

Increasing Primary Care Rates, Maximizing Medicaid Access and Quality

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As Medicaid completes its transformation from a welfare program to the nation's largest health insurance purchaser, it must refocus efforts to build a strong and robust primary care system to achieve better access and quality outcomes. The Affordable Care Act (ACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, requires that Medicaid reimburse primary care providers (PCPs) at parity with Medicare rates in 2013 and 2014.¹ States can use this short-term increase to achieve broader policy objectives, such as increasing the number of PCPs in Medicaid, infusing greater quality and access measurement into the market, and building more advanced models of primary care.

The Centers for Medicare & Medicaid Services (CMS), working together with state Medicaid programs and other key stakeholders, must work through numerous policy and technical issues to implement this health reform provision effectively and efficiently. States and CMS will want to establish clear goals and objectives for this provision to help drive regulation development, implementation, and program evaluation. Technical details of implementation could overwhelm the intended policy effects, particularly given the immediate demands on states to implement multiple components of health reform and the major changes many states are currently making to their Medicaid Management Information Systems (MMIS). Developing guidelines that ease the implementation burden on states, while enabling accurate federal reporting of increased expenditures, is critical.

Many states are already rising to the challenge of expanding coverage to the nation's uninsured, redesigning their delivery systems to produce better value, and linking payment to improved results. Paying PCPs at parity with Medicare is a key step in transforming the Medicaid primary care delivery system.

IN BRIEF

Health care reform requires reimbursement for Medicaid primary care providers at parity with Medicare rates in 2013 and 2014. States can use this rate increase to:

- Maintain or expand primary care networks;
- Infuse greater quality and access measurement; and
- Build more advanced models of primary care.

This brief discusses nine policy and technical issues for federal policymakers, states, and other Medicaid stakeholders to consider as they implement the rate increase. The authors identify implementation approaches that can support improvements in the primary care delivery system well beyond 2014.

Made possible with support from The Commonwealth Fund, this brief highlights critical issues related to primary care payment policy and describes how Medicaid stakeholders can make strategic, short-term decisions to maximize the long-term impact on primary care quality and access. It is the first in a series of papers that the Center for Health Care Strategies (CHCS) will produce as CMS provides guidance and states begin to implement the rate increase.

Background

Across the country, Medicaid agencies recognize payment reform and primary care redesign as important components of developing high-performing health systems. As Medicaid prepares to serve up to 80 million Americans by 2019, it should be able to use its purchasing power to obtain higher-value health care, while achieving

increased operational efficiency. Notably, ACA expands eligibility for health insurance coverage to more than 30 million people through Medicaid and subsidized health insurance. This expansion presents enormous opportunities for states running both Medicaid and the insurance exchanges to make advances in the transformation of primary care.

The persistent rise of health care costs in the U.S. has largely overshadowed the crisis in primary care. Today's PCPs are treating larger volumes of patients with increasingly complex needs, while fewer medical students are opting for careers in primary care.^{2,3} Inadequate payment and reimbursement systems that reward volume rather than quality of care drive providers to practice "hamster-wheel medicine" in 15-minute visits and to focus on acute health problems rather than prevention and management of chronic conditions.⁴ As a result, patients often face barriers to timely and appropriate care.

The primary care crisis may be more acute in Medicaid, which spends an estimated \$427 billion to care for approximately 60 million individuals in the U.S. annually.⁵ While office-based PCPs have long been a significant source of care for Medicaid beneficiaries,⁶ a declining number of PCPs are accepting Medicaid patients⁷ – a trend likely driven by low payment rates and burdensome administrative processes.

Medicaid has long reimbursed physician services at a lower rate than private payers and Medicare, discouraging physician participation and potentially hindering practice transformation efforts.⁸ While some states have increased reimbursement in recent years, 2008 Medicaid fee-for-service (FFS) PCP payments nationally averaged only 66 percent of the rates paid by Medicare.⁹ That same year, only five states paid FFS rates close to Medicare rates, while FFS rates in 45 states fell well below.

Cumbersome Medicaid administrative processes are also a deterrent. PCPs cite delayed reimbursement, as well as time-consuming billing requirements and paper work as reasons for not accepting new Medicaid patients.¹⁰ In response, a number of states have not only increased payment rates, but also simplified administrative practices.

