

# Implementing the Medicaid Primary Care Rate Increase to Improve Access to Care

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On May 11, 2012, the Centers for Medicare & Medicaid Services (CMS) released proposed regulations on a provision of the Affordable Care Act (ACA) requiring Medicaid agencies to increase primary care reimbursement to parity with Medicare rates in 2013 and 2014. This rate increase can significantly impact the Medicaid primary care delivery system, potentially enhancing access for current and new beneficiaries and helping to reduce unnecessary emergency department visits.<sup>1</sup>

Improving access to primary care is essential, particularly for those states that are ramping up to serve the 15 million Americans who will become eligible for Medicaid in 2014 through health reform.<sup>2</sup> As the proposed rule indicates, a primary aim of the rate increase is to “promote access to primary care services in the Medicaid program before and during the expansion of coverage that begins in 2014.”<sup>3</sup> Through this provision, states will receive an estimated \$11.8 billion, which is 100 percent funded by federal match in 2013 and 2014.<sup>4</sup> Although federal funding for the increase is time-limited, PCPs, who often cite low reimbursement rates as a reason for not participating in Medicaid, may be more willing to accept Medicaid beneficiaries given these additional resources.<sup>5</sup>

This brief, prepared with support from The Commonwealth Fund and additional support from the New York State Health Foundation, outlines recommendations for leveraging the rate increase to sustain or improve primary care access. It provides practical guidance to help states:

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

## IN BRIEF

As many as 15 million Americans will become eligible for Medicaid in 2014 as a result of the Affordable Care Act (ACA). Already burdened by a shortfall of primary care providers (PCPs) willing to accept Medicaid beneficiaries, states face the task of ensuring that these new beneficiaries have adequate access to primary care.

A provision of the ACA requires that Medicaid reimburse primary care providers at Medicare levels for two years – a “bump” that is funded 100 percent by the federal government. States have an opportunity to leverage this increase to encourage PCPs to see more Medicaid beneficiaries, or begin to accept them if they do not already do so. This brief identifies opportunities for Medicaid agencies to engage PCPs; target regions that have historically struggled with access; address additional factors that discourage provider participation in Medicaid; and measure how the rate increase will impact access to care.

## Background

Access to primary care has been shown to improve health outcomes for a number of conditions, including cancer, heart disease, stroke, and infant mortality.<sup>6</sup> Research using Medicare data suggests that increases in primary care rates can both improve access and reduce total costs over the long-term.<sup>7</sup> Conversely, for those with chronic conditions, cuts in Medicaid physician fees have resulted in shifts away from PCP’s offices towards the increased use of emergency and outpatient departments.<sup>8</sup> Regions with a higher proportion of PCPs have been associated with decreased health care utilization, including inpatient admissions, outpatient visits, surgeries and emergency department utilization, presumably as a result of greater access to primary care.<sup>9</sup>

Under the ACA, states have the option to expand Medicaid to cover uninsured single adults with incomes below 138 percent of the federal poverty limit. This new insurance coverage will provide much-needed access to health services for a high-need population. This expansion, however, will occur within a delivery system that is already straining to provide adequate primary care access. The national shortage of PCPs is particularly acute within Medicaid, where a declining number of PCPs participate.<sup>10</sup> In a national survey of office-based PCPs, 66 percent were willing to accept new Medicaid patients. In comparison, 83 and 82 percent of PCPs were willing to accept patients with Medicare and commercial insurance, respectively.<sup>11</sup> As a result, Medicaid beneficiaries are less likely to obtain primary care services and are more likely to frequent emergency departments for routine care than privately insured individuals.<sup>12</sup>

The reluctance of PCPs to accept Medicaid patients is due in large part to inadequate reimbursement, which is cited regularly by physicians as a disincentive to participate in Medicaid.<sup>13</sup> Medicaid generally pays PCPs lower rates than Medicare or commercial payers. In 2008, Medicaid fee-for-service (FFS) rates for primary care averaged 66 percent of Medicare rates.<sup>14</sup> Raising Medicaid rates to Medicare levels, if only for two years, may compel PCPs to either increase their Medicaid panel, or begin to see Medicaid patients if they have not already done so. An analysis of PCPs found that an increase in the primary care

