Access & Equity in Medicaid

ROBUST PRIMARY CARE IS A MUST

pcc primary care collaborative

California Health Care Foundation

August 2023

Authors

Sarah Greenough, MPP | Primary Care Collaborative

Leighton Ku, PhD, MPH | Center for Health Policy Research, Milken Institute School of Public Health, George Washington University

Contributors

Noah Westfall, MPH | Primary Care Collaborative

Ann Greiner, MCP | Primary Care Collaborative

Larry McNeely, MPA | Primary Care Collaborative

Kirsten Barboza, BA | Primary Care Collaborative

Reviewers

Kathryn E. Phillips, MPH | California Health Care Foundation

Stephanie Glier, MPH | American Academy of Pediatrics

Megan Douglas, JD | National Center for Primary Care, Morehouse School of Medicine

PCC Medicaid Workgroup

PCC's Medicaid workgroup advised the project by offering scoping and assessment criteria, prioritizing strategies, and identifying related policy options. Workgroup participation does not imply individual or organizational support for the strategies described in this report.

Brandon Wilson, DrPH, MHA | Community Catalyst (Co-Chair)

Stephanie Glier, MPH | American Academy of Pediatrics (Co-Chair)

Louise Cohen, MPH | Primary Care Development Corporation (PCDC)

Nicholas DeGregorio, MD | UPMC Health Plan

Amanda Fredriksen, MHS | AARP

Frank Harrington, JD | American Association of Nurse Practitioners

Vacheria Keys, JD | National Association of Community Health Centers

Chelsea Newhall | AmeriHealth Caritas

Leighton Ku, PhD, MPH | Center for Health Policy Research, Milken Institute School of Public Health, George Washington University

Subject Matter Experts

Ignatius Bau, JD | Health Equity Consultant

Timothy Day, MSPH | Centers for Medicare & Medicaid Services

Hector Flores, MD | Altais/Family Care Specialists Medical Group

Mollie Gelburd, JD | AHIP

Tricia McGinnis, MPP, MPH | Center for Health Care Strategies

Kelsey Brykman, MS | Center for Health Care Strategies

Matt Salo | Salo Health Strategies; formerly National Association of Medicaid Directors

Acknowledgements

This publication was produced with funding from the California Health Care Foundation (CHCF), an independent, nonprofit philanthropy helping Californians with low incomes get the health care they need. Learn more at chcf.org. To learn more about efforts to strengthen primary care in California, visit www.chcf.org/primary-care-matters

PCC is especially grateful to Kathryn E. Phillips, CHCF Associate Director, Improving Access to Care, for her support and thoughtful input throughout the project.

California Health Care Foundation

PCC also thanks its seven subject matter experts for sharing their experiences and wisdom through interviews; its workgroup members for their time and guidance, particularly the group's generous and adept co-chairs, Stephanie Glier and Brandon Wilson; the brief's reviewers, including the co-chairs and Megan Douglas of Morehouse School of Medicine, for their careful reads and additions; and the project's advisor, Leighton Ku of George Washington University, for his helpful contributions and overall commitment to improving care for the underserved.

About the PCC

The Primary Care Collaborative is a national multi-stakeholder organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care. Representing a broad group of public and private organizations, PCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support the growth of high-performing primary care that treats the whole person.

Executive summary

Primary care is an essential, and today largely undervalued, foundation of the U.S. health care system. That may be especially true in Medicaid where beneficiaries—disproportionately high-need, children, pregnant women, and people of color—require robust primary care but are often underserved. The Primary Care Collaborative (PCC) undertook a review of existing evidence and emerging practices to identify the most effective payment and care delivery strategies for strengthening primary care in Medicaid, independent of other policy options, such as eligibility or benefit expansions. That process, consisting of literature reviews and key informant interviews, and overseen by a multi-stakeholder workgroup, identified eight strategies for improving primary care access and outcomes in Medicaid:

1. **Report and increase the share of Medicaid spending going to primary care**
2. **Increase payment to primary care clinicians**
3. **Support behavioral health and primary care integration**
4. **Pursue population-based payment models**
5. **Stratify data and incorporate health equity quality incentives into payment models**
6. **Increase federal funding for community health centers and create new access points**
7. **Pay for community health workers**
8. **Encourage Patient-Centered Medical Home (PCMH) attributes, including care coordination**

This report describes the evidence for each and considerations for implementation. It also recognizes the important role managed care plays as a lever to realize and amplify their effects.

