

Figure 6. Distinct MCO Providers and Clients Age 0-3 Distinguished by E&M Billing ED/Hospital Physician or E&M Billing Office Physician.



**Data based on TMHP Business Objects FFS/MCO data pull from 2011-2020 set on Physician's Taxonomies and Targeted ACA Procedure Codes.*

Figure 7. Distinct FFS Providers and Clients Age 0-3 Distinguished By E&M Billing ED/Hospital Physician or E&M Billing Office Physician.



**Data based on TMHP Business Objects FFS/MCO data pull from 2011-2020 set on Physician's Taxonomies and Targeted ACA Procedure Codes.*

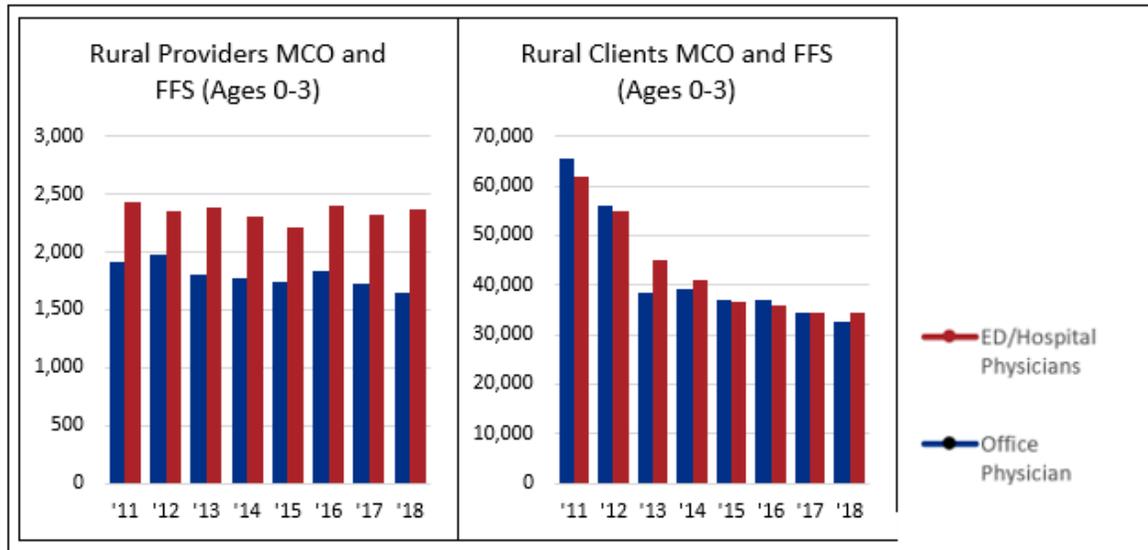
E&M Data: Ages 0 to 3 in Rural Setting and in 2013 Cohort

External stakeholders also suggested that HHSC look at rural data to evaluate Medicaid changes for rural populations (Figure 8). Within the rural data, distinct E&M claims from rural providers for clients aged 0 to 3 by an office physician have been on a slight decrease in the last decade. This is expected as many providers continue to move from rural areas to metro and micro populations. Distinct E&M claims from rural providers for clients age 0 to 3 by an ED/Hospital physician have remained relatively stable.

On the client side, distinct E&M claims from rural clients age 0 to 3 have significantly decreased in the last decade. Notably, the number of distinct rural clients aged 0 to 3 seen by a hospital physician overtakes the number of distinct clients seen by an office physician in 2013, 2014 and again in 2018 (2013: 44,999 ED/Hospital physician, 38,485 office physicians; 2014: 41,165 ED/Hospital physician, 39,169 office physicians; 2018: 34,435 ED/Hospital physician, 32,704 office physician). Though, there are many factors which could have influenced this change.

