Enhancement of Primary Care Access for Medical Assistance Clients

Engrossed Substitute Senate Bill 6032, Section 213(eee); Chapter 299; Laws of 2018

December 1, 2018

Enhancement of Primary Care Access for Medical Assistance Clients

Washington State Health Care Authority

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Executive Summary

ESSB 6032 tasked the Health Care Authority (HCA) with coordinating a study and subsequent report to the Legislature regarding the identification of strategies and recommendations for enhancing access to primary care for medical assistance clients. Specifically, the legislation states:

> "(eee) $50,000 of the general fund—state appropriation for fiscal year 2018 and $100,000 of the general fund—state appropriation for fiscal year 2019 are provided solely for the authority to conduct a study to identify strategies for enhancing access to primary care for medical assistance clients. The authority may collaborate with other stakeholders as appropriate. The authority shall provide a report with recommendations to the appropriate committees of the legislature by December 1, 2018. The study shall, to the extent possible:
>
> (i) Review the effect of the temporary rate increase provided as part of the patient protection and affordable care act on:
>
> (A) The number of providers serving medical assistance clients;
>
> (B) The number of medical assistance clients receiving services; and
>
> (C) Utilization of primary care services.
>
> (ii) Identify client barriers to accessing primary care services;
>
> (iii) Identify provider barriers to accepting medical assistance clients;
>
> (iv) Identify strategies for incentivizing providers to accept more medical assistance clients;
>
> (v) Prioritize areas for investment that are likely to have the most impact on increasing access to care; and
>
> (vi) Strategically review the current medicaid rates and identify specific areas and amounts that may promote access to care."

Access to care is a multi-pronged concept that is impacted by several factors: member utilization, provider engagement and participation in Washington Apple Health (Medicaid), health care network adequacy and quality improvement activities. This report emphasizes the importance of member access and experience.

The study describes the impact of one-time rate increases between 2013 and 2014 for primary care practitioners and the impact on utilization. The report describes provider and client barriers to primary care access. The report also highlights the Managed Care Organizations (MCOs) and the Healthier Washington Medicaid Transformation team activities to enhance access by redesigning and implementing team-based care structures that will target the right care, for the right patient, by the right provider. The report will also describe opportunities to advance primary care access by providing incentives for care delivery redesign through value-based payment incentives.

The Affordable Care Act (ACA) mandatory two-year increase (2013-2014) in fees for primary care services raised Medicaid reimbursement to the same rate as Medicare reimbursement. After that period, Washington State's Medicaid reimbursement returned to pre-ACA levels. The one-time nature of the fee bump had limited impact on provider access and participation in Washington

State, reflecting the findings of a July 2018 Health Affairs study using nationwide data. The temporary nature of Medicaid one-time fee bump resulted in limited improvements in provider participation (Decker & Lipton, 2017).

A 2014 University of Washington (UW) Center for Health Workforce Studies report titled *The Impact of Medicaid Primary Care Payment Increase in Washington State* also found that the one-time 2013-2014 fee increase would not impact decisions to accept or continue care for Apple Health patients for a majority of primary care physicians (PCPs) and large health care organizations. The lack of sustainable funding did not create enough incentive for some providers to participate. Most of these providers noted that continuing higher reimbursement rates or other strategies, such as streamlining payment and improving access to specialty care and referrals, may encourage them to continue seeing or accepting new Medicaid patients (Patterson, Andrilla, Skillman, & Hanscom, 2014).

As of July 2016, 19 states fully or partially continued the primary care fee bump through 2016 for fee-for-service Medicaid (Milbank Memorial Fund, 2018).

The 2017 Washington State Health Care Authority External Quality Review Organization (EQRO) technical report (Qualis Health, 2018) reports on the Healthcare Effectiveness and Data Information Set (HEDIS) and Consumer Access to Health Plans Survey (CAHPS) quality measures and findings. Performance on 2017 HEDIS adult access to care measure results are at the 40th percent of MCO performance nationwide and 2017 CAHPS measure results for "Getting Needed Care and Getting Needed Care Quickly" are at the 20th percent of MCO performance nationwide. This reflects low and declining rates of access for adults. HCA's Medicaid Program Operations and Integrity team works closely with MCO's to improve performance on access to care (Qualis Health, 2018).

Providers report that rates are a critical barrier to participation and access to care. Other provider barriers include administrative burdens in claims payment and clinical criteria or processes, and the complexity and time required to manage Apple Health clients (Ubel, 2013; Long, 2013).

Member barriers to primary care access include accessible and convenient office hours and appointment times, lack of resources (transportation, translation, day care), lack of understanding of care and office processes, challenges in getting time off work, perceptions of value for member time and gaps in understanding primary care provider role and relationship (Qualis Health, 2018).

Medicaid Transformation promises to lower access barriers and support expansion of accessible, timely services through value-based payment, integrated physical and behavioral health, and expanding the use of primary care teams.

Specific recommendations are included in the Recommendations Section of this report.

Overview

> "Primary care is the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. It is the means by which the two main goals of a health services system, optimization and equity of health status, are approached."
>
> ~Johns Hopkins, Bloomberg School of Public Health, Primary Care Policy Center (2018)

Primary care professionals are often people's first point of contact with the health care system. Adults with a primary care provider have 19 percent lower odds of dying compared with those who see only specialists. Because these practitioners offer preventive services and treat minor health problems before they become serious, adults with a PCP also have 33 percent lower health care costs (Freundlich, 2013).

The Apple Health Managed Care contract (Section 1.146) defines a primary care provider as:

> "…a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCP's include, but are not limited to pediatricians, family practitioners, general practitioners, internists, naturopathic physicians, medical residents (under the supervision of a teaching physician), physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNP) as designated by the contractor…"

The ACA included a mandatory two-year increase in fees for primary care services in 2013 and 2014 that raised Medicaid reimbursement rates to the same rate as Medicare reimbursement. After that two-year period, Washington State's Medicaid reimbursement rates returned to their pre-ACA levels.

Primary Care Access

> Primary care access is the foundation for "patient-centered, coordinated, high quality care. Improving access is about getting the supply of primary care services to match the demand for services."
>
> *~A 2020 vision of patient-centered primary care (Davis, Schoenbaum, & Audet, 2005)*

Access to care is a multi-pronged concept. Federal rule requires that Apple Health measure access from provider, member, and administrative perspectives. Adequate access depends on many factors, including availability of appointments, ability to see a specialist and primary care

practitioner, adequacy of the health care network, and availability of transportation and translation services. Member perception of the availability and accessibility of timely services is perhaps the most critical aspect of access (Qualis Health, 2018).

