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Advancing Comprehensive Primary Care in Medicaid

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STAFF

Katherine Hayes

Director, Health Policy

G. William Hoagland

Senior Vice President

Lisa Harootunian

Senior Policy Analyst, Health Project

Eleni Salyers

Project Associate, Health Project

Kevin Wu

Policy Analyst, Health Project

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ADVISORS

The Bipartisan Policy Center staff produced this report in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank Henry Claypool and Tim Westmoreland for their contributions to this report, as well as Health Management Associates for providing cost estimates for the policy recommendations.

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DISCLAIMER

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Glossary of Terms

Affordable Care Act (ACA)	Managed Care Organization (MCO)
Agency for Healthcare Research and Quality (AHRQ)	Medicaid and CHIP Payment and Access Commission (MACPAC)
Assistant Secretary for Planning and Evaluation (ASPE)	Medicaid Disproportionate Share Hospital (DSH)
Calendar year (CY)	Medicaid Fiscal Accountability Regulation (MFAR)
Centers for Disease Control and Prevention (CDC)	Medical loss ratio (MLR)
Centers for Medicare & Medicaid Services (CMS)	National Association of Medicaid Directors (NAMD)
Children's Health Insurance Program (CHIP)	Patient-centered medical home (PCMH)
Community Health Center Fund (CHCF)	Per member per month (PMPM)
Community health worker (CHW)	Request by an Interested U.S. Federal Government Agency (IGA)
Coronavirus Aid, Relief, and Economic Security Act (CARES Act)	Upper payment limit (UPL)
Families First Coronavirus Response Act (FFCRA)	U.S. Department of Health and Human Services (HHS)
Fee-for-service (FFS)	U.S. Government Accountability Office (GAO)
Federal Medical Assistance Percentage (FMAP)	
Federal poverty level (FPL)	
Fiscal year (FY)	
Graduate Medical Education (GME)	
Health Resources and Services Administration (HRSA)	
International Medical Graduate (IMG)	

Executive Summary

Access to primary care can help individuals live longer and help avoid or delay the onset of costly chronic conditions such as diabetes, heart disease, and cancer. Access to primary care can also help reduce more expensive care, including hospitalizations and emergency department visits. As health care policymakers seek to move away from volume-driven fee-for-service health care toward better integrated systems of care, they recognize the importance of primary care providers to improve health outcomes and lower overall healthcare costs.

As evidence builds on best practices, primary care providers—who are among the lowest paid health professionals—are being asked to do more than just see patients and treat their illnesses. Effective primary care models incorporate physicians, nurses, pharmacists, social workers, and other professionals to address a broad range of patient needs. New payment and delivery models that have proven effective include patient-centered medical homes and Medicaid health homes. Historically, those payment models have included additional payments to coordinate care, enhanced payment rates, and payments or grant funding to help cover the up-front costs of building a comprehensive primary care practice. Some care models receive a share of savings generated through better coordination. The majority of Medicaid-enrolled individuals under age 65 receive care through Medicaid Managed Care Organizations. Despite the benefits of these new models, only about half of all states include language in their managed care quality assessment and improvement strategies to improve primary care through payment reform.

While this report identifies barriers to the provision of primary care in Medicaid, all payers would benefit from a more comprehensive approach to improving primary care. Improving access to health insurance coverage is not the focus of this report, but lack of access to health insurance coverage is a significant barrier. Another barrier is a lack of nurses, physicians, and other providers who choose to go into primary care—in many cases because of lower payment rates across payers. The difference in payment between primary and specialty care is even more problematic for those who choose to serve low-income populations, given historically lower payments in Medicaid. BPC also identified as a barrier to primary care in Medicaid—and across our health care system — the need to address racial, ethnic, and economic barriers to care. Many of these recommendations will increase Medicaid spending in the short-term. However, failure to address the lack of good primary care will lead to even higher state and federal costs in Medicaid over time.