The rate increase required by Section 1202 enables Medicaid to sustain and potentially expand its primary care network for new and current beneficiaries, and creates a critical opportunity for Medicaid to drive

improvements in primary care access and quality. Accordingly, this brief aims to help Medicaid agencies and CMS consider how best to: (1) implement the primary care rate increase; and (2) leverage Section 1202 to improve patient access and quality of care, advance primary care delivery and payment models, and support the expansion of Medicaid coverage. Given that the rate increase is only funded for two years, and many Medicaid programs have recently weathered significant workforce reductions, this brief identifies efficient implementation approaches for states and CMS to consider.

Investments in Primary Care under ACA

- Medicaid primary care services paid at parity with Medicare rates.
- A 10 percent increase for Medicare primary care physician services.
- Increased Title VII funding for primary care residencies.
- \$11 billion in funding for operation, expansion, or construction of new Federally Qualified Health Centers.

Overview of Section 1202

The provision's requirement that states increase Medicaid PCP reimbursement to reach parity with Medicare applies to both FFS and managed care systems. States must reimburse for:

Primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII [Medicare].¹¹

In addition, the legislation provides 100 percent federal funding for the incremental costs of meeting this requirement in 2013 and 2014, as described below:

Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to

such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent.¹²

Section 1202 defines covered services as those Evaluation and Management (E&M) codes and immunization services that are covered by Medicare. The Current Procedural Terminology (CPT) codes for E&M services range from 99201 to 99499, as follows:

*Evaluation and management (E&M) services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and (2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system.*¹³

Notably, as Medicaid coverage expansion does not go into effect until 2014, the first year of increased reimbursement will apply to treatment for current Medicaid beneficiaries.

Implementation Considerations

Medicaid agencies must move swiftly to: leverage opportunities associated with this increase; address numerous technical and policy issues underlying successful implementation; and consider strategies to sustain the rate increase beyond 2014. States should consider the following nine issues in this process:

1. Identifying the primary care services covered in the increase;
2. Identifying providers and places of service eligible for the increase;
3. Understanding baseline primary care rates in FFS and managed care;
4. Implementing a new fee schedule and capitation rates;
5. Modifying federal matching expenditure calculations and reporting procedures;
6. Leveraging the rate increase to expand and maintain the provider network;
7. Linking enhanced reimbursement to access and quality standards;

8. Implementing advanced primary care payment methodologies; and
9. Sustaining the rate increase beyond 2014.

These issues are discussed below:

1. Identifying the Primary Care Services Covered in the Rate Increase

While Medicare regularly updates and maintains the full set of procedure codes outlined in the provision, not all codes are eligible for coverage under Medicare payment rules. Exclusions apply to certain office and inpatient consultations (codes 99241-99255), specific preventive services (99381-99401), and services delivered telephonically (99408-99450). Accordingly, some essential health promotion and prevention services may not be eligible for the enhanced match. Codes 99455 and 99456, which apply to disability examinations, are technically covered by Medicare, but paid at \$0.00. And finally, a subset of immunization CPT codes that are covered in Section 1202, and vital to Medicaid, will be retired by 2013. CMS may want to consider whether and how these codes are covered under this provision.

Notably, applying the rate increase to a specific subset of services and codes may create incentives for “code creep,” in which coding behavior shifts in favor of covered services. This incentive may be particularly strong in states that currently reimburse at a low rate relative to Medicare. Such changes in coding behavior will not necessarily reflect a true shift in service utilization and could result in an unexpected increase in primary care expenditures.

There are a handful of technical considerations, as well. Some Medicaid agencies and health plans may use a primary care coding system or a version of CPT codes that differs from the primary care CPT codes used in Medicare. Medicaid payers will need to identify primary care codes that do not match to covered Medicare codes and update or crosswalk their existing codes to Medicare as necessary.

Furthermore, bundled payments for some procedures and services, such as outpatient services and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, may include payment for associated primary care services. In order to precisely adjust these fees, states will need to “unbundle” payments by service type to reflect enhanced primary care rates. Given scarce resources, states will

require flexibility in determining the most efficient way to adjust bundled payments in 2013 and 2014.

