

Examining the Implementation of the Medicaid Primary Care Payment Increase

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Preface

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) describes its mission as being to “advise the Secretary of the Department of Health and Human Services on policy development in health, disability, human services, data, and science; and provide advice and analysis on economic policy.” To that end, ASPE conducts and funds research and evaluation designed to inform the design and implementation of policies critical for public health.

Between January 2013 and December 2014, the Affordable Care Act mandated that qualifying providers of primary care services participating in the Medicaid program would receive an enhanced payment for certain primary care services that would be temporarily funded by federal dollars. The purpose of the policy was to encourage provider participation in Medicaid prior to and during the expansion of the Medicaid program that began in January 2014 in many states. To better understand differences in approaches and potential challenges in implementing the policy from the perspective of Medicaid officials, providers, patients, and health plan administrators, ASPE commissioned the RAND Corporation to conduct an independent case study into stakeholder experiences before, during, and after the policy’s implementation. During the summer and fall of 2016, RAND held discussions with these stakeholders to elicit their experiences planning for, implementing, and evaluating the impact of the policy. This report describes the results of this work.

The findings should be useful to state and federal policymakers by providing preliminary direction for strategies to improve upon the design or implementation of future payment policies. In addition, the health plan, provider, and patient communities might use the lessons learned from the implementation of this policy to recommend specific approaches to policy implementation that minimize unintended consequences while achieving a policy’s goals.

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Table of Contents

- Preface iii
- Boxes, Figures, and Tablesvi
- Summary vii
- Acknowledgmentsxv
- Abbreviations.....xvi

- 1. Introduction..... 1
 - Medicaid Primary Care Payment Increase 1
 - Payment Enhancement Policy After 20142
 - Prior Research Examining the Impact of the Policy3
 - Scope of the Current Study3
- 2. Synthesis of Key Themes5
 - Preimplementation Context.....5
 - Physician Participation in Medicaid Prior to the Payment Increase5
 - Patient Access and Utilization7
 - Concurrent Payment or Delivery System Reforms.....8
 - Preparing for Policy Implementation9
 - State Coordination with Providers9
 - State Coordination with Managed Care Organizations.....10
 - State Coordination with Patient Advocacy Organizations.....10
 - State Plan Amendment Submission11
 - Amending Contracts Between States and Managed Care Organizations11
 - Implementation: Physician Attestation11
 - Overview of Attestation Processes.....11
 - Challenges with Attestation13
 - Perceived Rate of Attestation.....16
 - Eligibility Audits.....16
 - Implementation: Payment17
 - Payments to Fee-for-Service Providers.....17
 - State Methodologies for Paying MCOs18
 - MCO Methodologies for Paying Providers.....19
 - Determining MCO Pass-Through Payment Amounts.....20
 - Making Payments.....22
- Evaluation.....24
 - Extent of Evaluation Activity.....24
 - Effect on Physician Participation25
 - Effect on Primary Care Utilization26
 - Effect on Provider Experiences.....27

Impact of Medicaid Expansion Status.....	28
Evaluation Challenges.....	28
State Decisions to Extend or End the Policy.....	29
Extending the Policy	29
Ending the Policy	31
3. Stakeholder-Identified Strategies to Improve Implementation.....	34
Longer Lead Time Prior to Implementation.....	34
Clearer Program Requirements from Federal Agencies.....	34
Increased Flexibility in State Program Design.....	35
Clear, Consistent Communication with Stakeholders.....	36
Targeted Outreach to Specific Stakeholder Groups	36
Electronic Submission and Tracking of Attestations	37
Avoiding Claims Reprocessing	37
Longer Duration of Payment Increase.....	37
4. Conclusions.....	38
Appendix A: Methods.....	39
Appendix B: Discussion Protocol Topic Guides	49
References.....	55

Box, Figures, and Tables

Box

S.1. Case Study Stakeholder Types viii
2.1 Attestation Models Used by Case Study States 12

Figures

S.1. Map of Case Study States viii
A.1. Map of Case Study States 41

Tables

2.1. Summary of Payment Methodologies and Payment Initiation Dates, by State 18
A.1. Case Study States: Key Characteristics 40
A.2. Case Study State Selection: Supplemental Characteristics 41
A.3. Characteristics of Nine Case Study States 43
A.4. Stakeholder Group and Rationale for Inclusion in the Study 44
A.5. Number of Discussions and Respondents by State and Stakeholder Type 46
A.6. Model Data Abstraction Template 47

Summary

For more than 50 years, the Medicaid program has played a critical role in meeting the health care needs of millions of low-income and disabled individuals. In spite of the program's success in ensuring access to care for these vulnerable populations, provider participation in the program is sometimes insufficient to meet patient demand (Barnes et al., 2016; Sommers, Paradise, and Miller, 2011). Past research has shown that participation in Medicaid is positively correlated with reimbursement levels (Medicaid and CHIP Payment and Access Commission, 2013). Yet, average Medicaid payment rates for primary care services in 2012 were lower than Medicare rates in 48 states and the District of Columbia (Zuckerman, and Goin, 2012).

The Affordable Care Act (ACA) increased Medicaid payments for primary care services during calendar years 2013 and 2014 so that they matched Medicare's rates. The goal of the Medicaid payment "bump" policy was to increase primary care providers' participation in the Medicaid program to accommodate the large influx of new Medicaid enrollees who would gain eligibility through the ACA's Medicaid expansion in January 2014.

Providers eligible for enhanced payments included those with a board-certified primary care specialty of family medicine, general internal medicine, or pediatric medicine, or for whom eligible primary care services represented at least 60 percent of Medicaid claims in the prior year. Advanced practice clinicians, such as nurse practitioners and physician assistants, were also eligible if they were supervised by eligible physicians. All providers were required to attest that they met the eligibility requirements.

In his fiscal year 2017 budget, then-President Barack Obama called for the restoration of the Medicaid primary care payment increase for all states; however, the payment increase was not included in subsequent appropriations legislation. To better prepare for the implementation of a similar future policy, we examined differences in implementation approaches and challenges associated with the 2013–2014 Medicaid primary care payment increase from the perspective of Medicaid officials, providers, patients, and health plan administrators in nine states, and synthesized key lessons from the policy's implementation.

Methods

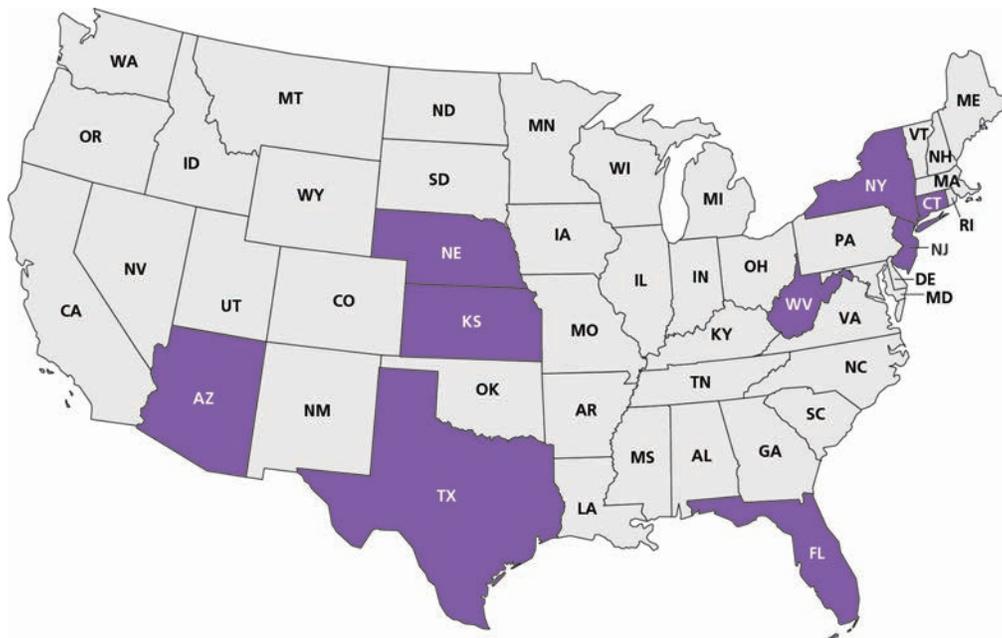
We selected nine states using criteria designed to include a diversity of state policy environments and stakeholder experiences. State selection criteria included magnitude of the estimated impact of the policy in relation to the size of the payment increase in each state (based on a separate RAND Corporation analysis of Medicaid claims both before and after the policy), state Medicaid expansion status, decision of whether to continue the enhanced payments without full federal funding, and a state's inclusion in prior case studies exploring the payment increase.

These criteria were applied to all 50 states and the District of Columbia and resulted in the selection of nine states representative of a mix of all criteria.

Key informant discussions were held with a range of stakeholders involved with policy design or implementation to assess their experiences. Stakeholder types included state Medicaid administrators responsible for implementing the policy, managed care organizations (MCOs) responsible for disbursing enhanced payments to managed care providers, providers who received the enhanced payment, and patient advocacy organizations concerned with access to care for Medicaid enrollees.

Stakeholders and states included in this case study are identified in Figure S.1 and Box S.1.

Figure S.1. Map of Case Study States



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NOTE: Case study states include Arizona, Connecticut, Florida, Kansas, Nebraska, New Jersey, New York, Texas, and West Virginia.

Box S.1. Case Study Stakeholder Types

Stakeholder Types

1. State Medicaid lead responsible for payment policies
 2. State Medicaid lead responsible for MCO contracting
 3. MCO representative
 4. Provider organization representative
 5. Patient organization representative
-

This case study approach yielded 43 semistructured discussions with 89 individuals between July and November 2016. Each discussion was recorded, transcribed, abstracted into a

standardized data collection template, and analyzed for content and key themes. Areas of agreement and disagreement between states or stakeholders were identified and explored to distinguish trends and inconsistencies. The team used a consensus-based approach to identify key themes and worked collaboratively to summarize results in this report.

Summary of Key Themes

Although stakeholder experiences of the primary care payment increase varied, several key themes emerged across states and stakeholder types. Overall, officials in many states described implementation of the policy as challenging. Contributing factors included the short time frame in which to prepare for and implement the policy, difficulty identifying eligible providers, and updating or developing new systems to make enhanced payments to providers. Effects of the policy were reported anecdotally as being minimal, with limited change in provider participation rates, and they appeared to be related primarily to the short duration of the payment increase. In spite of this, many providers and patient advocates viewed the policy positively and suggested that both groups benefitted from its implementation.

Seven of the nine states included in this study did not continue the payment policy following the conclusion of full federal funding, citing the lack of state funding as the key factor. Connecticut and Nebraska, however, continued the payment increase in some form. Both states identified strong support in their executive branches as pivotal to the policy's survival, while also noting that the anticipated negative fiscal impacts did not come to fruition. Additionally, Connecticut credited a strong stakeholder advocacy community with helping to secure the policy. Both states also identified key challenges in their implementation of the policy; however, these challenges did not appear to affect the decision to extend the enhanced payment, especially in light of executive priorities and stakeholder support.

A summary of key themes related to the context, planning, implementation, and impact of the payment increase follows.

Primary Care Provider Participation Rates in Medicaid Are Linked to Reimbursement Levels and Administrative Burden

For most states, primary care provider participation was generally viewed as high preceding the policy, though this perception varied somewhat by state, region, and respondent. Some respondents noted that providers may participate in Medicaid due to the high proportion of enrollees in their area, therefore making Medicaid the most significant payer in their book of business. Conversely, providers who decline to participate tend to do so because of low reimbursement rates, administrative difficulties (such as the burden of enrolling and payment delays), and challenges associated with caring for Medicaid patients (e.g., higher rates of complex medical conditions). The payment policy addressed reimbursement rates but not other participation barriers.

Implementation Complicated by Limited Time Line

States did not receive final guidance until two months before the policy was mandated to begin and additional clarification was required subsequently. This delay had cascading effects for states, including delays in developing attestation processes, configuring claims-processing systems, and initiating payments. In most states, increased payments to providers began six to eight months after the start of the policy—a delay that frustrated many providers.

Implementation Challenges Posed by Provider Eligibility Criteria

Most respondents viewed the eligibility criteria as being unusually broad because a large number of subspecialists associated with the three designated specialties were eligible for the payment increase as long as they met all other criteria. Many stakeholders viewed these providers as specialists, rather than primary care physicians. Additionally, several respondents suggested that the eligibility criteria failed to reflect the way primary care was delivered in their states. For example, although nurse practitioners can practice independently in many states, only those working under supervision of an eligible physician were eligible to receive the enhanced payments. Similarly, both obstetrician/gynecologist (OB/GYN) physicians and specialists who practice in primary care shortage areas may deliver high levels of primary care, but both were ineligible under the policy. These eligibility criteria caused confusion among providers and posed a communications challenge to Medicaid officials and medical societies.

High Administrative Burden Linked to Short Preparation Period

The policy placed a large administrative burden on many stakeholders. Developing information technology systems to accommodate the enhanced payments posed technical challenges for some states and MCOs. Reprocessing claims to make enhanced payments retroactive to January 2013 (because of the policy's delayed implementation in all states) was also time-consuming and led to payment delays and provider frustration in many states.

State Variation in Payment Methodologies

Eight of nine states paid the enhanced payments to their fee-for-service providers using a fee schedule adjustment (Texas issued lump-sum payments). Among the eight states with MCO programs,¹ three used capitation to pay MCOs the enhanced fees, while five used retrospective reconciliation. The MCOs, in turn, used a combination of fee schedule adjustments (four states) or lump-sum payments (four states) to distribute the enhanced payments to providers. Although Medicaid officials did not report difficulty in determining payment amounts, MCOs from several

¹ Connecticut discontinued its managed care program in 2012 and currently reimburses Medicaid providers on a fee-for-service basis.

states reported difficulty doing so for providers in subcapitation arrangements because each plan had to perform the task of determining the amount of payments for eligible primary care services already accounted for in the capitation payment.² States that were expanding managed care programs expressed a preference to link enhanced payments to existing pay-for-performance programs rather than simply increasing payments to all eligible providers.

No Formal Evaluations Conducted or Planned by State-Level Stakeholders; Perception of Limited Impact

A single state (New Jersey) conducted an assessment of the policy (within its managed care program); all other stakeholder views on the policy's impact were based on perceptions, anecdotes, or monitoring of utilization or stakeholder experience data collected for other purposes. Most respondents indicated that the policy had, at best, a modest impact on incentivizing higher rates of provider participation or acceptance of Medicaid patients. Other respondents reported that the policy had no real impact. Most respondents said the payment bump was just one of many policy and payment reforms enacted during the period and that the transition to Medicaid managed care and the introduction of patient-centered medical home programs were more likely to improve access than the payment bump.

Limited Continuation of the Payment Increase by States

Of the nine case study states, only Connecticut and Nebraska opted to continue the bump after the two-year period of full federal funding ended.³ The main argument in favor of continuing the policy was to continue improving access to care for Medicaid enrollees. The central arguments against continuing the bump were state budget constraints, a general resistance to implementing ACA-related policies, and lack of evidence on the policy's impact. While providers in several states did not expect the payment increase to continue in the absence of full federal funding, other providers were frustrated by their state's decision to discontinue the policy after they had increased the size of their Medicaid patient panels.

