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Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services

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Medicaid and CHIP Payment and Access Commission

www.macpac.gov

Overview

- Background
  - Access to physician services in Medicaid
  - Medicaid payment for physician services
  - Recent policy developments
- Literature review
  - Conceptual framework
  - Findings
- Expert panel themes
- Next steps

Background

Access to Physician Services in Medicaid

- Physicians are less likely to serve patients covered by Medicaid than those with Medicare or private insurance
- MACPAC's prior analyses of 2017 data found variation in Medicaid acceptance rates among different types of providers and states
  - Higher acceptance rates for obstetrics and gynecology, lower for psychiatrists
  - Higher Medicaid acceptance rates for physicians employed by community health centers, faculty practice plans, and practices with more mid-level providers
- A small number of providers serve a high share of Medicaid patients
- Medicaid beneficiaries report similar levels of unmet health needs as other low-income adults and children with private health insurance

Medicaid Payment for Physician Services

- States have considerable flexibility to set Medicaid payment rates
- Fee-for-service (FFS) base payment rates for office-based physicians was about 72 percent of the Medicare rate in 2019
- Managed care organizations (MCOs) have flexibility to pay providers differently, but many MCO payment rates are likely similar to FFS
- States can make FFS supplemental payments and managed care directed payments to physicians up to average commercial rates
  - $1.6 billion in FFS supplemental payments to physicians in 2021
  - $7.8 billion in managed care directed payments as of February 2023
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are paid a prospective payment rate, initially based on costs

Recent Policy Developments

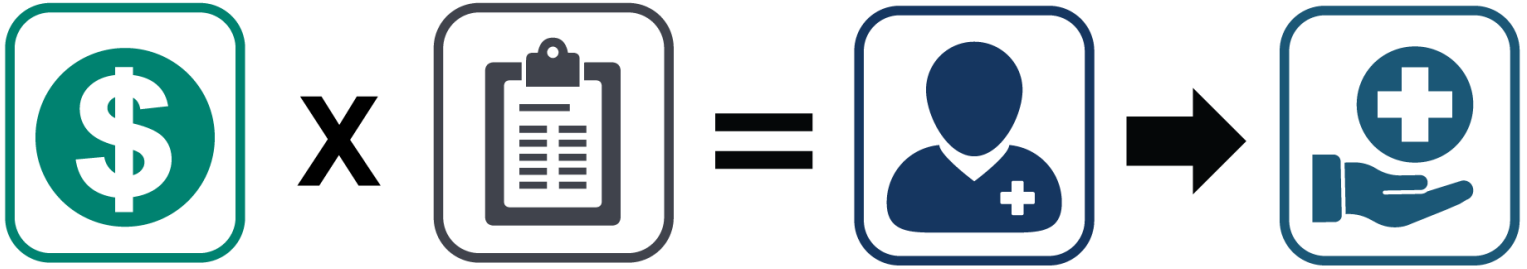
- The Affordable Care Act (ACA) temporarily increased Medicaid payment for primary care to Medicare rates in 2013 and 2014
- Beginning in 2022, the Centers for Medicare & Medicaid Services (CMS) has included minimum payment requirements in several new Section 1115 demonstrations to pay for health-related social needs
  - Average payments for primary care, obstetric and gynecology, and behavioral health services must be at least 80 percent of the Medicare payment rate
- In 2023, CMS proposed two new rules for access and managed care
  - Would require annual payment analyses comparing primary care, obstetric and gynecology, and behavioral health rates to Medicare
  - In managed care, a proposed beneficiary experience survey and wait time limits

Literature Review

Context for Study

- Physicians often cite low Medicaid payment rates as the primary reason why they do not take new Medicaid patients
- Research establishing the link between Medicaid payment rates and access is limited and results are mixed
- In 2022, MACPAC recommended a new access monitoring system that considered three domains of access
  - Potential access (e.g., provider participation)
  - Realized access (e.g., use of care)
  - Beneficiary perceptions and experiences (e.g., ease of accessing care)

Conceptual Framework



Medicaid payment policies
- Payment amounts
- Payment methods

Non-financial factors
- Provider enrollment
- Claims denials
- Challenges serving Medicaid patients

Provider participation
(Potential access)