2. Identifying Providers and Places of Service Eligible for the Rate Increase

The rate increase applies only to physicians designated in family medicine, general internal medicine, or pediatric medicine. Stakeholders will need to consider a broad set of policy and technical implications associated with applying these parameters to the current system. For example, the provision excludes physician extenders, such as nurse practitioners (NPs) and physician's assistants (PAs), as well as certain specialists (e.g., OB/GYNs), who often act as PCPs. CMS may want to clarify whether pediatric subspecialists, who often are the primary source of care for chronically ill children, will be eligible. Excluding these providers may hamper the provision's intended bolstering of primary care capacity for current and new beneficiaries and could increase unnecessary emergency room utilization. Additionally, as the fee schedule for physician extenders is often set as a percentage of physician rates, states should consider the increased costs and potential benefits of increasing NP/PA rates in kind.

Sample Technical Issues Requiring CMS Clarification

- Are pediatric sub-specialties included?
- What methods may states use to identify qualifying PCPs?
- How should states manage immunization codes that will be phased out?
- Will new fee schedules need to vary by place of service and Medicare region?

In order to apply the increase to the subset of *eligible* physicians, states and health plans must be able to clearly and accurately identify these physicians. However, some states do not collect this information or may simply allow physicians to self-declare specialty type. For states without robust processes to identify and verify physician specialty, the most efficient path may be to deem certain physicians as qualified PCPs, rather than to collect board certifications. For example, states can assess the percentage of a physician's services that include E&M codes to determine if a physician practices as a PCP. This would eliminate the manual, time-consuming process of obtaining this information directly from physicians.

Medicaid payers must also have the systems capability to set payment levels on the basis of provider type and location of service delivery. Many states do not currently make payments on the basis of specialty type, and/or use antiquated MMIS systems that lack this capacity. States may also need to set different primary care fees based on location of service delivery. Under the current Medicare fee schedule, payment levels vary by place of service, such as a physician's office or a hospital setting. CMS should clarify if Medicaid reimbursement will similarly need to vary by place of service and whether the increase applies to primary care received in institutions such as hospitals/outpatient departments.

3. Understanding Baseline Primary Care Rates in FFS and Managed Care

The 100 percent federal match applies to the differential between Medicaid baseline rates (as of July 1, 2009) and Medicare rates. The resources needed for states to delineate baseline rates will depend upon the methods that Medicaid agencies and health plans currently use to set both FFS reimbursement rates and capitated payments to managed care organizations (MCOs).

Within FFS, states that use Medicare's Resource-Based Relative Value Scale as a basis for their payment methodology and/or set rates as a percentage of Medicare will be well-positioned to obtain the baseline fee schedule. States may be able to obtain the fee schedule from their State Plan Amendment, effective July 1, 2009, or by analyzing FFS claims history. However, some states may use older versions of CPT codes, which may hinder establishing a baseline comparable to Medicare. States with a fee schedule that is not based on Medicare should identify the most efficient approach to understanding the payments associated with covered Medicare E&M codes.

Within managed care, states can choose from a variety of approaches to determine baseline rates. States with robust encounter data, including allowed payment amounts, may use these data to determine the baseline primary care rates paid. However, CMS will need to outline approaches that reflect the highly variable depth and quality of encounter data across states. Depending on the structure of the new fee schedule, states could analyze encounter data either in aggregate or by plan, region, provider type, and place of service. States without encounter data will need to review information on primary care utilization rates and allowed costs embedded in the actuarial models in place on July 1,

2009, to develop baseline estimates. Medicaid MCOs often reimburse PCPs at rates higher than state FFS rates, calling for states to be cautious about using their FFS rates as a baseline within the context of managed care. CMS should provide flexible guidelines to assist states that cannot rely upon encounter data to develop baseline rates.

Finally, CMS should provide guidance on whether states and MCOs need to incorporate pay-for-performance and other existing PCP bonus programs into baseline rate calculations.

4. Implementing a New Fee Schedule and Capitation Rates

States will confront complex technical and operational issues while implementing a new FFS primary care fee schedule and managed care capitation payment rates. How they address these issues will depend on the degree to which their current fee schedules mirror the current Medicare fee schedule and the flexibility they have to implement the Medicare fee schedule (which adjusts during the calendar year and varies by provider, place of service, and region). Given the temporary nature of the increase, CMS and states should look for the most efficient, automated approach to implementation.

In FFS delivery systems, states will use the published Medicare fee schedules to create fee schedules beginning in 2013. The new rate will include the 10 percent increase that Medicare PCPs will receive under Section 5501 of ACA (similarly designed to strengthen primary care).¹⁴ Per Section 1202, states will administer the Medicare fee schedule with the highest rate— as reflected by either the 2013 or 2009 fee schedule. This policy will protect states against a potential PCP rate decline if Medicare rates drop below 2009 levels due to sustainable growth rate adjustments.