Medicaid-to-Medicare reimbursement ratio to 100 would demonstrably increase acceptance of new Medicaid patients by approximately 11 percent.<sup>15</sup> A separate analysis found that states that currently have low Medicaid-to-Medicare reimbursement ratios could see a roughly 24 percent increase in Medicaid PCP supply as a result of the rate increase, and states that currently have high ratios could expect to see a 10 percent increase in PCPs.<sup>16</sup> For those PCPs already serving Medicaid beneficiaries, the additional resources may make it easier for them to expand office hours and staff availability.

### Provider Outreach Strategy

Engaging providers around the primary care rate increase will be essential to states' efforts to encourage existing Medicaid providers to expand their patient panels and new providers to begin to see Medicaid beneficiaries. Outreach to these two distinct provider groups is a necessary step to increasing access to care in Medicaid. Following is list of suggested state outreach activities.<sup>17</sup>

#### **Identify and convene key stakeholders.**

States should work to identify key stakeholders including state chapters of physician specialty organizations; societies that represent physician extenders; large integrated provider groups, regional multi-payer collaboratives, and state quality improvement organizations; and provider network contacts at Medicaid managed care organizations (MCOs). These stakeholders

### Medicaid, Insurance Exchanges and Access

States can leverage the primary care rate increase to help reduce the negative impact of individuals moving between Medicaid and the health insurance exchanges (also known as "churn"), by creating provider networks that closely align, as much as possible, between Medicaid and the exchanges. Providers who participate in both Medicaid and the exchanges can continue seeing those patients at the Medicaid eligibility cutoffs, regardless of changes in income. These individuals might otherwise be forced to change providers if changes in income required them to switch from Medicaid coverage to coverage through the exchanges. In turn, better continuity of coverage may compel greater PCP participation in Medicaid.

can form an advisory workgroup that can help plan and implement outreach strategies, and will be particularly effective in reaching PCPs not currently serving Medicaid beneficiaries.

**Determine an effective outreach strategy that builds on the state’s delivery system relationships.** For FFS and primary care case management (PCCM) states, it should be relatively easy to identify eligible providers for direct outreach based on Medicaid rolls. For states with both FFS and managed care, states will need to work with MCOs to determine how to delegate outreach activities. States that rely solely on managed care will need to work closely with health plans to reach providers regarding the rate increase.

**Develop an outreach work plan.** A clear work plan that outlines the staging of outreach to providers and communications mechanisms can be established through the advisory workgroup. Communications vehicles might include state Medicaid and medical society provider portals and websites; Medicaid, MCO, and medical society newsletters; direct emails to eligible providers; webinars/conference calls and in-person meetings, among others.

**Craft key messages to reach eligible providers.** The advisory workgroup should identify key messages that states can

disseminate to targeted groups. Messages should ideally appeal to both the providers’ resource concerns as well as their desire to best serve their patients.

### **Target Regions with Low Medicaid Primary Care Access**

States should target PCP rate increase outreach efforts to areas where Medicaid has struggled with access. In particular, states can look for regional pockets where a significant portion of providers choose not to contract with Medicaid, but may contract with other payers (e.g., Medicare and commercial health plans).<sup>18</sup>

An analysis of access variation by region can help states identify areas of opportunity. States should examine PCP participation across payers in various regions, information which may be available through state workforce surveys. By overlaying this information with the Medicaid PCP network, states can identify regions where there are additional PCPs to recruit (*see call-out box*).

