HEALTH CAPITAL Topics
Volume 7
Issue 10
October 2014
Todd A. Zigrang, MBA, MHA, ASA, FACHE, Publisher • Jessica L. Bailey, Esq., Editor ©

Access to Healthcare Remains Stable Under Affordable Care Act

There are fears that the U.S. will soon face a crisis of access to healthcare services, as the aging of the *"baby boomer"* population will likely increase demands of healthcare services from the physician workforce.[1] Additionally, the physician workforce itself is also aging, which may lead to a shortage of providers as many doctors enter retirement or move into a part-time role.[2] The latest generation of physicians, replacing the outgoing retirees, may tend toward fewer hours worked per week.[3] This may further reduce the supply of health services providers, exacerbating the potential shortage of physicians. Lastly, and perhaps most visibly, significant reforms to the U.S. healthcare delivery system may greatly increase the number of people who have health insurance.[4] These trends may indicate a physician shortage in the near future, due to a growing demand for healthcare services, a shrinking supply of healthcare services, or both. If such a shortage does materialize, access to healthcare services may deteriorate, as more and more beneficiaries seek treatment from fewer and fewer physicians.

As the U.S. prepares for more people to sign up for health insurance through the health insurance marketplaces during the ACA's 2015 *"open enrollment"* period, healthcare industry professionals have debated both current and potential future methods to ensure *"network adequacy"* (i.e., the ability of a health insurance plan to provide access to a network of physicians).[5] One demographic that may have particular difficulty accessing healthcare services is Medicaid beneficiaries, the number of which is expected to rapidly increase in the coming years due to expanding Medicaid eligibility in specific states. In September 2014, the *Office of the Inspector General* (OIG) of the *U.S. Department of Health and Human Services* (HHS) released a report entitled *"State Standards for Access to Care in Medicaid Managed Care."* This report analyzes the regulations that states use in their oversight over Medicaid Managed Care plans, to ensure that these plans maintain a certain level of access to care for their beneficiaries.[6]

Medicaid Managed Care plans are health plans wherein *managed care organizations* (MCOs) deliver health services to Medicaid beneficiaries via a network of providers; assume the financial risk of delivering said services; and, receive reimbursement for these services from the state in which the MCO operates.[7] The OIG found that of the 33 states which utilize Medicaid Managed Care plans, 32 states had standards setting a maximum distance or time a beneficiary must travel in order to see a provider; 31 states had standards setting a maximum number of days a beneficiary must wait in order to see a provider; and, 20 states had standards setting a maximum on the number of beneficiaries per provider.[8] Although the types of standards Medicaid MCOs are required to meet are similar, the benchmarks that different states set for Medicaid MCOs vary widely. For example, the maximum number of beneficiaries allowed per primary care provider ranged from as low as 100 beneficiaries to as high as 2,500 beneficiaries.[9]

In addition to reviewing the standards for access to care, the OIG report studied the oversight and compliance policies related to these standards, again finding a wide variety between states. Only eight states actually conducted tests to determine whether plans were in compliance with access to care standards. Other states use a variety of oversight methods, with some being as simple as an annual *"self-attestation"* from the health plan, whereby the plan assures the state that the health insurance plan is in compliance with the state's access to care standards.[10] The OIG's report concluded that, due to the wide variety in standards and oversight regarding access to care for Medicaid Managed Care plans (some of which allowed for patients to wait up to two months to see a specialist), the *Centers for Medicare and Medicaid Services* (CMS) should improve oversight over the states.[11] The OIG's report recommended that CMS issue guidance to strengthen state standards for access to care and require that states (or a state contractor) conduct direct tests on MCOs, to ensure that the MCOs are in compliance with standards for access to care.[12]

As the OIG report demonstrates, regulatory scrutiny of access to care for Medicaid beneficiaries has increased, due in part to the large population of Americans who receive health insurance coverage through Medicaid. Currently, Medicaid is the single largest source of health insurance in the U.S., providing health insurance coverage to over 60 million Americans during fiscal year 2010.[13] Since October 2013, Medicaid has enrolled approximately eight million new beneficiaries, and by 2016, one in four Americans may have health insurance coverage through Medicaid.[14]