In addition, Medicaid fee schedules may need to mirror the many adjustments that Medicare makes to its fee schedules throughout the calendar year. CMS should clarify how often states will be required to make these adjustments. The most efficient option for states will be to fix the fee schedule annually, with no retrospective adjustments or cumbersome reconciliation process to account for the multiple Medicare adjustments. In addition, as it may take some states with older systems months to update their MMIS with new fee schedules, CMS may even want to consider allowing states to

reimburse at the 2013 rate for both years, with sufficient lead time to put the new rates in place.

CMS will need to clarify whether states must make regional and place-of-service adjustments to the fee schedule consistent with Medicare. This process may be complex and time-consuming if a state has a large number of Medicare regions, if rates vary among regions that do not easily map to Medicare regions, or if a single state-wide rate is in place.

Adjusting capitation payments to reflect Medicare rates within managed care may be considerably more complex. States must apply an adjustment to their actuarial models, reflecting both the differential between baseline managed care rates and Medicare FFS rates, and anticipated changes in primary care utilization. If Medicaid MCO payments vary regionally or by plan, revision of several actuarial models and capitation rates may be needed.

To simplify the adjustment of capitation rates, states could calculate the state-level differential and establish a single capitation rate for all MCOs. This approach would result in aggregate expenditures that closely match a more detailed accounting method. However, the differential that each MCO receives relative to its baseline capitation rate may vary and potentially create financial winners and losers. States can mitigate this variation by separately applying the statewide per member per month (PMPM) differential to each MCO baseline PMPM. However, MCOs that rely heavily on Federally Qualified Health Centers and Rural Health Centers, which are already paid at full cost and do not qualify for the rate increase, may receive a higher increase than warranted by their PCP network. Ultimately, states will need flexible guidance from CMS on the approaches that will comply with regulations.

Further downstream in the delivery system, Medicaid MCOs must consider how to apply the rate increase to PCP reimbursement. MCOs using a standardized fee schedule can apply methods similar to those described above for Medicaid FFS. For Medicaid MCOs that pay PCPs through capitated arrangements, appropriately adjusting payments will be complicated, as payment levels may vary by physician or physician organization. States will need to consider reporting mechanisms to verify that MCOs are passing the increase through to their PCPs, with an eye toward structuring these mechanisms to be efficient and not overly burdensome to the plans.

5. *Modifying Federal Matching Expenditure Calculations and Reporting Procedures*

Section 1202 specifies that the federal government will match the primary care increase differential at 100 percent – considerably higher than the federal match for Medicaid services that most states currently receive. CMS will require states to separately report the differential expenditures stemming from the rate increase. The agency’s reporting requirements will shape how states establish new fee schedules and capitation rates, as well as determine the level of implementation complexity and ultimate costs that states incur. To facilitate efficient implementation, CMS may want to offer states direct consultation to review and approve acceptable state reporting methods.

Within FFS delivery systems, states may need robust processes to: (1) maintain two different fee schedules for Medicaid baseline and Medicare rates; (2) calculate the differential between Medicaid baseline rates and Medicare rates at the E&M code level; and (3) apply that differential to the volume of services provided under the specified code.

As states track the rate differential associated with each code, they must account for any variations by place of service and region required by CMS regulations. States should be able to adapt existing systems used to track the volume of services provided by E&M code to calculate volume by provider type, place of service, and region. However, this could be resource-intensive, particularly for states that do not currently vary payments in this way.

Calculating the rate differential is more complex within managed care systems, calling for CMS guidance. For example, states could track the statewide or MCO-specific differential in PMPM rates associated with the rate increase, and apply that differential to the correct patient volume. It will be resource-intensive for states to calculate the managed care differential at a claims level, and especially difficult for states without complete encounter data. States may need to calculate the differential separately for each plan, or could require MCOs to provide and certify expenditures quarterly, depending on CMS guidance and how new capitation rates are set.

Considerations for CMS in the Development of Federal Matching Requirements

- Administrative simplicity and efficiency are critical to creating workable guidelines.
- States will seek guidelines that provide well-defined, yet flexible approaches that account for a wide range of technical capabilities.
- Guidelines should enable states to use electronic processes already in place, not require new manual processes.
- Payment reconciliations are administratively complex and burdensome for states to implement.