Short Duration of the Policy

Respondents in most states noted that increased payments over a span of only two years may not have provided a potent incentive for previously nonparticipating physicians to begin

² Providers who are reimbursed by MCOs through a subcapitation arrangement are paid on a prospective basis rather than a fee-for-service basis.

³ As of June 2016, the Centers for Medicare & Medicaid Services (CMS) reported that a total of 15 states and the District of Columbia had elected to continue the payment increase in full or in part following the conclusion of full federal funding: Alabama, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Iowa, Kentucky, Maine, Mississippi, Montana, Nebraska, New Mexico, South Carolina, Vermont, and Wisconsin.

accepting Medicaid patients or for physicians already participating in the program to make investments that might help to expand access over a longer time frame.

Patients and Providers Realized Policy Benefits

Although the implementation of the primary care payment increase was often characterized as challenging and too brief, most respondents suggested that the program was beneficial. Stakeholders in some states reported that patients experienced improved access to care as a result of shorter wait times, slightly expanded provider networks, or merely an increase in the provider's capacity to accept Medicaid patients. Providers claimed that the payment increase represented an acknowledgement on the part of the government that Medicaid rates are "inadequate" and allowed them to make small but tangible changes that would not have been possible without the payment increase. Although the overall impact on provider relationships was mixed, most respondents claimed that providers "appreciated" the payment increase and felt more satisfied with their participation in Medicaid as a result.

Summary of Stakeholder-Identified Strategies to Improve Implementation

If policymakers were to consider a similar policy in the future, they could greatly improve the implementation process by first looking at several specific strategies noted by our respondents.

Longer Lead Time Prior to Implementation

Most respondents cited the short time frame between the release of the final rule and the policy's initiation as a barrier to effective implementation. Both state administrators and MCO representatives explained that many aspects of the policy required several months of deliberation before they could be finalized. For example, stakeholders reported that building electronic processes for collecting provider attestations; determining how payments would be passed through and disseminating this information to providers; modifying claims-processing systems to pass through the enhanced payments; and developing streamlined recordkeeping and auditing processes are all complex tasks that require a much longer lead time to fully vet proposed methodologies and conduct systems tests. Stakeholders felt that the few months between the release of the final rule in November 2012 and policy implementation in January 2013 were insufficient to plan and complete all of these tasks. Additional lead time would help states to ensure that policies and procedures critical to program function are in place before launch and reduce the need to retool or revise midstream.

Clearer Program Requirements from Federal Agencies

Respondents explained that the eligibility requirements were confusing and needed to be clarified earlier in the process to ensure a rapid start to the program. Uncertainty about eligibility

requirements both before and after release of the final rule limited the ability of states to communicate eligibility criteria to providers and design systems to collect necessary information to evaluate providers' eligibility. While stakeholders felt guidance provided by CMS was helpful, many said it should have come well before the policy's start date.

Increased Flexibility in State Program Design

Many respondents urged CMS to allow for more flexibility in implementing similar payment policies in the future that better reflect the primary care delivery system in their state and that are complementary with other ongoing payment and delivery reforms. For example, most states indicated that they would have included additional primary care providers, such as OB/GYN physicians and independently practicing nurse practitioners, in the policy. States that were expanding managed care programs expressed a preference to link enhanced payments to existing pay-for-performance programs rather than simply increasing payments to all eligible providers. Providing states with greater flexibility in implementing policies such as the payment increase would enable states to better meet the goals of the policy while achieving alignment with existing programs.

Clear, Consistent Communication with Stakeholders

Each stakeholder group may have unique perspectives on policy design that can minimize administrative burdens and improve effectiveness. Given the complexities of the policymaking and implementation environment, clear, bidirectional communication with key stakeholders is important to ensure a smooth implementation process. Additionally, because these communications help set stakeholder expectations during a policy's implementation and can help reduce tensions between stakeholders and the state, outreach should be made to all relevant groups who will be affected by policy changes.

Targeted Outreach to Specific Stakeholder Groups

Although states reported several different communication strategies for stakeholder engagement, most strategies focused on outreach to groups that already receive messaging from the state. By also performing targeted outreach to stakeholders who fall outside of existing communication channels or stakeholder groups (e.g., primary care providers not currently enrolled in Medicaid), states may be able to expand program participation and stakeholder buy-in for future policy initiatives. States might benefit from additional guidance on how to conduct outreach to these groups.

Electronic Submission and Tracking of Attestations

Several respondents reported that better systems were needed to process the attestations electronically. Specifically, stakeholders advocated web-based attestation forms that would be

securely and centrally collected, and a system that provided status updates as the form moved through the approval process. In some states, a rolling attestation deadline increased the complexity of issuing retroactive payments and, according to respondents, should be avoided. Other stakeholders felt that the attestation process could have been avoided altogether by linking eligibility for enhanced payments to procedure codes without regard to a provider's specialty.

Avoiding Claims Reprocessing

Stakeholders reported that the need to make payments retroactively, to recoup monies that were improperly disbursed, and, in some states, the protracted period over which providers were able to attest, placed a large burden on the state, MCOs, and providers. Properly sequencing eligibility determinations and the initiation of enhanced payments and ensuring that they align with a policy's start date would substantially lower the burden on all stakeholders.

Longer Duration of Payment Increase

Health care providers make strategic decisions using a time horizon longer than two years. Respondents reported that health care providers would have been more inclined to make investments to expand their capacity had the federal government provided full funding for a period longer than two years.

Taken together, feedback from stakeholders involved in implementing this policy suggests that adequate planning and preparation, clear guidance from rulemaking authorities, state flexibility in policy design, and a longer period of enhanced funding could contribute to increased stakeholder satisfaction with the policy implementation process and improve the ability of such policies to result in positive results for states.

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We extend our sincerest gratitude to the 89 individuals who participated in 43 discussions for the purposes of this project. We are indebted to them for sharing their insights candidly and for the valuable input they provided. The findings reported here are only possible because of their participation.

The RAND Quality Assurance process employs peer reviewers, including at least one who is external to RAND. This report benefited from two rigorous technical reviews that improved the quality and clarity of the material presented.

This research was conducted under contract with ASPE, an office within the U.S. Department of Health and Human Services. The project was conducted with ASPE input; however, the material contained in this report is the responsibility of the study team alone, and does not necessarily reflect the views of the sponsoring agency.

Abbreviations

ACA	Affordable Care Act
ASO	administrative services organization
ASPE	Assistant Secretary for Planning and Evaluation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
FY	fiscal year
MCO	managed care organization
MMIS	Medicaid Management Information System
NPI	National Provider Identifier
OB/GYN	obstetrician/gynecologist
PCMH	patient-centered medical home
SPA	State Plan Amendment

1. Introduction

Medicaid and the Children’s Health Insurance Program (CHIP) provide vital health care coverage for qualifying individuals with limited incomes and the disabled, including more than 69 million Americans in 2014, or nearly 22 percent of the U.S. population (Centers for Medicare & Medicaid Services [CMS], 2015). The program’s authorizing statute provides states with significant flexibility to design payment rates and systems as long as payment is deemed to be “sufficient to enlist enough providers so that care and services are available under the plan . . .” (42 U.S.C. 1396a). In the intervening decades since this provision was enacted, states have developed a range of fee schedules and payment strategies for providers participating in the Medicaid program. This, in turn, has led to a wide variation in Medicaid payment rates across the United States. For example, in 2014, the ratio of Medicaid-to-Medicare fees ranged from just over 0.3 in Rhode Island to 1.4 in North Dakota (Kaiser Family Foundation, 2014).

Over the past several years, providers across several states have claimed that Medicaid payments are too low to adequately cover service costs. Indeed, the average Medicaid payment rate for primary care services in 2012 was lower than the Medicare rate in 48 states and the District of Columbia and represented an average of approximately 59 percent of the Medicare rate (Zuckerman and Goin, 2012). Research into Medicaid provider participation rates and program satisfaction indicate that nearly 90 percent of surveyed providers cite “low reimbursement” as a key driver in their decision to avoid or reduce their level of participation in the Medicaid program (Barnes et al., 2016), a finding that is consistent with related studies conducted over the past 30 years (Collins, Bussard, and Combes, 2003; Dombi, 1991). Other issues around reimbursement are also frequently cited as factors that discourage Medicaid participation, including delayed reimbursement (Sommers, Paradise, and Miller, 2011), high administrative burden associated with enrollment and billing processes, and lower reimbursements for nurse practitioners and physician assistants relative to physicians (Sommers, Paradise, and Miller, 2011; Barnes et al., 2016). In response to these concerns, policymakers have explored strategies to strike a balance between increasing Medicaid provider rates and controlling costs, including the Medicaid Primary Care Payment Increase, described next.

Medicaid Primary Care Payment Increase

Section 1202 of the Affordable Care Act (ACA) temporarily increased payments to Medicaid primary care providers to achieve parity with the Medicare physician fee schedule (42 U.S.C. 1396a). Referred to as the “Medicaid Primary Care Payment Increase” or “payment bump,” the purpose of the policy was to encourage greater participation in the Medicaid program by primary care providers, and, as a result, to improve Medicaid patients’ access to primary care services in advance of the January 2014 Medicaid expansion. Between January 1, 2013, and December 31, 2014, states

received an increased federal medical assistance percentage to cover the increased reimbursement for eligible services.

CMS issued a Proposed Rule for the policy on May 11, 2012, and published the Final Rule on November 6, 2012. The payment bump was subject to specific parameters as outlined in the Final Rule:

- **Provider type:** Only providers with a board-certified primary care specialty of family medicine, general internal medicine, or pediatric medicine, or for whom eligible primary care services (defined below) represented at least 60 percent of Medicaid claims in the prior year were eligible for the increase.
 - Advanced practice clinicians (e.g., nurse practitioners and physician assistants) were also eligible if they were under supervision of an eligible physician—a relationship in which the physician accepts legal liability for the services provided by the nurse.
 - All providers were required to attest that they met the eligibility requirements.
- **Applicable service codes:** Only specific Evaluation and Management codes and immunization or vaccine codes were eligible for increased reimbursement.
 - Services provided to CHIP enrollees in states with stand-alone CHIP programs and services provided at federally qualified health centers and rural health clinics were not eligible for increased payments.
- **Time-limited implementation:** The increase only applied to eligible services provided between January 1, 2013, and December 31, 2014.

States were given flexibility to design the methodology to pay the enhanced fees to fee-for-service (FFS) providers and to managed care organizations (MCOs)—including fee schedule adjustments, lump-sum payments, or capitation—and to implement site-of-service and geographic adjustments to payments.

Payment Enhancement Policy After 2014

After the expiration of the program at the end of 2014, 15 states chose to continue the program without the benefit of full federal funding, while 35 states and the District of Columbia did not (Medicaid and CHIP Payment and Access Commission, 2015). Then-President Barack Obama called for the restoration of the Medicaid primary care payment increase in his fiscal year (FY) 2017 budget; however, the payment increase was not included in subsequent appropriations legislation. The proposed budget would reestablish the payment increase “for primary care services delivered by certain physicians through calendar year 2017, with modifications to expand provider eligibility and better target primary care services.” Although details about the modifications are not described in the budget, the proposal set aside \$7.6 billion in FY 2017 and \$1.9 billion in FY 2018 to support the enhanced payments (White House, 2016).

Prior Research Examining the Impact of the Policy

Previous efforts to evaluate the impact of the policy have yielded mixed results. One study by Polsky et al. (2015) used a “secret shopper” methodology to assess changes in appointment availability in ten states before and after implementation of the payment increase. The analysis by Polsky et al. showed that appointment availability for Medicaid patients increased by 7.7 percentage points after the payment increase, while there was no simultaneous increase for privately insured patients. However, other efforts that have used stakeholder interviews as part of multistate case studies to assess the impact of the policy have found different results. For example, Medicaid officials and leaders of Medicaid MCOs in eight states contacted by representatives of the Medicaid and CHIP Payment and Access Commission reported overwhelmingly that there was little or no change in either provider participation or use of primary care services as a result of the policy (Medicaid and CHIP Payment and Access Commission, 2015). Case studies conducted by researchers from the Center for Health Care Strategies produced mixed results; ultimately, the researchers concluded that the gains in primary care physician participation observed in some states could not be conclusively attributed to the policy as opposed to other concurrent delivery system reforms (Crawford and McGinnis, 2014). An in-depth examination of the implementation context in a diverse sample of states may provide useful contextual information to help interpret the results of these and other quantitative analyses of the policy’s impact.

Scope of the Current Study

This report examines the implementation of the primary care payment increase as described by state Medicaid officials and representatives of MCOs, providers, and patient advocacy organizations in nine states¹ that were selected by the RAND Corporation in conjunction with the Office of the Assistant Secretary for Planning and Evaluation (ASPE). States were primarily selected based on estimates of the magnitude of the impact of the policy in relation to the size of the payment increase in each state from analyses conducted by RAND as part of a separate project, and included both states that expanded and did not expand Medicaid eligibility in 2014 and states that did and did not continue the payment increase after 2014.

What follows synthesizes the challenges that stakeholders encountered in implementing the policy, provides stakeholder perspectives of its effectiveness, and identifies effects of the expiration of the policy. This report synthesizes findings from 43 discussions that were conducted between July and November 2016, long after the conclusion of federal funding in December 2014.

¹ Case study states include Arizona, Connecticut, Florida, Kansas, Nebraska, New Jersey, New York, Texas, and West Virginia.

Chapter Two provides an in-depth report of key themes that emerged throughout the course of our discussions with stakeholders. Chapter Three describes strategies to improve implementation of future, similar policies that stakeholders identified during these discussions. Chapter Four contains concluding remarks. Our appendixes include a detailed explanation of our methods and outlines of discussion topics that were provided to each respondent in advance of the discussions.

2. Synthesis of Key Themes

Although stakeholder experiences of the primary care payment increase varied, several key themes emerged across states and stakeholder types. Overall, officials in many states described implementation of the policy as challenging. Contributing factors included the short time frame in which to prepare for and implement the policy, difficulty identifying eligible providers, and updating or developing new systems to make enhanced payments to providers. Effects of the policy were reported anecdotally as being minimal, with limited change in provider participation rates, and they appeared to be related primarily to the short duration of the payment increase. In spite of this, many providers and patient advocates viewed the policy positively and suggested that both providers and patients benefitted from its implementation. A summary of key themes related to the context, planning, implementation, and impact of the payment increase follows.

Preimplementation Context

Implementation of the Medicaid primary care payment increase coincided with a shifting health care landscape in many states because of both ACA-related policies and other state-level efforts to expand access to care and control Medicaid spending. These changes contributed to high levels of primary care physician participation in the Medicaid program on the eve of the payment bump policy's implementation.

Physician Participation in Medicaid Prior to the Payment Increase

Physician Participation Rates

Overall, most respondents reported that primary care physician participation in Medicaid was adequate or high in the years preceding the payment bump. Notably, participation rates were reported to be between 60 and 70 percent (Arizona and New Jersey) and 90 percent (Nebraska) of all providers in a state, even though respondents acknowledged that participation often varied by county or region. Explained one Texas respondent,

Access was extremely variable, so it is not possible to make general statements about a state with 254 counties and 23 metro areas. . . . There are some parts of Texas where virtually every physician participates in Medicaid and CHIP within the Rio Grande Valley. There are other places where it is very difficult to find a Medicaid provider. So it's highly localized.

