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

Physicians often cite low Medicaid payment rates as the primary reason why they do not take new Medicaid patients, but research establishing the link between Medicaid payment and access is limited. For example, although prior MACPAC work found an association between Medicaid primary care payment rates and physician acceptance rates, this correlation has not been found in subsequent analyses of payments for other physician services (Zhu et al. 2023, Holgash and Heberlein 2019). Research has also found that other factors, such as delays in Medicaid reimbursement and challenges with Medicaid provider enrollment, may also affect Medicaid physician participation (Dunn et al. 2023, Gordon et al. 2018, Gottlieb et al. 2018, Timbie et al. 2017, Cunningham and O'Malley 2008).

In recent years, Medicaid physician payment rates have received increased interest from policymakers. Since 2022, the Centers for Medicare & Medicaid Services (CMS) has approved five Section 1115 demonstrations that include requirements for states to increase payment rates for primary care, obstetrics, and behavioral health as a condition for receiving additional federal funding for investments in social determinants of health. In 2024, CMS finalized fee-for-service (FFS) and managed care access and monitoring regulations, including requirements for states to conduct annual analyses of payment rates for these services (42 CFR 447.203).

To further explore the relationship between Medicaid payment rates and beneficiary access, MACPAC contracted with Mathematica to conduct a literature review and convene a roundtable of experts from federal agencies and academia to discuss known challenges in access to physicians in Medicaid, including variation across specialties, practice types, and states as well as considerations and opportunities for future research. Roundtable participants discussed the overall supply of physicians, the potential policy goals of changes in payment such as increasing the supply of physicians who accept Medicaid or increasing the capacity of existing providers to serve additional beneficiaries, the effects of past changes to payment policy and how they may enhance our understanding of the relationship between payment and access, and the advantages and limitations of data sources. Specifically, the key themes that emerged during the roundtable included:

- the 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 physician practice and organizational characteristics;
- the role of managed care; and
- the need to refocus analyses of payment and access on beneficiary needs and experiences.

This brief begins with background information on physician services and physician payment in Medicaid before reviewing recent federal policy and regulatory changes. It then provides a summary of findings from the literature review and the roundtable discussion before concluding with opportunities for future research.

Background

The Medicaid statute requires all state Medicaid programs to cover physician services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services. Payment for services must be "consistent with the efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population in the geographic area" (§ 1902(a)(30)(A) of the Social Security Act (the Act)). Despite this requirement, Medicaid payment rates are typically substantially lower than those paid by other sources of health care coverage, such as Medicare and commercial insurers (Zuckerman et al. 2021, MACPAC 2017).

In this issue brief, we focus primarily on access to office-based physicians who see patients in a solo practice, group practice, or clinic setting. Although Medicaid also covers the services of advanced practice providers such as nurse practitioners and physician assistants, these providers are outside the scope of the literature review included in this paper.

Below, we briefly review the broader context for research on the relationship between Medicaid physician payment and beneficiary access, including (1) access to physician services, (2) physician payment rates, and (3) recent policy developments that could affect the relationship between physician payments and beneficiary access in Medicaid.

Access to physician services in Medicaid

In general, physicians are less likely to serve patients covered by Medicaid than those with Medicare or private insurance. In a MACPAC analysis of the 2017 National Electronic Health Records Survey (NEHRS), fewer physicians reported accepting new Medicaid patients (74 percent) compared to those accepting new Medicare patients (88 percent) or new privately insured patients (96 percent) (MACPAC 2021). In this study, there was substantial variation across physician specialties in their Medicaid patient acceptance rates: obstetrics and gynecology physicians had higher acceptance rates, primary care physicians had average acceptance rates, and psychiatrists had much lower acceptance rates. The study also found higher rates of acceptance of new Medicaid patients at community health centers, faculty practice plans, and practices with above-average levels of advanced practice (mid-level) providers. When compared to data from 2011-2013, overall Medicaid patient acceptance rates were unchanged. This study also showed substantial variation across states in terms of overall Medicaid patient acceptance rates, ranging from 42 percent in New Jersey to 99 percent in North Dakota.