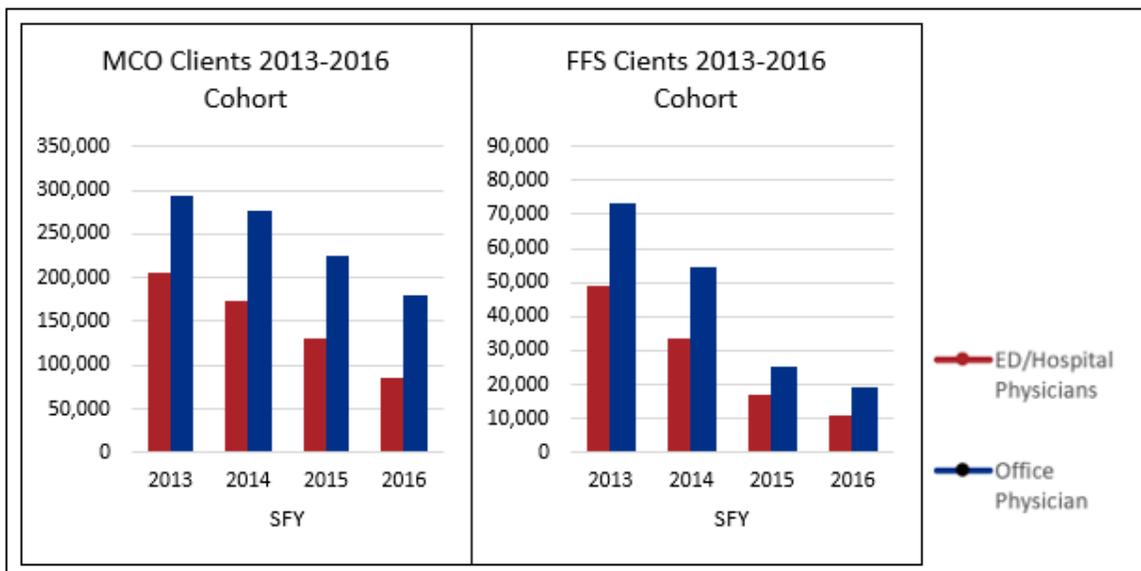
Stakeholders also suggested that HHSC look at a cohort of clients born in 2013 (Figure 9). For clients born in 2013, MCO and FFS E&M data shows that the overall amount of all services decreased from birth to when they turned three years old. These changes may be more due to patient age, as older children tend to have fewer physician visits annually.

Figure 8. Distinct MCO and FFS Providers and Clients Age 0-3 in Rural Populations Distinguished by Either ED/Hospital Physician or Office Physician E&M Billing.



**Data based on TMHP Business Objects FFS/MCO data pull from 2011-2020 set on Physician's Taxonomies and Targeted ACA Procedure Codes.*

Figure 9. Cohort Data: MCO and FFS Claims for Unique Clients Born in 2013 Distinguished by Either ED/Hospital Physician or Office Physician E&M Billing.



**Data based on TMHP Business Objects FFS/MCO data pull from 2011-2020 set on Physician's Taxonomies and Targeted ACA Procedure Codes.*

Actuarial Analysis

Medicaid managed care capitation rates are developed prospectively on a state fiscal year basis. Medicaid capitation rates are actuarially sound if projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. When accounting for changes in policy, benefit reimbursement, or other changes to the Medicaid program, the assumptions must have an actuarially sound basis, meaning that the adjustment can be evaluated and quantified in an actuarially sound manner. The rates must reflect an actuarially sound estimate of what a reasonable and appropriate impact to Texas Medicaid will be from the change.

To evaluate the impact of the proposed changes, HHSC would need to develop actuarially sound assumptions to address the following:

1. Impact of provider rate increase on cost.
2. Increased utilization of the services for which there is a rate increase.
3. Savings as listed in the rider but not exclusive to the listed items.
4. Any other impact not listed above but expected to have a significant impact on cost or savings.

Upon review of literature and data, HHSC finds it difficult to confirm whether the impact of the proposed rate increases for services provided in any setting by a physician, including a specialist, to children ages 0 to 3 is both reasonable and appropriate when considering HHSC's criteria for actuarial soundness. While increases to physician reimbursements may increase health care access, there is still debate as to the potency of this strategy, especially when rate increases are the only variable being manipulated. This makes it difficult to evaluate, quantify, and project the utilization and savings-related outcomes resulting from the proposed changes.

It is also difficult to predict exactly how much governing authorities should invest in increased reimbursements to receive a desired outcome, especially since most published research only covers a significant change in reimbursement methodology. Research does not show whether there is a threshold or breakpoint in which reimbursement rates should be increased, which would become a key factor if HHSC were to pursue such a route while attempting to maintain cost neutrality and actuarial soundness. This also hinders HHSC's ability to estimate the impact to

Texas Medicaid of potential utilization-based savings that would require a dynamic fiscal impact estimate.

Conclusion and Recommendations

HHSC employed three main efforts in researching the questions proposed by this rider. These included:

- Regular discussions with external stakeholders so HHSC could receive guidance from providers that directly work with various Medicaid populations;
- A survey which was sent out MCOs in Texas. This was done to learn whether MCOs have historically increased rates paid to pediatric providers to reduce unnecessary ED, hospital, and NICU stays or if they had employed any other successful methods; and
- Independent research conducted by HHSC using published literature, consultation of knowledgeable persons on the topic, and data analysis from available Medicaid claims data.