Access is impacted by several factors, including:

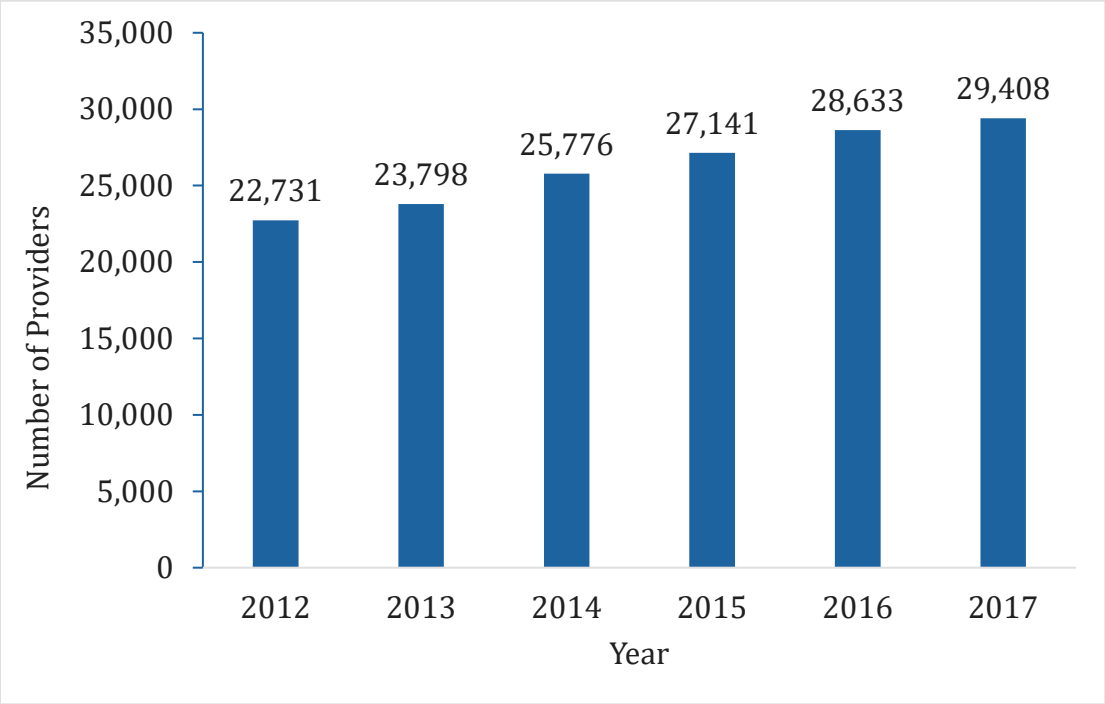
- Use of primary care services by members: This perspective considers how many members receive primary care and what services they receive. It includes the number of members receiving primary care services and the number of providers available to deliver those services in a geographic area. This measure does not reflect potential gaps in capacity and access or demand for care by members who did not receive care due to access limitations during the measurement period.
- Provider engagement and participation in Apple Health: Provider participation impact on access must go beyond simply counting the number of available providers. It is essential to consider how provider payment rates impact a practice or clinic's availability of, and timely access to, primary care appointments and services. These factors include Apple Health "open" or "closed" panel status[1] and the proportion of Apple Health members included in a provider's panel. These factors have significant "real time" impacts on timeliness and availability of appointments for members.
- Quality improvement: Apple Health measures an MCO's performance on access to care as part of quality improvement activities. The 2017 Washington State Health Care Authority EQRO technical report (Qualis Health, 2018) reports on the HEDIS and CAHPS quality measures and findings. National Committee for Quality Assurance's (NCQA) HEDIS and CAHPS performance data measures a member's satisfaction with getting needed care — and getting care quickly. The performance measures also include member satisfaction regarding their access to — or use of —primary care services that follow clinically appropriate standards.
- Overall network adequacy assessment and standards: Apple Health outlines the ability of each MCO's network to provide coverage and availability of five critical provider types (adult and pediatric PCPs, obstetricians, hospitals, mental health, and pharmacies), as well as proximity of the providers to the potential enrollee. The MCO's network adequacy reporting is used to determine an MCO's eligibility for enrollments and/or assignments based on the percentage of coverage for the five critical provider types in each service area.

The following tables show how access to primary care for Apple Health clients has changed in recent years. They include data from 2012 (before passage of the ACA), 2013 and 2014 (the years that the Medicaid reimbursement rate increased), and 2015 to 2017 (when the reimbursement rates fell to pre-ACA levels).

[1] "Open" panel indicates a provider is accepting new Medicaid patients. "Closed panel" indicates a provider is not accepting new Medicaid patients.

Measuring access by examining primary care service utilization provides one way to measure access. Table 1 illustrates the steady rise, 30 percent, in the absolute number of individual providers performing primary care services from 2012 to 2017.

Table 1: Apple Health Providers Offering Primary Care Services (2012–2017)

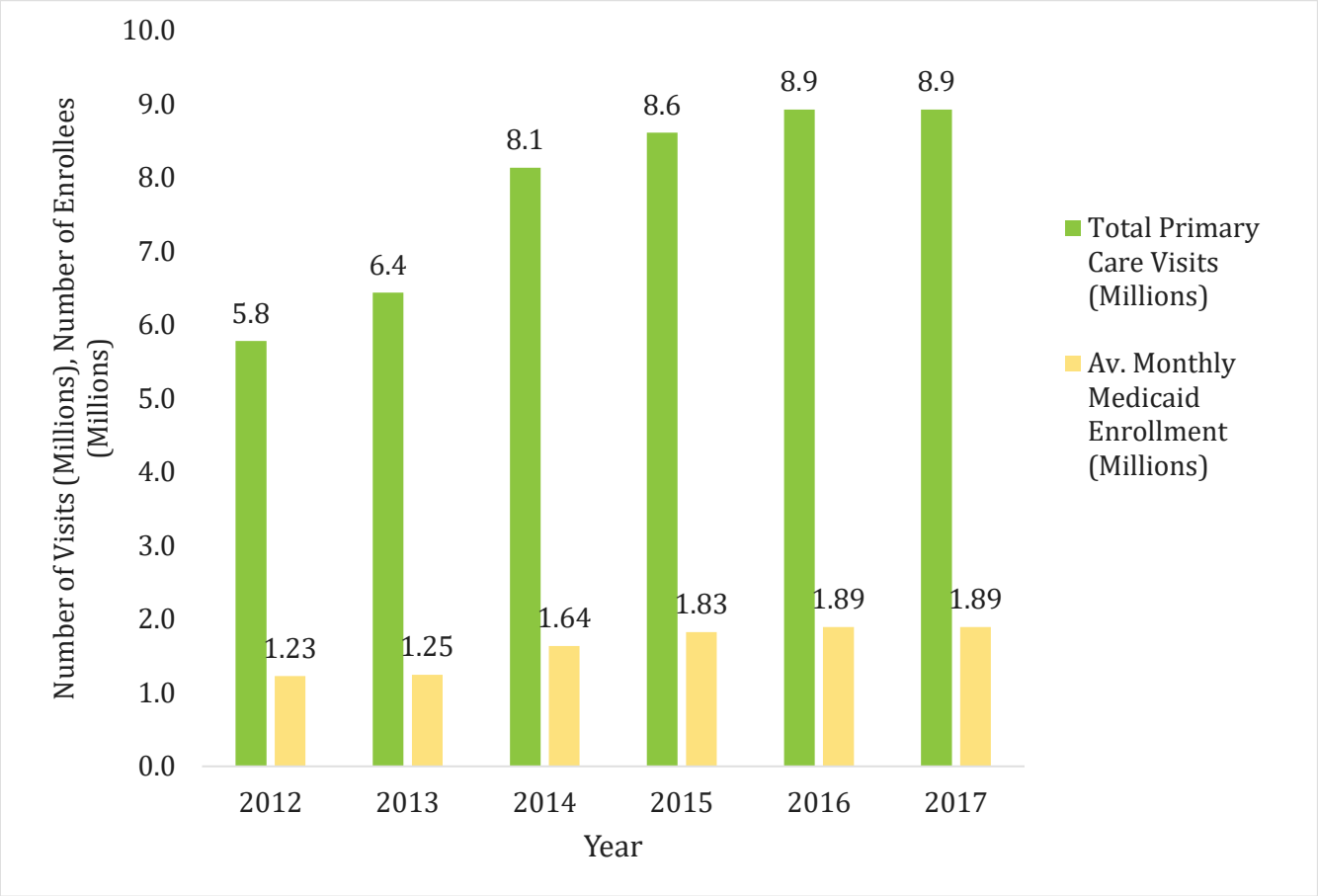


Data Source: Administrative claims only; Health Care Authority, HCA Office of Medicaid Systems and Data, and ProviderOne (P1) system, as extracted by HCA May 18, 2018.