A small number of providers serve a large share of Medicaid patients. In an analysis of 2016 Medicaid claims and administrative data, about one in three physicians did not serve any Medicaid patients or served fewer than one Medicaid patient per month over the course of one year (Luo et al. 2023). In another study using 2015–2017 claims data from four states, researchers found that Medicaid beneficiaries' care was highly concentrated among a small proportion of physicians (Ludomirsky et al. 2022). MACPAC's previous analysis of NEHRS data found that physician practices with higher Medicaid caseloads were more willing to accept new Medicaid patients than practices with below average caseloads (MACPAC 2021).

Despite lower physician participation in Medicaid, some measures of access to physician care are comparable for Medicaid beneficiaries and those with other sources of health insurance. For example, children enrolled in Medicaid reported similar rates of seeing a doctor or having a wellness visit in the past year as children with private health insurance (MACPAC 2024a). In addition, some studies have shown that Medicaid beneficiaries receive the same level of some preventive care services as those with Medicare or private insurance (Cabral et al. 2022, Abdus 2021).

Medicaid payment for physician services

Medicaid FFS base payment rates are generally less than Medicare or private insurance rates for the same service (Zuckerman et al. 2021). State Medicaid officials have broad flexibility to determine payments for physician services in their FFS programs.[1] State Medicaid programs typically establish base payment rates based on the resource-based relative value scale (RBRVS), a percentage of Medicare's fee, or a state-developed fee schedule incorporating local factors. State officials often adjust these rates based on factors such as provider type, geographic location, site of service, and patient age. They may also add incentive payments through programs such as pay-for-performance, primary care case management, or other value-based care arrangements (MACPAC 2017a).

According to the most recent national comparisons using data from state FFS payment schedules in 2019, Medicaid FFS rates for 27 common primary care, obstetric, and other physician services were, on average, 72 percent of the rate Medicare paid for the same services; this ratio is largely unchanged from 2008 (Zuckerman et al. 2021). At the state level, there was significant variation in the Medicaid-to-Medicare FFS payment ratio, ranging from 37 percent in Rhode Island to 111 percent in Montana. This study did not include changes to physician payment rates during the COVID-19 public health emergency. However, another study of Medicaid payment rates for a range of behavioral health services in 2021 continued to find that Medicaid FFS rates were lower compared to Medicare rates (Clemans-Cope et al. 2022).

Most Medicaid beneficiaries are enrolled in managed care, and managed care organizations (MCOs) generally have flexibility to establish provider rates. Approximately 85 percent of Medicaid beneficiaries are now enrolled in some form of Medicaid managed care (CMS 2024a). MCOs have substantial flexibility to pay providers at rates and with methods that differ from the state-established FFS rate (MACPAC 2014). However, MCOs have historically based provider reimbursement on the FFS rate (Hinton and Musumeci 2020).

Some states use FFS supplemental payments to increase physician payment rates. In 2023, to help compensate for low Medicaid FFS base rates, 31 states and the District of Columbia made a combined $2.6 billion in supplemental payments to physicians and other practitioners, accounting for 22 percent of FFS payments to these providers (MACPAC 2024b). States are allowed to make FFS supplemental payments up to the average commercial rate for physician services. According to the Congressional Budget Office's review of recent studies, commercial rates for physician services are about 129 percent of Medicare payment rates overall and 117 percent of Medicare payment rates for primary care services (CBO 2022).

State health officials also have the option to direct MCOs to pay providers according to certain methods and rates, which are referred to as state-directed payments (SDPs) (MACPAC 2024c). These SDPs are typically used to (a) establish minimum payment rates for certain types of providers or (b) require MCOs to make additional payments that can raise total reimbursement to levels that equal or exceed the Medicare rate and, in some cases, equal the average commercial payment rate. MACPAC's analysis of directed payments approved between February 2023 and August 2024 found that states have approved 33 directed payment arrangements for physicians and other practitioners, and estimated annual spending associated with these arrangements totaled $12.4 billion, about 11 percent of total state-directed payment spending identified in MACPAC's review (MACPAC 2024c).