Areas where the rate increase will be greatest will provide opportunities to recruit new PCPs. The proposed rule requires Medicaid to apply Medicare geographic region adjustments when adopting the Medicare fee schedule. Analyzing the size of the rate increase across regions can help

### **Regional Opportunities to Encourage PCP Participation in Medicaid**

To identify variations in Medicaid provider participation by region, states can:

1. Analyze PCP participation across payers throughout the state, and identify areas where there is low Medicaid participation and greater participation by providers who contract with other payers. States may set a particular percentage difference (e.g., 40% difference between the two groups) to identify these areas.
2. Assess whether access issues exist for Medicaid beneficiaries by examining available access metrics (see measurement section below) to segment the state into regions based on identified scores.
3. Calculate the differential between the Medicaid July 2009 and the 2013 and 2014 Medicare fee schedules by regions.
4. Identify regions of opportunity, where the rate increase may be significant, Medicaid participation is low, and access to care is low. This will help states identify regions where the rate increase will be most meaningful to access and recruitment efforts.

states identify specific regions where it is most feasible to attract greater Medicaid participation.

States may also wish to conduct similar analyses of PCPs in managed care arrangements, where rates are more likely to vary regionally, to the extent that fee schedule information is available for that group. This data can be used in discussions with health plans and local medical societies to explore a strategy to recruit more PCPs to accept Medicaid and outreach to existing PCPs regarding the increase.

### **Beyond Reimbursement: Addressing PCP Reluctance to Participate in Medicaid**

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Provider reimbursement increases, especially large ones, have been associated with PCPs' greater willingness to accept new Medicaid patients, even when rates remain lower than other payers.<sup>19</sup> Besides low reimbursement rates, providers cite numerous reasons for not seeing Medicaid beneficiaries.<sup>20</sup>

Following are some of these commonly cited factors and potential strategies to help states begin to address these issues:

#### **Payment Delays**

Reimbursement delays offset much of the effect of high payment rates, leading to a concern that rate increases will not be as effective in areas with long waits for reimbursement.<sup>21</sup> However, Section 5001(f)(2) of the American Recovery and Reinvestment Act of 2009 (ARRA) requires states to address delayed reimbursement times in Medicaid. ARRA includes prompt payment requirements for Medicaid, legislating that 90 percent of clean claims are paid within 30 days of receipt of claim and 99 percent are paid within 90 days of receipt.<sup>22</sup> Nonetheless, physicians continue to cite reimbursement delays as barriers to accepting Medicaid, which suggests that providers are not aware of the new requirement or improvements states have made.<sup>23</sup> To address this issue, states can:

- **Publicize prompt reimbursement.** States can use provider outreach to ensure that providers and practice managers are aware of timely payment policies linked to recent ARRA requirements.

#### **Administrative Barriers and Complexity**

The complex processes for Medicaid provider credentialing, eligibility verification, claims processing, and billing discourage some providers from accepting Medicaid beneficiaries, especially those in small practices. Providers have also noted that prior authorization and preferred drug list policies make it difficult for them to practice freely. Prior authorization and preferred drug list programs have been shown to reduce access and quality of care when improperly designed.<sup>24</sup> While administrative barriers exist for all Medicare and commercial payers, many providers state that Medicaid's administrative hurdles make it particularly unattractive.<sup>25</sup> To address this issue, states can:

- **Streamline administrative processes.** States should consider strategies for minimizing unnecessary and complex paperwork, using electronic enrollment verification and claims submission and processing technology, and streamlining administrative processes in general. To simplify administrative processes for their Medicaid dental programs, for example, states have implemented universal claims forms, designated a single point of contact, and employed electronic fund transfers for payment.<sup>26</sup>
- **Justify prior authorization.** When executed correctly, prior authorization practices, including preferred drug lists, can reduce costs and unnecessary treatment. However, to foster provider acceptance of these programs, it is important to make certain that they are evidence-based and allow providers to access treatment options that they believe to be of high quality. Involving

providers in developing prior authorization programs can help assure that there is physician buy-in for such programs.

### Communication and Customer Service

Perceived poor communication between providers and Medicaid is often cited as a factor that deters provider willingness to participate in the program. Providers cite good customer service, easily available program information, and a culture of respect and trust between providers and the state as features that make a network more attractive to join.<sup>27</sup> To address this issue, states can:

- **Prioritize customer service.** Providers appreciate friendly, polite, and helpful customer service when working with Medicaid. One survey conducted in a state with low reimbursement rates, found that provider participation was high due to a strong partnership between the provider community and the state Medicaid agency that included excellent customer service and provider involvement in decision-making processes.<sup>28</sup> States should maintain a frequently updated Medicaid website that includes useful information for providers. Additionally, even if complex paperwork cannot be eliminated, clear guidance can ease the payment process.