- Paid claims and encounters. Professional, early, and periodic screening; diagnosis and treatment program (EPSDT) services, including emergency medicine (EM), vaccinations (<19 years old), alcohol and substance use disorder (SUD) screenings, and servicing provider National Provider Identifier, when available.

While the number of providers offering primary care services increased by 30 percent during this six-year period, that increase was outpaced by Apple Health enrollment, which grew by nearly 50 percent. Despite the higher number of providers, timely access to primary care may have been effected. Table 2 illustrates the growing demand for, and use of, primary care.

Table 2: Primary Care Visits and Apple Health Enrollment (2012–2017)

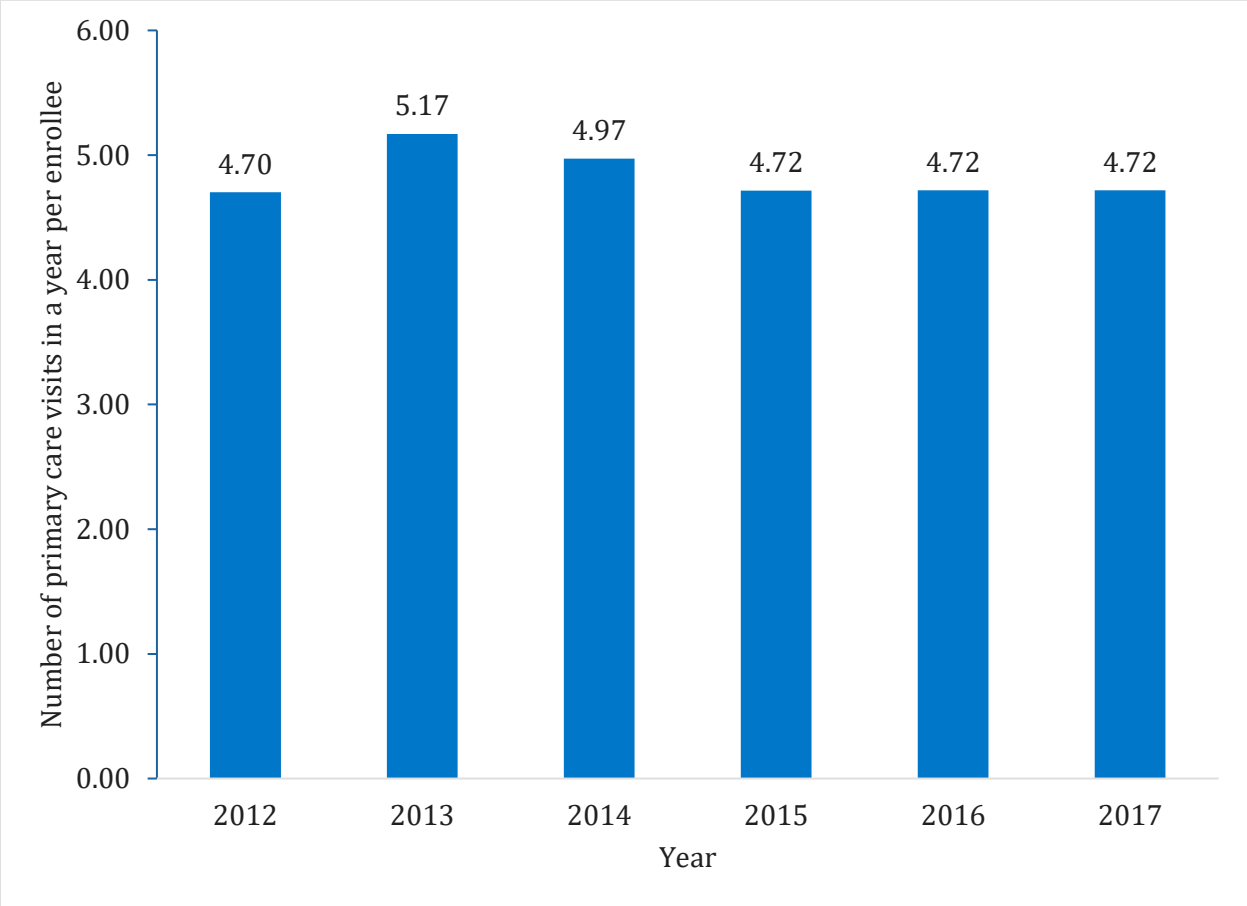


Data Source: Administrative claims only, P1 system, as extracted by HCA on May 18, 2018

- Paid claims and encounters; professional and EPSDT services, including EM; vaccinations (<19 years old); alcohol and SUD screenings
- Includes all Medicaid enrollees, including those with Medicare eligibility, partial medical benefits, and Third Party Liability

Table 3 shows that annual visits per enrollee rose by about 10 percent in the initial years after the ACA's Medicaid expansion. The expansion population increased Apple Health membership and caused a temporary increase in the total annual visits per member from 4.7 in 2012 to 5.17 in 2013; after 2014, the number of annual visits returned to 2013 levels. The term "expansion population" identifies individuals who were newly eligible for Medicaid benefits. Most of this new-to-Medicaid population had been uninsured for a long period of time and were sicker than the pre-expansion population (Decker & Lipton, 2017).

Table 3: Apple Health Annual Primary Care Visits Per Enrollee (2012–2017)