Although participation rates were reported to be generally high, respondents were quick to identify ongoing challenges with ensuring physician participation and distinguished between the participation rates of FFS and managed care providers, which we turn to in the next section.

Factors That Affected Physician Participation

Respondents were nearly unanimous in reporting reimbursement rates as the key factor affecting physician participation in Medicaid. Respondents noted that reimbursement affects participation in three main ways: (1) low FFS rates negatively affected participation; (2) higher reimbursement rates from managed care plans improved participation; and (3) the market share of Medicaid patients in a given area might make it more or less feasible for physicians to accept low rates that could otherwise discourage participation. Less critically, the administrative burden associated with participating in Medicaid, along with the unique challenges of treating the Medicaid population, were also identified as factors that could discourage participation.

The low reimbursement under FFS Medicaid was identified as the most significant deterrent to participation in the program. Some stakeholders characterized their states as having Medicaid reimbursement rates that were “among the lowest in the country,” and several were particularly vocal about the challenges imposed by inadequate reimbursement. As one respondent stated,

Medicaid pays so poorly here . . . that primary care physicians just can’t sustain their practices if they see very many Medicaid [patients]. They just don’t make enough money to even pay their bills if they take in a lot of Medicaid and, therefore, they refuse to see any.

In contrast, some states reported that the high proportion of Medicaid patients in some areas made it infeasible for physicians to decline to participate in the program despite low payment rates. One respondent from Texas noted bluntly,

In many of the counties along the U.S.-Mexico border, anywhere from 50 percent to 70 percent of the children who live there are enrolled in Medicaid or CHIP, so you’re not going to have a . . . practice unless you take Medicaid.

In some states, MCOs may have helped to alleviate some of the reimbursement concerns. Providers in several states who participate in MCOs reported being able to negotiate reimbursement rates in excess of the Medicaid FFS fee schedule—particularly providers in rural areas. In addition, Arizona, New York, and Texas respondents argued that network adequacy requirements help to boost physician participation in Medicaid MCOs. MCOs can also leverage participation in their commercial networks in exchange for physicians accepting Medicaid.

Regardless of delivery system and its associated payment rate, however, respondents also acknowledged that the perceived administrative burden and care management challenges unique to the Medicaid population might discourage participation. For example, New Jersey and New York respondents explained that “the billing process, the credentialing process, the comfort level with the systems” in Medicaid serve as a deterrent to provider participation. These issues may be growing as a result of the expansion of managed care in some states and may offset some of the benefits of higher payments from MCOs relative to FFS, as explained by one Texas respondent:

As Texas has expanded managed care, we now have about 87 percent of all Medicaid enrollees . . . in managed care. The complexity of the program has grown and the red tape associated with managed care has also increased. So

when you combine low payments with high overhead for participating, it really discourages physicians from seeing Medicaid patients.

These issues, compounded by perceived challenges of working with the Medicaid population, make Medicaid a less attractive payer than others in the market. Notably, many respondents characterized Medicaid enrollees as having “a higher no-show rate,” poorer health, “more complex” medical issues, and requiring a more dedicated follow-up than other patients.

Respondents noted that these challenges, low reimbursements, and a history of payment cuts when state budgets were lean contributed to an uneasy relationship between providers and the state. Respondents in Connecticut, Florida, Texas, and West Virginia referred to provider “mistrust” in Medicaid, or a “hostile” or “heated” relationship between providers and the state or federal government. One provider specifically addressed the implementation of the payment bump within this environment, explaining that,

[T]he biggest problem is convincing providers that Medicaid will have a decent rate of reimbursement—and, I think the other big thing [is] that [the payment bump] won’t disappear. That was the big fear, is that you promised a lot, and if the federal money is gone . . . I’m left holding the bag, as a provider.

Patient Access and Utilization

The ability of Medicaid patients to access primary care services was characterized in similar terms as those used to describe provider participation: overall, it was generally viewed as sufficient, but spotty or variable across regions. The key concerns around access largely dealt with access in rural areas, areas with low managed care penetration, and areas without a large number of federally qualified health centers; traditional access barriers (e.g., transportation); and limited access to specialty care.

Respondents in several states identified traditional access barriers, such as transportation, outdated provider directories and network information, and limited accommodations for the disabled as issues that curbed patients’ abilities to receive necessary primary care services. Dense populations of Spanish speakers in areas with few bilingual providers and long wait times to obtain a first appointment were also identified as limiting patient access. One Florida respondent described the range of access issues:

Transportation . . . families where they’re assigned to a primary care physician that’s not in any way geographically accessible to them. . . . There’s issues about provider directories, because they’re often inaccurate and they don’t give all the information families need to make a good decision about primary care physicians, like whether they speak another language, whether their office has accommodations. . . .

These views contrasted sharply with those of Medicaid officials in several states who described few access barriers for patients enrolled in MCOs. One administrator reported that “on the managed care side, there is no lack of access. The plan is obligated [to provide a service] if there is a need and it’s a covered Medicaid benefit.”

Most respondents, however, felt that access to specialty care was a far more pressing issue than access to primary care. Psychiatric services, behavioral health, dermatology, neurology, and gastroenterology were all identified as significant areas of need with few options available to ameliorate demand. As succinctly summarized by one Texas respondent, “Specialty care tends to be the worst problem in Medicaid.”

Concurrent Payment or Delivery System Reforms

Other than the ACA-related Medicaid expansion, the most commonly mentioned reforms implemented around the same time as the payment bump were the transition to or expansion of Medicaid managed care and patient-centered medical home (PCMH) programs. These reforms introduced changes in the method or level of reimbursement for a large number of primary care physicians, and the payment bump was often swept into these reforms. As stated by one respondent, “Kansas converted to an almost-100-percent managed care environment on January 1 of 2013. The bump was kind of built into our go-live.”

Among other case study states, Nebraska experienced a statewide expansion of its managed care program in August 2012, and both New York and Florida initiated mandatory managed care enrollment programs during the period immediately preceding the implementation of the payment bump.

Connecticut and New York identified PCMH expansion as a significant concurrent reform, with Connecticut describing several payment changes attributable to the new model:

One of the things we went live with on the first of January [2013] was a person-centered medical home program . . . primary care providers would get an increase and enhanced fee-for-service rate, and they would also be, in addition, eligible for incentive payments based upon performance on quality measures.

Respondents mentioned a host of other programmatic and systems reforms, although the interplay between these programs and the payment bump was rarely described. Other reforms noted by respondents include integrated behavioral and physical health programs (Arizona), early Medicaid expansion (Connecticut) or Medicaid expansion generally (Arizona, New Jersey, New York, and West Virginia), a shift away from managed care to an administrative services organization (ASO) model (Connecticut), Delivery System Reform Incentive Payment (DSRIP) program projects (Texas), 1115 Demonstration Waivers (New Jersey), and value-based payment (New York).

Because the Medicaid primary care payment increase was implemented as part of a suite of health care reform programs and policies, many respondents reported that other programs and policies likely had a much larger impact in their state. One Arizona respondent summarized the sentiment by reporting that

At the time of going into this particular payment increase, we had just gone through the expansion. There were a lot of things happening with Medicaid. So I think the payment increase itself . . . was probably quite a bit under the radar in comparison with all these other pretty substantial and historic policy decisions that were going on.

Preparing for Policy Implementation

States reported the use of standard approaches to prepare for the implementation of the payment bump. The extent to which other departments, organizations, or stakeholders were involved in the design of the policy or revised payment systems, performed outreach and education activities, and engaged in related efforts was largely reported to be no different from any other policy. Similarly, states made use of a wide variety of tools to facilitate implementation ranging from the utilization of existing partnerships, communication methods, or contracting language. Although the payment bump largely represented “business as usual,” the delayed guidance from CMS about critical elements of the policy (e.g., provider eligibility, attestation requirements) posed unique challenges to states and MCOs and limited their ability to plan or prepare for a smooth implementation process.

State Coordination with Providers

State coordination with providers ranged from minimal outreach and education activities to vigorous partnerships with provider organizations and medical societies. Several respondents suggested that these coordination activities largely reflected the existing relationship between the state and providers: in states that already enjoyed close collaborative relationships between the Medicaid agency and provider organizations, those relationships were leveraged in the design and implementation of the payment bump.

States used a variety of communication strategies to inform providers of the payment bump, including regular provider bulletins or newsletters, email communications through state or provider organization listservs, notices sent through the state’s Medicaid Management Information System (MMIS), educational programs at annual meetings, webinars, information posted to the department website, banner messages submitted with remittance advices or fee schedules, fax blasts, and postal mailings. Communication strategies were nearly always broad-based; no respondents reported efforts by states to specifically target primary care physicians who were not participating in Medicaid before 2013.

By far, the most common method for reaching out to individual providers was through regular communication channels, with no extra efforts particular to the bump policy. A common method described by Nebraska respondents noted that, “Any provider that is licensed to practice in the state of Nebraska is on [a] listserv with an email,” and “any changes in regulations or anything new, those are sent out on the listserv [as] a provider bulletin.” Other states took a more hands-on approach to outreach. In Connecticut, for example, the state was particularly active, with respondents reporting that “the medical society disseminated information” that was provided by state administrators, and that state “provider relation[s] staff went directly to [physician] offices. It was a ‘feet on the street’ intervention.” Additionally, at least one provider group within the state arranged for state officials to participate in outreach and education events. As reported by a provider representative:

We invited DSS [the Department of Social Services] to various educational programs and our annual meetings to have booths and hand out materials. We included materials in those packets for those programs so that people were aware.

As a result of these multipronged education efforts, states largely reported that providers were aware of the payment bump prior to implementation. As summarized by one Arizona respondent,

I never heard anybody say that they weren't aware of the payment increase or they were surprised about or just learned about it when it was being discontinued.

In spite of the generally high rates of awareness, states reported ongoing efforts to provide information to providers and MCOs as a result of critical program guidance disseminated by CMS through the first few months of 2013.

State Coordination with Managed Care Organizations

Both state and MCO representatives reported having a close working relationship; as a result, coordinating efforts on the primary care payment increase did not pose any substantial challenges to the usual policy planning process, though both parties identified the short time line as the biggest challenge to implementation. States and MCOs worked together to try to alleviate the administrative issues associated with the short time line; our respondents did not indicate that there were any other concerns about the state-MCO relationship.

State Coordination with Patient Advocacy Organizations

Patient advocates indicated that state coordination with their organizations was mixed. For organizations that play a heavy role in lobbying for Medicaid issues or serve as the leader of a coalition of health care stakeholders, respondents reported having some contact with the state regarding the payment increase. One respondent explained that their organization worked directly with state officials:

[Our organization was] invited by the governor and the secretary to be a member of [a statewide workgroup]. So we spent the past year working as the consumer voice on that team with payers and providers. . . .

Most organizations that focus on patient needs or general health promotion, however, did not interface as directly with state officials. Several of our respondents reported that they coordinated with one or more state provider organizations or medical associations and interacted with the state passively as a member of these loose coalitions.

Overall, representatives of patient advocates indicated that they played little to no role in outreach or education activities relating to the policy, noting that it was not something that was “immediately obvious as something [that would be] important for patients to know.” Although coordination with the state may have varied, most respondents reported minimal outreach efforts by state officials to engage patient advocates on the payment increase.

State Plan Amendment Submission

Respondents noted that State Plan Amendments (SPAs) are filed frequently to accommodate changes to the state Medicaid program. All respondents indicated that submitting the SPA to accommodate the payment bump was relatively straightforward and did not represent a substantial effort. Respondents were more likely to report a months-long delay in obtaining approval of SPAs by CMS as the main implementation challenge.

Amending Contracts Between States and Managed Care Organizations

Similar to the SPA process, Medicaid officials and MCOs both suggested that revising their MCO contracts to accommodate the payment bump was easily incorporated into the normal contract revision process. Although the specifics of payment methodologies between states and MCOs and between MCOs and providers were often finalized over the first several months of 2013, establishing the contractual requirement for MCOs to abide by the final payment methodology typically occurred through amendments to contracts that already contained generic requirements about compliance with federal regulations. Both state and MCO respondents echoed the explanation of one New York respondent, who stated,

[The payment increase] kind of fell into our regular update process. . . . There are things that come up during the course of the administration of the program where we implement things before it is actually specified in the model contract. . . . The model contract has some generic language about compliance with federal law and state law. . . .

Given the other challenges associated with implementing the bump, the often-adaptable nature of contracting was widely perceived as a nonissue among case study states.

Implementation: Physician Attestation

Overview of Attestation Processes

Providers were required to self-attest to meeting the eligibility criteria necessary to receive the payment increase; namely, that they practiced in one of the three eligible primary care specialties and that they were either board certified in an eligible specialty or at least 60 percent of their Medicaid claims in the prior fiscal year were for services eligible for the rate increase. As summarized by one of CMS's Frequently Asked Questions documents, "states [were] not required to independently verify the eligibility of each and every physician who might qualify for higher payment;" however, each physician was liable to an audit to ensure their eligibility ex post facto (CMS, undated). States designed and utilized attestation processes that varied by method, agent responsible for attestation, and use of deadlines that were allowed under the final rule to facilitate administration of the policy.

States pursued three different approaches for managing the attestation process—a “centralized” model, in which a single entity managed the process; a “delegated” model, where both the state and MCOs independently collected attestations for their physicians; and a “shared” model, in which both the state and MCOs had responsibilities for managing the attestation process, but one entity relied at least in part on the other for sharing some attestation data. Box 2.1 displays a summary of approaches by state.

Box 2.1 Attestation Models Used by Case Study States

Centralized Model	Shared Model	Delegated Model
Arizona Connecticut Kansas Nebraska New York Texas	Florida New Jersey	West Virginia

In most states included in the study, the attestation process was centralized: the state, its fiscal intermediary,² or another state agent (e.g., Connecticut’s ASO) would collect and process attestations for both FFS and managed care providers. The state would then update its MMIS and send lists to MCOs that identified providers eligible for the enhanced payment. A respondent from New York explained their method as follows:

[The state] put an indicator on the provider’s file that they qualified for the [primary care rate increase]. And then those providers were extracted from the provider enrollment dataset to create a list of all providers who qualified. That was shared with the plan.

Only three states in our sample handled the attestation process differently. West Virginia required providers to attest twice (once for FFS, once for managed care). Both Florida and New Jersey split the attestation responsibilities between the state and MCOs in slightly different ways. In Florida, all providers were required to attest to the state as part of the initial attestation process. In 2014, the state devolved this responsibility for providers who contracted exclusively with MCOs. New Jersey’s approach was unique in its use of a “passive” attestation approach for physicians who contracted with MCOs only. Under this model, MCOs reported to the state which of their providers met all eligibility criteria, meaning that the only physicians obligated to attest in the state were those who participated in the FFS program only.

Some states provided a link to an electronic attestation form on their health department website or online provider portal to facilitate the attestation process. For example, Connecticut

² A fiscal intermediary is a third party that contracts with the government to provide financial and administrative services. State Medicaid programs use fiscal intermediaries to perform reimbursement review, pay medical claims, track or monitor expenditures, and related tasks.

respondents reported that they converted their form into a survey administered by SurveyMonkey. Several other states used a paper-based attestation system or a hybrid: Kansas, Nebraska, and Texas required providers to download the attestation form from the health department's website or online provider portal and submit the completed form via fax, postal mail, or email attachment. As described by one Nebraska respondent,

[Providers] weren't happy about the manual nature of our process. We didn't have an online portal where they could go in and check a box or anything like that. It's a paper-driven process.