### Specialist Referrals

Many PCPs are hesitant to see Medicaid beneficiaries because they have significant difficulties finding specialists for referrals.<sup>29</sup> Though the proposed rule for this provision identifies some specialists as eligible for the rate increase, which will help address this concern, many specialist types are not included. To address this issue, states can:

- **Encourage greater specialist participation in Medicaid.** Increasing Medicaid reimbursement rates for specialist providers who are not otherwise eligible for the primary care rate increase can encourage greater

participation in Medicaid. States can also consider grant or loan forgiveness incentives for providers who willingly serve areas with large Medicaid beneficiary populations for some fixed amount of time (e.g., five years).

A consistent effort to communicate new developments to providers and solicit their feedback to address these barriers will make it more appealing for providers to participate in Medicaid.

### Performance Measurement: Assessing the Impact of the Rate Increase

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Understanding the impact of the primary care rate increase on access for Medicaid beneficiaries is critical information for making the case to sustain the increase beyond 2014. Given the short two-year timeframe of this provision, states should identify metrics that can be assessed quickly. At the same time, states will be interested in the long-term impact of the rate increase. As such, a 'phased' measurement strategy can track the impact of the rate increase over the short- and long-term.

Because there are many other health systems transformation activities in the current environment, ascribing changes in access to the primary care rate increase may be difficult. Nonetheless, an assessment of readily available access and utilization metrics could help states understand the impact of the rate increase.

Access to primary care is associated with improvements in health outcomes, reduced visits to emergency departments, improved patient self-ratings of physician and mental health, reductions in overall costs, and increased health equality between population groups. To measure potential changes linked to the primary care rate increase, states will need to: (1) identify access and related metrics that can be easily tracked; (2) establish a baseline for 2013, when the rate increase goes into effect; (3) track the measures through the end of 2014,



when the rate increase ends; and (4) continue tracking the metrics for a few years thereafter. By looking past 2014, states will be able to assess if there are any residual effects of the rate increase on access.

To understand the impact of the primary care rate increase on beneficiary access to care, states should consider measures to assess: (1) providers' willingness to see Medicaid beneficiaries; and (2) changes in the utilization of health care services resulting from greater access to primary care.

Following are potential measurement strategies that states can adopt related to these two core measures:

### **Provider Willingness to See Medicaid Beneficiaries**

States have multiple potential sources of metrics that they can use to track the impact of the rate increase on provider willingness to see Medicaid beneficiaries.

- **PCP enrollment in Medicaid** – States should review the number of PCPs enrolled in Medicaid before, during, and after the rate increase is put in place. States with FFS would likely have this information readily available. States with managed care delivery systems will need to work with their MCOs to understand the impact of the rate increase on their networks.
- **Access Metrics from MMIS Data** – A state's MMIS can provide basic access metrics for tracking the impact of the rate increase, such as:
  - Patient-to-PCP ratio (broken down by physician and physician extenders);
  - Ratio of PCPs accepting new Medicaid patients to the total number of PCPs in the state; and
  - Number of Evaluation and Management (E&M) visits with a PCP, per beneficiary (by age bands).

- **State Physician Workforce Surveys** – Physician workforce surveys are often conducted by states to assess projected statewide health care needs against projected provider supply. The surveys typically examine access and provider availability, including:
  - Percent of patient panel insured by different payers, including Medicaid;
  - Whether physicians accept new Medicaid patients;
  - Time to appointment for a PCP or pediatrician visit for existing patients;
  - Time to appointment for a PCP or pediatrician visit for new patients; and
  - Number of hours of direct patient care per week.
- **CAHPS Access Measures** – The supplemental CAHPS survey can be used to evaluate provider willingness to see Medicaid beneficiaries. States with both FFS and managed care delivery systems use the CAHPS survey. As a result these states may have data that is easily accessible. The Clinician and Group CAHPS survey includes questions that focus on patient access to PCPs, including:
  - Appointment availability;
  - Scheduling wait times for routine and urgent care; and
  - Comparable questions for the pediatric population.