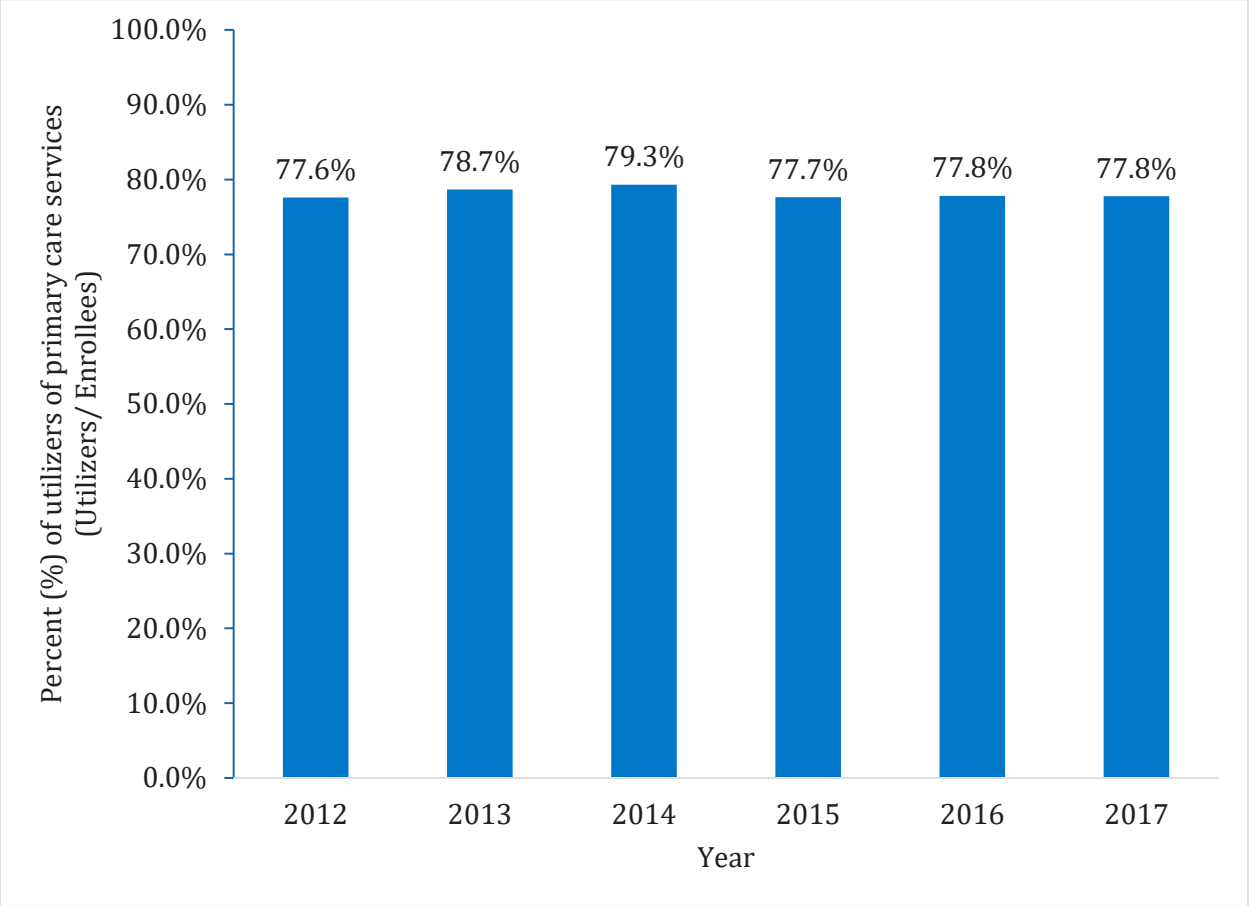


Data Source: Administrative claims only, P1 system as extracted by HCA May 18, 2018

- Paid claims and encounters; professional and EPSDT services, including EM; vaccinations (<19 years old), alcohol and SUD screenings
- Includes all Medicaid enrollees, including those with Medicare eligibility, partial medical benefits and Third Party Liability

Table 4 below shows that the proportion of members using primary care services between 2012 and 2017 remained stable at 77.6 percent to 79.3 percent.

Table 4: Proportion of Apple Health Members Using Primary Care Services (2012–2017)



Data Source: Administrative claims only, P1 system, as extracted HCA May 18, 2018

- Paid claims and encounters; professional and EPSDT, services including EM; vaccinations (<19 years old), alcohol and SUD screenings
- Includes all Medicaid enrollees, including those with Medicare eligibility, partial medical benefits, and Third Party Liability

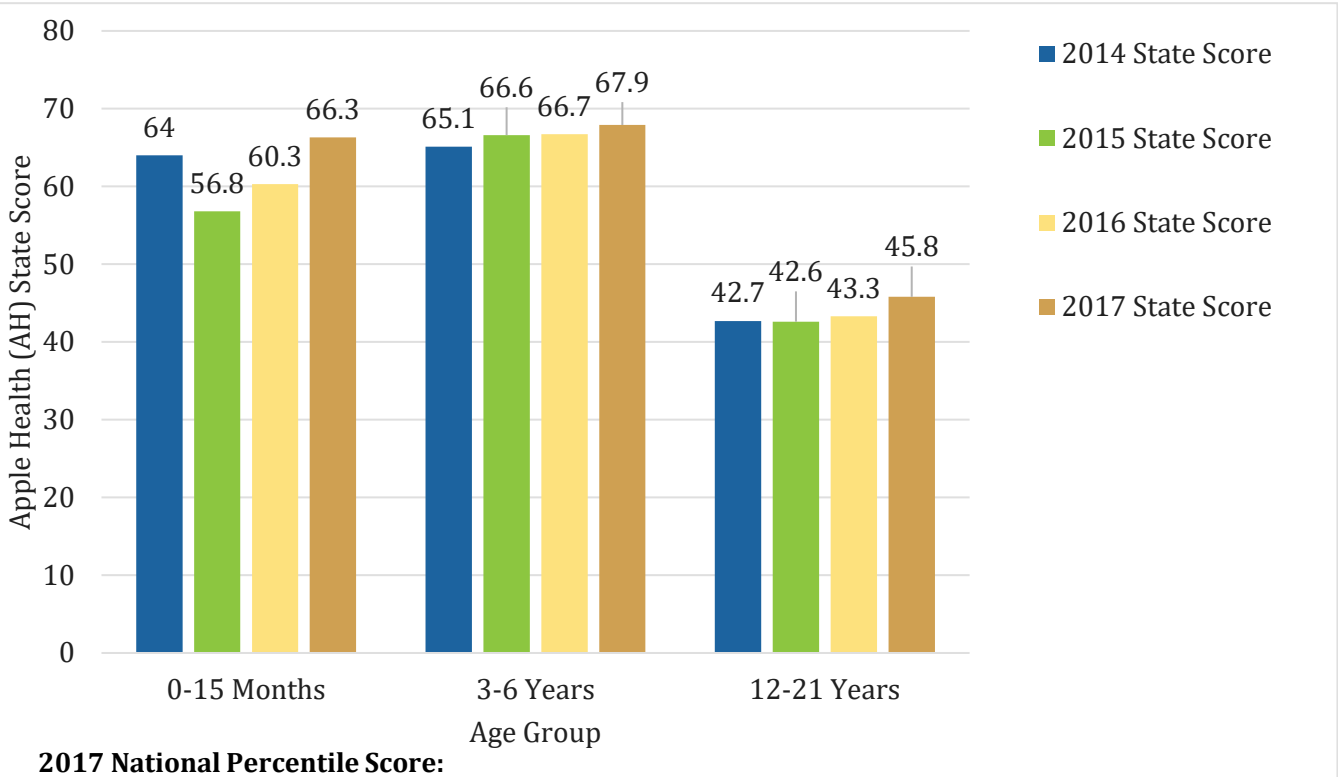
Most primary care visits (about 85 to 90 percent from 2012 to 2017) are classified as evaluation and management services. Targeting reimbursement for these services suggests a broad approach to rate adjustments for primary care practitioners. A more targeted approach might focus on creating alternative reimbursement options, such as enhancing incentives for team-based care through value-based payment arrangements. This option proposes incentive payments or other alternative payment mechanisms for specific services delivered by team members who are not currently eligible for direct Apple Health reimbursement. This includes care management and coordination delivered by registered nurses or health education delivered by medical assistants.

Other important insights about primary care access can be gained through quality metric reporting. Federal requirements mandate that every state Medicaid agency that contracts with MCOs provide for an annual external quality review of the accessibility, timeliness and quality of care for Apple Health MCO and members. Qualis Health's (2018) EQRO review reports on the audit and validation of the NCQA's HEDIS and CAHPS measures and findings. HEDIS measure validation includes an adult access to care measure assessing whether members see a primary care provider at least once annually and children's measures that assess whether members are able to access appropriate care, including well child visits. Measures reflect both the steps taken to obtain needed health care and the patient experience before receiving care (Qualis Health, 2018).

The EQRO review also includes compliance monitoring of prior year MCO corrective action plans and performance improvement projects (PIPs). Compliance monitoring evaluates MCO compliance with federal and state contractual standards. Corrective action plans are implemented based on whether an MCO received a "partially met" or "not met" score for specific contractual and performance standards, including availability of services (Qualis Health, 2018).

MCOs are required to design and implement PIPs to achieve sustainable improvements in care delivery. Validation ensures that state and federal guidelines are met in designing and carrying out PIP activities. MCOs are working collaboratively on a PIP to improve well child visit rates. At least one MCO is working on a PIP for adult access to preventive/ambulatory health services (Qualis Health, 2018).