Other policies relevant to Medicaid beneficiaries' access to physician services include value-based payments and payments to federally qualified health centers (FQHCs) and similar clinics. Within the flexibilities for FFS, managed care payments, and waiver authorities, many state Medicaid programs have developed alternative payment models (APMs) for physician services that seek to enhance the quality of care, improve health outcomes, and reduce costs (MACPAC 2023). Many value-based approaches aim to move away from traditional FFS payment models, which can make it difficult to compare payment rates under APMs to Medicare, which is also expanding its use of APMs. Value-based payment in Medicaid was outside the scope of the literature review.

Payment for services physicians provided at FQHCs and rural health clinics (RHCs) are statutorily required to be based on the prospective payment system (PPS), which was developed based on facility costs adjusted for inflation (MACPAC 2017c). It is important to note that FQHCs are a major source of primary care for Medicaid enrollees. For example, FQHCs, FQHC look-alike clinics, and rural health centers provided 44 percent of Medicaid primary care visits in California from late 2017 through 2019 (DuPlessis and Goddeeris 2022). However, Medicaid payment policies for FQHCs were outside the scope of the literature review included here.

Recent statutory and policy requirements

At the expert roundtable, participants discussed research on the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) primary care fee increase, the feasibility of evaluating new minimum payment requirements included in Section 1115 demonstrations, and the potential implications of the recently finalized managed care and access rules. Below, we discuss these issues in more detail.

ACA. The ACA required all states to increase their Medicaid payment rates for primary care services to 100 percent of the Medicare rate for the same services in 2013 and 2014. However, implementation of this payment increase was delayed in many states, varied in timing for FFS and managed care programs, and was confusing to many clinicians (MACPAC 2015). Although the mandate expired in 2014, as of the last report study in July 2016, 19 states had fully or partially continued the primary care fee increase (Zuckerman et al. 2017). However, there are no published assessments of whether and how states have continued the increase from August 2016 to present.

Section 1115 demonstrations. Under Section 1115 of the Act, the Secretary can waive almost any Medicaid state plan requirement under Section 1902 to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program.

In 2022 and 2023, CMS approved Section 1115 demonstrations in Arizona, California, Massachusetts, New Jersey, and Oregon that include minimum payment requirements for primary care, obstetrics, and behavioral health services. Specifically, these demonstrations require states to ensure that average payments for these services are at least 80 percent of the Medicare FFS payment rate (CA DHCS 2023, NJ DHS 2023, AHCCCS 2022, MassHealth 2022, OHA 2022). In Arizona, Massachusetts, and Oregon, Medicaid payment rates in 2019 were already near or above 80 percent of Medicare rates for some of these services. However, most Medicaid payments in New Jersey and California appear to be below the 80 percent threshold, and the terms of the waivers require the state to increase Medicaid payment rates by 2 percent per year until it reaches the threshold.

Although all states with approved Section 1115 demonstration programs must submit evaluation plans that specify the hypotheses being tested and the measures and methods that will be used to monitor progress toward expected outcomes (42 CFR 431.424), none of the currently available evaluation plans for these five states address minimum payment requirements.

Managed care and access rules. In April 2024, CMS simultaneously released two final rules (CMS 2024b, CMS 2024c). The rules take several steps to address the Commission's prior recommendations about the need to ensure access to care for Medicaid beneficiaries, including improving monitoring of access by beneficiaries.

The FFS access rule included a number of provisions designed to meet the statutory obligations to ensure that Medicaid provides access to services by increasing payment rate transparency, standardizing reporting, and promoting beneficiary engagement. Notably, it would require states to publish FFS rate information for all services on their websites, beginning July 1, 2026.