Health Management Associates evaluated each of the proposed legislative options to determine the potential costs or savings to the federal government over the next 10 years. Current expectations in Medicaid, including the

assumed impact of the COVID-19 economic downturn over the next several years were accounted for in these calculations. It was found that two of the proposed options, namely allowing non-expansion states an opportunity to expand their Medicaid programs with an enhanced Federal Medical Assistance Percentage as well as auto-enrolling individuals in Medicaid or Marketplace plans, could increase the federal budget by \$100-200 billion over 10 years, while also reducing the number of uninsured by 2.5-6.0 million. Other proposed options, including allowing states to offer 12 months of continuous Medicaid eligibility for adults, increasing Federal Medical Assistance Percentage for primary care services in Medicaid if paid at the same level as Medicare, or reauthorizing funding for community health centers for 10 years, could each increase the federal budget by \$25-40 billion over 10 years. Finally, some of the proposed options would likely have an uncertain impact on the federal budget, as evidence of costs or savings is not well established.

BPC's efforts to develop policy recommendations to overcome these barriers began in August 2019. COVID-19 has amplified the barriers to primary care in Medicaid. Primary care providers are increasingly worried about their ability to continue to manage their practices. Two million Americans have filed unemployment claims, resulting in an increase in the number of individuals without employer-sponsored health insurance. The resulting increase in Medicaid eligibility and decrease in tax revenues will force states to make difficult choices in the coming year. BPC's recommendations seek to address both the short-term and long-term barriers to primary care in Medicaid.

RECOMMENDATIONS

A. Support for a Comprehensive Framework for Improving Primary Care

To promote a comprehensive framework for improving primary care, Congress should:

- 1. Direct the secretary of HHS to work with existing learning collaboratives and researchers to elevate primary care as a priority for Medicaid and share best practices on primary care among states.**
- 2. Direct the secretary of HHS to work with states and other stakeholders to promote measurement and report of spending on primary care as a percentage of total health care spending.**
- 3. Appropriate funding for the Primary Care Extension Program.**

B. Improve Access to Insurance Coverage

To improve access to affordable health insurance coverage, Congress should:

- 1. Permit non-expansion states to expand Medicaid coverage under one of these options:**

- i. Provide coverage to adults with incomes up to 138% of the federal poverty level with 100% Federal Medical Assistance Percentage phased down over five years to 90%; or**
 - ii. Provide coverage to adults with incomes up to 100% of the federal poverty level with 88% Federal Medical Assistance Percentage, provided they expand coverage within two years of enactment.**
- 2. Permit states to auto-enroll individuals eligible for coverage under Medicaid, Children’s Health Insurance Program (CHIP), or Marketplace subsidies in the appropriate programs. Marketplace auto-enrollment should only apply if the individual’s subsidy meets or exceeds Marketplace premium costs.**
- 3. Create a new state option for 12-month continuous Medicaid eligibility for adults.**

To ensure preventive services are affordable and accessible, Congress should:

- 4. Require coverage of preventive care services for adults in traditional Medicaid without cost-sharing.**

C. Strengthen the Medicaid Primary Care Workforce

To ensure that reimbursement for primary care providers is sufficient to support access to primary care services in Medicaid, Congress should:

- 1. Increase state Federal Medical Assistance Percentages to 100% for primary care services for states that reimburse at Medicare rates for five years.**

To strengthen MCO network adequacy requirements, Congress should:

- 2. Direct the HHS secretary to delay proposed changes to managed care organization network adequacy requirements and direct the Medicaid and CHIP Payment and Access Commission to develop data-driven access standards, taking into account the impact on medically underserved populations, including rural residents. Congress should direct the secretary to promulgate regulations based on the new data-driven standard.**

To increase primary care workforce capacity by addressing health professional shortages, Congress should:

- 3. Direct the HHS secretary to establish a comprehensive plan to ensure oversight and coordination of all federal programs that address healthcare workforce needs.**
- 4. Reauthorize the Conrad 30 program and expand the number of J-1 Visa Waivers each state receives through the program from 30 to 50, with priority given to those in rural areas.**

5. **During a public health emergency, revise restrictions on international medical graduates on H-1B visas to permit an employer to deploy an international medical graduate from an assigned site of service to another within the health system and permit an international medical graduate to provide telehealth services outside that location.**
6. **Reauthorize federal funding for the Community Health Center Fund at the current level of \$5.6 billion annually, including both mandatory and appropriated funding.**

D. Address Racial, Ethnic, and Economic Disparities in Medicaid

To prevent discrimination and to encourage states to address disparities in Medicaid, Congress should:

1. **Block implementation of the June 2020 final rule eliminating non-discrimination provisions, and direct GAO to determine the impact of the rule.**
2. **Direct the secretary of HHS to provide CMS guidance to states on defining and reimbursing community health workers, where evidence has demonstrated improved outcomes for those with chronic conditions.**

To increase accountability for ensuring nondiscrimination and access to Medicaid benefits for individuals with disabilities, Congress should:

3. **Direct the HHS secretary to require states to establish monitoring and enforcement mechanisms that ensure providers who receive Medicaid and CHIP funding comply with laws prohibiting discrimination against individuals with disabilities.**

To improve the financing and coverage of proven cost-effective interventions to address social needs for high-risk populations, Congress should:

4. **Provide the HHS secretary with the authority to approve Medicaid coverage of non-medical services that address social needs if the secretary certifies the following:**
 - i. **Peer-reviewed evidence demonstrates the benefit improves or maintains health or function for the targeted population.**
 - ii. **The CMS Office of the Actuary certifies coverage of the defined benefit for the defined population would result in no net increase in Medicaid spending over the long-term.**
 - iii. **Additional benefits apply only to patients who are enrolled in Medicaid managed care or other health care payment and delivery models that include a comprehensive team-based approach to care management.**

Background

A. INTRODUCTION

As part of its ongoing work to improve access to quality health care, the Bipartisan Policy Center developed policy recommendations to improve the availability of comprehensive primary care services in Medicaid. Over the past year, BPC hosted roundtable discussions, a public event, and conducted dozens of interviews with stakeholders representing Medicaid enrollees, health plans, providers, and state and federal policymakers to identify recommendations that address the barriers to comprehensive primary care in Medicaid.

Strengthening primary care in the United States has been a priority for state and federal policymakers. While progress has been made in the identification of effective delivery and reimbursement models, a number of federal policy barriers limit the spread and scale of effective primary care. Effective primary care services have the potential to result in better healthcare outcomes and cost-savings, while reducing disparities.¹ Medicaid is the primary source of coverage for millions of low-income and vulnerable Americans,² yet many beneficiaries still lack a relationship with a primary care doctor.³ When low-income adults have both health insurance and access to a regular care provider they are “less likely to report cost-related access problems, more likely to be up-to-date with preventive screenings, and report greater satisfaction with the quality of their care.”⁴

Medicaid and COVID-19

Amid the COVID-19 pandemic, access to primary care is more critical than ever for the 74 million individuals enrolled in Medicaid in federal fiscal year 2019⁵ and the estimated 11 to 23 million additional individuals who are likely to enroll as a result of the pandemic.⁶ When compared to the general population, Medicaid-eligible individuals have higher rates of chronic conditions⁷ and complex health needs,⁸ which makes them especially vulnerable to COVID-19.⁹ Primary care providers play an essential role in the COVID-19 response by identifying and managing COVID-19 patients whose symptoms do not require hospitalization, reducing demand for hospital services.¹⁰

Health Care Providers

States report that COVID-19 has had a significant impact on a broad range of Medicaid providers, including behavioral health and substance use providers, rural providers, Federally Qualified Health Centers (FQHCs), children’s

hospitals, personal care service providers, and other providers.^{11,12} According to the National Association for Medicaid Directors (NAMD), states' health care provider infrastructures are deteriorating because of decreased utilization of services resulting from social distancing requirements and the delay of elective treatments and procedures.¹³ The National Governors Association (NGA), similarly indicates that critical Medicaid providers report being at risk of closing their practices due to high costs—including staffing and personal protective equipment costs—and loss of typical visit volume.¹⁴

Federal policymakers have acted to help support states during this crisis. The Families First Coronavirus Response Act (FFCRA) temporarily increased the Medicaid Federal Medical Assistance Percentages (FMAP) by 6.2%,¹⁵ which resulted in an increase of federal Medicaid funding to states by about \$40 billion.¹⁶ In order to receive the increased FMAP, states are prohibited from: (1) restricting Medicaid eligibility standards, methodologies, and procedures that were in place as of January 1, 2020; (2) increasing Medicaid premium amounts beyond the amounts in place as of January 1, 2020; (3) discontinuing coverage for Medicaid enrollees from March 18, 2020 through the end of the month in which the emergency period ends, unless the individual voluntarily terminates eligibility or ends residency in the state; and (4) imposing cost-sharing for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.^{17,18} The FFCRA also established a state option to cover COVID-19 testing and testing-related services for the uninsured through Medicaid with the federal government covering the full cost.¹⁹