6. *Leveraging the Rate Increase to Expand and Maintain the Provider Network*

Some states have low levels of provider participation in Medicaid and are at risk of losing additional providers to more attractive health insurance products (with potentially higher rates) offered through the health insurance exchanges. In 2004 and 2005, for example, 14.6 percent of surveyed physicians reported that they received no revenue from Medicaid, an increase from 12.9 percent in 1996 and 1997.¹⁵

States face several obstacles to maintaining or expanding their provider networks. Historically, Medicaid has reimbursed physician services at a lower rate than private payers and Medicare, often discouraging physician participation in Medicaid and creating barriers to access for Medicaid beneficiaries. In fact, studies show that decreases in income contribute to physicians’ decisions to stop accepting Medicaid patients.¹⁶

Limited physician participation is also due to the administrative burdens associated with Medicaid, such as delayed reimbursement, and cumbersome adjudication and eligibility verification processes. These delays in reimbursement can offset the effects of higher Medicaid fees.¹⁷ Among physicians accepting no new Medicaid patients in 2004 and 2005, for example, 70 percent cited billing requirements and paper work, and 66 percent cited delayed reimbursement as reasons for not accepting new patients.¹⁸ In light of the expected fluctuation of lower-income beneficiaries between Medicaid and subsidized insurance products under the new health insurance exchanges, it will be important for Medicaid to enhance its processes to facilitate seamless transitions between

Sample Areas for Administrative Improvements

- Improve claims processing (e.g., seamless electronic claims submission).
- Streamline the information collected for reimbursement.
- Improve payment turn-around time.
- Ease the burden of auditing.
- Simplify Medicaid eligibility verification processes (e.g., through automated eligibility verification systems).
- Revise referral procedures to ease referral of Medicaid patients to specialists.
- Improve utilization management and automate authorization processes for easier prior-authorization for prescriptions and diagnostics.
- Simplify provider manuals.

coverage options. Medicaid should explore strategies to reduce its administrative burdens to become a more attractive business partner to PCPs.

States will also need to develop outreach strategies to expand access to primary care. One option is to deploy a provider relations strategy well before 2013 to notify PCPs about the increase, highlight the associated enhanced revenue potential, and encourage PCPs to accept Medicaid beneficiaries. States should develop a “pitch” to PCPs, state medical associations, and medical schools and students that is tailored to the primary care dynamics within the state. State and local medical societies can assist with outreach and recruitment efforts. These organizations can potentially help states “make the case” for physicians to participate in Medicaid. Through collaboration with physician-based organizations, Medicaid may leverage the rate increase to also help support physicians in primary care transformation.

7. Linking Enhanced Reimbursement to Access and Quality Standards

Measuring and publicly reporting patient access and quality of care metrics can create a more accountable and higher-quality primary care delivery system. While Medicaid frequently establishes performance measurement requirements with its health plans, such requirements may not exist within FFS arrangements or between MCOs and their primary care networks.

Although the rate increase is not contingent upon physician performance, states may consider ways to leverage the increase to implement primary care access

and quality measures that support high-quality care. For example, the increase in revenue can help open dialogue with the physician community about undertaking or expanding upon performance measurement activities. This presents an opportunity to create a core set of physician-level quality and access metrics, which would also help to measure the impact of the increase.

Medicaid agencies can draw from a range of existing performance metrics to develop these measures. Their commercial counterparts across the country are using provider-level HEDIS and CG-CAHPS measures, nationally recognized measurement sets developed by the National Committee for Quality Assurance (NCQA).^{19,20} States may also use the Children’s Health Insurance Program Reauthorization Act (CHIPRA) core measures for children.²¹ Section 2701 of ACA requires Medicaid agencies to report performance on a new set of adult core measures to be developed by the Agency for Healthcare Research and Quality by 2012, starting in 2014.²² States could begin to enlist early physician participation as part of their PCP outreach and recruitment efforts. Medicaid can also track avoidable readmissions and emergency room use as critical measures of access. Finally, Medicaid could establish standards for practice transformation work. For example, Medicaid can use locally adopted standards and tools or NCQA’s PPC-PCMH recognition measures, which assess a practice’s progression toward becoming a patient-centered medical home (PCMH).²³

When considering how to leverage the fee increase to drive provider-level access and quality measurement, it is important that states explore whether such activities would discourage physician participation. This would obviously undercut the legislative intent of Section 1202.