The managed care rule included similar provisions related to Medicaid and CHIP managed care access, financing, and quality. Among other provisions, the proposed rule would require states to:

- conduct an annual enrollee experience survey for beneficiaries enrolled in managed care with an exception for those enrolled a Medicare Advantage (MA) dual eligible special needs plan (D-SNP), which already requires such a survey;
- implement a wait time maximum of 10 business days for routine outpatient mental health and substance abuse disorder appointments, a wait time maximum of 15 business days for routine primary care or obstetrics and gynecology services, and a state-determined wait time standard for a state-selected service for the first rating period beginning on or after July 9, 2027, which would be validated by secret shopper surveys for the first rating period beginning on or after July 9, 2028; and
- for rating periods beginning on or after July 9, 2026, require states to submit an annual payment analysis that compares managed care plans' payment rates as well as the percentage that results from dividing the total amount paid by the published Medicare payment rate for the same services for evaluation and management common procedural terminology (CPT) codes for primary care, obstetrics and gynecology, and mental health and substance use disorder services. An annual payment analysis that compares managed care plan rates to the published Medicaid state plan payment rates for homemaker services, home health aide services, personal care services, and habilitation services is also required. Payment rates for adult and pediatric services must be reported separately if the percentage differs between adult and pediatric services. Payments made to FQHCs and rural health centers are excluded from this payment analysis.

Literature Review

To better understand the existing literature on Medicaid payment and access, we examined peer reviewed studies published since 2013.[2] Overall, we found some relationship between Medicaid payment and beneficiary access, but the studies of this relationship were generally limited by the use of less rigorous analyses that used cross-sectional data from a single point-in-time or survey reports from physicians.

Data sources

Researchers generally used four types of data to measure access: (1) claims, (2) ongoing nationally representative surveys, (3) study-specific surveys, and (4) key informant interviews. In addition, prior research focused heavily on measures of potential access, particularly the number of physicians participating in Medicaid. Measures of realized access, which include service use by beneficiaries and beneficiary experience of care, were less commonly reported.

The studies derived payment data from (1) published fee schedules and ratios and (2) paid claims. None of the studies included data on Medicaid managed care payment rates or supplemental payments. Common data sources included Medicaid and Medicare claims from state and federal agencies (e.g., the Transformed Medicaid Statistical Information System (T-MSIS), the Medical Expenditure Panel Survey, National Ambulatory Medical Care Survey, and Behavioral Risk Factor Surveillance System). Several articles also used claims from commercial vendors as sources.

Researchers assessed relatively few nonfinancial factors for their impact on physician access, but they included a wide range of contextual factors as covariates in their analyses. A few studies used primary surveys or qualitative interviews to assess billing difficulties; only one study included direct measures of specific types of billing difficulties (Dunn et al. 2021). Other nonfinancial factors, such as challenges to physician enrollment, were only

assessed through qualitative interviews that focused on physician perspectives regarding factors that affect their willingness to provide care for Medicaid beneficiaries.

Findings

The literature does not find a conclusive relationship between Medicaid physician payment rates and access and notes several methodological limitations. In 12 of the studies with original empirical research, the authors used a cross-sectional design to evaluate the association between Medicaid payment rates and beneficiary access to physician services. Among those 12 studies, 3 found an explicit quantitative association between Medicaid payment and a measure of access (Barnett et al. 2018, Halpern et al. 2014, Holgash and Heberlein 2019), 2 found an implicit quantitative association between payment and access based on a comparison of Medicaid beneficiaries and patients with other health coverage (Oostrom et al. 2017, Bisgaier et al. 2014), and 2 studies found no association between payment and access (Zhu et al. 2023, Tipirneni et al. 2019). One study noted that pediatricians (78 percent), general surgeons (88.4 percent) and obstetricians and gynecologists (70.8 percent) accepted new Medicaid patients at higher rates than physicians overall (70.8 percent) (Holgash and Heberlein 2019). Psychiatrists (35.7 percent) accepted new Medicaid patients at a lower rate than physicians overall (70.8 percent) (Holgash and Heberlein 2019).