NAMD²⁰ and NGA²¹ have asked Congress for an additional increase of 5.8% in FMAP to bring the full increase to 12%. The requests are based on state concerns that the FFCRA increase will not be enough to address the expected rise in the number of eligible individuals and cost of implementing continuous enrollment and new testing and treatment requirements.²² In addition to an increased FMAP, states have asked for immediate supportive payments for financially fragile Medicaid providers.^{23,24} Provider and advocacy groups have also asked Congress for additional funding to support vulnerable patients and providers.²⁵

Congress sought to address the need for health care provider relief through a \$100 billion appropriation in the Coronavirus Aid, Relief, and Economic Security (CARES) Act,²⁶ and an additional \$75 billion appropriation in the Paycheck Protection Program and Health Care Enhancement Act.²⁷ The Centers for Medicare & Medicaid Services (CMS) has distributed \$50 billion based on providers' share of Medicare fee-for-service reimbursements in 2019.²⁸ An additional \$10 billion was allocated to hospitals based on their inpatient COVID-19 admissions, \$2 billion to Medicare Disproportionate Share Hospitals, and \$10 billion was allocated to rural providers, including hospitals, rural health clinics, and rural community health centers.²⁹ In June, CMS announced the release of \$15 billion in additional funding to providers participating in Medicaid and CHIP program that had not received funding

from the \$175 billion in appropriations as well as \$10 billion to safety net hospitals.³⁰

Telehealth

States have had significant flexibility to offer Medicaid-covered services through telehealth, but many have imposed limits on the use of these services. Since the start of the public health emergency, CMS has encouraged states to consider telehealth options as a flexibility available to address COVID-19 challenges and increase access to providers.³¹ Accordingly, several states have updated their Medicaid policies on coverage of services delivered through telehealth.³² State policy changes have included clarification of payment rates for telehealth services and expansion of services, provider types, and modalities eligible for reimbursement through telehealth.³³ While some states and territories have set expiration dates for their new telehealth policies, 13 have not specified an end date.³⁴ The number of states and territories covering delivery of primary care services through telehealth has increased from about 36 states and territories before to the public health emergency to about 51 states and territories since.³⁵

Gaps in access to affordable broadband internet, however, limit the availability of telehealth services in certain regions, particularly in rural areas and on Indian reservations.³⁶ The CARES Act included funding to support telehealth access during COVID-19. Specifically, the CARES Act appropriated \$200 million to the Federal Communications Commission to enable the provision of telehealth services, \$100 million for additional grants under the Rural Utilities Service Broadband Deployment Pilot Program, and \$25 million for the Rural Utilities Service Distance Learning, Telemedicine, and Broadband Program, among other appropriations.³⁷ Other federal efforts remain ongoing to improve broadband access in these underserved areas.³⁸

This report provides background on Medicaid coverage of primary care services, identifies federal policy barriers to the provision of those services, and makes recommendations to advance primary care, including comprehensive primary care in Medicaid. Recommendations seek to achieve four goals:

- 1. Support a Comprehensive Framework for Improving Primary Care**
- 2. Improve Access to Insurance Coverage and Health Care Services**
- 3. Strengthen the Medicaid Primary Care Workforce**
- 4. Address Racial, Ethnic, and Economic Disparities in Medicaid**

B. OVERVIEW AND ROLE OF THE MEDICAID PROGRAM

The Medicaid program provides health insurance coverage to low-income individuals. The program is jointly funded by the states and the federal government, under federal rules, which include both mandatory and optional populations, as well as mandatory and optional benefits. In federal fiscal year 2019, Medicaid provided health insurance coverage to about 1 in 5, or 74 million low-income Americans,^{a,39} expending \$408 billion on the federal share of program costs.⁴⁰ According to CMS, total federal and state Medicaid spending is projected to be \$639.4 billion in fiscal year 2019.⁴¹ In all states, categories of individuals that qualify for Medicaid are those receiving cash assistance under Transitional Assistance for Needy Families or Supplemental Security Income, low-income children and their parents, pregnant women, individuals with disabilities, and other groups.⁴²