Over the course of the two-year implementation period, states adopted different approaches for defining attestation deadlines due to confusion about the CMS rules and the feasibility of providing accurate reporting to CMS on compressed time lines. As described by one state respondent,

We received clarification from CMS that we actually didn't need to have a deadline for attestations to be retroactive to January 1st, and after getting that in writing from them, we proceeded to allow at any point during the two years for a provider to retroactively attest to January 1, 2013. CMS later said this was incorrect.

Other states reported that they had to set an attestation deadline to administer the program in accordance with federal rules:

After a certain point, there was no way you could possibly do it [allow providers to attest] and make sure that we could accurately report back to the feds. So at a certain point, we couldn't do that anymore.

Although variations in state infrastructure and resources contributed to the wide variation in attestation processes, most respondents suggested that the variability was due to the abbreviated implementation time line. Without adequate time to build an electronic portal or a more streamlined process for attestation, states adopted piecemeal or "Band-Aid" solutions to ensure that physicians could attest quickly.

Challenges with Attestation

Respondents identified several challenges associated with the attestation process, including unclear or perceived inappropriate provider eligibility criteria, processing and administration issues or delays, unclear or variable attestation parameters, and documentation challenges.

Determining Provider Eligibility

Providers and state respondents expressed frustration with the statute's provider eligibility criteria, both in terms of its overall clarity and the specific criteria used to identify eligible providers. The three main challenges included the scope of primary care as defined by the policy, the definition and restrictiveness of the 60-percent claims threshold, and the eligibility of advanced practice clinicians.

The largest source of initial confusion around provider eligibility was associated with the scope of primary care specialties. As described by one Medicaid official,

Once CMS started coming out with their [Frequently Asked Questions] and [we started] having calls with them—it took months once [the regulations were] totally complete, just figuring out exactly which specialties were in and which were out.

The subsequent guidance then required the state to both refine its internal processes and issue clarification communications to providers and MCOs. As described by another state official,

We started our fee-for-service attestation probably as soon as the final rule came out in November, and then I think there were a couple of changes in January. So we had to send out clarifying documentation to our providers to ensure that we received what we needed to be able to reimburse them.

As the eligibility criteria became clearer, different provider groups took issue with the definitions, with some criticizing the criteria as being “too broad,” while others complained that they were too narrow. For many respondents, the payment bump seemed to include some providers that were not typically considered primary care providers while excluding others who often provided high levels of primary care, as one respondent explained:

The specialty and subspecialty [categories] were so broad that you had some providers that were receiving enhanced rates of reimbursement that truly should not have been eligible, while you had other providers that were actually primary care physicians but they did not receive the reimbursement because they didn’t meet the 60-percent bill codes.

The 60-percent billing requirement further compounded this problem because the threshold was too high for many specialists—even those who were providing substantial amounts of primary care. One state respondent summarized this issue accordingly:

I recognize that the 60-percent [threshold] was a national requirement, but there should have been some recognition that in certain parts of the state, where you don’t have any primary care physicians and these specialists are acting as such, they should have received the same benefit everyone else did.

Furthermore, in another state, a respondent reported that “emergency room doctors were eligible for the enhancement and we could see from our fee-for-service side that . . . our largest reimbursement [was for] codes for the emergency room visit.” Taken together, these comments suggest a mismatch between the policy’s eligibility criteria and the unique features of the primary care delivery system in many states.

Finally, most states reported challenges determining whether advanced practice clinicians were eligible for the policy in the first place, and later, how to document relationships between these clinicians and their supervising physicians. Respondents across all stakeholder groups and states reported some “volatility” around the issue of reimbursement for advanced practice clinicians—particularly because these providers represent a critical component of the delivery

system in many states, especially in low-access areas. One Medicaid official explained a wide range of concerns:

We entertained a lot of conversations with nurse practitioners that didn't feel like they needed the supervision of a physician and they did not really understand why the rule [was] written that way. They felt that they should be eligible for the reimbursement. There were some nurse practitioners that had difficulty getting physicians to sign the document saying that they were being supervised. So, it kind of limited the number of nurse practitioners that actually participated. We had 982 that were actually enrolled as nurse practitioners in 2013, but we only had 23 that were eligible to participate in the program.

Some state officials noted that many nurse practitioners in their state practice independently or under collaborative agreements, but later guidance from CMS clarified that collaborative agreements were not equivalent to a supervisory relationship.

States reported strikingly different approaches to defining the eligibility of nurse practitioners. Medicaid officials in two states reported that nurse practitioners were simply ineligible for the payment increase because they were “not physicians” (and only physicians were eligible for the increase). A few other states mentioned that their attestation forms allowed eligible physicians to indicate all of the nurse practitioners the physician supervised, which would allow the state or MCO to certify each nurse practitioner as eligible. Other states noted that they neither sought to collect information on nurse practitioner-physician relationships through the attestation process nor were they able to indirectly associate nurse practitioners with their supervising physicians based on the co-occurrence of clinician identifiers on claims. These findings suggest that nurse practitioners participated at low levels or not at all in many states.

Processing Forms and Integrating with Claims Processing Systems

States reported that processing the attestation forms was often a significant administrative challenge. Although several MCOs reported that it only took one week after receiving the state's attestation files to start paying claims at the enhanced rate, the high volume of attestations created a backlog that stalled payments in some states. Similar experiences were reported in other states, with one provider suggesting that the delays may have hindered provider participation:

So, they said “we're going to pay, we're going to engage in the Medicaid activities,” but then it took another six months to determine who and what, and then it took them time to actually pay people. So you missed an entire window of opportunity of signing people up and the momentum was very much lost at that time.

Both states and MCOs had to create or revise existing systems to translate the provider attestations into payments, a process that put a significant strain on MCOs. According to respondents, the long time line over which physicians could attest prolonged the period during which claims reprocessing was required (see “Payment” sections later in this chapter), and

attestation dates that varied by person (as well as incorrect attestation dates) added another layer of complexity to paying physicians. According to a Kansas respondent:

The ongoing pain point really was just the incorrect attestations that resulted in a retro correction to an effective date. . . . You never knew for sure if something was in flux because you could have paid for six months and then get a notice that says, “Whoopsies. The effective date should have been March 1st, not January 1st, and now we need you to go back and take back money for three months from the provider.” [The primary care providers] were not happy, not happy at all.

Finally, the eligibility requirements posed challenges for some providers who had either older or expired certifications, or who had lifetime certifications rather than board certifications for specific specialties. States reported working with state boards and CMS to find workarounds for these providers, with varying rates of success.

Perceived Rate of Attestation

Both state and MCO respondents reported that attestation rates were not monitored or evaluated over time, but expressed curiosity when questioned about rates in their own state. Most respondents assumed that attestation rates were high. As summarized by one Kansas respondent,

I’d be interested to know [the attestation rate] but I would imagine it was a high percentage. I don’t think I ever looked at it in that way.

This was echoed in several states, with West Virginia postulating that upward of 70 percent of providers attested and successfully received enhanced payments.

Medicaid officials noted that it would be difficult to quantify attestation rates simply because the universe of primary care providers (let alone eligible primary care providers) in the state is hard to determine. Thus, although states were able to report absolute numbers of attesting physicians, many felt that it would be difficult to reliably report attestation *rates* in the context of tracking participation during the implementation period.

Eligibility Audits

States were permitted to begin rendering payment to providers based on self-attestation alone if, at the end of calendar years 2013 and 2014, the state reviewed “a statistically valid sample of providers who received higher payment to verify” that they were eligible for participation in the program (CMS, 2012). Although this allowed states to distribute the payments more quickly than if each provider were verified prior to payment, the auditing process resulted in some administrative challenges for states.

One state seemed to suggest that some “audits” could be performed during the attestation process and include all of the provider population rather than just a sample:

On the managed care side, it wasn’t difficult because we had a certified network file and they [providers] have to be—you know, they are identified there through the credentialing process.

However, Medicaid officials in most states conducted audits at the end of the calendar year using a sample of selected providers. Some states verified board certification first before moving on to the 60-percent threshold, whereas other states reported reversing these criteria. Respondents noted no significant advantage to one method or the other. The agent responsible for performing these checks varied, however, and could have been the state, the state's fiscal intermediary, or the MCO.

After ineligible providers were identified, nearly all states reported issues with collections. Several Medicaid officials agreed with the sentiment of one respondent who noted that "taking money back from providers is always difficult." One official indicated that doing so was especially difficult in cases where providers disenrolled from the Medicaid program.

Overall, the approach to confirming provider eligibility varied only slightly across states. The timing and extent of the audits, the agent responsible for performing them, and the criteria used were implemented differently across states, but nearly all states reported issues in recouping incorrectly issued funds.

Implementation: Payment

States took a number of different approaches to pay the enhanced payments to both their FFS providers and the MCOs with which they contracted. Table 2.1 displays the key differences across states and the approximate timing of when payments were initiated.

Payments to Fee-for-Service Providers

In all but one case, states adjusted their fee schedules to allow the enhanced payments to be made to each eligible FFS provider on a per-claim basis. The only exception was Texas, which issued lump-sum payments to FFS providers on a quarterly basis. Texas may have adopted this approach to match its MCO payment methodology (discussed in the next section), which also used lump-sum payments. Stakeholders overwhelmingly asserted that implementing the payment policy for FFS providers was far easier than for providers participating in MCOs.

Table 2.1. Summary of Payment Methodologies and Payment Initiation Dates, by State

State	FFS Payment Methodology	State Methodology for Paying MCOs	MCO Methodology for Paying Providers ^a	When Payments Started to Be Made to FFS Providers	
				FFS Providers	Managed Care Providers
Arizona	FS adjustment	Reconciliation	FS adjustment	August 2013	July 2013
Connecticut	FS adjustment	—	—	June 2013	—
Florida	FS adjustment	Reconciliation	Lump-sum payment	Late 2013	May 2013
Kansas	FS adjustment	Capitation	FS adjustment	Unknown	Mid-2013
Nebraska	FS adjustment	Capitation	FS adjustment	October 2013	Unknown
New Jersey	FS adjustment	Reconciliation	Lump-sum payment	November 2013	September/October 2013
New York	FS adjustment	Reconciliation	Lump-sum payment	Unknown	December 2013
Texas	Lump-sum payment	Reconciliation	Lump-sum payment	Mid-2014	Mid-2014
West Virginia	FS adjustment	Capitation	FS adjustment	July/August 2013	September 2013

FS = fee schedule

^a These payment methods were used for providers who are paid on an FFS basis by their MCOs. Other providers are paid on a capitation basis by their MCOs.

State Methodologies for Paying MCOs

To distribute the increased payments to MCOs, states employed one of two primary payment methods: an enhanced capitation payment or retrospective reconciliation. Five of the eight states that were operating managed care programs in 2013–2014 selected a retrospective payment model in which states made supplemental payments based on reports submitted periodically by MCOs that summarized the amount of enhanced payments that was due to providers (or the MCO already paid to providers). In contrast, Kansas, Nebraska, and West Virginia used a capitation model to issue payments prospectively.

Although payment methods varied, we found little evidence to suggest that one method was superior to another. While one state thought a prospective approach might be more efficient, the state’s actuaries were not willing to certify that the capitation rates would be actuarially sound. State actuaries were concerned about uncertainty in the number of physicians that would ultimately attest to being eligible for the payment increase, as well as the impact the policy might have on utilization of primary care services. Texas Medicaid officials noted that they initially considered a prospective model but later determined it was not feasible because the state’s actuaries were uncomfortable using utilization assumptions from 2009 to set the capitation rate—a period preceding the large expansion of managed care in the state. Several states reported a lot of back and forth with their actuaries in the process of determining the capitation rates.

Prospective models were seen to complement the existing payment structures and environment in the states that pursued this approach. For example, one Kansas respondent noted

that the state's choice of a prospective payment method was linked to the rollout of the state's Medicaid managed care program (KanCare), which occurred on the same day as implementation of the payment bump.

MCO Methodologies for Paying Providers

Medicaid officials and MCOs described two types of systems that were used to make payments to providers participating in MCOs: (1) a fee schedule adjustment approach that relied on existing claims-processing systems, and (2) a lump-sum payment approach that operated outside of the claims-processing system. Some physicians were also paid through capitation arrangements (discussed in a later section).

In half of states with MCO programs, respondents reported that the increased rates were paid through existing claims systems. This allowed providers to receive the increased rate through their usual payment channels, while also ensuring that providers had a detailed explanation of payments on a per-claim basis through remittance advices. This system also allowed states to track payments from MCOs to providers using encounter records that MCOs routinely submit to states. MCOs also submitted detailed reports to states summarizing all claims subject to the payment increase (on a monthly or quarterly basis).

Other MCOs made payments outside of claims in a parallel system, due to the abbreviated implementation time line, a desire to keep the enhanced rates and normal rates separate, or technical challenges associated with incorporating the payment increase into the existing claims system. Medicaid officials in Florida, New Jersey, and New York were explicit in their requirements for MCOs to pass the lump-sum payments through to providers outside their existing claims-processing systems to ensure that the higher payments would not inflate MCO capitation rates in subsequent years, which are calculated using payment amounts on encounter records submitted by MCOs to the state.³

The actual funding from the MCO to the provider was done outside of both our claims and encounter reporting system. So we made it very clear to the MCOs that the encounters that came back for those time periods should not reflect those enhanced payments because we could potentially be overstating future capitation rate development if the program did not continue, and it did sunset after '14, so we just did not want that funding to interfere with how we were going to set capitation rates prospectively.

MCOs that implemented fee schedule adjustments often faced technical challenges adapting their systems. However, respondents also noted that making payments within their claims-processing systems made it easier to administer the program. One respondent from Nebraska noted:

³ States typically set capitation rates for each MCO using expenditures from one or more prior years.

[The policy was] very cleanly tied to an increase in a fee schedule rather than through some other pass-through mechanism, [which] made the process easier to administer and, therefore, less costly to us than in other states where the state did not adjust the fee schedule, largely because the states weren't convinced that they would maintain it over time.

States that used a lump-sum payment methodology avoided the technical challenges related to updating their claims-processing algorithms but had to reconcile their payments in a separate system. A few stakeholders in these states reported that doctors had difficulty understanding whether these payment amounts were accurate because they were not tied to specific claims.

Determining MCO Pass-Through Payment Amounts

The policy provided states with some latitude to vary the level of enhanced payment within the payment model. Specifically, states were given the option to make payment adjustments that varied by geographic location within the state or site of service (e.g., office setting vs. hospital setting). These adjustments were applied to any existing adjustments states made for nonphysician providers. However, the biggest challenge was determining payment amounts to subcapitated physicians.