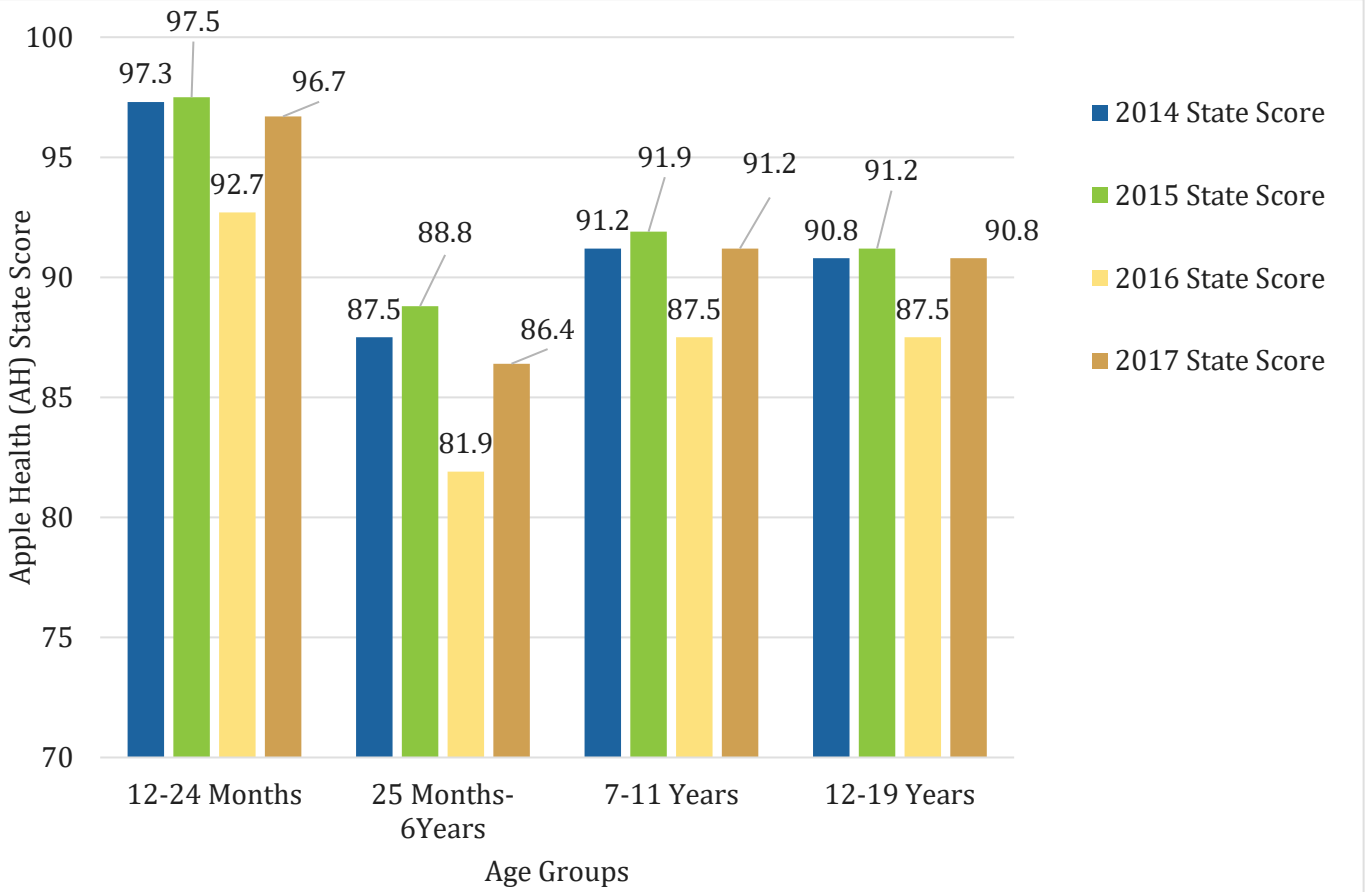
Table 5: Well-Care Visits



2017 National Percentile Score:
0-15 Months: 4th Quintile, Apple Health (AH) scores are between 60-79% of plans nationwide
3-6 Years: 2nd Quintile, AH scores are between 20-39% of plans nationwide
12-21 Years: 2nd Quintile, AH scores are between 20-39% of plans nationwide

- Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.
- Data Source: DataAccess to Health Plan employee data and Information Set (HEDIS) Measures 2012–2017

Table 6: Children and Adolescent Access to Primary Care Practitioners



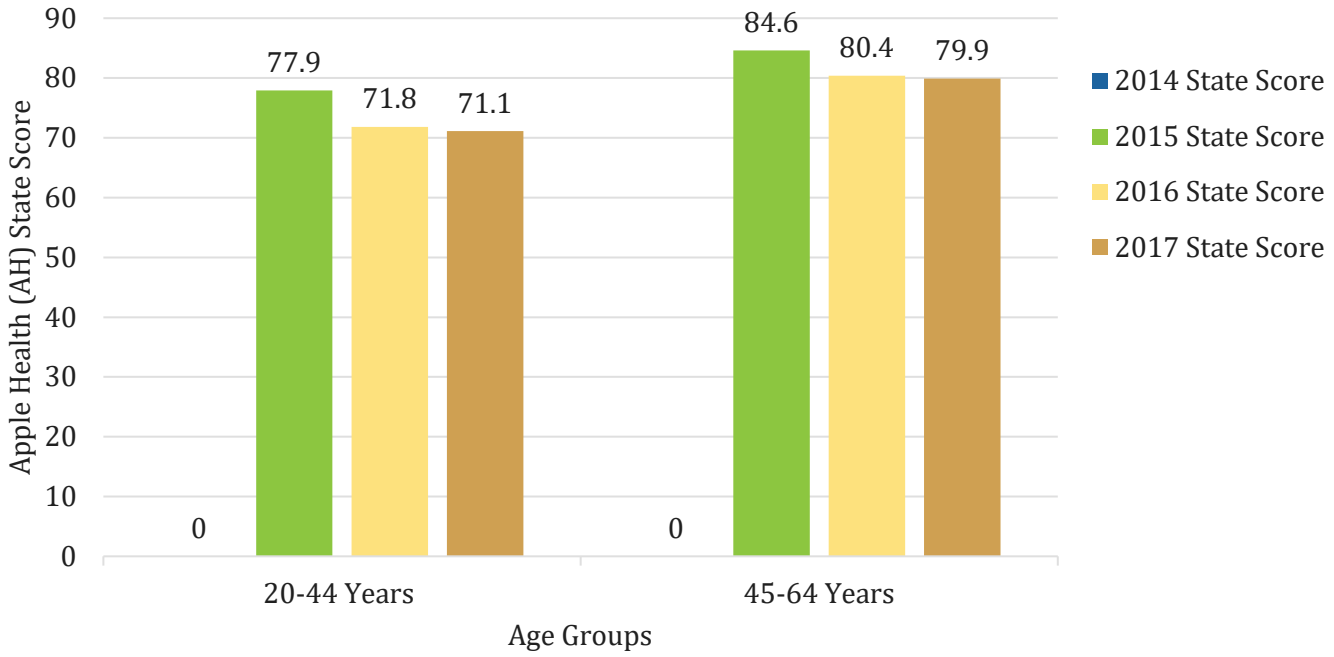
2017 National Percentile Scores:

12-24 Months: 4th Quintile
25 Months- 6 Years: 2nd Quintile
7-11 Years: 3rd Quintile
12-19 Years: 3rd Quintile