Five of these studies described qualitative data or survey reports from physicians regarding the influence of payment on their decisions about serving Medicaid patients (GAO 2020; Timbie et al. 2019, 2017; Gordon et al. 2018, Lindley et al. 2018). In one study, researchers conducted case studies and summarized the respective experiences of state Medicaid officials, providers, beneficiary advocacy organizations, and managed care organizations during the implementation of the ACA primary care provider payment increase. Stakeholders identified several implementation challenges, including the need for clearer guidance from federal and state rulemaking authorities and limited efforts to engage nonparticipating physicians given the two-year duration of the increase.

The ACA Medicaid physician fee increase had some effect on use of services but less of an effect on physician participation. Researchers typically used pre-post design to assess the effect of the ACA primary care fee increase on access to care for beneficiaries. The ACA required states to increase the Medicaid rate for primary care services to 100 percent of Medicare rates in calendar years 2013 and 2014. While the majority of studies found that the increase in Medicaid payments was associated with an increase in at least one measure of access, a few found no relationship between the rate increase and the specific measures of access analyzed. One study found mixed results; increases in Medicaid payments led to increased use of outpatient services but, according to patient reports, limited improvements in physician access.

Six quasi-experimental studies of the ACA primary care payment increase found mixed results. A study by the Agency for the Healthcare Research and Quality compared changes in visit rates for dually eligible beneficiaries who receive Medicaid and Medicare benefits to Medicare beneficiaries with low incomes whose fees did not change (Fung et al. 2021). Overall, primary care visit rates for dually eligible beneficiaries were unchanged or decreased slightly. However, the decrease was partially offset by increases in visits with nonphysician clinicians. Four studies found that this fee increase resulted in significant improvements in at least one measure of access (Gangopadhyaya et al. 2023, Maclean et al. 2023, Cabral et al. 2022, Alexander and Schnell 2019). These measures of access included reducing reports of providers turning away beneficiaries, increasing the probability of visiting a physician, better self-reported health, and reduced school absenteeism. Participants suggested that the mixed findings could relate to limited increases in physician participation but greater effects on the capacity of physicians already serving Medicaid beneficiaries.

An additional five studies also used quasi experimental methods to assess the effect of rate increases and decreases prior to the implementation of the ACA fee increase. Three of these studies found that increases in payment resulted in changes in access, including improvements in the number of prenatal visits by pregnant women and greater breast and cervical cancer screenings for beneficiaries enrolled in managed care (Sabik et al. 2020, Sonchak 2015). A study from the National Bureau of Economic Research (NBER) focused on children with special health care needs (CSHCN), "a group that faces serious access problems" (Chatterji et al. 2020). This NBER study found that raising Medicaid primary care payment rates to at least 90 percent of the Medicare rate reduces the likelihood that CSHCN lack a usual source of care, is associated with improved access to specialty care, and improves caregiver satisfaction (Chatterji et al. 2020). The two remaining studies found no relationship between Medicaid fees and the five preventive care services that were measured (screening for colorectal, cervical and breast cancer; hypertension; and high cholesterol) (Atherly and Mortensen 2014). Another study found mixed results with increases to Medicaid payment leading to increased outpatient physician visits, emergency department visits, and prescription fill but limited improvements in patient-reported access (Callison and Nguyen 2018).

Six studies examined administrative burdens that state Medicaid agencies have the potential to influence directly. These administrative challenges include claim resubmission rates, payment denial rates, physician reports of general billing challenges, and variation in MCO processes (Dunn et al. 2023, GAO 2020, Alexander and Schnell 2019, Timbie et al. 2019, Gottlieb et al. 2018, Lindley et al. 2018). In five studies, the authors included the state's ACA eligibility expansion status for adults (Fung et al. 2021, Spivack et al. 2021, Holgash and Heberlein 2019, Decker 2018, Maclean et al. 2018). In general, the authors reported that these administrative challenges were associated with Medicaid beneficiary access to care, but they often did not specify the strength of the quantitative associations. One key exception is the study by Dunn et al., which used all-payer data on claims remittances to estimate the administrative costs of claims denials and resubmissions. Overall, they estimated that physicians lose 17.6 percent of the contractual value of a typical Medicaid visit, which is much higher than the rate estimated for Medicare (4.7 percent) or commercial insurance (2.4 percent). The authors conclude that these administrative barriers may affect provider participation as much as payment rates do in some states (Dunn et al. 2023).