Medicaid may mitigate the burden of performance measurement by aligning with existing payer measurement activities. Greater alignment across payers can provide consistency, focus quality improvement efforts, and make it easier for PCPs to work with Medicaid. For example, the Robert Wood Johnson Foundation’s *Aligning Forces for Quality* initiative supports cross-payer collaboration among commercial payers and Medicaid stakeholders in 17 regions across the country in order to create system-wide, sustainable improvements in the quality and efficiency of care delivery.²⁴ The Health Information Technology for Economic and Clinical Health provisions included in the American Recovery and Reinvestment Act offer states the opportunity to disseminate incentive

payments to eligible providers for adoption, implementation, and meaningful use of electronic health records.²⁵ The Center for Medicare and Medicaid Innovation (CMMI) recently selected eight states to participate in the Multi-payer Advanced Primary Care Practice demonstration, which will allow Medicare to join Medicaid and private insurers in state-based reform efforts to improve primary care delivery and create consistent quality and access measurement standards across payers.²⁶ Medicaid agencies can tap into such regional or statewide efforts to leverage existing PCP programs to create enhanced measurement expectations for Medicaid beneficiaries.

8. Implementing Advanced Primary Care Payment Methodologies

While Section 1202 enhances primary care reimbursement by building on existing FFS payment methodologies, many states are testing alternative payment methods – including medical homes, episode-of-care payments, and global payments for accountable care organizations – to incentivize enhanced access and quality. Continued reliance on FFS payment methods will undermine current primary care transformation efforts.

Medicaid agencies are using or considering various payment models that match the cycles of practice transformation. These payment models, such as FFS plus an up-front care management fee, capitation and/or global payments, and/or performance-based incentives, use payment to support more advanced primary care models. Medicaid programs can consider how to continue to support both enhanced practice and payment models with enhanced federal funding available through Section 1202.

States using or exploring these advanced payment models will need flexibility in implementing the increase and reporting the differential to secure the federal match, as the models do not easily accommodate FFS. One approach is to calculate the expected additional Section 1202 reimbursement in aggregate and incorporate the additional funds into alternative payment programs, such as PCMH, episode-of-care payments, and global or bundled payments. CMS should consider how to structure guidance so that such innovative payment approaches are not hampered by the increase. States may need to work closely with their provider communities to underscore the feasibility of delivering the increased fees under alternative models.

9. Sustaining the Rate Increase Beyond 2014

The temporary nature of federal funding for the rate increase – ending one year after Medicaid eligibility expansion – may inadvertently limit the provision's main intent to expand and maintain the Medicaid primary care network. States will need strategies to prepare for 2015 and build the case for sustained federal or state funding.

Prior to implementation, states and CMS should consider a clear set of goals and objectives for the increase. These goals will drive the evaluation design, including the kinds of metrics states will collect at the aggregate level to produce valid and reliable measurements of the provision's impact. States will need to build this evaluation capacity early to accurately capture baseline metrics. PCPs may be more willing to participate in and support measurement activities that could help build the case for sustaining the increase. Evaluation results must be available by the end of 2013 to allow stakeholders to advocate for sustaining the increase in 2014 and secure funding by 2015. If results demonstrate cost reductions or are budget-neutral, there may be opportunities to obtain additional and/or ongoing funding through CMMI.

States will need to collect data across a strategic set of performance metrics. In particular, PCP access metrics will help lawmakers understand if the goals of Section 1202 have been achieved. Such metrics could include: the number of PCPs accepting Medicaid; patient-to-PCP ratios; patient panel size; and patient satisfaction with access to primary care. Other changes that may result from the resulting increase in primary care access include: (1) declines in utilization of non-urgent emergency room care; (2) reductions in hospital readmissions and longer-term inpatient utilization; (3) increases in utilization of preventive services; and (4) potential improvements in primary care quality, as captured by a core set of quality metrics previously outlined.

Once states collect these measures, it will be important for them to use valid program evaluation techniques to assess the impact of the provision, especially if other, potentially confounding, Medicaid efforts are in place to improve access and quality and lower costs. In addition, states could conduct a return-on-investment (ROI) analysis, which compares the economic costs and benefits of increasing reimbursement. ROI calculations can help policymakers decide whether funding should be continued beyond 2014 given scarce public resources.

While the political climate might hinder using federal funding to extend the increase beyond 2014, states may want to assess what funding vehicles exist and at what level (state versus federal) for doing so. States could also look to enhanced federal funding for the Medicaid expansion population post-2014. Given the immediacy of the provision, it may be best for state exploration of financing options to begin now.