Given the growing population of Medicaid beneficiaries, as well as the potentially lacking standards regarding access to care for Medicaid Managed Care beneficiaries, combined with the looming threat of a general shortage of physicians, intuition would indicate that the U.S. may soon face a crisis

(Continued on next page)

of access to healthcare services, especially among Medicaid beneficiaries. However, research on the topic has yet to substantiate this suspicion. First, 2012 survey data (i.e., data collected prior to the full implementation of the ACA) indicated that Medicaid beneficiaries had comparable access to a usual source of care, well-child checkups, general doctor visits, and specialist visits when compared to beneficiaries covered by *employer sponsored insurance* (ESI).[15] Furthermore, a 2014 study investigating access to care *after* the expansion of Medicaid eligibility found no evidence that expanding Medicaid eligibility resulted in a reduction in access to care (as measured by the perceptions of Medicaid beneficiaries), nor did expanding Medicaid eligibility result in increased use of emergency room services (which may be expected if a beneficiary were to be unable to receive treatment from a non-emergency provider).[16] In short, research data indicates not only that access to care for Medicaid beneficiaries was comparable to that of ESI beneficiaries (with regard to basic health services) early in the life of the ACA, but also that access to care for Medicaid beneficiaries did not deteriorate with the expansion of Medicaid eligibility (and the ensuing increase in the number of Medicaid patients).

With an increasing population of Medicaid beneficiaries (and a corresponding increase in demand for healthcare services), and a stable population of physicians to provide those services, why has access to care for Medicaid beneficiaries remained at a stable level? One possible explanation is that although the general population of physicians is stable, provisions included in the ACA may increase the number of providers of basic health services. For example, the ACA raised Medicaid payment rates for most primary care services by an average of 73%, which may cause more physicians to begin accepting Medicaid patients, therefore potentially increasing the pool of providers available to Medicaid beneficiaries.[17] Furthermore, the ACA provided funding for expanding community health centers, which may also provide health services to Medicaid patients.[18] Another possible explanation is that the ACA has not added as many new Medicaid beneficiaries as the initial estimates indicated. More detailed analysis of the influx of Medicaid beneficiaries reveals that many of the added beneficiaries would have been eligible for Medicaid regardless of the ACA, and still other "*new*" beneficiaries were previously enrolled in Medicaid, and are simply renewing their coverage for another year.[19] As of September 2014, one analysis puts the number of enrollees who now have Medicaid coverage strictly as a result of the ACA at 5.6 million, out of the total 10 million new Medicaid enrollees.[20] Finally, a third possible explanation is that the U.S. simply has not yet felt the full impact of the ACA's implementation. As noted above, the population of Americans who receive health insurance coverage through Medicaid is projected to continue to increase over the next several years.

The U.S. may indeed be facing a healthcare delivery and supply crisis, in which there is an insufficient number of providers to meet the needs of the aging population, despite significant efforts to provide health insurance coverage to a larger share of the population. An aging *"baby boomer"* population and a growing number of insured beneficiaries demanding more health services, combined with an aging physician workforce entering retirement, may result in a significant supply shortage in the healthcare industry.[21] However, recent research indicates that the U.S. has not yet reached a point at which there is insufficient access to basic healthcare services for the growing population of Medicaid beneficiaries. Therefore, although the U.S. may not be able to control the demographic shifts discussed above, the U.S. may benefit from acting quickly, to address issues of regulatory standards regarding access to care and provisions to increase the pool of available healthcare providers, in order to mitigate the effects of the potential shortage of healthcare services.