In all states, MCOs paid the difference between their negotiated rate with their providers and the Medicare fee schedule. Most states attempted to facilitate this process by disseminating a fee schedule that reflected the payment amount that would achieve parity with Medicare—known as a “parity” fee schedule. This strategy helped to ensure that MCOs would be using the same fee schedule to determine the amount of the pass-through. As one respondent noted:

[The state] derived the rates that were going to be payable to the providers who were eligible for this and essentially indicated to the MCOs how much those rates were going to be by code, by location, so forth and so on. So, what they did is, they published those rates throughout, and they published them in a number of different locations where we could access the rates and understand by code, by date of service, how much these providers were supposed to receive for those services.

MCOs had more difficulty determining payment amounts for physicians in subcapitation arrangements.⁴ The two main challenges MCOs faced were (1) developing the level of payments for eligible services already covered under each provider's capitation payment, and (2) making projections about patients' utilization of primary care services when the policy was in effect. Several Medicaid officials and MCOs reported that this was not an easy task. As one New York respondent explained:

I think obviously those that were paying on a fee schedule, it was a lot easier—but those who had agreements with providers that were based on a subcapitated

⁴ Providers who are reimbursed by MCOs through a subcapitation arrangement are paid on a prospective basis rather than an FFS basis.

relationship, that was not as easy. So we worked with the health plan associations to develop a methodology that was employed by all. It was recommended by the state that all the plans employ that methodology and they actually went out to each individual provider and educated them on how those baselines were going to be calculated and how the overall payment enhancement would be calculated.

A few other states or individual MCOs took steps to promote consistent methods for paying physicians who participated in subcapitation arrangements and to obtain buy-in from MCOs. For example, an MCO in one state conducted focus groups with their capitated providers to vet their proposed methodology in advance of submitting the plan for the state's approval. Another stakeholder reported that the MCOs conducted outreach to individual providers to "educate them on how baseline payment rates were going to be calculated." Several states indicated that more guidance from CMS on subcapitation methodologies would have been helpful.

For MCOs in some states, different provider types were paid different portions of the primary care payment increase, with advanced practice clinicians often receiving a smaller portion than physicians. The practice of reimbursing midlevel clinicians less than physicians, which is common in many states, resulted in an additional layer of complexity for MCOs calculating the rate increase. As described by one respondent:

The biggest challenge for us was that the nurse practitioners received a different rate. . . . Then you would have to look at the physician or the practitioner's specialty and there were special rules for nurse practitioners. And the rule was that they received 75 percent of the rate.

Only one respondent noted that site-of-service adjustments were contentious:

Well, the whole issue had to do with whether hospitals or hospital-based physicians were getting even more of a payment bump because they were potentially going to get the 125 percent of Medicare because [of the] 25 percent site-of-service differential versus the doctors in the community just getting 100 percent.

The site-of-service issue was seemingly resolved in this respondent's state when "... they paid for some services at the 125 percent, but not all services," though the respondent indicated that "complaints" about equity characterized the debate.

For some plans, geographic adjustments appeared to add complexity to the payment system. One MCO in New Jersey noted that the state's decision to use a single geographic area (instead of the two that are used in the Medicare fee schedule) simplified implementation because, in the words of the respondent, "if we had to differentiate fee schedules based on geographic area, I don't know that our systems would have been able to support that."

Respondents in a few states indicated that providers occasionally questioned the amount of the enhanced payments they received, which respondents attributed to differences in negotiated rates between providers.

Making Payments

Respondents reported that issuing the primary care payment increase was a lengthy process that incurred several delays and required overcoming several challenges. Before payments could be issued, the state had to finalize policy decisions and communicate the rules to MCOs, claims systems had to be retooled to accommodate the increase, and tracking systems had to be designed. Many respondents described this process as onerous, including one who noted:

We had to first have the [primary care provider bump capitation] methodology approved before we could submit the contract amendments and . . . I believe that they probably approved the rates in June of '13. So we had to retroactively adjust their rates back to January of that year. On the fee-for-service side, we were not able to make a system change until October of '13, to reimburse fee-for-service claims for the enhanced primary care.

Another MCO described the systems limitations associated with implementing a short-term and provider-specific payment increase as “problematic.” The respondent clarified,

What we learned is that we didn't have any automated way for that information [provider and enhanced rate] to be loaded into our system because there's really not something inherent with the processing system we have to use to price something at our standard fee schedule and then a secondary fee schedule.

The greatest challenge associated with payment implementation, however, was the short period of time between the release of the final rule and the program start date. With the final rule issued in November 2012, respondents stated that they had little time to implement changes to their claims-processing systems necessary to accommodate the payment increase. By the time the payment bump went live on January 1, 2013, states and MCOs had had less than two months to reconfigure their systems, which ultimately prolonged the period during which MCOs made retroactive payments and made the reconciliation process more challenging. As described by one MCO,

[There was] not adequate time for a health plan to implement [updates to the claims-processing system] . . . we initially had to do payments outside of our claim system. It took us several months to implement a process within our claim system so that it would show up on a remittance advice so providers could actually see what they were getting paid for. So, I would say, yes, that the short time frame presented challenges that weren't a good business practice.

Medicaid officials in one state described their usual protocol for implementing a systemwide change, which includes “technical consortiums and workgroups [where] we work through the solutions. There was a mandated testing window for each of the health plans [in which] they needed to complete a limited set of scenarios . . . [so we could] be assured that we were all on the same page.” This process was put into place in the state but doing so led to some delays in making payments. One state also indicated that MCOs may not be able to adjust their systems independently and may need to rely on vendors to do so, and, as a result, have to work with the vendor's time line.

By mid-2013, most plans had begun to deliver the enhanced payments, including payments for real-time claims and retrospective payments. However, respondents reported that it took a long time to reprocess claims to make retroactive payments in most states. System limitations and the sheer volume of claims contributed to these delays:

We could only reprocess up to 40,000 claims in any given one-week period. . . . We had . . . in excess of 300,000 claims that we had to reprocess. And so, we had to send over batches of claims . . . to get them reprocessed and essentially re-extracted to send an encounter file.

Managed care respondents reported that the retroactive payments represented a significant administrative burden due to repeated processing of claims, which often required manual review. One respondent characterized the process as follows:

There's a pretty significant administrative lift in scrubbing through that amount of claims just to identify the claims and then just the amount of work that it takes to then push those back through the system. You can push them through in a batch and hopefully all of those go through. But generally, even with a good batch submission, you'll have a 15- or 20-percent fallout rate that then somebody has to manually stop and look at . . . [and] any time you have to manually review and push a claim through, it's significantly more time-consuming and expensive.

A few respondents also noted that the policy did not cover the administrative costs to plans to comply with the policy.

While several states noted that they made efforts to ensure that the reprocessing of claims did not require any additional effort on the part of providers, at least one MCO noted that remittance advices explaining a physician's payments could be quite lengthy—suggesting that physicians may have incurred additional burden reviewing paperwork associated with these payments.

Although the burden of retroactive payments was identified as the primary challenge associated with issuing the payment increase to providers, group enrollment in the Medicaid program posed similar challenges and required states and MCOs to parse the individual eligible providers at the attestation phase to ensure that only eligible providers received the payment increase. As described by one state respondent,

I think our biggest issues making those payments retroactively was in relation to our [group] providers who, in our state, they file their claims as a group. . . . We had to go back and create another process for those [providers] to be able to attest with their group NPI [National Provider Identifier] so that we could capture them.

Another challenge concerned payments to advanced practice clinicians, who were only eligible to receive the enhanced payment if their claim was submitted under the supervision of an eligible physician. As explained by one respondent,

There's not a way for nurse practitioners to [be identified on claims]. They have to bill under supervision, so that became a little bit complicated as well, because the physician's NPI may or may not have been on the claim.

MCO representatives in several states also reported challenges issuing enhanced payments in cases where Medicaid was not the primary payer. MCOs had to build additional logic into their claims-processing systems to ensure the payment bump took into account other forms of coverage. One stakeholder noted that a patient’s primary source of coverage is not always known at the time of the initial payment, so these cases often involved multiple adjustments.

In states in which lump-sum payments were made to providers, some physicians reported concerns that they could not determine whether the level of payment was appropriate, and were worried about their inability to associate the payments to individual patients in the event of an audit.

As a result of these challenges, payments were often delayed by several months. The response from providers was mixed. Although some respondents reported that providers considered it “ridiculous” that it took six to nine months to receive their enhanced payment, others noted that providers typically expect payment delays from Medicaid. One New Jersey respondent indicated that some delays were excessive. The respondent reported “fielding those calls a surprisingly long time after the program ended, like 12, 15 months after the program was over. I was still getting calls [in 2016] that our providers hadn’t been reimbursed for their service in 2014.”

Evaluation

Extent of Evaluation Activity

None of the respondents reported conducting, participating in, or planning to perform a formal evaluation of the Medicaid primary care payment increase. The only exception appeared to be New Jersey’s Medicaid agency, which required MCOs to report lists of physicians enrolled in each MCO’s network both before and after the policy was implemented.

More commonly, respondents cited general and ongoing research, reports, or monitoring performed in the state that may have been used (or could be used in the future) to identify deviations in trends during the period of the payment bump. Examples of these sources include provider organizations’ ongoing member surveys, patient experience surveys that include questions on access to care, MCO readiness reviews and performance audits for the state, or analyses of utilization data for the purposes of setting capitation rates. Additionally, some states contract with external quality review organizations to issue public reports, and some advocacy organizations perform a general “pulse check” on health care access writ large in their state. Respondents suggested that these materials could shed light on provider or patient experiences during the period of the payment bump, though direct effects of the policy would be extremely difficult to measure. Many respondents noted, however, that it was beyond the resources of their organizations to evaluate the policy.

Other feedback we received from stakeholders about the policy was primarily anecdotal (e.g., providers discussing their experience with the state medical society, complaints logged with the health department) or was limited to a small and focused group. For example, one MCO reported that it performed a postmortem on the payment bump once it had concluded. The respondent explained,

We did go through some sort of retrospective review of everything on this with the state and the other MCOs to . . . discuss the pain points of it, how we might be able to better implement something like this. So it was sort of a debriefing where we just discussed the entire process and how it impacted what we were doing and if there was a way, if something like this came up in the future, to mitigate it or make it a little bit easier on us.

Effect on Physician Participation

Different stakeholder groups had varying definitions for the payment bump's success. Greater rates of provider participation, increased patient access and utilization, improved provider relationships with the state, infrastructure improvements, and successful disbursement of the enhanced payments were all identified as desirable outcomes of the policy, which respondents reported were achieved to greater or lesser degrees. However, most stakeholders speculated that the policy was unlikely to have large effects on patient access to primary care services.

Multiple stakeholders in New Jersey, where the most systematic analysis was conducted, described expansions in physician participation, although not on the scale that was anticipated at the start of the program. In only one other state (Connecticut) did we hear even anecdotal reports of increases in physician participation. The majority of states believed that the policy did not attract many new primary care physicians into the Medicaid program.

One common explanation stakeholders offered for the lack of a strong impact was that participation was already high before the policy was rolled out. A Medicaid administrator summed it up in the following way:

A third of the population of our state receives Medicaid benefits. If a provider doesn't accept Medicaid members, then they're missing out on a huge piece of the market. So I think from a provider participation perspective, you know, we were already there. I don't think [the policy] moved the needle any at all. It didn't move the needle while the policy was in effect and didn't move it after it was discontinued.

Stakeholders from Kansas and Nebraska echoed this interpretation, while respondents from New Jersey noted that their managed care plans have an obligation to provide a network of physicians that ensures high levels of access. Several states noted that the policy would have achieved a far greater impact had it focused on improving participation of specialists. For example, one Florida respondent noted:

It [is] difficult to say what the long-term impact of the program was, because it came and went about just as quickly. It didn't go into effect right away and it only affected a narrow subset of providers. . . . Our biggest . . . issue was specialist participation in the Medicaid program and it didn't address that.

The greatest deterrent to new participation in the program, reported by an overwhelming number of stakeholders, was the limited duration of the policy. One provider organization summed it up:

In the back of everyone's head, I think everyone kind of knew that . . . this was a program that was only going to be in effect for a short time.

Other comments repeated by stakeholders in many states indicate a deep-seated lack of trust with the Medicaid program on the part of some providers. These respondents described a history of rate cuts or provider taxes that were levied on Medicaid providers to raise general funds to support the program, which made many providers skeptical of a temporary payment increase.

Respondents, including Medicaid officials, often questioned the premise behind the payment bump policy—namely, the assumption that low payment rates were the primary reason for low participation in the program. Many respondents spoke to the administrative burden and uncertainties associated with the Medicaid program. According to one provider:

That's one of the reasons they don't participate—they're always hearing about the rates being cut or services being changed and modified and the rules continue to change frequently.

Stakeholders in a few states noted that some physicians simply are not interested in serving a vulnerable population, regardless of reimbursement levels.

Effect on Primary Care Utilization

Although few stakeholders perceived that physician participation improved over time, several respondents felt that the policy may have improved access to services among physicians already participating in the program. In particular, Medicaid officials in Connecticut noted that access to primary care services increased consistently and they even were beginning to see decreases in their per-member-per-month payments in certain areas, which they attributed, at least in part, to the rate increase. Similarly, Medicaid officials in Kansas identified a significant increase over time in the utilization of primary care services, but because those trends remained unchanged after 2014 (when the policy had ended) they speculated that the impact might have had more to do with the state's managed care expansion than the payment bump policy.

Other respondents felt that the impact of the bump on utilization was more modest, mixed, or hardly felt at all. For example, Arizona and Nebraska officials reported that analyses of primary care utilization conducted as part of the states' capitation rate-setting processes suggested there was not a large increase in primary care visits. While Medicaid officials in Florida reported no changes in Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures over the period of the bump (or subsequently) and no changes in enrollee complaints about access

problems, both providers and patients in the state felt that providers were able to accept more patients because of the payment increase. In addition, a provider organization in one state perceived the effects to be greatest for pediatricians, who tend to take on a disproportionate share of Medicaid patients.

Respondents speculated that providers might have used the enhanced payments to support new office or administrative staff, additional clinician hours to manage the increased patient load, infrastructure investments (e.g., computer systems or diagnostic equipment), or compensation for unpaid or charity care. However, several respondents also noted that the policy's two-year time horizon was a barrier to making these investments. A provider in one state noted, "You're not going to staff up with a two-year window."

Effect on Provider Experiences

Providers reported that, even if the policy did not result in greater participation by new or existing physicians, the policy helped to shore up an insurance system that had suffered budget cuts in recent years and from which providers were increasingly considering disenrollment. A common sentiment in most states was that the policy helped to keep Medicaid providers "afloat" for a few years.

As a result, most respondents reported that the payment increase had a positive effect on provider satisfaction with Medicaid. According to one Connecticut respondent:

I think the providers were really happy about it. I think they never feel like they're getting enough. They will still tell you that the Medicaid rate does not cover their costs, but the increase was certainly welcome from my recollection. And then when the state agreed to continue that increase for primary care, people were really happy about that as well.

This theme was similarly echoed in Kansas, Nebraska, New York, Texas, and West Virginia. One provider suggested, "In terms of perception, it might have helped make doctors less negative about the Medicaid program."

In some states that discontinued the payment increase, however, this goodwill fostered between providers and the Medicaid program was short-lived. Respondents in New York, Texas, and West Virginia all reported that the discontinuation strained an already fragile relationship. One provider stated, "Everybody thought [the policy] was pretty good. They just got mad when they stopped it." Another provider respondent noted the discontinuation of the policy may have worked against efforts to build trust between Medicaid providers and the state:

They're upset and yet there's all these other innovative reimbursements coming down the pike. You know, there's a healthy distrust of [Medicaid] because this particular program, you know, basically went away.