Expert Panel Themes

Tension between goals of expanding number of providers participating in Medicaid and expanding access among providers who already participate

When discussing past research findings, several participants concluded that the ACA physician fee bump appears to have had a larger effect on improving access among providers already participating in Medicaid than it did on encouraging new providers to participate in Medicaid. This discrepancy may help explain why some studies evaluating the share of providers participating in Medicaid, a measure of potential access, did not show statistically significant effects of the ACA fee bump, while other studies of the number of patient visits and unmet need (measures of realized access and beneficiary experience with care) did find positive effects.

One of the consequences of improving access to care among providers who already serve Medicaid patients without expanding the overall number of providers participating in Medicaid is that physician services have become concentrated among a relatively small number of providers. Participants discussed whether or not this result was desirable. On one hand, the lower number of participating Medicaid providers limits choice and may disrupt continuity of care for beneficiaries moving between Medicaid and private coverage. On the other hand, some safety net Medicaid providers, such as FQHCs, may be better equipped to provide quality care for Medicaid beneficiaries, including access to enabling services that may not be available in other settings.

Participants noted that states face tradeoffs between (1) increasing payment rates for office-based physicians to expand provider participation and (2) increasing payment rates for safety-net providers, such as FQHCs, to improve use of services. However, there is little research available to help states understand how best to weigh these tradeoffs.

Data collection and research challenges

Participants agreed that T-MSIS data hold great promise for future research on potential access, realized access, and provider payment rates. However, participants also noted several concerns, including the variability of data quality on provider types and physician specialties among states, missing payment data for managed care encounters, and a lack of standardization of the definitions of providers types.

A few participants noted that all-payer claims databases (APCDs) present opportunities to compare Medicaid and private insurance. These participants pointed out that comparisons between Medicaid beneficiaries and individuals with private insurance coverage could be more relevant than comparisons to Medicare for some groups such as children and adults under 65 and for some services such obstetrics and pediatric care. Several experts said that access to APCD database is often difficult to obtain for single state, much less the multiple states that would be required for a robust comparison, and that using data from APCDs can require a substantial investment of resources to assess and clean data. There are several commercial data sources that could supplement research on payment and access but they are proprietary products with limitations on data use and sharing.

Participants noted several challenges in their ability to evaluate new minimum payment requirements, including that most states already set rates at or near 80 percent of the Medicare payment rate. Several participants mentioned the difficulty in evaluating minimum payment changes that occur concurrently with other policy changes such as Section 1115 demonstrations and the introduction of VBP models, such as pay-for-performance incentives, shared savings arrangements, or other alternative payment models.

Overall, participants were hopeful that the new data transparency requirements in the proposed FFS access and managed care rules would help address data challenges. However, at this time it is not clear when these new data will be made available for researchers.

Variations by practice and organizational characteristics

Prior research findings demonstrate that a small share of providers care for a high proportion of Medicaid beneficiaries. Participants reflected on this research with one expert noting, and several concurring, that providers who serve a large number of Medicaid beneficiaries differ from those serving largely private insured individuals. Providers serving a large number of Medicaid beneficiaries were more likely to work in hospital-based practices or community health centers (Sommers, Paradise, and Miller 2011). Given this finding, participants agreed that future research is needed to examine how increasing payment rates affects these providers.