In 2011, the National Committee for Quality Assurance implemented the CAHPS Patient Centered Medical Home survey for the first time. This survey includes access and communication metrics that address provider willingness to see Medicaid beneficiaries, including whether after-hours care is made available and, in turn, whether patients were able to get needed care after hours.

- **State Licensing Renewals** – States can look toward their licensing renewal process to capture whether providers are willing to see Medicaid beneficiaries. If states do not capture this information currently, they may want to consider including this data point during future renewal efforts.

### Changes in Health Care Utilization Resulting from Greater Primary Care Access

Increased use of primary care services has been linked to reductions in hospital emergency department use.<sup>30</sup> Additionally, in regions with a relatively high proportion of PCPs, inpatient admissions, outpatient visits, surgeries, and emergency department utilization are reduced.<sup>31</sup> Tracking the following and other utilization metrics, such as those related to ambulatory care sensitive conditions, can help states understand the impact of the rate increase:

- **HEDIS Measures**<sup>32</sup> – These utilization measures that may be impacted by beneficiary access to primary care include:
  - Inpatient Utilization—General Hospital/Acute Care;
  - Ambulatory Care: Emergency Department Visits; and
  - Ambulatory Care: Outpatient Visits.
- **Prevention Quality Indicators (PQI)**<sup>33</sup> – PQIs were developed by the Agency for Healthcare Research and Quality (AHRQ) to measure hospital admission rates for 16 ambulatory care-sensitive conditions in adult populations as well as to evaluate inappropriate use of health care services. Potential PQI measures states can use include:
  - Asthma in Younger Adults Admission Rate;
  - Hypertension Admission Rate;
  - Uncontrolled Diabetes Admission Rate; and
  - Diabetes Long-Term Complications Admission Rate.

- **Pediatric Quality Indicators**<sup>34</sup> – Pediatric Quality Indicators (PDI) are a set of measures developed by AHRQ to screen for health issues that may be impacted by intervention at the provider level. With appropriate primary care access such health issues should occur less frequently. Potential PDI measures states can use include:
  - Asthma Admission Rate; and
  - Diabetes Short-term Complications Admission Rate.
- **Additional Measures** – Following are other measures that states might use:
  - Plan all-cause readmissions;<sup>35</sup>
  - Hospital-wide all-cause readmission measure;<sup>36</sup>
  - PICU Unplanned Readmission Rate;<sup>37</sup> and
  - Review of Unplanned PICU Readmissions.<sup>38</sup>

### Conclusion

Medicaid beneficiaries face serious challenges in accessing primary care services. PCPs are far less willing to see patients covered by Medicaid than those with Medicare or commercial insurance coverage.<sup>39</sup> States can use the 2013-2014 primary care rate increase to encourage providers to see Medicaid beneficiaries or increase their Medicaid panel.

To leverage the rate increase, states must directly engage their primary care provider community; target areas where Medicaid has historically struggled with access; address non-monetary factors that discourage provider participation in Medicaid; and measure the impact of the rate increase on access to care. This last step will be critical in making the case for extending the rate increase beyond 2014. By addressing these issues, states can take important steps to improve access to primary care services for Medicaid beneficiaries, current and future—a central aim of this health reform provision.

## ***Leveraging the Medicaid Primary Care Rate Increase***

This brief is a product of *Leveraging the Medicaid Primary Care Rate Increase*, a CHCS initiative made possible by The Commonwealth Fund, with additional support from the New York State Health Foundation. Through this initiative, CHCS is working with Medicaid stakeholders in six states, as well as with the Centers for Medicare & Medicaid Services, to help translate CMS guidance and implement the Medicaid primary care rate increase mandated under health care reform.

## **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 access and quality for low-income Americans. 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. Its core priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. Visit [www.chcs.org](http://www.chcs.org).



## Endnotes

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