4th Quintile, AH scores are between 60-79% of plans nationwide
3rd Quintile, AH scores are between 40-59% of plans nationwide
2nd Quintile, AH scores are between 20-39% of plans nationwide

- Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.
- Data Source: DataAccess to Health Plan employee data and Information Set (HEDIS) Measures 2016–2017

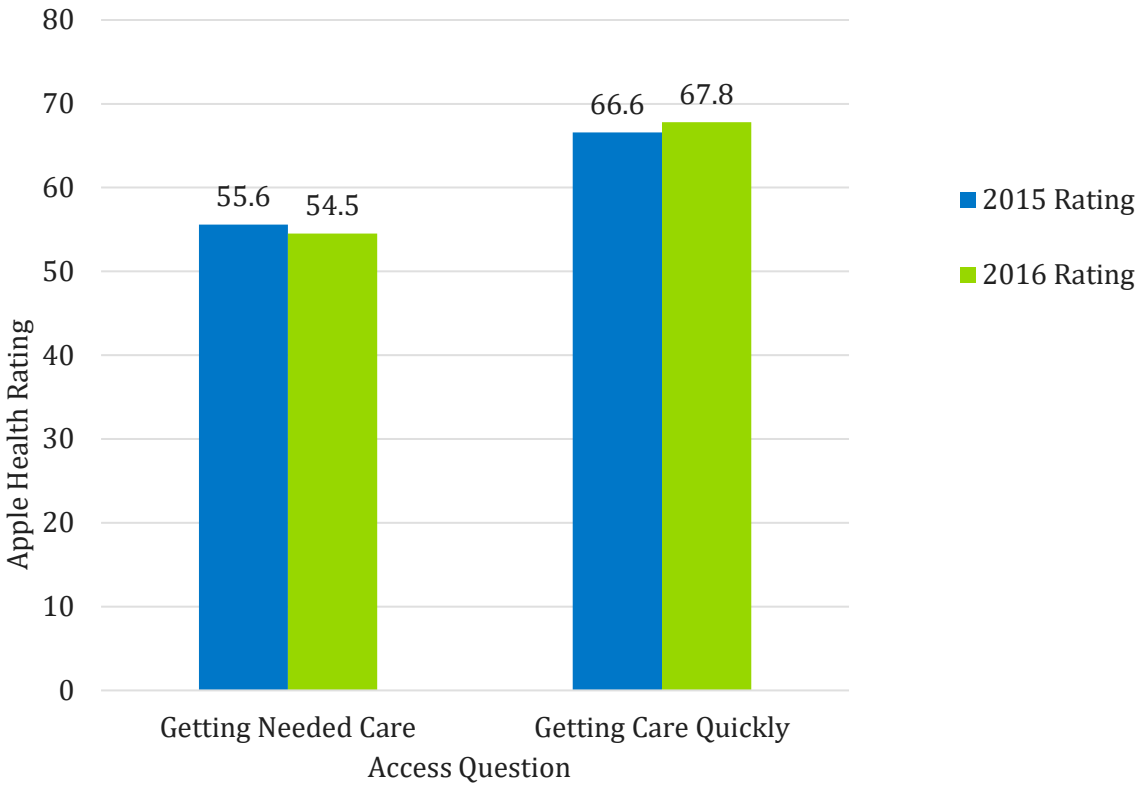
Table 7: Adult Access to Preventive/Ambulatory Health Services



2017 National Precentile Scores:
20-44 Years: 2nd Quintile, AH scores are between 20-39% of plans nationwide
45-64 Years: 1st Quintile, AH scores are below 20% of plans nationwide

- Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.
- Data Source: DataAccess to Health Plan employee data and Information Set (HEDIS) Measures 2016–2017

Table 8: Consumer Assessment of Health Plan Survey (CAHPS) Rating Results 2015–2016



2017 National Percentile Scores:
Getting Needed Care: 1st Quintile, AH scores are in the lowest 20% of results nationwide
Geetting Care Quickly: 1st Quintile, AH scores are in the lowest 20% of results nationwide

- Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20 percent of results and the highest quintile indicates performance in the top 20 percent of results.
- Data Source: CAHPS Measures 2017 Report

The 2017 EQRO report indicates statewide rates for access measures improved between 2016 and 2017, except for adult access to primary care. Adult primary care access declined slightly for all age groups between 2016 and 2017. Qualis Health (2018) indicates that the CAHPS measure "Getting Needed Care" declined from 55.6 percent in 2015 to 54.5 percent in 2016. This reflects the low and declining rates of access for adults, as indicated by HEDIS performance measures results in Table 7. Adult access to preventive and ambulatory health services for 20- to44-year-olds declined from 77.9 percent in 2015 to 71.1 percent in 2017, and from 84.6 percent in 2015 to 79.9 percent in 2017 for adults 45- to 64-years-old (Qualis Health, 2018).

Child and adolescent access to primary care practitioner performance declined slightly for some age groups (12- to 24-month-olds and 25-month to 6-year-olds) with flat performance for 7- to 11-year-olds and 12- to 19-year-olds between 2015 and 2017. There was a slight but significant improvement in the 7- to 11-year-old and 12- t0 19-year-olds populations' access to primary care

practitioners in 2017. This followed a single year decline in 2016, likely related to data collection and reporting corrections by a single plan. Despite limited improvements, performance on access measures for adults' and children's primary care at the 40th percent of MCO performance nationwide. This means that Apple Health MCO performance is exceeded by 60 percent of all other MCOs included in NCQA's national Medicaid MCO analysis (Qualis Health, 2018).

Analysis

Selden, Lipton, and Decker (2018) found in a national study that, as of 2015, adults in the Medicaid expansion population — like those in Washington — faced greater difficulty accessing primary care services than adults in non-expansion states. This is likely because more adults sought care due to the higher enrollment in expansion states, straining capacity within a limited supply of primary care providers.

Despite growth in the number of Apple Health providers from 2015 to 2017, declining HEDIS and CAHPS performance illustrates the negative impacts on members' timely and needed access to care during this time. The current gap is also related to slower growth in provider capacity than member enrollment.

During summer 2018, HCA reviewed rates for potential decision package submissions to request authority and funding for Apple Health rate increases, including primary care provider rate increases. Primary care provider rates have not increased in over a decade, except for the one-time fee increase in 2013 and 2014, associated with ACA requirements. The one-time fee increase in 2013 to 2014 and its lack of sustainable funding may not have provided enough incentive for some primary care providers to participate. The current rate structure is not competitive and providers report that it does not support the cost of their services — particularly given the complexity of care for Apple Health members.

Providers report that rate increases are a critical need for sustaining or improving access to care for Apple Health members (Ubel, 2013; Long, 2013; Patterson et al., 2014). The one-time fee increase did not yield a sufficient increase to sustain primary care provider participation at the levels needed to care for the Apple Health expansion.

A 2014 UW Center for Health Workforce Studies report, *The Impact of Medicaid Primary Care Payment Increase in Washington State*, outlined the impact of the one-time 2013 to 2014 Medicaid primary care fee bump on PCPs. The study found that a majority of PCPs and large health care organizations, with less than 50 percent of their patients receiving Medicaid, reported that the one-time Medicaid payment increase had little effect on their willingness to accept or continue care for Medicaid patients. They noted that the temporary nature and minimal impact of the one-time increase was not enough to sustain their practices. Providers with more than 50 percent of their patients receiving Medicaid reported that the payment increase made them more willing to accept new Medicaid patients and continue providing care for current Medicaid patients (Patterson et al., 2014).

