WHOM DOES THE HEALTH WORKFORCE SERVE?

An Examination of Provider Participation in Medicaid

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Questions

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THE HEALTH WORKFORCE EQUITY EVIDENCE REVIEW SERIES

The Fitzhugh Mullan Institute for Health Workforce Equity defines health equity as *a world in which there is a diverse health workforce that has the competencies, opportunities, and courage to ensure everyone has a fair opportunity to attain their full health potential.*

At least six critically important factors drive health workforce equity, as shown in the figure below. These domains apply to workers across the health care spectrum, including home healthcare, support staff, allied health professionals, public health, physicians, nurses, and many others.

This series reviews existing literature on the nature and magnitude of each problem, the impact of this problem on health equity, and the policies and programs that affect it.

DOMAIN 4: To improve healthcare access and health equity, there must be a sufficient supply of healthcare workers to serve the needs of Medicaid beneficiaries, the uninsured, underinsured, and high-need populations. However, a variety of factors often result in people from these populations being denied or going without care. This evidence review focuses on provider service to patients who are low income and publicly insured through Medicaid.

The Problem

Access to healthcare depends on an available health workforce for all individuals, but access is particularly problematic for those groups made vulnerable, including low income, uninsured, publicly insured, and/or among groups that have been historically disenfranchised (e.g., individuals with mental health disorders, experiencing homelessness, LGBTQ+, and women). Lack of access can be attributed to provider shortages and geographic maldistribution (see Evidence Review 3) and the degree to which available clinicians provide service to these disadvantaged groups.

This evidence review focuses specifically on provider service to low-income and publicly insured patients through Medicaid. Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care to more than 80 million of the country's most disadvantaged populations.[1] While a large body of evidence shows that Medicaid beneficiaries have better access to care than the uninsured and are, therefore, less likely to postpone or forgo needed care due to cost,[2] individuals with Medicaid are still more likely to report access barriers compared to those with private insurance or Medicare.

Studies show that healthcare providers are less likely to accept patients with Medicaid than patients with private insurance or Medicare. This is evident in a variety of measures: providers accepting (or not) new patients with Medicaid,[3,4,5,6,7,8] providers accepting patients with Medicaid less often than those with private insurance or Medicare,[9,10] and providers limiting their Medicaid intensity, measured as the share of Medicaid patients in a provider's practice or patient panel.[11,12]

Population measures of Medicaid provider participation vary widely across states.[13] A 2009 analysis of Medicaid claims found the percent of active physicians serving Medicaid patients ranged from 46.5% in Colorado to 86.8% in South Dakota, and 18.2% of physicians served five or fewer Medicaid enrollees.[14] A Mullan Institute analysis of 2016 Medicaid claims found that the percentage of primary care providers who saw no Medicaid patients ranged from 12% in Iowa to 30% in Hawaii. A more nuanced examination of the density of primary care providers, which begins to match supply with at least a crude measure of need (Medicaid population), found a range from 35.5 primary care providers per 10,000 Medicaid population in California to 146.5 in Nebraska.

We also know that providers' participation in Medicaid varies across and within states. While each state's Medicaid program characteristics may determine this, provider-level and community-level factors have also played a role. Figure 1 summarizes these factors and related policies.

Regarding state-level factors, **payment rates** are assumed to be, and indeed may be, the primary cause of low provider participation. In 2016, Medicaid paid primary care providers (PCPs) an average of 72% of Medicare fees, and the rates ranged widely across states from 38% to 126%.[15] Research, however, shows that provider responses may be linked to Medicaid rates compared to

other local payers and not to the absolute rates by themselves (or to any rate increases). A 2018 systematic review found the evidence that increasing Medicaid fees leads to increases in provider participation is mixed.[16] They posit that the magnitude of Medicaid fee changes relative to other local payers, including Medicare and private insurers, is likely to moderate the impact of Medicaid fee changes. A more recent 2019 survey study found that physicians in states that pay above the median Medicaid-to-Medicare fee ratio accepted new Medicaid patients at higher rates than those in states that pay below the median, with acceptance rates increasing by nearly 1 percentage point (0.78) for every percentage point increase in the fee ratio.[17]

A second important state-specific issue is the **administrative burden** of Medicaid reimbursement. Payment delays, rejection of claims due to incorrect billing forms, inability to verify patients' Medicaid eligibility, pre-authorizations, and complexities of the rules and regulations on how claims are filed can offset the effects of high Medicaid reimbursements and can lower participation to levels that are closer to those in states with relatively lower payment rates.[18] Combining the costs of incomplete payments with the revenue never collected, physicians lose 17% of Medicaid revenue to billing problems, compared with 5% for Medicare and 3% for commercial payers.[19] Thus, healthcare providers base their supply decisions not only on the pre-determined contractual terms agreed upon with a specific payer, but also on the administrative costs necessary to collect revenues after the events of care.