Taken together, the strategies are largely consistent with calls for primary care transformation system-wide, including in NASEM's 2021 **report** on primary care: Medicaid must pay primary care more, and pay primary care differently, to improve the health of its beneficiaries. Those new dollars through value-based payments can strengthen existing advanced primary care models and provide resources for key attributes that will improve the quadruple aim and health equity, including connections to community-based services and greater support for behavioral health integration.

1 Report and increase the share of Medicaid spending going to primary care

Increasing the proportion of health care dollars that goes to primary care, including in Medicaid, is a direct and trending strategy to strengthen primary care. Evidence of its effect include **inverse associations** between primary care investment and hospitalizations and emergency department visits, and **positive relationships** between Medicaid managed care plan spending on primary care and composite measures of quality. Today, more states are working to shift spending towards primary care using a **range of methods**. Medicaid spending on primary care varies by state—both in absolute terms and relative to commercial payers. A few states are going beyond reporting to setting enforceable targets for levels of primary care spending, including in Medicaid.

Key informants and the literature noted several implementation considerations for the strategy, including how to best report and set targets. Interviewees were largely in agreement that levels of Medicaid investment in primary care were too low but differed on the efficacy of using targets to increase them and where to invest allocated dollars.

2 Increase payment to primary care clinicians

Pay for primary care clinicians is **notably low** relative to their peers. This is especially true in Medicaid where, nationally, average fee-for-service primary care physician fees are **just 67%** of those paid in Medicare, **contributing** to lower Medicaid participation by clinicians. Evidence of the impact of pay increases on primary care access—largely focused on the Affordable Care Act's (ACA) Medicaid parity provision—is **mixed**. Potential reasons include its short time frame and implementation obstacles. Administrative burden and **late payments** in Medicaid may also generally inhibit clinician acceptance of Medicaid. Still, some point to the ACA fee bump as a positive given that **nineteen states** chose to continue the temporary policy change in some form. And there is stronger evidence of a **positive effect** for dual-eligible Medicare and Medicaid beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) have been pursuing this strategy through its waiver authority by requiring states (such as California, Arizona, Oregon and Massachusetts) to increase rates for certain specialties. Congress could also act by increasing state Federal Medical Assistance Percentages to states that reimburse primary care at Medicare levels. Network adequacy standards may be another way to encourage managed care organizations to increase their rates in order to expand provider networks. In its May 2023 proposed Medicaid rules (**one** addresses managed care; **the other** primarily fee-for-service), CMS proposed new standards for measuring access in managed care and new rate transparency provisions for primary care.

3 Support behavioral health and primary care integration

Medicaid enrollees have better outcomes when behavioral health is integrated with primary care. Two leading approaches to this are the Collaborative Care Model (CoCM) and the Primary Care Behavioral Health (PCBH) model. CoCM—a model that utilizes primary care providers in collaboration with behavioral health care managers and psychiatric consultants—has some of the most robust **evidence of impact**, including significant **improvement** in depression and anxiety. And its effect sustains, and in some cases, may be even greater, for publicly insured patients. Separately, PCBH, a **team-based approach** to managing biopsychosocial issues involving an integrated behavioral health consultant, has demonstrated success improving **outcomes** and patient and clinician **experience.** This success appears to hold true in **safety net settings**, including **reduced preventable inpatient utilization**. A third approach integrates primary care with community behavioral health centers—showing **mixed results**.