The majority of providers surveyed in the study noted that various forms of higher reimbursement rates for PCPs could encourage them to continue seeing Medicaid patients or accept new patients. Nearly three-quarters of PCPs in smaller practices in the UW study reported that they would stop or limit acceptance of new Medicaid patients without payment increases in 2015 and beyond. Rural practices were less likely than urban practices to report they would stop providing care or reduce care for new or current Medicaid patients (Patterson et al., 2014).

Some PCPs and large health organizations said that if payments reverted to pre-fee increase levels, their practice may restrict access for patients. Table 9 describes the reported potential options discussed for restricting access (Patterson et al., 2014).

Table 9: Primary Care Physician (PCP) Responses to 2015 Discontinuation of Medicaid Payment Increase

Response	Percentage of PCPs
Make no changes	26.5%
Restrict Medicaid patient access in one or more of the following three ways:	73.5%
1. Stop accepting new Medicaid patients	38.1%
2. Limit the number of new Medicaid patients	33.9%
3. Reduce or stop seeing current Medicaid patients	19.0%

- Family medicine, general internal medicine, or pediatric practices of 50 or fewer physicians. Multiple responses were possible; percentages do not total 100. Primary care physicians who indicated the question was not applicable because they did not make this decision or did not see Medicaid patients (17.8% of primary care physicians) were excluded from this analysis.
- Data source: Patterson et al., 2014

PCPs in the UW study indicated that continuing the 2014 payment increase was the most attractive option for sustaining Medicaid provider participation. PCPs and large health organizations indicated that the following hypothetical Medicaid program changes would likely encourage them to see new Medicaid patients or continue to provide care for current Medicaid patients:

- Continue increasing payments after the fee bump
- Raise Medicaid rates to commercial insurance levels
- Increase payment for complex-needs patients
- Improve access to specialty care and referral for complex-needs patients
- Administrative improvements to reduce the waiting time for payment and streamline paperwork (Patterson et al., 2014).

As of July 2016, 19 states fully or partially continued the primary care fee bump for fee-for-service Medicaid (Milbank Memorial Fund, 2018).

Barriers to Access

Medicaid Enrollees

Table 10 illustrates the member barriers to primary care, as reported by MCOs in their well-child visit and access-to-care PIPs.

Table 10: Client-Identified Access Barriers

Identified Barrier	Details
Lack of Resources	Not having transportation to and from appointment
	Not having paid time off or the ability to take time off work for well-visit appointments
	Do not understand that there is no patient cost for visits
	Lack of support to overcome single-parenting demands
	Not having a translator available
Medicaid Client Perception of Value	Not understanding the importance of establishing care with an assigned primary care provider
	Perceived limited value for well-child visits, especially among families with special needs children who are likely to place more value on specialist appointments
	Misperception that a regularly-scheduled specialist visit equals a well-child visit
Provider Availability	Lack of clinics with extended hours, or hours outside of the 8:00 a.m. to 5:00 p.m. business day
	Long wait times for well-child visits
	Lack of appointment time slots for families with multiple children

Providers

Table 11: Provider-Identified Access Barriers

Identified Barrier	Details
Rates	Have not increased since the temporary ACA increase, and the HCA's request to have the temporary rate increase made permanent has not been adopted
	The 2014 temporary ACA rate increase required additional administrative resources, which limited the participation of primary care practitioners
Administrative Burden	Complex administrative process and requirements for referrals
	Complex Medicaid billing and reimbursement process
	Challenges staying current with changing billing rules and requirements
	Challenges understanding the criteria for visits that qualify for well-child or Early and Periodic Screening, Diagnosis, and Treatment billing
	Delays in claims payment and challenges resolving claims issues
Unique Needs of Medicaid Clients	Social and behavioral needs of Medicaid clients require additional time for physicians and support staff
	Difficulties finding specialists to meet patients' needs
	Managing patient no-show visits

References: Ubel, 2013; Long, 2013; Qualis Health, 2018; and HCA 2017 Well-Child Visit Performance Improvement Plan findings

Apple Health program staff noted that the administrative requirements for participation in the one-time fee increase created difficulties for some primary care providers. In addition, the one-time 2013 to 2014 fee increase may not have provided enough incentive or sustainable funding for some providers to participate.

Long (2013) reported results from a 2011 survey and focus-group in which Washington State PCPs were asked about how to increase Medicaid participation. About 49 percent reported that reimbursement rates were a serious barrier to participation. Physicians welcomed planned increases in Medicaid reimbursement rates (Long, 2013).

Providers also experience a range of barriers to Medicaid participation. The data indicate possible ways to increase their willingness to see Medicaid patients:

- Lowering the costs of participating in Medicaid by simplifying administrative processes (23.6 percent)
- Speeding up reimbursement (13.4 percent)
- Reducing the costs associated with caring for those patients (25 percent) (Long, 2013)

Physicians who cared for both commercial insurance and Medicaid patients reported higher rates of dissatisfaction due to these barriers to participation. Other barriers included the complexity of care for Medicaid patients and the limited availability of specialty and behavioral health referral resources (Long, 2013).

Apple Health and Medicaid Transformation are moving providers into value-based payment arrangements that transition care delivery to person-centered, team-based care. Value-based payment and team-based care offers new options for structural and financial incentives to support improved access to care.

Telehealth and telemedicine could be used to increase access to primary care and referred specialty services. One example is offered by Molina Healthcare. Their Molina Virtual Care program provides "24/7" health care from a doctor or nurse practitioner. The program is available at no cost to Molina's Apple Health members. Molina practitioners provide virtual care for non-emergency care such as minor illnesses and conditions that don't require blood work, X-rays, or lab testing. The practitioners will talk with members to help them identify options for care — including phone- or video-based care and treatment for non-emergency illnesses — and direct them to appropriate emergency care services.

Substitute Senate Bill 5175 (2015) asked HCA to submit a report by December 31, 2018[2] to measure telemedicine's impact on care access for underserved communities and Medicaid costs. We suggest that future telehealth activities to enhance access to care consider both this report and the telemedicine report.

Improving Access to Care

ESSB 6032 directs HCA to:

- Identify incentives to enable and encourage providers to accept more medical assistance clients;
- Prioritize investment areas that are likely to increase access to care; and
- Review the current Medicaid rates; identify specific areas and amounts that may promote access to care.

Work in Progress

Quality Improvement Activities

Measuring and providing access to primary care services in an evolving, person-centered, integrated delivery system requires consideration of member experience on access measures and quality performance (Murray & Tantau, 1999). Quality and member satisfaction are often defined as providing the right care, in the right way, at the right time (Davis et al., 2005). Adequate access

[2] When released, the Impact of Telemedicine on Medicaid report will be available at https://www.hca.wa.gov/about-hca/legislative-reports

depends on many factors including availability and timeliness of appointments; network adequacy; navigating time off work; and the availability of transportation, child care, and translation services.

HCA's value-based payment strategies use quality and performance incentives to achieve goals. Aligning access-based quality and performance measures across HCA contracts (including Apple Health, fee-for-service, and foster care) reduces provider burden and creates incentives for providers to build or enhance systems to improve access to care.

Monitoring and Coordinating Access to Care Performance Improvement Activities

HCA is monitoring where MCOs underperform on certain HEDIS performance standards. In 2018 and 2019, HCA is also monitoring MCOs' required PIPs for HEDIS access-to-care measures. These include adult access to care and well child visits for children ages 3- to 6-years-old where performance is below the 40th percentile compared to MCOs across the nation. In addition, HCA is working with MCOs on a collaborative performance improvement plan for adult access to care, and with Washington State Department of Health and the MCOs on a collaborative improvement plan for well child visits. These PIPs are coordinating activities and best practices across MCOs, including the use of MCO-clinic pilot project partnerships to identify and implement best practices.