Potential Long-Term Impacts of Section 1202 on Primary Care

Even if the Medicaid primary care increase is sustained beyond 2014, and states and health plans successfully navigate the above issues, the increase in revenue alone will not achieve desired long-term improvements in access, quality, and costs. True primary care transformation will require: (1) a solution to the PCP shortage; (2) payment levels and reforms that support advanced primary care models and avoid volume-based reimbursement; (3) education and supports to transform the primary care team; and (4) changes to how and when patients use primary care.

If states are able to expand their network of PCPs, the expansion may only be temporary and built on a shrinking pool of PCP resources. With the increase, Medicaid and Medicare rates will still fall significantly below commercial rates, all of which will continue to be less than specialists' reimbursement levels. The dynamic of lower relative pay and an increasingly complex patient population may continue to deter medical students from primary care. All payers will need to develop comprehensive solutions that encourage additional funding for primary care and support advanced primary care models.

Notably, supporting advanced primary care models will require states to reimburse physicians for services outside of a visit, such as email/phone consultation, group visits, or patient outreach. States will also need to pay for non-physician services provided by nurses, pharmacists, and

health coaches, which are increasingly important, particularly for patients with expensive, complex care needs. States may want to push beyond this initial infusion of much needed revenue for primary care to also build and support more expansive approaches to primary care.

Finally, the rate increase may not drive utilization of appropriate primary care services, as it does not explicitly discourage patients from inappropriate use of the emergency room. Without changes in how and when patients can access care, Medicaid beneficiaries may continue to find it more convenient to use the emergency room for non-urgent care. This may be particularly true in the expansion population, which is accustomed to using the emergency room for regular care, and lacks experience with the health insurance system. States seeking to encourage the utilization of office-based primary care should consider financial mechanisms that expand access, including incenting patients to use primary care rather than emergency care, and developing programs to educate patients about the expanded primary care services available to them.

As states look to sustaining the rate increase beyond 2014, they should also address these long-term issues related to the viability of a necessary and critical component of the health care system.

Conclusion

Health reform presents a unique opportunity for Medicaid agencies to provide the primary care system with a much-needed infusion of increased revenue and expand the size of its primary care network. Medicaid can also use its increased purchasing power to drive improvements in the quality of care and efficiency of services for Medicaid beneficiaries. A state's ability to take full advantage of this provision will depend upon efficient implementation of numerous technical changes, as well as maximizing the opportunity to push a broader primary care transformation agenda.

Endnotes

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- ²⁴ For more information, visit: <http://www.rwjf.org/qualityequality/af4q/about.jsp>.
- ²⁵ Public Law 111-5. "American Recovery and Reinvestment Act of 2009."
- ²⁶ Centers for Medicare & Medicaid Services (2010). "Medicare Demonstrations: Details for Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration--Press Release Announcing Selected Sites." November 16, 2010.

Increasing Primary Care Rates, Maximizing Medicaid Access and Quality—Resources from the Center for Health Care Strategies

This brief is part of CHCS' broader effort to provide technical assistance to Medicaid agencies and health plans implementing the primary care rate increase and other health care reform provisions. With support from The Commonwealth Fund, CHCS is helping stakeholders develop solutions for efficiently implementing the two-year payment rate increase and evaluating the impact to sustain funding beyond 2014. Technical assistance is focused on how to apply anticipated federal funding to sustain and expand the Medicaid primary care network for beneficiaries entering the system in 2014, and drive innovations in advanced payment models and improvements in primary care access and quality.

To learn more about CHCS' *Increasing Primary Care Rates, Maximizing Medicaid Access and Quality* initiative or to download related resources, including policy briefs, and hands-on-tools to help guide state health care reform implementation efforts, visit www.chcs.org. Sample resources include:

- **Medicaid and Health Reform 101**– This presentation provides an overview of key opportunities available to states through ACA, and outlines implications of state insurance reform, health insurance exchanges, delivery system reform, Medicaid expansion, state legislation, and state budgets.
- **Medicaid Payment Reform: What Policymakers Need to Know About Federal Law** – This brief examines requirements of federal law that govern Medicaid payment practices, and the implications of health reform.
- **The Affordable Care Act: Opportunities for Medicaid to Advance Ambulatory Quality Care** – Webinar presentations detail reform provisions that can support Medicaid primary care transformation, including key timelines for funding applications and reform implementation, and related considerations for states.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.