Payment is often cited as a key barrier to better behavioral health integration (BHI). Fee-for-service billing codes for integrated care have had partial uptake. As of June 2022, 24 state Medicaid agencies were **covering CoCM codes**—though with varying rates and **levels of policy complexity**. Key informants pointed to 'expanded and consistent' coverage of codes to improve BHI in Medicaid, while noting implementation alone **does not necessarily** lead to notable utilization. Alternative payment models may offer a better way to sustainably achieve BHI in Medicaid. Examples include models out of **Colorado** and **Oregon**. And states can **play a major role** in advancing BHI in managed care.

4 Pursue population-based payment models

Medicaid primary care population-based payment (PBP) models—offering "**upfront, flexible payments**" tied to quality—have been implemented in several states, including **Colorado, Maine, Washington**, and **Oregon**, and through the Center for Medicare and Medicaid Innovation (CMMI). States **pursue these models** through waivers, state plan amendments, CMMI, and CMS review of managed care rates and contracts, with Medicaid agencies **increasingly doing so**. Rigorous, long-term evaluations of primary care PBPs for enrollees exclusively covered by Medicaid are still in the "evidence-building phase". Out of CMMI, Comprehensive Primary Care Plus (CPC+), whose "track 2" involved hybrid capitation, showed **mixed results**; Medicaid-focused models were **not included in analyses**, and practices in disadvantaged areas had **lower participation**. Many more Medicaid PBPs are newer, but their available results are described as promising, with models that "**make intuitive sense**" to improve quality, experience, and equity. Medicaid accountable care organization arrangements exist in 14 states with **mixed results**.

Multi-payer alignment—described as "absolutely necessary" for success of these models—was among the most recurrent themes of PCC's key informant interviews. Yet challenges abound: the diversity of state policies, approaches, and managed care plans; constraints on CMMI's statutory authority to waive Medicaid policies; and existing fragmentation of performance measures and incentives. Nevertheless, many felt that CMS and CMMI must ultimately lead the way with PBP models. Future processes, interviewees advised, must involve more active conferring with states and plans and must better include small practices. (CMMI's **latest primary care model** aims to target "the large proportion" of safety net and primary care providers that have not participated in previous models.) Other implementation considerations include: addressing clinician apprehension of capitated models; offsetting the capacity and infrastructure constraints on small practices; and the potential unintended consequences of PBPs, such as practices limiting care or selectively serving healthier patients.

5 Stratify data and incorporate health equity quality incentives into payment models

States can leverage payment innovations to further health equity goals, including equity-focused alternative payment models (APMs), **payment enhancements to safety net providers**, and primary care payment **tailored to patient populations** according to health status, social risk, and historic under-investment. Momentum is growing on this front. In 2021, a **dozen states** were linking Medicaid financial incentives to health disparities metrics, up from just two states in 2019. The evidence on their impact—how well they address disparities in care/outcomes and if they have unintended consequences—is almost entirely left to be seen.

Measures stratified by race, ethnicity, language, or disability status, are key to meaningfully address disparities, including through APMs. Today, data on race and ethnicity in Medicaid are largely **incomplete**. A majority of states are now making **explicit efforts** to address data completeness, including requiring disaggregated quality metrics through managed care contracts and using 1115 waivers to pay for stratified reporting. Interviewees acknowledged that "we are still figuring out the right way to incorporate equity into payment models", cautioning that value-based models must be intentionally designed to ensure that disparities are addressed, rather than worsened.

6 Increase federal funding for community health centers and create new access points

Community health centers—which provide **comprehensive primary care** to patients in underserved areas—are integral to Medicaid and vice versa. Serving **one in five** Medicaid enrollees, health centers receive **over 40%** of their revenue from the program. Over decades, health centers have reliably shown to provide the **same or higher quality** primary care as other settings and **better access** for underserved populations. This holds for Medicaid enrollees. Moreover, health centers are often recognized as leaders in reducing health care disparities in primary care. Such care is associated with **lower overall health care costs**—with health centers saving 15% among Medicaid fee-for-service adults and 22% among children.