Network Adequacy

The MCOs' network adequacy report is used to determine how members are assigned to plans. This report measures overall network capacity for primary care providers and other critical providers within a geographic service area. Network adequacy does not indicate access to a specific provider within a service area. MCOs report network adequacy information to Apple Health on a quarterly basis. The report outlines the ability of each plan to provide coverage within each provider type and service area. The MCOs' network adequacy and eligibility for enrollments and/or member assignments are determined using the percentage of coverage for five critical provider types in each service area: adult and pediatric PCPs, obstetricians, hospitals, mental health, and pharmacies. This calculation is determined by the number of critical providers within the service area, as well as proximity of the providers to the potential enrollee. Plans are determined eligible for enrollment and/or assignments by:

- Both assignments and enrollments (over 80 percent client coverage by service area for five critical provider types).
- Enrollments only (70 to79 percent of critical provider types).
- Inadequate network (below 70 percent of critical provider types by service area and not allowed to participate in the service area)

Most service areas have at least two — but most likely three or four — MCOs with the capacity to serve 80 percent of the eligible population. HCA believes the built-in additional capacity has been adequate to absorb the increased population. In anticipation of the increase in enrollment that full implementation of the ACA brought, HCA deliberately set the standard at 80 percent of total eligible individuals in a given service area.

Conclusions

Access to care for Apple Health members has expanded substantially, but it has not kept pace with member growth since 2013. A one-time fee rate increase in 2013 to 2014 did not result in improved access to care, likely due to the administrative complexity associated with enrolling and participating in payments and the lack of sustainable funding. As of July 2016, 19 states fully or partially continued the primary care fee bump in 2016 for fee-for-service Medicaid, according to publicly available fee information (Milbank Memorial Fund, 2018).

Washington State saw a substantial increase in provider participation between 2012 and 2017, but it was not adequate to compensate for the even larger increase in the Medicaid population from Medicaid expansion. Providers report these reasons as their primary barriers to Medicaid participation:

- Payment rates that have not kept pace with increasing costs of services.
- Administrative complexity in clinical criteria, claims submission, and payment.
- Challenges in meeting the complex needs and time requirements for Apple Health members.

These findings support a multi-pronged approach to addressing access to care. Rate increases remain an important strategy, particularly in primary care where reimbursement is lower than for specialty care. Primary care providers report that rate increases or enhancements are the most successful strategy to encourage willingness to participate in Apple Health and make positive impacts on access to care for new and current Apple Health members. They report that the one-time 2013 to 2014 fee increase was not sufficient to sustain their practices (Patterson et al., 2014). HCA supports rate increases, and as a result, has conducted recent analyses and developed a prioritized list of provider rate increases which we believe would be the most impactful to enhancing client access to care.

Other financial incentives or value-based care payment arrangements are a related and complementary strategy for addressing a common barrier to access. This innovation creates financial and quality incentives that rewards providers and clinical teams for creating new workflow and processes to enhance access to timely services using care managers, pharmacists, and other team members. A transformed delivery system will also encourage providers and clinics to work with community-based organizations to address social determinant of health risk factors. This will allow physicians and health care team members to focus on clinical needs and improve the member's access by delivering the right services at the right time, in the right place, using the right community-based organizations and resources.

Medicaid Transformation promises to lower barriers to accessible, timely services by integrating physical and behavioral health and expanding the use of primary care teams. Adopting team-based care frees up capacity for the primary care practitioner and offers more timely and responsive access for patients. A team-based care approach optimizes the use of all primary care team members — including nurses; care managers and coordinators; medical assistants; pharmacists; behavioral health practitioners; and community health workers — to directly address patient needs

using skills at the top of their scope of practice, through services such as care coordination, chronic condition management, and community-clinical care linkages.

Apple Health and the Medicaid Transformation Project are moving providers into value-based payment arrangements that transition care delivery to person-centered, team-based care. This type of care offers new options for structural and financial incentives to support improved access to care.

Telehealth and telemedicine could be used to promote increased access to primary care and referred specialty services. Substitute Senate Bill 5175 (2015) directed HCA to submit a report to measure telemedicine's impact on access to care for underserved communities and Medicaid costs. HCA suggests considering future telehealth activities that align the results of this report and the telemedicine report.

Opportunities exist to align MCO and ACH Medicaid Transformation Project activities. Aligning resources may reduce provider burden and duplication, and encourage broader participation and dissemination of best practices that enhance access to care. MCOs and ACHs may also help practices and clinics integrate community or MCO resources to manage social determinants of health that effect access to primary care and to reduce the complexity of care needs that are managed directly by primary care providers.

Recommendations

1) Apple Health rates have not increased in the past decade and are not keeping pace with the cost of services. Providers report rate increases as a key incentive for maintaining and improving access.
   - **a. Recommendation:** HCA supports increasing Apple Health primary care provider rates as a strategy for improving access and sustaining primary care provider participation and engagement.
   - **b. Recommendation:** HCA will explore opportunities to improve timely primary care payments and streamline administrative processes.
   - **c. Recommendation:** HCA will analyze provider payments to identify options to reduce the financial risk of value-based payment arrangements for primary care providers and critical access services in underserved communities, including rural areas. Options should include analysis of temporary rate increases and technical assistance to rural health systems or facilities and primary care providers.
   - **d. Recommendation:** Continue support for HCA's Rural Health Multi-Payer Initiative using rate increases and other funding options to support critical service delivery during the transition to value-based or alternative-payment structures.

2) Explore additional opportunities to align value-based payment incentives to encourage clinical and administrative improvements that enhance primary care access.
   - **a. Recommendation:** Identify opportunities to create reimbursement structures, such as team-based care quality or performance incentive payments, that expand access to

care for services delivered by team members who are not currently eligible for reimbursement. Options might include creating new care coordination or care management reimbursement structures, such as direct payments or quality incentives for care management/coordination services delivered by registered nurses or health education services delivered by medical assistants.

b. Recommendation: HCA should explore opportunities to coordinate HCA and MCO access to care performance improvement activities with the Accountable Communities of Health (ACHs) planning and implementation of Medicaid Transformation Project.

c. Recommendation: Identify options to support planning and implementation of access to care improvements for providers in underserved communities who may be at risk for financial impacts using existing value-based purchasing incentive payment strategies.

3) Explore options to improve access to primary care services through innovative services and partnerships with MCOs, physician practices, or clinics, such as telehealth or community-clinical linkages.

a. Recommendation: Align telehealth and telemedicine primary care access improvements with the HCA's Impact of Telemedicine on Medicaid report and its recommendations (SSB 5175, 2015).[3]

b. Recommendation: Assess feasibility of supporting expanded roles for community-based programs to assist providers and members to address barriers and improve access and follow-through with primary care services, such as Project Access Northwest or the Pathways HUB care coordination programs offered in six ACH's through the Medicaid Transformation.[4]

c. Recommendation: HCA will explore options to attract and sustain Apple Health specialty provider relationships that support primary care providers in managing the needs of complex Apple Health patients.

[3] When released, the Impact of Telemedicine on Medicaid report will be available at https://www.hca.wa.gov/about-hca/legislative-reports

[4] Project Access Northwest is a nonprofit organization that matches volunteer specialty care providers and hospital partners with carefully pre-screened patients in need of care. Pathways HUB programs are care coordination programs provided through six of the nine Accountable Communities of Health as part of the Medicaid Transformation Project.

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