Lastly, states vary in the degree to which they rely on **Medicaid-managed care organizations (MCOs)** to administer the program, but in general, the MCO industry is growing. More than two-thirds of Medicaid patients are enrolled in a comprehensive managed care plan. While a major policy goal for increased managed care penetration was to improve physician participation, there is no evidence that there is an association between the rate of managed care in states with physicians' decisions to accept new Medicaid patients.[17] On the contrary, one study found narrow networks in Medicaid MCOs can limit access and increase provider turnover affecting continuity of care.[20] Another study found the implementation of primary care case management (PCCM) was associated with reductions in the proportion of physicians participating in Medicaid, reductions in the number of very small Medicaid practices, and declines in Medicaid visit volumes across all participating physicians.[21] Thus, the role of MCOs in increasing or decreasing provider participation remains, at best, an open question.

Regarding **provider-level factors**, primary care provider participation has been associated with their beliefs and attitudes concerning their commitment to caring for the underserved. Providers with a self-reported commitment to the underserved were more likely to accept new Medicaid patients.[7] Demographics of the providers also matter. Increased Medicaid participation among primary care providers has been associated with being older, female, Black or African American, Hispanic, Asian, and an international medical graduate.[7,11,22] Provider specialty and profession are also important. Pediatricians are most likely to participate in Medicaid among primary care physicians, followed by OBGYNs, family medicine, internal medicine, and psychiatry.[5,6,10] Nurse practitioners and physician assistants have also been more likely to accept new Medicaid patients than physician providers following Medicaid expansion.[7]

There is some research on **practice characteristics.** Practices where providers are on a fixed salary,[7,11] have smaller patient panels,[12] have higher ratios of nurse practitioners and physician assistants,[10,23,24] and are patient-centered medical homes[25] are associated with increased Medicaid participation by clinicians. In addition, certain practice types are also associated with higher Medicaid acceptance, including Federally Qualified Community Health Centers (FQHCs), Rural Health Clinics (RHCs), academic medical centers, hospital-based practices, mental health centers, non-federal government clinics, family planning clinics, and HMO practices.[5,10,11,12,26,27] Smaller, independent clinics are less likely to participate in Medicaid.[8]

Finally, **community and market-level factors** play a role, but the effects are complex. Physicians practicing in high-poverty areas are more likely to accept Medicaid.[12,28] Studies also show that practices in rural areas had higher Medicaid participation[8,27] Yet rural communities continue to face disproportionate barriers to access compared to urban communities.[29,30] This apparent dichotomy highlights the likely interaction between the sufficiency of providers and Medicaid participation. While physicians with higher Medicaid caseloads[10] are more likely to accept new Medicaid patients, a saturation of existing providers may limit further service. Indeed, qualitative studies have shown that providers frequently cite capacity to accept new patients, availability of specialists, access to behavioral health services, and the high clinical burden of Medicaid patients as factors in Medicaid acceptance.[7,31] While one post-Medicaid expansion study found practices in low-provider supply areas were no more likely to turn away patients than practices in higher supply areas, a different study, before expansion, found that practices in low-supply areas were indeed less likely to accept new Medicaid patients that practices in high-supply areas.[32]

In addition, race appears to play a role at the community level. Even in high poverty communities, studies show that physicians in areas with greater Black or Hispanic populations and with high racial segregation were less likely to accept Medicaid.[22,33,34]

Another important clue about what affects Medicaid participation emerged in a study of changing healthcare markets. They found physician practices located in more concentrated insurer markets were more likely to accept new Medicaid patients, possibly due to the large insurers' stronger bargaining position reducing the reimbursement differences with Medicaid.[31] The same study found that while larger physician groups were also associated with increased Medicaid acceptance, the increase was largely driven by non-vertically integrated practices (e.g., physician offices that are not owned by larger health systems).