NASEM's 2021 primary care **report** calls on the Department of Health and Human Services, enabled by Congressional appropriations, to "target sustained investment in the creation of new health centers" in federally designated shortage areas. Ultimately, the number and scope of community health centers largely depends on funding for Section 330. Mandatory funding for health centers expires at the end of fiscal year 2023, and there are **bipartisan efforts** to extend and expand health center funding, although the outcome is not yet known.

7 Pay for community health workers

Increasingly, community health workers (CHWs) are considered key members of primary care teams. They both improve primary care outcomes and "**open the door to primary care**" by connecting low-income individuals to Medicaid. Several models exist for integrating CHWs, including embedding them in primary care teams as patient navigators, advocators and/or accompaniers. Evidence of their **impact is strong**: CHWs improve outcomes, "such as chronic disease control, when CHWs are engaged in team-based care". Results remain strong in safety net settings, with some of the most **promising evidence** coming from the **IMPaCT model**, an intervention that integrates CHWs in primary care to address health barriers among low-income populations.

Today, at least **21 states** authorize Medicaid payment for CHW services; **12 states** specifically address the use of CHWs in managed care contracts. And states across the political spectrum are exploring **how to finance** CHW services through Medicaid. However, current law and regulation do not require coverage of CHW services in federal programs, although this may change soon in Medicare if **pending regulatory proposals** are finalized. NASEM's primary care **report** acknowledges that payment often inhibits the use of CHWs who are currently paid through a "**patchwork of funding options**"; and that comprehensive payment models, with flexible resource allocation, offer the best way forward. Experts highlighted the important role CHWs play as members of expanded care teams under value-based payment and as "health equity change agents".

8 Encourage PCMH attributes, including care coordination

Advanced primary care models are integral to better health, and the Patient-Centered Medical Home (PCMH) is the most widely implemented. The **model** employs a multi-disciplinary care team holistically managing patients' health. Medicaid beneficiaries are **inconsistently served** by medical homes, with variation across and within states. Some states **go beyond common standards** to include elements such as integration of primary care with public health and social services.

Research around the PCMH model overall has shown improvements in quality, utilization, and costs, though not uniformly. In Medicaid specifically, there is mixed, though more promising in the longer-term, evidence for the potential of PCMH elements to improve outcomes. This report summarizes the evidence from large evaluations of federal programs involving Medicaid enrollees as well some state efforts.

While PCMH is a care delivery strategy, the payment that underlies it largely dictates the model's success and sustainability. Many of the PCMH demonstrations to-date have relied on fee-for-service payments, with an additional—and usually meager—care management fee on top. NASEM's primary care **report** highlights this challenge, along with lack of multi-payer alignment, and PCC's interviewees echoed it. They noted the challenge for primary care practices to cover upfront and ongoing transformation costs without greater investment and realigned incentives. Others pointed to a primary care medical education system that leaves clinicians unprepared and burned out—contributing to growing workforce shortages.

The takeaway

Some of the identified strategies have strong evidence of success; others show promise but are new and need time to demonstrate their impact. Most are known strategies, with several in operation for decades but not at scale, while others are at least generally accepted today. Still, Medicaid beneficiaries continue to face substantial barriers to access and equitable, high-quality care. This report suggests that to realize the aim of accessible, advanced primary care in Medicaid, what's needed is not a single "silver bullet" innovation. Rather, the country needs broad, vocal, and focused support for an agreed upon set of policies that strengthen primary care. These policies must be pursued systematically and with sustained, sufficient investment, transparent reporting, and enforcement mechanisms that provide accountability. Only then will we realize the full promise of primary care to better the health of those covered by Medicaid.

References are available in the full report. To download, please visit thePCC.org/medicaid.

pcc primary care collaborative

thePCC.org

601 Thirteenth Street, NW
Suite 430 North
Washington, DC 20005