Some respondents differentiated between providers' opinions of federal and state authorities in their perspectives about the implementation of the policy. As one provider characterized it,

I don't think they [providers] view this as the Medicaid program's problem. They view this as Congress let them down, you know? They established a program and it was only a two-year program and they didn't follow up with additional monies to perpetuate it. And so, they don't blame the state at all; they blame Congress.

Overall, respondents reported that providers responded positively to what they perceived as an acknowledgement of the low reimbursement rates under Medicaid and an attempt to bridge the payment gap. These were especially compelling reasons to extend the policy, according to respondents in Connecticut and Nebraska. In most states, however, payment delays and the short duration of the policy limited the potential for the payment increase to improve provider relationships with Medicaid.

Impact of Medicaid Expansion Status

The perceived lack of an effect of the policy by stakeholders in Medicaid expansion states suggests that the policy may not have accomplished its intended goal—to expand physician participation in anticipation of the 2014 expansion. All stakeholders noted that implementation of the payment bump was significantly delayed in their state. In expansion states, this meant that there was a limited amount of time between the effective date of the payment bump policy and the beginning of the expansion in 2014. This may have led many to conclude that the marginal effect of the payment bump was small or negligible. Stakeholders in many states noted that it would be very difficult to assess the impact of the payment bump separately from the effect of the expansion.

A few stakeholders hypothesized that Medicaid expansion would likely have been a far more potent incentive for physicians to participate in the program or to increase their share of Medicaid patients in their practices because the expansion would guarantee payments for their formerly uninsured patients on a permanent basis.

Evaluation Challenges

Respondents identified several challenges that evaluators might face when seeking to estimate the impact of this payment policy. In some cases, respondents offered strategies that might help evaluators identify effects of the policy should they exist.

Stakeholders in nearly all states questioned the ability of any evaluator to isolate the effect of the primary care payment increase from the effects of other policies implemented during the same time frame. As stated by one provider,

I'd say if you just had that policy in and of itself, I'm sure it would have had a very positive impact. I'm sure it did have a positive impact, but it'd be hard to understand that or process that in the context of the other policy issues that were going on.

As noted earlier in this report, numerous states implemented Medicaid expansions, managed care expansions, or other delivery system reforms during this period, which will complicate efforts to

estimate the effect of the payment bump policy alone. The fact that some primary care providers were ineligible or otherwise excluded from the policy—including obstetrician/gynecologist (OB/GYN) physicians and nurse practitioners in some states—suggests that comparison groups of “unexposed” providers may be available in certain states. In addition, providers that failed to meet the 60-percent claim threshold but were otherwise eligible may also represent a compelling comparison group in an evaluation of the policy.

Identifying the actual timing of the initiation of payments will also be important for any evaluator, which will require data from state officials and MCOs. Nearly all states encountered payment delays extending through at least the first half of 2013. At the same time, some states with even longer delays continued to make payment through 2015. Correctly specifying the window of “exposure” to the payment increase in each state will be critical for appropriately estimating the effect of the policy.

Discussions also highlighted the fact that evaluators might need to consider heterogeneous effects within states. For example, counties that have disproportionately high numbers of Medicaid enrollees or highly underserved areas (such as regions with few federally qualified health centers) might be associated with larger effects. Certain specialties, such as pediatricians, who provide services to a disproportionate percentage of Medicaid enrollees in certain states, may also be a useful subgroup in which to examine the impact of the policy.

State Decisions to Extend or End the Policy

After full federal funding ended on December 31, 2014, states were left with the option to discontinue the payment increase and revert to their previous Medicaid primary care rates or to accommodate the higher rates using state funds in conjunction with each state’s federal medical assistance percentage. Of the states included in this study, only Connecticut and Nebraska continued the payment bump while, in October 2016, Florida implemented a related policy for board-certified pediatricians and obstetricians whose practices have either met quality benchmarks or have received PCMH recognition. Florida’s program requires MCOs to fund the payment increase (up to the Medicare rate as in the ACA Section 1202 policy) using cost savings achieved through enhanced care coordination.

Across all states, respondents identified similar reasons in favor of continuing or discontinuing the bump. The main reason in favor of the bump was to continue to improve provider participation and patient access through higher reimbursement levels. The main argument against continuing the bump was the pressure on state budgets, inability to find state-level funding for the increase, or lack of evidence of the policy’s impact on access to care.

Extending the Policy

Respondents in Nebraska identified support of executive leadership, benefits to stakeholders, and low fiscal impact to be the key reasons that the policy was continued. Specifically, the state

Medicaid director served as a vital force to move the policy forward and sought approval from varying levels of government to continue the policy “indefinitely.” According to another respondent, the benefits of the payment bump were significant and helped to support arguments to continue it following the conclusion of federal funding:

It’s been a positive thing for our state, for our providers, physicians, and especially for our Medicaid patients, because it further lessens the likelihood that providers will no longer be able to provide those services because of a low reimbursement rate. Again, there’s probably room to grow and improve on that aspect, but the increase, I think overall, has helped that sustainability.

Furthermore, respondents from Nebraska, a state that did not expand Medicaid and whose 2009 Medicaid payment rates were near the median across all states, suggested that these benefits outweighed the costs of extending the program, with one respondent stating,

I tend to think that the decision to continue was allowed because the fiscal impact wasn’t as big as we initially were concerned it to be. There was a lot of discussion, I think even at the national level, about how more expensive this was going to be and what the cost was going to be to the states that continued it after the federal match went away. I think that the experience in Nebraska was such that it wasn’t [too] big of an impact to continue it.

A third factor in Nebraska’s decision to renew the policy may have been advocacy from providers who were concerned about the impact of the policy’s discontinuation on their practices. State officials noted that providers were very concerned about the potential for the restoration of lower payment rates, and voiced the possibility of disenrolling from Medicaid should the policy be discontinued.

Connecticut’s decision to continue the policy was described by respondents as the result of the alignment of state policy and program goals with the will of stakeholders. One respondent posited that

Under our new model of care, we’ve been emphasizing primary and preventive care, and doing everything we can to do that. I think the rate bump was consistent with that, and helped it.

Connecticut respondents suggested that, consistent with these policy goals, the payment increase had improved health care access and provider participation rates, which in turn led to an aggressive stakeholder advocacy campaign that concluded with strong support from executive leadership to continue the program. As described by one respondent,

Frankly, our budget office in the executive branch of government was very supportive of this, because they felt that with increased access to primary care, we were seeing less use of a lot of specialty services, imaging procedures, and hospital services, so they felt that it was sustainable and made policy sense. Our general assembly, I think, were influenced strongly by a lot of our—we have a very active group of so-called member advocates or patient advocates in Connecticut, and they were pushing for the continuation and so they carried a lot of our water for us on that one.

Stakeholders in Connecticut described the payment bump as just one element of an overall strategy of investing in the state's primary care infrastructure, which included a shift away from managed care, a concerted effort to expand the state's primary care network, and implementation and expansion of medical homes in the state, which included enhanced funding. The payment bump was a key element of this bundle of initiatives.

The most important factor contributing to Connecticut's decision to extend the policy, however, was the state's receptive political environment. As explained by one respondent:

I think we all have to appreciate politics plays a big role, and our governor, when elected, said he would implement health reform with federal support . . . So you had an administration willing to do that. Most legislators love their home town docs that are . . . calling them and talking to them all the time. So you had legislative support for this, you had administrative support, you had a need to increase access by advocates and pushing that agenda. So I don't know anybody that was opposed to the increase at all. It came at a time where we, as a state, were ready to embrace that, and so gladly and willingly we took it on, and I don't remember any detractor.

Notably, both Connecticut and Nebraska changed some aspects of the policy when federal funding ended. Specifically, they revised the list of eligible primary care codes and changed the eligible provider criteria to suit their state's needs. In Connecticut, revising the list of eligible codes was the primary mechanism by which the state was able to fund the payment increase. As one respondent explained,

... A number of codes that CMS had listed in their list of primary care codes were inpatient codes, and a number of them . . . were not primary care codes, such as intensive care resuscitation in the emergency department. They were all inpatient codes and they were being billed by intensivists, and so when you added up all of those codes, and they were very expensive codes, they were not used that frequently, but they were about a third of the financial outlay, so we took the inpatient codes out and continued the primary care rate increase as it was for the outpatient codes, and that essentially kept us within the appropriation.

Some providers appear to have been disproportionately affected by the cuts that were needed to prolong the payment policy. In particular, rates for certain services (delivery and ultrasound procedures) were cut for OB/GYN physicians and radiologists. This led one respondent to lament that the state was "robbing Peter to pay Paul" because the services whose rates were cut were typically those used by high-risk Medicaid patients.

Notably, nurse practitioners were included as eligible providers in both states' continuation policies without regard to whether they were under the personal supervision of a physician.

Ending the Policy

Unfortunately, the high cost of the program was cited as an enormous challenge to overcome in most states. Several respondents alluded to the tight nature of state budgets, cutbacks that date back to the 2008 recession, and, in some states, the tendency for the legislature to cut Medicaid

spending to accommodate budget shortfalls. One Texas respondent explained that the overall price tag for funding the increase was too high given competing priorities for the state legislature:

The general revenue estimate cost for primary care was about \$460 million. Well, for all providers, not just primary care, it was nearly \$1 billion . . . It all comes down to cost . . . The legislature isn't interested in adding more money to the [Medicaid] program, just reshuffling things around instead.

To a lesser degree, respondents acknowledged challenging political environments that were hostile to health care reform that made discussions about continuing the payment increase difficult. One respondent illustrated the problem as follows:

The Health and Appropriation Committees in both of the houses [of the state legislature] have a lot of influence. And of course they basically are the ones who [have] the authority for the state Medicaid agency to act and they influence the appropriations provided. . . . At that time, the chairs or the leaders of those committees are very . . . “not impressed” . . . about the ACA. It was very political and I think you know we're not into expansion [in our state]. So anything [related to] ACA, they were kind of resistant to. Now those leaders of the health care committees have risen up and they are now pretty much leaders of the legislature. . . . So we still have that anti-ACA mentality [in terms of] who's leading the legislature.

Additionally, one MCO respondent identified implementation issues that made the continuation of the payment increase less attractive to administrators. The respondent clarified,

From an implementation perspective, there was relief when it ended, because of the administrative burden. I mean, there was a lot of [information technology] development, hundreds of hours and resources to make this happen, both the “Band-Aid” approach and then the permanent one.

Grassroots support for the payment increase was generally strongest among provider and patient organizations, though most stakeholder groups acknowledged a kind of resignation toward the policy's discontinuation. Respondents reported that provider organizations in their states lobbied the legislatures to continue funding the payment increase; one provider even reported lobbying at several levels of government:

I had made a trip to D.C. and talked to some of our representatives from West Virginia in the U.S. Congress. We even talked to our state representatives. Of course, the state representatives really couldn't do much for it; it all came from the federal level. But, yes, and all of our state representatives were in support of it.

In contrast, other respondents reflected the sentiment of one provider representative who explained,

I think most people generally just saw it coming . . . I didn't have any members say, “I'm going to write to my Congressperson or that person.” I think it was pretty much assumed there was advocacy behind it, but you sort of know when, as Kenny Rogers said, “When to hold 'em” because there were other battles to be

dealt with and I think this was kind of doomed from the beginning because it was new. And when times are tight, it's the new programs that get cut.

In a few cases, respondents described adverse effects associated with the discontinuation of the policy. For example, in Texas, some gains in patient access may have been reversed with the discontinuation of the policy. As described by one respondent:

We did hear during the two-year period, from our primary care physicians, that many of them were using the additional moneys to increase the number of patients they will accept, that allowed them to have additional slots in their practices for Medicaid patients. Since then, as you might expect, since the rate increase was not extended by our legislature, we've heard just the reverse, which is without the higher payments and given their rising overhead costs, that they're cutting back to pre-2013/2014 levels.

Although other stakeholders reported similar anecdotes, they also cautioned that, since a large number of new providers did not join the program during the two-year period, there was limited potential for a mass exodus after the policy ended in 2014.

All states reported a desire to authorize better reimbursements for Medicaid providers and identified these reimbursements as key to ensuring adequate access and utilization for Medicaid patients. Although states reported similar reasons for electing to continue or discontinue the payment bump, the greatest facilitator to continuation was the ability to identify novel sources of state funding for the increased rate. Furthermore, although all states identified challenges with implementation to greater or lesser degrees, none of our respondents suggested that implementation challenges were the most important contributing factor to the state's decision to discontinue the policy.

3. Stakeholder-Identified Strategies to Improve Implementation

Respondents offered several suggestions for ways to improve the implementation of similar policies in the future given their experience with the Medicaid primary care payment increase. Nearly all respondents cited the need for additional time to prepare for the policy's implementation. Clearer and more flexible eligibility requirements would have sped implementation and promoted alignment with primary care priorities in each state, while greater flexibility in the design of payment models would have built on existing value-based purchasing initiatives. Online systems for attestation or eliminating the attestation requirement altogether would have made the process smoother. Finally, expanding the duration of the payment policy beyond a two-year time frame was seen as critical to achieving a larger impact. We discuss these strategies in more detail in this chapter.

Longer Lead Time Prior to Implementation

Most respondents reported that the short period between the receipt of final CMS guidance (November 2012) and program implementation (January 2013) was too brief to allow adequate time for planning or preparations. A longer lead time would allow CMS and states to finalize eligibility criteria, develop state-level policies and processes, design and test MCO claims and payment systems, and engage in effective outreach and education campaigns with stakeholders. As one MCO respondent explained:

It was a very compressed time line . . . that was really the main issue upon implementation: how do you get the funds flowing if the providers have to attest and that information has to be shared with the plans of who attested?

The amount of lead time required to prepare for future policies will depend on the complexity of the policy or the eligibility and payment rules and may vary according to the capacity of Medicaid programs or MCOs in each state.

Clearer Program Requirements from Federal Agencies

Several state administrators and provider representatives reported that the physician eligibility criteria were difficult to understand—particularly the eligibility of advanced practice clinicians and the 60-percent billing requirement. One respondent captured the challenges associated with the latter as follows:

It was confusing to practices and us when it came to how to identify what percentage of your practice was primary care. Most physicians look at revenue generated or volume of patients, not necessarily volume of services. And so, it

was confusing. It was confusing to many physicians at the onset and then still moving forward.

Respondents suggested that these nuances were not captured in the program's final set of requirements and took time to resolve. Furthermore, these and other program requirements could have been simplified or expanded to better meet their needs and communicated to physician groups both earlier and more clearly to improve implementation of the program.

Increased Flexibility in State Program Design

Many state respondents expressed a desire for greater flexibility in designing and implementing programs in their state. Several respondents reported that the design of the primary care payment increase did not align with their primary care delivery system or evolving payment systems in their states.

Most importantly, some states have scope-of-practice laws that allow advanced practice clinicians to practice independently, and respondents said they would have appreciated being allowed to include these providers in the policy. Other states noted that the 60-percent requirement prevented some specialists from being eligible for the bump, which was not reflective of how Medicaid services were being delivered on the ground.