The Patient Protection and Affordable Care Act (ACA) expanded the Medicaid program by requiring states to provide Medicaid coverage for all non-disabled, non-elderly adults with incomes up to 138% of the federal poverty level (FPL).^{b,43} The requirement to expand Medicaid was struck down by the Supreme Court in *National Federation of Independent Business v. Sebelius*,⁴⁴ making the Medicaid expansion a state option.⁴⁵ As of July 2020, 37 states and the District of Columbia have expanded Medicaid eligibility.⁴⁶

States have historically delivered Medicaid services through traditional fee-for-service (FFS).⁴⁷ Under FFS, states pay providers directly for covered services provided generally through a claims-based system.⁴⁸ Increasingly, however, states are contracting with Managed Care Organizations (MCOs) to provide services more effectively and efficiently through set per member per month payments.⁴⁹ In recent years, almost 70% of all Medicaid beneficiaries were enrolled in comprehensive managed care and about 82% were enrolled in some type of managed care.⁵⁰ Despite the high utilization of managed care as a payment and delivery model, only about half of all states include language in their managed care quality assessment and improvement strategies to improve primary care through payment reform.⁵¹

States are also exploring delivery models that adopt some of the principles of managed care to promote a more comprehensive approach to treating patients, such as patient-centered medical homes and health homes.⁵² This is especially important for Medicaid beneficiaries, who are often more

a 73.9 million Americans were enrolled in Medicaid for the equivalent of a full year, a measure identical to average monthly enrollment.

b In 2020, 138% of FPL is \$17,609 per year for an individual and \$36,156 for a family of four. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs," HHS Poverty Guidelines for 2020. Available at: <https://aspe.hhs.gov/poverty-guidelines>.

vulnerable with complex health needs. Nearly half of adults with Medicaid are age 50 or older and many have multiple chronic conditions, behavioral health needs, or physical limitations or disabilities.⁵³ Compared to low-income privately insured individuals, the Medicaid population is sicker and has more disabilities.⁵⁴ Improving primary care through development of new payment and delivery models and improvement of existing models, including managed care, is critical to improving patient outcomes, slowing or stopping the onset of chronic conditions, and eliminating more costly care.

Medicaid Spending

Despite the complex health needs of the Medicaid population, Medicaid accounts for a smaller percentage of total national health expenditures than Medicare or private insurance.⁵⁵ According to CMS, Medicaid spent \$597.4 billion in calendar year 2018, accounting for 16% of total national health expenditures, while Medicare accounted for \$750.2 billion, or 21%, and private insurance accounted for \$1.24 trillion, or 34%.⁵⁶ CMS projects this trend will continue in 2019, as Medicaid spending is projected to be \$621 billion, or 16.3% of total national health expenditures in 2019, while Medicare is projected to be \$800.7 billion, or 21%, and private insurance is projected to be \$1.29 trillion, or 33.8%.⁵⁷

Enrollment was greater in private insurance than in Medicaid or Medicare in 2018, and program spending per enrollee was highest in Medicare.⁵⁸ In 2018, private insurance served 200.5 million people and spent \$6,199 per enrollee; Medicaid served 72.8 million people, spending \$8,201 per enrollee; and Medicare served 58.7 million people, spending \$12,784 per enrollee.⁵⁹ The annual growth rate for spending per enrollee was smaller for Medicaid than for Medicare or private insurance, and CMS projected this to continue in 2019.⁶⁰

As Medicaid enrollment and spending typically increase during economic downturns,⁶¹ both will likely grow in fiscal year 2020 as a result of the negative economic impacts of COVID-19. A May 2020 estimate from the Kaiser Family Foundation indicates Medicaid enrollment and spending could increase by 0.8% and 6.2%, respectively, from 2019 to 2020.⁶²

C. PRIMARY CARE VS. COMPREHENSIVE PRIMARY CARE

Primary Care

The value of primary care has long been recognized as a means of improving health outcomes and preventing more costly care over the long-term. Primary care lies at the heart of high-performing health care systems.⁶³ The Institute of Medicine defines primary care as “[t]he provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership

with patients, and practicing in the context of family and community.”⁶⁴

Studies have shown the value of primary care to the health care system. Whether measured by the number of primary care providers, patients using primary care providers as their usual source of care, or receipt of high-quality primary care services,^c more primary care has been associated with better health outcomes, lower health care costs, and reduced health disparities.⁶⁵ Care models have evolved over time as researchers and practitioners gained a better understanding of the benefits of coordination among providers to improve patient outcomes.⁶⁶