Stakeholder opinions favor increased primary care reimbursement to increase primary care participation in and satisfaction with the Medicaid program. However, based on the findings presented in this study, HHSC cannot validate that increased reimbursements would be cost neutral within a two-year period to the Medicaid program as a result of reduced use of higher-cost services or other access to care-related savings for children ages 0 to 3.

HHSC finds that additional methods, such as the ones currently being researched by the University of Texas Health Science Center at Houston, should also be considered, though even those methods have required investments of funds that were supported via the Network Access Improvement Program or the Delivery System Reform Incentive Payment Program. Alternative strategies may provide efficient methods for increasing health care availability for Medicaid beneficiaries. For instance, education and quality care focused programs that aim to reduce ED, hospital, and NICU stays may be an option for state Medicaid managed care and may have more immediately measurable impacts on utilization.

Based on our research, only broad-based increases for physician services such as the one observed during the ACA have been proven to be effective, and such increases are not cost neutral in the short-term. In conclusion, rate increases are not the singular driver that would impact children ages 0 to 3 and result in a cost-neutral impact to the Medicaid program from reduced ED visits, reduced hospital admissions, reduced extended stays in NICUs in a two-year period. Rate increases

would not likely be cost neutral within a biennium and additional strategies to influence behavior and choice would likely be appropriate to target in addition to reimbursement rates.

List of Acronyms

Acronym	Full Name
HHSC	Health and Human Services Commission
ED	Emergency Department
ER	Emergency Room
NICU	Neonatal Intensive Care Unit
PCP	Primary Care Provider
E&M	Evaluation and Management
ACA	Affordable Care Act
NBER	National Bureau for Economic Research
MCO	Managed Care Organization
FFS	Fee for Service
TMHP	Texas Medicaid and Healthcare Partnership

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Appendix A. MCO Survey

Table 1. Survey Questions with Responses.

Question 1	Does your MCO have a current or past program that used payment rate increases for primary care or specialty physician services in an attempt to reduce usage and costs from any of the following? Please select all that apply:	Count
Response	No current or past program	7
Response	Yes, emergency department visits	5
Response	Yes, hospital admissions	1
Response	Yes, NICU stays	2
Response	Other	2
Question 2	What types of physicians did program design target? Please select all that apply:	Count
Response	Pediatrician	7
Response	Family practitioner	6
Response	Pediatric specialist	1
Response	Pediatric subspecialist	0
Response	Other	3
Question 3	Was the rate increase targeted for a specific clientage group?	Count
Response	0-3 years	1
Response	0-18 years	1
Response	0-21 years	0
Response	All ages	4
Response	Other	2
Question 4	Was the program design directed toward specific diagnoses? Please select all that apply:	Count
Response	No specific target diagnosis	4
Response	Asthma	1

Response	Diabetes	1
Response	Hypertension	1
Response	Prematurity	0
Response	Other	4
Question 5	By what percentage were rates increased?	Count
Response	0-5%	1
Response	5-10%	3
Response	11-20%	0
Response	21-30%	0
Response	31%-40%	0
Response	41% or more	0
Response	Not applicable.	0
Question 6	Were any alternative payment mechanisms designed into the program, such as an incentive for holding evening or weekend office hours?	Count
Response	Yes	3
Response	No	5
Question 7	What was the duration of the rate increase program?	Count
Response	0-6 months	1
Response	6 months-1 year	0
Response	1-4 years	1
Response	5+ years	1
Response	Ongoing	4
Question 8	Did the rate increase affect physician participation?	Count
Response	Increased participation measured	5
Response	Decreased participation measured	0
Response	No change in participation or unable to measure	3

Question 9	Was the rate increase program successful in reducing costs?	Count
Response	Yes	3
Response	No	1
Response	Unsure	4
Question 10	How much were costs reduced annually?	Count
Response	\$0-\$50K	1
Response	\$50K-\$500K	1
Response	\$500K-\$2.5m	0
Response	\$2.5m or more	0
Question 11	How much were costs reduced per member per year?	Count
Response	\$1-\$10 per member per month	2
Response	\$11-\$50 per member per month	0
Response	\$51-\$100 per member per month	0
Response	\$100 or more per member per month	0
Response	Other	0
Question 12	What was the methodology for observed savings? Please select all that apply.	Count
Response	Reduced emergency room visits	2
Response	Reduced hospital admissions	1
Response	Reduced stays in neonatal intensive care units	1
Response	Other	1
Question 13	Has your organization employed other strategies to reduce preventable ED visits, reduce hospital admissions or reduce neonatal intensive care stays?	Count
Response	Yes	10
Response	No	2