Several participants suggested the need for research to assess the effects of Medicaid payment policy for FQHCs, noting that such facilities have been excluded from or neglected in studies because of the challenges associated with using Medicaid and other claims data to identify the physicians who work in such facilities. FQHCs receive a PPS rate based on facility costs that is generally higher than the Medicaid payment rate for office-based physicians. One of the roundtable participants shared preliminary research findings that Medicaid beneficiaries in states with lower office-based physician payment rates are more likely to use FQHCs. However, other roundtable participants noted that FQHCs still face many financial challenges because of their lack of a

large privately insured patient population. In addition, some participants noted that some states have begun to test new VBP models for FQHCs and these efforts could be worthwhile to study.

The roundtable also discussed the role physician awareness can play as a mediator of the relationship between payment and access. Although the ACA rate changes were highly publicized, qualitative work suggested physicians were unaware of the implications for their practice. This was echoed by several of the physician participants who said that, as salaried employees, rate increases would not necessarily change their clinical practice as decision-making rests with larger entities such as system administrators. Prior research on Medicaid payment and access is largely silent on the role of practice or system administrators in decision making related to accepting Medicaid beneficiaries and whether to expand or contract capacity to serve additional beneficiaries. One panelist noted a study that showed an increase in Medicaid access that coincided with consolidation of health systems and hypothesized that larger practices and systems might have more resources for addressing the administrative challenges in Medicaid. However, other participants noted that it is equally plausible that there are many situations when an individual physician might be willing to treat Medicaid beneficiaries, but the practice or health system is not.

Several experts noted provider shortages can limit access for Medicaid beneficiaries and that shortages are particularly acute in behavioral health and some specialties. A few experts noted that the effect of increasing Medicaid payment rates could be negated by provider shortages and that plans to remedy such shortages typically involve recruitment of professionals from other states. Such recruitment may improve local or regional access but leave national access unchanged. One participant mentioned that primary care physicians may be hesitant to care for Medicaid beneficiaries because of the difficulties identifying specialty care providers that accept Medicaid when a referral is needed. Participants noted that Medicaid beneficiaries often have more complex needs or health related social needs than privately insured individuals that may necessitate specialist referral, and more research is needed to understand how the actual and perceived challenges of meeting patient needs affects physician and practice decisions about their capacity to serve Medicaid beneficiaries or not serve them at all.

To address shortages of physicians, roundtable participants suggested opportunities for more work on the use of advanced practice providers, such as nurse practitioners and physician assistants. MACPAC's prior research has found that physician practices with a greater use of advanced practice providers are more likely to accept new Medicaid patients (MACPAC 2021).

Participants also noted that there are tradeoffs in directing resources to specific provider types (e.g., physicians) or specialties (e.g., primary care) that might result in fewer resources for other groups (e.g., advanced practice providers), and the existing research rarely acknowledges or assesses the potential effects of these tradeoffs.

Role of managed care

Roundtable participants noted a lack of research on the relationship between payment rates and access in managed care. Most prior research has focused on FFS payment rates because these are easier to measure. Although managed care payment rates are often developed based on the FFS fee schedule, MCOs often have considerable flexibility to pay providers differently.

Participants also noted that MCOs may have flexibility to help reduce some of the administrative barriers to payment that can deter provider participation, such as provider enrollment processes and prior authorization. Two participants described their recent work that found that these types of administrative barriers had equivalent effects on physician participation as payment rates (Dunn et al. 2023). This work examined how Medicaid

compared to other payers in the aggregate so there may be opportunities for additional analyses of how variations in administrative barriers by state and by health plan affect access to care.

Participants also discussed issues related to managed care network adequacy requirements and the potential for using forthcoming data on provider directories to better evaluate managed care provider networks. Some participants were concerned that measures of the number of providers participating in a plan may not be the best measure of access, especially if some of the participating providers serve very few or no Medicaid patients. Congress has recently taken some action to address issues of so-called "ghost provider networks," but roundtable participants questioned the reliability of provider directories and generally suggested that it may be better to use T-MSIS for analyses of participating providers.