Models of Comprehensive Primary Care and the Evidence

Patient-Centered Medical Home

The patient-centered medical home (PCMH) takes a comprehensive approach to primary care delivery. The Agency for Healthcare Research and Quality (AHRQ) defines the medical home as encompassing the following five attributes:⁶⁷ (1) Comprehensive care, (2) Patient-centered, (3) Coordinated care, (4) Accessible services, and (5) Quality and Safety. The PCMH model has been endorsed by primary care physician societies⁶⁸ and has become widespread in the United States with almost 500 public and private sector PCMH initiatives.⁶⁹

The Centers for Disease Control and Prevention (CDC) and National Center for Health Statistics found PCMH practices, when compared to non-PCMH practices, were more likely to: include at least one physician assistant, nurse practitioner, or certified nurse midwife; have electronic transmission as the primary method for receiving information on hospitalizations or hospital visits; and report quality measures or quality indicators to payers or organizations monitoring quality.⁷⁰

PCMHs have also provided higher quality care, fewer hospital admissions, lower costs, and more satisfied patients compared to non-PCMH practices.⁷¹ Importantly, as health disparities continue to increase, PCMHs provide better outcomes for minority patients.⁷² The success of PCMHs has been recognized by CMS and other agencies within the Department of Health and Human Services. An HHS workgroup found that the PCMH is “a conduit to lowering health care costs, increasing quality, reducing health disparities, achieving better outcomes, lowering utilization rates, improving compliance with recommended care, and coordinating a spectrum of medical and social services required by the individual across the lifespan.”⁷³ These encouraging results have led to wider adoption of PCMHs in both public and private reform efforts. As of state fiscal year 2019, 30 states have a PCMH in place where at least some of their Medicaid

c Quality defined by adequacy of primary care delivery characteristics as measured by WHO: first-contact access for each need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere.

beneficiaries were served through the PCMH.⁷⁴ Four states reported plans to expand or enhance their existing PCMH programs in fiscal year 2020.⁷⁵

Health Homes

The PCMH model provided the foundation for implementation of the Medicaid Health Homes model,⁷⁶ a state option authorized by the ACA. Medicaid Health Homes are patient-centered and support enhanced integration and coordination of Medicaid primary, acute, behavioral and long-term services and supports for individuals with chronic conditions.⁷⁷ Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow up, patient and family support, and referral to community and social support services.⁷⁸ CMS also strongly encourages the use of health information technology to link these services.⁷⁹ States receive a 90% enhanced match for health home services for the first eight quarters of their program.⁸⁰ As of April 2020, 20 states and the District of Columbia have Medicaid Health Homes, with some states having multiple models for different target populations.⁸¹ A few additional states are planning Health Homes.⁸² More than one million Medicaid beneficiaries have been enrolled in Health Homes.⁸³

Evidence on the impacts of Medicaid Health Homes lend further support for a more comprehensive approach to primary care. Specifically, a report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), within HHS, found the model showed improvements in care management, care transitions, behavioral health integration, and linkages to services to address social determinants of health.⁸⁴ Results from state evaluations also demonstrate improvements in emergency department and inpatient admission, costs, and quality.⁸⁵ ASPE concluded that the model shows promise for improving care and achieving cost-savings for individuals with chronic conditions.⁸⁶ The majority of states with Health Homes continued the program beyond the enhanced match period, suggesting they found value in the model.⁸⁷

The success of the PCMH and Health Home models highlights the advantages of a comprehensive approach to primary care and has informed BPC's work. These models promote higher quality care, reduced hospital admissions, and cost-savings, among other benefits discussed above. However, the Bipartisan Policy Center has identified policy barriers that have limited the widespread adoption of these models and believes work remains to be done to ensure delivery of comprehensive primary care that goes further than these models and is available for all Medicaid populations.