And [state name] has a . . . not-so-unique situation in that many of the primary care services that are being provided to patients are being provided by internal medicine specialists, so a GI [specialist] . . . may spend 40 percent of their time doing primary care because they're in the inner city and they happen to be the only one taking Medicaid in that area. So therefore, even though they're primarily a GI, they were acting as a primary care physician for many of their patients on Medicaid.

As a result, the rigidity of the policy limited its effectiveness and made it difficult for policymakers to implement. These issues were concisely summarized by one respondent, who expressed concern that the statute "didn't leave it up us to identify who these providers were. It was, 'no, these are the providers.'"

Additionally, some states noted that the payment bump was being implemented at the same time as a host of other reforms, and allowing states to execute the policy in a way that made sense for their current structures was needed. One respondent explained:

So if [the state was] already revamping their Medicaid program or expanding it, or, in this case, going from a state fee-for-service to a managed care, then allowing for some other mechanism to satisfy the policies during those transition times might in fact help. . . . We probably could have just estimated the payments to providers that were operating in the state and cut them some checks and squared it up later and we probably would have come out pretty close.

Several respondents noted that increased flexibility would have better aligned the payment bump with existing state-level reforms. Many noted that the FFS-focused policy was difficult to implement in an environment where states were shifting large portions of their Medicaid

enrollees into managed care plans or were experimenting with other payment and delivery reforms such as PCMHs. Several respondents noted that the bump should have been tied to performance metrics. One respondent noted:

Rather than just giving a unit cost increase, [a better approach would be to] give an increase for people that come in for their well-child visit, that have their immunizations, more concrete health outcome measures, quality measures. . . . We believe [such a model would] more directly lead to better health outcomes and reductions in total cost of care through inpatient and emergency care to the taxpayer.

Respondents noted that increased flexibility in implementation would allow them to enact the policy in a way that supported other ongoing efforts.

Clear, Consistent Communication with Stakeholders

The relationship between state officials and stakeholders can vary from cooperative to unengaged. While some states reported frequent communications with provider and patient groups, others limit their outreach to official announcements or notifications. States that engage in active dialogue with stakeholders may be more likely to report fewer issues with provider eligibility confusion, attestation challenges, or stakeholder dissatisfaction with payment delays. This experience suggests that engaging in clear, consistent communication can help to set and manage expectations during a policy's planning and implementation phases.

Targeted Outreach to Specific Stakeholder Groups

States reported a variety of ways that they communicate with patients and providers: listservs, provider bulletins, MMIS notices, community events, etc. Although these outlets provide states with the opportunity to engage with a broad swath of relevant stakeholders, few states were able to describe ways of approaching specific groups of stakeholders or identifying outreach strategies for individuals who are not currently participating in the program.

Although most states reported high rates of provider participation in Medicaid prior to the implementation of the primary care payment increase, some respondents felt that participation was stagnant or could otherwise improve. By performing targeted outreach to previously or minimally participating providers, or developing strategies for engaging with stakeholders who do not currently receive communications from the state, Medicaid officials might be able to expand program participation and further the goals of similar, future policies. States might benefit from federal guidance about designing these campaigns or support to build the infrastructure to engage in this work.

Electronic Submission and Tracking of Attestations

Providers, Medicaid officials, and MCO representatives all commented on the burden associated with issuing, collecting, inputting, and tracking paper-based data systems. Several respondents suggested that the development of an electronic attestation tool would alleviate workloads, create automatic datasets that require minimal upkeep, and simplify the tracking and monitoring process. In addition to reducing administrative burden on behalf of the state, a simpler attestation process would relieve participant burden and reduce barriers associated with more complicated attestation procedures. For example, some stakeholders felt that the attestation process could have been avoided altogether by linking eligibility for enhanced payments to procedure codes, without regard to a provider's specialty.

Avoiding Claims Reprocessing

Both state administrators and MCO officials reported that the short planning and preparation period required them to implement the primary care payment increase before their systems had been designed or tested. As a result, payments were made retroactively, which required the reprocessing of individual claims. Relatedly, the attestation audits often resulted in additional processing of settled claims and required the state to attempt to recoup paid monies from ineligible providers. Respondents suggested that designing policies and time lines that allow for the proper sequencing of eligibility determinations and payments would avoid many of these issues and, as a result, substantially minimize the burden on stakeholders.

Longer Duration of Payment Increase

Respondents reported that they make strategic decisions about business practices on a much longer time scale than the duration of the Medicaid primary care payment increase. The two-year time horizon of the policy provided few incentives for either Medicaid administrators or health care providers to invest in the kinds of infrastructure improvements or staff expansions required to fully meet the policy's intended goal of increasing provider participation in the Medicaid program and improving patient access and utilization. By increasing the duration of the policy, respondents speculated that participation rates would improve and would enable primary care providers to fold the payment increase into long-term planning and business practices.

4. Conclusions

The challenges associated with implementing the Medicaid primary care payment increase of 2013–2014 offer several valuable lessons about the ways in which eligibility rules, time lines, and the duration of such a policy might contribute to its effectiveness. While implementation of the policy was widely viewed as “bumpy,” both states and MCOs succeeded in delivering enhanced payments to eligible Medicaid providers. However, stakeholders felt that a few key aspects of the policy’s design contributed to its limited impact and should be addressed in future policies.

The policy’s short planning time line limited the amount of time states and key stakeholders had to determine eligibility, develop attestation systems, and adapt or create new payment systems. The challenging timeline had cascading effects that slowed the collection and processing of provider attestations and the initiation of payments, and led to a lengthy period of claims reprocessing in many states. These delays and the added administrative burden caused by systems that were developed hastily to expedite the delivery of the enhanced payments frustrated several stakeholder groups—particularly physicians.

On the other hand, stakeholders worked together effectively to disseminate information about the policy and to keep stakeholders informed as eligibility questions were clarified in early 2013. In addition, some states were able to develop electronic attestation processes and, in a few states, conduct systems tests with their MCOs prior to launching the new payment systems that may have avoided future implementation problems.

Stakeholders were unanimous in their view that a temporary payment increase lasting two years was not sufficient to encourage providers to make the staff and other infrastructure investments necessary to either join or expand a physician’s level of participation in the Medicaid program. Rather, a sustained commitment to higher reimbursements for primary care services, coupled with lighter administrative requirements, could help overcome some physicians’ historical ambivalence toward participating in the Medicaid program. Stakeholders in some states reported that physician participation in the Medicaid program was already high, and no efforts were made to engage nonparticipating physicians, which might also have blunted the potential impact of the policy.

Stakeholders across the nine case study states identified the need for adequate planning and preparation, clearer guidance from rulemaking authorities, and greater state flexibility in policy design. Physicians and MCOs expressed a desire to provide input into the design of such policies prior to their implementation and to offer feedback on potential implementation issues—including ambiguities in the policy’s requirements, the relative burden or cost of alternative design options, and other unanticipated “pain points” that may lower participation or lead to payment delays. Most critically, however, better targeting of the policy to the primary care delivery systems in each state and a longer duration of enhanced payments were both thought to be critical in encouraging greater levels of physician participation in the Medicaid program.

Appendix A: Methods

A multistate, multistakeholder qualitative case study design was selected to provide a broad perspective of state experiences. A total of 43 semistructured telephone discussions were held with 89 respondents, then transcribed and analyzed to identify key themes and lessons learned.

Research Goals

To better understand barriers and facilitators to effective implementation of the payment increase in each state and the subsequent effects on patients and providers, we identified five topic areas to explore in our discussions:

- **preimplementation context**, including historical levels of provider participation in Medicaid, factors affecting provider participation, and other delivery or payment reforms occurring prior to or concurrent with the payment increase
- **policy implementation preparation activities**, including stakeholder engagement activities and involvement in the design of the policy, contracting requirements or revisions, and payment design efforts
- **implementation processes**, including attestation design and implementation, payment disbursement methodology and time lines, and reporting and auditing activities
- **evaluation activities**, including formal or informal assessments of the effect of the payment increase on provider participation in Medicaid, patient access and utilization, and relationships between the state and providers
- **postpolicy environment**, including the factors that contributed to a state's decision to continue or discontinue the payment increase without full federal funding.

By tracing the development of the policy from its planning phase through completion, these topics were selected to develop a detailed picture of the implementation context and experience in case study states.

Case Study State Selection

We examined a range of factors to inform the selection of case study states (Table A.1). First, we considered the magnitude of the payment increase in each state. Physicians stood to benefit to varying degrees from the payment bump, depending on the Medicaid payment rates in their state in 2009. We paired this information with preliminary estimates of the impact of the policy based

on analyses conducted by RAND as part of a separate project.⁵ Doing so allowed us to identify states in which the observed impact deviated from our expectations, which might suggest highly successful or highly problematic implementation experiences that might be particularly suitable candidates for case study.

Two other characteristics were also hypothesized to be either predictive factors or markers of positive implementation experiences. First, Medicaid expansion might be associated with a strong, state-level commitment to the successful rollout of the policy and might also provide a strong incentive for physicians to join the program. Second, a state’s decision to continue the primary care payment increase after the conclusion of full federal funding might signify that the policy was successful in the state.

Finally, states whose payment increase experience was explored in prior case study reports were excluded from consideration in this study to reduce the likelihood of low participation from second-round discussants and to expand the collective breadth of knowledge about this topic.

Table A.1. Case Study States: Key Characteristics

Key Characteristic	Definition and Rationale
Observed impact of the payment policy	Estimated impact of the policy on physician participation and patient access to care as measured by (1) the proportion of providers within a state that provide services to five or more Medicaid patients and (2) the number of visits by “existing” Medicaid patients per primary care physician per state.
Magnitude of the payment increase under the policy	Estimated percentage increase in primary care physician fees following implementation of the policy in each state (high, moderate, or low). We hypothesized that primary care physicians in states that experienced a larger increase in payments would increase their level of participation in the Medicaid program more than physicians in states that experienced a smaller or no increase in payments.
Medicaid expansion status	Whether a state elected to expand Medicaid to individuals with incomes up to 138 percent of the federal poverty level as of January 1, 2014. We hypothesized that primary care providers in states that expanded Medicaid on or before January 1, 2014, would be more likely to increase their participation in Medicaid—especially providers who served a large percentage of uninsured patients prior to the expansion.
Decision whether to continue the policy after 2014	Whether a state elected to continue the policy after the conclusion of full federal funding on December 31, 2014 (based on publicly available reports as of June 2016). ^a We expect that states’ decisions to continue the policy would be influenced by a variety of factors involved with the ease of implementation and/or state officials’ perceptions of the policy’s impact. Including states that both did and did not continue the policy would also help us better understand states’ decisionmaking around this issue.
Inclusion in prior case study reports	A state’s inclusion in prior case study reports that examined the primary care payment increase. States that were included in prior reports were excluded from consideration.

^a Medicaid and CHIP Payment and Access Commission, 2015.

We used three additional criteria to ensure variation across case study states in factors potentially associated with success and to ensure a diverse sample (Table A.2). First, RAND’s

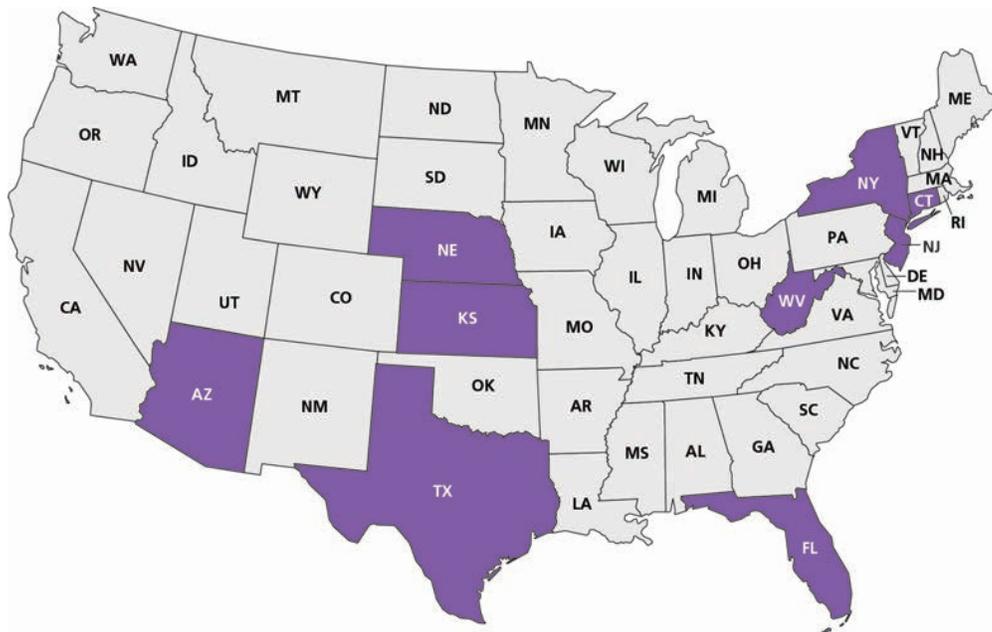
⁵ We thank Andrew Mulcahy and his team for sharing their work on the impacts of the Medicaid primary care payment increase.

prior quantitative analyses suggested two characteristics of states associated with positive impacts of the policy: a state’s Medicaid managed care penetration rate and the use of a fee schedule adjustment (as opposed to lump-sum payments) to implement the payment increase. Second, we sought to include a diverse sample of states by selecting states from each of four U.S. Census regions to the extent possible. The nine states selected for case study are displayed in Figure A.1.

Table A.2. Case Study State Selection: Supplemental Characteristics

Supplemental Characteristic	Definition
Medicaid managed care penetration in the state	Percentage of managed care enrollees participating in the Medicaid program
Payment methodology used to implement the payment increase	Payment methodology used to implement the payment increase (i.e., lump sum vs. fee schedule adjustment)
Geographic region	Geography based on Census region

Figure A.1. Map of Case Study States



RAND RR1802-1

NOTE: Case study states include Arizona, Connecticut, Florida, Kansas, Nebraska, New Jersey, New York, Texas, and West Virginia.

The selected states exhibit variation across each of the key characteristics (Table A.3). The list includes states whose observed impact matched our expectations (Connecticut, New York, and West Virginia), states that had a higher-than-expected impact (Kansas), and states that had a lower-than-expected impact (Arizona, Florida, Nebraska, New Jersey, and Texas). Two of the nine states—Connecticut and Nebraska—continued the payment bump even though, according to RAND’s prior analyses, the policy had minimal effects in Nebraska. The list includes five expansion states (Arizona, Connecticut, New Jersey, New York, and West Virginia) and four nonexpansion states (Florida, Kansas, Nebraska, and Texas). While the selected states vary in the level of Medicaid managed care penetration, all but one implemented the policy within its FFS program using a fee-schedule adjustment: only Texas used a quarterly lump-sum payment methodology.