---

1 "US Health Spending Trends by Age and Gender: Selected Years 2002-10" by David Lassman et al., Health Affairs, Vol. 33, No. 5, 2014, p. 815-822.
2 "Will there Be Enough Doctors?" by John Commins, Health Leaders Media, 2014, http://www.healthleadersmedia.com/content/MAG-92871/Will-There-Be-Enough-Doctors## (Accessed 10/07/14).
3 "Wanting it All: A New Generation of Doctors Places Higher Value on Work-Life Balance" by Eve Glicksman, Association of American Medical Colleges, https://www.aamc.org/newsroom/reporter/336402/work-life.html (Accessed 5/22/14).
4 "Medicaid Moving Forward" The Henry J. Kaiser Family Foundation, June 17, 2014, http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/ (Accessed 10/06/14).
5 "For Many New Medicaid Enrollees, Care is Hard to Find, Report Says" by Robert Pear, New York Times, September 27, 2014, http://www.nytimes.com/2014/09/28/us/for-many-new-medicaid-enrollees-care-is-hard-to-find-report-says.html?_r=0 (Accessed 10/06/14).
6 *Ibid*.
7 "State Standards for Access to Care in Medicaid Managed Care" by Suzanne Murrin, Deputy Inspector General for Evaluation and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services, September 2014.
8 *Ibid*.
9 *Ibid*.
10 *Ibid*.
11 *Ibid*.
12 *Ibid*.
13 The Henry J. Kaiser Family Foundation, June 17, 2014.
14 Pear, September 27, 2014.
15 The Henry J. Kaiser Family Foundation, June 17, 2014.
16 "Effect of Expansions in State Medicaid Eligibility on Access to Care and the Use of Emergency Department Services for Adult Medicaid Enrollees" by Chima D. Ndumele, PhD et al., Journal of the American Medical Association: Internal Medicine, Vol. 174, No. 6, 2014, p. 920-926.
17 The Henry J. Kaiser Family Foundation, June 17, 2014.
18 *Ibid*.
19 "Obama's claim that 7 million got 'access to health care for the first time' because of his Medicaid expansion" by Glenn Kessler, Washington Post, February 24, 2014, http://www.washingtonpost.com/blogs/fact-checker/wp/2014/02/24/obamas-claim-that-7-million-got-access-to-health-care-for-the-first-time-because-of-obamacares-medicaid-expansion/ (Accessed 10/07/14).
20 "The Graphs" by Charles Gaba, ACASignups.net, 2014, http://acasignups.net/graphs (Accessed 10/9/14).
21 Commins, 2014.

(Continued on next page)

HCC
HEALTH CAPITAL CONSULTANTS

(800) FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- **HCC Home**
- **Firm Profile**
- **HCC Services**
- **HCC Experts**
- **Clients & Projects**
- **HCC News**
- **Upcoming Events**
- **Contact Us**
- **Email Us**

HEALTH CAPITAL CONSULTANTS (HCC) is an established, nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, Missouri, with regional personnel nationwide. Founded in 1993, HCC has served clients in over 45 states, in providing services including: valuation in all healthcare sectors; financial analysis, including the development of forecasts, budgets and income distribution plans; healthcare provider related intermediary services, including integration, affiliation, acquisition and divestiture; Certificate of Need (CON) and regulatory consulting; litigation support and expert witness services; and, industry research services for healthcare providers and their advisors. HCC's accredited professionals are supported by an experienced research and library support staff to maintain a thorough and extensive knowledge of the healthcare reimbursement, regulatory, technological and competitive environment.

Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*Accountable Care Organizations: Value Metrics and Capital Formation*" [2013 - Taylor & Francis, a division of CRC Press], "*The Adviser's Guide to Healthcare*" – Vols. I, II & III [2010 – AICPA], and "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books]. His most recent book, entitled *"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services"* was published by John Wiley & Sons in March 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Matthew J. Wagner, MBA, CFA, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis. Mr. Wagner has provided valuation services regarding various healthcare related enterprises, assets and services, including but not limited to, physician practices, diagnostic imaging service lines, ambulatory surgery centers, physician-owned insurance plans, equity purchase options, physician clinical compensation, and healthcare equipment leases.

John R. Chwarzinski, MSF, MAE, is Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Jessica L. Bailey, Esq., is the Director of Research of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.