Need to refocus analyses of payment and access on beneficiary needs and experiences

Several participants noted the limitations of using the share of physicians participating in Medicaid as a primary measure of access to care. Although these data are more readily available than other measures of access, this measure does not reflect the fact that most care for Medicaid beneficiaries is often concentrated among a relatively small share of safety net providers. In addition, participants noted that comparisons to private insurance in the aggregate were not appropriate, since privately insured patients only have access to physicians who are part of their health plan, not physicians who accept any form of private health insurance.

Instead, many participants stressed the importance of reorienting access research to the perspective of beneficiaries, including their breadth of choice and experiences with accessing needed care. Beneficiary experience surveys are an important tool for collecting this information, but survey information available for Medicaid beneficiaries is limited. In 2022, MACPAC recommended that CMS conduct an annual Medicaid beneficiary survey for all enrollees. In 2024, CMS finalized rules requiring states to conduct an annual enrollee experience survey for each managed care plan (42 CFR 438.66). The final rule did not specify a specific survey instrument but rather required that whatever survey instrument the state selects meets the interpretation and translation criteria to ensure that the survey and the results are easy for beneficiaries to read, understand, and answer.

To orient future research toward a beneficiary perspective, several participants suggested that MACPAC examine the relationship between payment and access for a more specific subset of Medicaid beneficiaries, such as individuals with behavioral health needs. Such analyses could consider the types of care that these beneficiaries need to address their specific health needs, the full range of sites of care where they can potentially access this care (including office-based physicians, advanced practice providers, FQHCs, and Certified Community Behavioral Health Clinics), and how Medicaid payment policies differ for these different sites of care. Ultimately, research could inform discussion of whether current payment policies are most effectively targeting available resources to ensure that beneficiaries can access the care that they need at the right time and in the most appropriate setting.

Opportunities for Future Research

Participants identified potential opportunities for states, CMS, and MACPAC to improve the understanding of the relationship between payment and access to care for Medicaid beneficiaries. Suggestions centered around several key areas, including examining access by practice type and specialty, reviewing managed care policies and processes, centering the experience of beneficiaries, and exploring how payment policy can best support timely access to high quality care in the most appropriate setting.

- **Variations by practice type and specialty.** Several roundtable participants suggested the need for future research that examines the role of FQHCs and the effects of FQHC payment policy, including using T-MSIS to examine the share of Medicaid beneficiaries who currently rely on FQHCs as a usual source of care, and monitoring new alternative payment models for FQHCs that aim to reward high quality care.

- **Role of managed care.** Participants offered suggestions for future work related to managed care including using T-MSIS to further examine how managed care payment rates differ from FFS. Participants also suggested evaluations of how health plan provider enrollment and prior authorization policies affect provider administrative burden and participation in Medicaid networks but noted that it may be prudent to delay such work until the network adequacy requirements in the managed care rule are fully implemented.

- **The need to refocus analyses of payment and access on beneficiary needs and experiences.** There was consensus among participants that any evaluations of the relationship between payment and access should include data on beneficiary experience of care. While CMS addressed beneficiary surveys in the final managed care rule, several participants noted the data from such surveys will likely not be available for analyses in the near term. As an alternative, several roundtable participants suggested examining beneficiary experience by focusing on a specific subset of Medicaid beneficiaries, such as children with behavioral health needs. This approach could provide an opportunity for researchers to take a holistic look at the needs of beneficiaries, where they get their care, and how payment policy can best support timely access to high quality care in the most appropriate setting.

Endnotes

[1] Additional information about state options for Medicaid payment is included in MACPAC's issue brief, Federal requirements and state options: Provider payment (MACPAC 2017b).

[2] MACPAC contracted with Mathematica to conduct a literature review to identify peer-reviewed studies and gray literature (i.e., government-sponsored and other non-peer reviewed reports) published in English between January 2013 and August 2023 that included the terms "payment" or "provider participation" and "Medicaid." The literature review identified 38 sources using the above inclusion criteria.

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