Table A.3. Characteristics of Nine Case Study States

State	Magnitude of the Payment Increase			Observed Impact			Continuing Payment Bump		Expansion State		MCO Penetration Rate	FFS Fee-Bump Payment Method	Region
	Large	Moderate	Small	Yes	Unclear	No	Yes	No	Yes	No			
Arizona		X				X		X	X		84.4	Adj FS	West
Connecticut		X		X			X		X		0	Adj FS	Northeast
Florida	X					X		X		X	62.8	Adj FS	South
Kansas			X	X				X		X	82.5	Adj FS	Midwest
Nebraska		X				X	X			X	75.7	Adj FS	Midwest
New Jersey	X					X		X	X		87.9	Adj FS	Northeast
New York	X			X				X	X		75.5	Adj FS	Northeast
Texas	X				X			X		X	77.3	Lump-Q	South
West Virginia		X		X				X	X		52.8	Adj FS	South

NOTE: Adj FS = fee schedule adjustment; Lump-Q = quarterly lump-sum payment.

Key Informant Selection

We identified five stakeholder groups that would be most likely to provide detailed information about the implementation and impact of the payment increase in each state. The rationale for selecting each of the five different stakeholder groups is described in Table A.4.

The identification of specific respondents was informed by a combination of online searches for an organization’s policy or advocacy leadership and referral from other respondents. Each respondent was vetted against the research goals and the likelihood of their ability to contribute substantive information on the discussion topics. Contact and background information for all respondents was captured in a secure online database and utilized during project recruitment, which occurred between July and October 2016.

Table A.4. Stakeholder Group and Rationale for Inclusion in the Study

Stakeholder Group	Rationale
State Medicaid lead responsible for payment policies	<ul style="list-style-type: none"> • Familiarity with state Medicaid payment systems • Contributed to state decisionmaking regarding payment policy design, implementation, and extension or termination • Knowledgeable about state Medicaid participant access and utilization
State Medicaid lead responsible for MCO contracting	<ul style="list-style-type: none"> • Managed changes to MCO contracts required by payment policy implementation • Familiarity with payment flows among state, MCOs, and providers • Familiarity with reporting requirements
MCO representative	<ul style="list-style-type: none"> • Technical expertise or experience with the translation of state policy into the development and implementation of payment systems and delivery
Provider organization representative	<ul style="list-style-type: none"> • Experience with state stakeholder communication or outreach activities, attestation processes, and payment delays/challenges • Perspective on the effects of the policy on patient access to care or utilization of services
Patient organization representative	<ul style="list-style-type: none"> • Experience with state stakeholder communication or outreach activities • Perspective on the effects of the policy on patient access to care or utilization of services

Instrument Development

Following the clarification of the research goals and selection of stakeholder types, the study team met to develop the discussion protocols. A separate discussion protocol was developed for each stakeholder type to clearly probe on key issues and explore technical details specific to each stakeholder's experience of the Medicaid primary care payment increase policy implementation. Each protocol included priority questions, guiding probes, and follow-up questions that were reviewed by all members of the study team and finalized by consensus.

After the final draft of the discussion protocols were complete, each protocol was checked against the research goals and the other protocols to ensure that topics essential to the project were appropriately framed and stated. Additionally, the instruments were shared with ASPE for content and policy review before being finalized. All study team members responsible for conducting discussions or serving as a note-taker participated in a protocol training meeting to discuss consent procedures, content and organization of the protocols, qualitative research standards and decorum, and recording and note-taking processes. The protocols were then simplified and converted into Topic Guides that were circulated to respondents during the recruitment process and are included in Appendix B.

Data Collection

All case study discussions were conducted between July and November 2016. Respondents were invited to participate in a one-hour telephone discussion at a time mutually convenient for the respondent and study team. Brief calls (less than 20 minutes) occurred when the respondent was familiar with some aspect of stakeholder experience or Medicaid policy but was largely unfamiliar with the Medicaid primary care payment increase and therefore unable to respond to specific questions about its implementation or effects. Longer calls (more than 60 minutes) were almost always associated with Medicaid administrator discussions, during which the details of the policy were discussed at length.

The majority of discussions were conducted with either a single respondent (19 of the 43 discussions) or two respondents (14 of the 43 discussions). Ten discussions included three or more respondents, often representing a team that worked together to implement the policy. Notably, Medicaid officials in several states preferred to combine the Medicaid payment lead and MCO contracting lead discussions into a single call, resulting in both a large number of respondents and a longer meeting. The numbers of discussions and respondents by stakeholder type are outlined in Table A.5.

Table A.5. Number of Discussions and Respondents by State and Stakeholder Type

State	Number of Discussions	Number of Respondents				
		State Medicaid Agency ^a	MCOs	Providers	Patients	TOTAL
Arizona	4	7	1	3	0	11
Connecticut	4	4	0	2	2	8
Florida	5	2	6	1	2	11
Kansas	5	2	4	1	2	9
Nebraska	6	5	2	1	2	10
New Jersey	4	5	1	4	1	11
New York	5	3	5	1	2	11
Texas	5	4	1	4	1	10
West Virginia	5	3	2	1	2	8
TOTAL	43	35	22	18	14	89

^a State Medicaid respondents include both the state Medicaid lead responsible for payment policies and the state Medicaid lead responsible for MCO contracting.

A minimum of one respondent provided information for each stakeholder type per state with two exceptions:

- The state of Connecticut ended their managed care program in 2012 and operates an ASO model. As a result, no MCO-related discussions were pursued in this state.
- All patient advocacy organizations contacted in Arizona declined to participate in the study. As a result, no discussion was held with patient representatives in this state.

Each discussion was audio-recorded and professionally transcribed. Additionally, a note-taker attended each call to provide the study team with notes immediately following each meeting.

Analysis and Reporting

Analysis and reporting of the discussion data consisted of five phases:

1. informal weekly team debriefings
2. development and refinement of data abstraction template
3. data abstraction
4. thematic analysis
5. consensus and reporting.

Weekly Debriefings

At the beginning of each week, a research assistant collected all of the notes and transcripts from the previous week. The transcripts were set aside for abstraction (see next section); the notes

were reviewed each week by the study team to help gauge data collection progress, assess the effectiveness of the discussion protocols, and identify emerging themes in preparation for data analysis. These weekly debriefings enabled the team to identify probing strategies for new issues or topic trends and to adjust the content or structure of the data abstraction template as necessary. Summative information from the debriefings helped shape the team’s understanding of the policy as data collection proceeded and contributed to the design and organization of this report.

Data Abstraction Template

Using the discussion protocols as a guide, the study team developed a standardized abstraction template to help facilitate the identification of key themes and compare responses from states and stakeholders. The template was organized by state, stakeholder type, research topic, and discussion protocol topic, with dynamic columns to filter text. After an initial template was designed, the team consulted on the content and finalized the template via consensus. The abstraction template was piloted with a test transcript to identify opportunities for design improvements, then revised and finalized.

As new information or topics emerged in the weekly debriefings, the abstraction template was revised to reflect the changing shape of the project content; it is notable that few changes were made. A model of the abstraction template is displayed in Table A.6.

The data abstraction template was posted to an internal, cloud-based central desktop to facilitate simultaneous editing, abstraction review, and analysis. All team members were provided with access to this secure desktop.

Table A.6. Model Data Abstraction Template

State	Stakeholder	Preimplementation Context			
		Primary Care Provider Participation	Primary Care Provider Participation Key Factors	Reforms Prepolicy	Reforms During Policy
Arizona	Medicaid payment lead				
Connecticut	MCO representative				
Kansas	Provider representative				

Data Abstraction

After initial discussions were completed, the team initiated a rolling data abstraction process. Three coders were selected to perform the abstractions and underwent training that included an introduction to the policy, the project's research goals, each discussion protocol, the content and layout of the abstraction template, and the abstraction procedures. Each coder was then allocated a proportion of transcripts and abstracted the relevant text into the appropriate cell in the abstraction template. After the initial abstractions were complete, abstractions were assigned and completed on a rolling basis as new transcripts were delivered, resulting in a dynamic and evolving abstraction template for the duration of data collection.

Thematic Analysis

Thematic analyses are designed to examine patterns or themes within qualitative data. To maximize theme capture, the team conducted a two-block parallel review of the abstracted data. One block was tasked with reviewing the text associated with the implementation and evaluation research topics, while the other block was tasked with reviewing the text associated with the preimplementation, policy preparation, and postpolicy research topics. Study team members in both blocks were instructed to independently review the text to identify key findings, consistent themes, and conflict within or between states or stakeholders. Each block then met to discuss findings and resolve interpretation differences.

Consensus and Reporting

A final analysis workshop was held with study team members from both blocks in attendance. Frequent or dominant themes, discrepancies and disagreements between responders, and relevant examples or quotations were identified and discussed. The team collectively drafted a summary of results and resolved interpretation differences by consensus. The result summary was then used to create the outline and initial draft of this report.

Appendix B: Discussion Protocol Topic Guides

Discussion Topics: Medicaid Primary Care Payment Increase—Medicaid Payment Increase Policy Lead

Thank you for agreeing to participate in a one-hour interview to discuss your views on the Medicaid Primary Care Payment Increase. The discussion will explore a broad range of topics, including the design of the policy in your state, implementation challenges and strategies, impacts on beneficiary access, and related issues. ASPE will use the results to help shape future policy initiatives and streamline their implementation. A summary of discussion topics follows:

- **Payment Increase: Preimplementation Context**
 - primary care providers’ participation in Medicaid program
 - key factors affecting primary care providers’ decisions to participate in Medicaid
 - other unique delivery or payment reforms occurring before or during the payment bump time frame.
- **Policy Implementation Preparation Activities**
 - communication with providers and MCO
 - communication with or involvement of patient advocacy organizations.
- **Implementation Process**
 - challenges around filing the State Plan Amendment or making retroactive payments
 - experiences with the attestation process as well as provider participation and experience with this process
 - challenges identifying physicians, nurse practitioners, and physician assistants to participate.
- **Implementation Time Line and Other Challenges**
 - implementation process differences between FFS and MCOs
 - implementation challenges finalizing MCO contracts and how the MCOs reflected the payment increase
 - implementation support mechanisms
 - payment increase duration.

- **Evaluation Activities**
 - Completed, current, or planned evaluation activities
 - Measuring changes in access to care, physician participation, and the efficacy of the policy
 - Effectiveness of the policy.
- **Postpolicy: Decisions to Continue or Discontinue the Payment Increase**
 - Issues surrounding the decision to continue with the payment increase
 - Effects of the postpolicy decision on patients and providers.

Discussion Topics: Medicaid Primary Care Payment Increase—Medicaid Managed Care Organization Contracting Lead

Thank you for agreeing to participate in a one-hour interview to discuss your views on the Medicaid Primary Care Payment Increase. The discussion will explore a broad range of topics, including the design of the policy in your state, implementation challenges and strategies, impacts on beneficiary access, and related issues. ASPE will use the results to help shape future policy initiatives and streamline their implementation. A summary of discussion topics follows:

- **Payment Increase: Preimplementation Context**
 - primary care providers’ participation in Medicaid program
 - payment trends or changes
 - other unique delivery or payment reforms occurring before or during the payment bump time frame.
- **Policy Implementation Preparation Activities**
 - communication and coordination activities with MCOs.
- **Implementation Process**
 - MCO involvement with policy implementation decisions
 - payment methods and strategies
 - payment challenges
 - contracting process, successes, and challenges
 - attestation process and provider participation and experience.
- **Evaluation Activities**
 - completed, current, or planned evaluation activities
 - effectiveness of the policy.
- **Postpolicy: Decisions to Continue or Discontinue the Payment Increase**
 - issues surrounding the decision to continue with the payment increase
 - MCO perceptions of the policy
 - effects of the postpolicy decision on MCOs, patients, and providers.

Discussion Topics: Medicaid Primary Care Payment Increase—Managed Care Organization Representative

Thank you for agreeing to participate in a one-hour interview to discuss your views on the Medicaid Primary Care Payment Increase. The discussion will explore a broad range of topics, including the design of the policy in your state, implementation challenges and strategies, impacts on beneficiary access, and related issues. ASPE will use the results to help shape future policy initiatives and streamline their implementation. A summary of discussion topics follows:

- **Payment Increase: Preimplementation Context**
 - primary care payment trends or changes
 - other unique delivery or payment reforms occurring before or during the payment bump time frame.
- **Policy Implementation Preparation Activities**
 - state communication with providers, MCOs, and patient advocates
 - state-MCO coordination and contracting preparations.
- **Implementation Process**
 - MCO involvement with policy implementation decisions
 - issues surrounding selection of payment method
 - contracting process, successes, and challenges
 - attestation process and provider participation and experience
 - key implementation successes and challenges.
- **Evaluation Activities**
 - completed, current, or planned evaluation activities
 - effectiveness of the policy.
- **Postpolicy: Decisions to Continue or Discontinue the Payment Increase**
 - MCO engagement with the state’s decision on whether to continue the policy
 - MCO perceptions of the policy
 - effects of the postpolicy decision on MCOs, patients, and providers.

Discussion Topics: Medicaid Primary Care Payment Increase—Provider Representative

Thank you for agreeing to participate in a one-hour interview to discuss your views on the Medicaid Primary Care Payment Increase. The discussion will explore a broad range of topics, including the design of the policy in your state, implementation challenges and strategies, impacts on beneficiary access, and related issues. ASPE will use the results to help shape future policy initiatives and streamline their implementation. A summary of discussion topics follows:

- **Payment Increase: Preimplementation Context**
 - primary care providers’ participation in Medicaid program
 - key factors affecting primary care providers’ decisions to participate in Medicaid
 - other unique delivery or payment reforms occurring before or during the payment bump time frame.
- **Policy Implementation Preparation Activities**
 - state communication with and outreach to providers
 - provider engagement with decisions regarding covered services, delivery sites, and geographic adjustment approaches
 - provider views about the design of the policy.
- **Implementation Process**
 - attestation process and provider participation and experience
 - payment decision coordination and application
 - payment challenges and successes.
- **Evaluation Activities**
 - completed, current, or planned evaluation activities
 - measuring changes in access to care, physician participation, and the efficacy of the policy
 - effect of the policy on the dynamic between physician groups and the state.
- **Postpolicy: Decisions to Continue or Discontinue the Payment Increase**
 - decision to continue with the policy or not
 - factors that affected the state’s decision to continue the policy
 - effects of the postpolicy decision on patients and providers.

Discussion Topics: Medicare Primary Care Payment Increase—Patient Representative

Thank you for agreeing to participate in a one-hour interview to discuss your views on the Medicaid Primary Care Payment Increase. The discussion will explore a broad range of topics, including the design of the policy in your state, implementation challenges and strategies, impacts on beneficiary access, and related issues. ASPE will use the results to help shape future policy initiatives and streamline their implementation. A summary of discussion topics follows:

- **Payment Increase: Preimplementation Context**
 - activities relating to Medicaid advocacy
 - Medicaid patient access to services.
- **Policy Implementation Preparation Activities**
 - state communication with and outreach to patients and patient advocacy organizations
 - patient and patient advocate views about the design of the policy.
- **Implementation Process**
 - outreach and education activities to patients and providers
 - effectiveness of outreach and education strategies.
- **Evaluation Activities**
 - completed, current, or planned evaluation activities
 - measuring changes in access to care and the efficacy of the policy
 - effect of the policy on the dynamic between physician groups and the state.
- **Postpolicy: Decisions to Continue or Discontinue the Payment Increase**
 - decision to continue with the policy or not
 - factors that affected the state’s decision to continue the policy
 - effects of the postpolicy decision on patients and providers.

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