Problem Statement

Provider willingness to serve patients varies by factors such as insurance coverage. 12 to 30% of primary care providers, depending on the state, do not serve Medicaid patients.

Relationship to Health Equity

The evidence of low Medicaid provider participation on patient and population outcomes is still in its early stages. One study found that primary care provider Medicaid participation was associated with lower preventable emergency department (ED) visits.[28] In addition, two cross-sectional studies using survey data suggest Medicaid acceptance rates directly affected enrollee access measures, including having a usual source of care and lower unmet medical needs.[22,35]

Other studies provide some tangential evidence. One study on the effects of maldistribution examined the association between the pediatric dental workforce and preventive dental service utilization among Medicaid beneficiaries, finding that county-level density was associated with increased utilization of preventive dental care.[36] Additionally, a line of research has used secret shopper studies. While limited in their generalizability, these studies consistently reveal situations in which healthcare providers do not accept Medicaid, and Medicaid patients are unable to obtain appointments with providers, thereby limiting their access to care.[37,38]

Provider Participation in Medicaid is a Health Equity Issue

Early studies suggest that Medicaid beneficiaries experience more significant barriers to access than those who are privately insured and that this can occur even in areas with a high density of providers. Increasing insurance alone will not address larger equity goals and whether the health workforce contributes to the reduction (or perpetuation) of health disparities depends on the populations they serve.

Policies & Programs That Impact Provider Participation in Medicaid

The evidence on policies and programs that aim to increase Medicaid provider participation to improve access for Medicaid populations is fragmented and still in its infancy as a cohesive area of inquiry. Still, research on the problem suggests several areas of policy changes that may be fruitful.

The first area of policy change relates to state-level Medicaid program characteristics. As revealed in the research reviewed above, efforts to raise payment rates relative to other local payers may prove beneficial. Additionally, streamlining the administrative process for reimbursement would likely have positive effects. The role of MCOs is more complex, as shown in the studies mentioned above. It suggests that state agencies must monitor and hold MCOs accountable on two fronts 1) for the number of providers credentialed in their networks and 2) for the number of providers providing meaningful amounts of service to Medicaid beneficiaries. Having a large roster of providers in an MCO network is not enough if only a fraction of them see Medicaid beneficiaries.

Policies that target the professional pipeline are needed to address some of the issues that surfaced in research on provider characteristics (See Evidence Review 1 and Evidence Review 2). As reviewed in Evidence Review 3, we know that National Health Service Corps participants frequently work in community health centers and rural health centers. These organizations see a disproportionately high percentage of Medicaid patients.

A major shift is currently underway among primary care physicians (PCPs) regarding community and market forces. Many PCPs are moving from working at self- or physician-owned private practices to working in an employment-based situation whereby an external organization owns the practice and pays them salaries. In addition, more health systems are integrating vertically, with large health systems buying smaller physician practices and making them part of their network. As suggested by the research on practice characteristics, there may be an added positive effect on Medicaid participation related to settings in which primary care providers are on salary instead of being paid based on fee for service. However, vertical integration may negate some of the benefits of Medicaid participation.

Given the evidence that public programs are more likely to accept Medicaid, strengthening the safety net with increased funding to allow for the expansion of these settings is an important policy lever. Examples of these programs are community health centers/Federally Qualified Health Centers, rural health clinics, mental health centers, and family planning clinics.