Realized access
- Use of services
- Beneficiary experience of care

CONTEXTUAL FACTORS
Physician supply • Provider characteristics • Payment by other payers • Beneficiary care needs

Literature Review

- MACPAC contracted with Mathematica to review 44 relevant peer reviewed studies published since 2013
- Six rigorous quasi-experimental studies of the ACA primary care fee increase found mixed results
  - A major study by the Agency for Healthcare Research and Quality found no significant change in physician participation
  - Two studies from the National Bureau of Economic Research found positive effects of the fee increase in use of services and beneficiary-reported access
- Few studies on administrative burden, but a notable new study that quantified higher burden in Medicaid using claims denial data

Expert Roundtable

Expert Roundtable

- Mathematica convened an expert panel to discuss the research findings and considerations for future research
  - Panel included representatives from federal agencies, academia, and state Medicaid program evaluators
- Key themes
  - Tension between goals of expanding the number of providers participating in Medicaid and expanding access among providers who already participate
  - Data collection and research challenges
  - Variations by practice and organizational characteristics
  - Need to better understand the role of managed care
  - Need to refocus analyses on beneficiary needs and experiences

Competing Goals of Medicaid Payment Policy

- The Medicaid physician fee increase appears to have had a larger effect on improving access to providers already participating in Medicaid than it did encouraging new providers to participate
- Participants discussed whether this result was desirable
  - On one hand, fewer participating providers limits beneficiary choice
  - On the other hand, safety-net providers such as FQHCs may be better equipped to enabling services that support the unique needs of Medicaid beneficiaries
- States face tradeoffs in allocating limited resources but do not have evidence-based frameworks to use when weighing these options

Data Collection and Research Challenges

- The Transformed Medicaid Statistical Information System (T-MSIS) can help address limitations of past research on provider participation, realized access, and payment rates
  - Need to validate quality of data on provider types and sites of care
  - Managed care payment data is not widely available to all researchers
- All-payer claims databases would enable better comparisons to private coverage
- Even with better data, methodological challenges will persist since payment changes often occur concurrently with other changes
- New minimum payment requirements in Section 1115 demonstrations are not being evaluated

Variations by Practice Characteristics

- Care for Medicaid beneficiaries concentrated among safety-net providers, but there is limited research about the characteristics of practices that are willing to serve more Medicaid patients
  - Need for more research on FQHCs
  - Need for more research on the role of practice ownership and consolidation
- Medicaid participation rates also vary by region and specialty, but more research is needed to understand the root causes of this variation
  - Shortages in the overall number of providers in a region can be a barrier
  - Mid-level providers may help fill gaps in access to care when there are few physicians available and willing to serve Medicaid patients

Role of Managed Care

- The relationship between payment rates and access in managed care is not well understood
  - Most research relies upon published FFS rates
- Managed care plans may have flexibility to reduce administrative barriers to payment that deter provider participation
- Differing views on how to assess network adequacy in light of recent research on participating providers who serve few Medicaid patients
  - Forthcoming data on provider directories may enable future analyses
  - T-MSIS may be a better source for identifying providers that actively participate
  - Suggestions to consider new measures of network adequacy

Refocusing on Beneficiary Needs

- Share of physicians participating in Medicaid is an imperfect measure
  - Overall participation in any private insurance plan is not a good benchmark
- Policymakers should also consider measures of realized access and beneficiary experience
- Future research could focus on a subset of Medicaid beneficiaries with unique health needs, such as children with behavioral health needs
  - What care does this subpopulation need?
  - Where is that care provided?
  - What are Medicaid payment policies for these sites of care?
  - Are current policies best targeting available resources to ensure access to care?

Next Steps

- Plan to publish issue brief summarizing findings from literature review and themes from expert roundtable
- Staff would appreciate feedback on the key themes and what topics MACPAC should prioritize in its future work

Themes and Potential Future Work

Theme	Potential work
1. Tension between expanding provider participation and improving access to safety-net providers	Expand on MACPAC's existing payment and access frameworks to include considerations for sites of care
2. Data challenges	Continue to examine T-MSIS and monitor new access rules
3. Variations by practice type	Further explore FQHC payment policy
4. Role of managed care	Examine how managed care rates relate to FFS, administrative burden, and network adequacy requirements
5. Refocusing on beneficiary needs	Apply payment and access frameworks to a subpopulation with unique needs

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