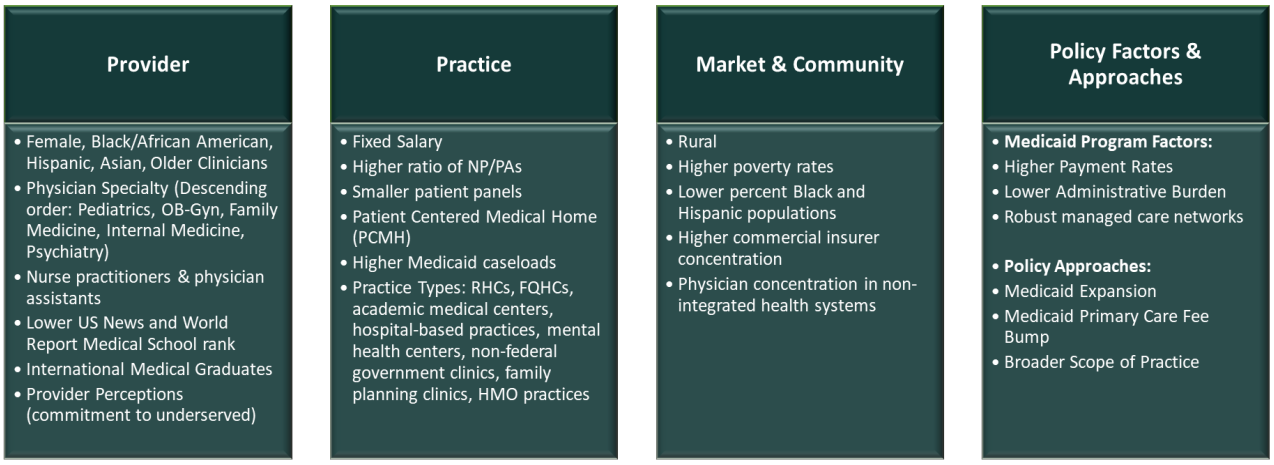

Figure 1: Factors Associated with Medicaid Participation and Policy Approaches

Additional federal policies that are specific to Medicaid are important to review. In 2010, the Affordable Care Act (ACA) included a pilot Medicaid Primary Care Fee-Bump. Early evidence on whether the Medicaid fee bump increased access to primary care for Medicaid enrollees is complex. Some studies show an increase in the availability of appointments for Medicaid patients[39] and physician Medicaid share of patients.[40] Another study using the National Electronic Health Records Survey and the National Health Interview Survey found no overall increase in primary care physicians' acceptance of new Medicaid patients.[41] One study examining the effect

of declining Medicaid fees following the fee bump found that four states with large changes in Medicaid experienced substantial increases in appointment availability; two of these states experienced subsequent decreases in appointment availability when the fee bump expired.[42] The mixed evidence on the impact of the Medicaid fee bump on provider participation is likely due to the temporary nature of the fee increase, which lasted for only two years (2013-2014). Operational issues in implementing the payment bump and lack of provider awareness of the program have been cited as potential factors. These studies suggest that making the fee bump permanent could have a beneficial effect.

The continued expansion of Medicaid may also be a policy lever for expanding provider participation. Relatively limited literature examines the association of Medicaid expansion with the supply-side response. Some evidence supports increased appointment availability associated with expansion,[43,38] although one study found no significant differences in overall or new Medicaid patient acceptance rates following Medicaid expansions.[17] In the only national study to use claims data, clinicians with a high proportion of Medicaid enrollees before the expansion were most likely to increase their Medicaid service further.[44] In a follow-up study, they found clinicians slightly rebalanced their patient panels toward Medicaid and away from commercially insured patients instead of increasing their total labor supply without a significant loss in commercial revenue.[45]

A final policy area related to full state scope of practice for nurse practitioners (NPs) and physician assistants (PAs) and 100% reimbursement. Studies reviewed above show that NPs are more likely to accept Medicaid patients than other primary care providers. Additional evidence suggests that expanded scope of practice is associated with a higher likelihood of clinics in underserved areas accepting more Medicaid patients.[7,11,23] Specifically, in states with a full scope of practice autonomy, clinics with more non-physician clinicians are associated with better access to office visits for Medicaid patients.[23] Another study showed that in states that allow for 100% NP Medicaid reimbursement (as opposed to the traditional 75% of physician payment), NPs had higher odds of practicing in primary care. States with a full scope of practice and 100% reimbursement for NPs had 20% higher odds of NPs practicing in primary care.[46] While the outcome of this study was not specific to Medicaid participation, the higher payment for NPs and PAs is specific to Medicaid would suggest that higher Medicaid participation is also likely.

Policies and Programs that Impact Provider Participation in Medicaid

Evidence suggests that state-level Medicaid policies, including lower payment rates relative to other payers and administrative burdens for reimbursement, represent barriers to provider participation in Medicaid. Other policies such as the Primary Care Fee Bump demonstrate mixed results. Policies that may increase provider participation in Medicaid include expanded scope of practice and full reimbursement for advanced practice clinicians, increased funding for safety-net clinics, and Medicaid expansion under the Affordable Care Act

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