Defining Comprehensive Primary Care in Medicaid

As researchers and providers examined successful primary care practices and identified common attributes, they used the term "comprehensive primary care" to distinguish patient-centered practices from traditional primary care. While

stakeholders do not completely agree on a definition of comprehensive primary care, or even a definition of primary care, there is a willingness to identify common elements and a recognition that core services may differ depending on the population, e.g. aged, blind, or disabled individuals; pregnant women; children; and adults without disabilities. Stakeholders acknowledge and evidence from PCMH and Health Homes models suggests that certain attributes support comprehensive primary care in Medicaid, but they should be aspirational rather than mandatory. For the purposes of BPC's discussion with stakeholders, key elements of comprehensive primary care would include the following:

- Featuring multi-disciplinary teams that are diverse and include a full range of health professionals, including community health workers, who have the ability to identify and coordinate the provision of both health and social services
- Providing an integrated, or at least coordinated, delivery system that includes clinical health services, behavioral health services, and social services and supports, with a focus on traditionally-defined, outcomes-based population health and community-level public health services
- Accessing these services outside the traditional medical office or clinic setting
- Engaging the patient and family to identify patient needs and preferences
- Addressing equity and eliminating disparities
- Delivering adequate payment with mechanisms for sustainable financing that reward high value
- Identifying and financing services that have the ability to improve social determinants of health
- Using "real time" data to assess system performance in assuring high quality care
- Establishing continuity in both relationship with and knowledge of patients through all stages of their care and life

Policy Barriers and Recommendations

BPC worked with stakeholders to identify the following barriers to comprehensive primary care:

- Insufficient resources for primary care innovation.
- Lack of insurance coverage and affordability.
- Primary care workforce shortages.
- Ongoing racial, ethnic, and economic disparities in care.

To address these barriers BPC developed a set of policy recommendations that would achieve four goals:

- Support a comprehensive framework for improving primary care.
- Improve access to insurance coverage.
- Strengthen the Medicaid primary care workforce.
- Address racial, ethnic, and economic disparities in Medicaid.

A. SUPPORT FOR A COMPREHENSIVE FRAMEWORK FOR IMPROVING PRIMARY CARE

Barriers to expanding comprehensive primary care models include a misalignment of payment and delivery models, including financial incentives and state policy and managed care contracts that do not promote innovation in primary care.⁸⁸ Additionally, many primary care practices lack the time and resources necessary for implementation of innovative programs.⁸⁹

Recommendations

To promote a comprehensive framework for improving primary care, Congress should:

- 1. Direct the secretary of HHS to work with existing learning collaboratives and researchers to elevate primary care as a priority for Medicaid and share best practices on primary care among states.**

Over the last decade policymakers have promoted delivery system reform in the Medicare program and have encouraged states to innovate in Medicaid. CMS has supported the design and testing of delivery models to improve quality and efficiency in primary care. These efforts include PCMHs, Medicaid

Health Homes, Accountable Care Organizations, and models including Comprehensive Primary Care Plus and Primary Care First. These models promote some of the attributes of comprehensive primary care. CMS has also promoted collaboration among providers in rural areas where patient volume has not supported care models such as Accountable Care Organizations. With foundation support, the Center for Health Care Strategies is working with five states to help promote the spread and scale of best practices for serving vulnerable populations in Medicaid managed care.⁹⁰

CMS has used learning collaboratives in Medicaid to provide opportunities for states to share best practices, including the Medicaid Prevention Learning Network,⁹¹ though research suggests there are robust external entities involving Medicaid agencies as well as independent researchers that are capable of fostering constructive, thoughtful learning on primary care delivery and payment reform.⁹² To help the spread and scale of successful primary care models and promote innovation in Medicaid managed care, CMS should build on the agency's previous learning collaboratives to develop and support existing external initiatives through a focus on primary care.

Through this primary care focused learning collaborative, CMS should share best practices with states on topics including addressing the social determinants of health, reducing health disparities, and expanding the use of telehealth in Medicaid. Given the impact of COVID-19 on provider practices, particularly small provider practices which have been disproportionately affected,⁹³ these learning collaboratives should also include a focus on how to support these providers. This support should include best practices to help providers transition from a fee-for-service payment model that is sensitive to utilization fluctuations to value-based payment approaches that are more resistant to those fluctuations and supportive of innovation.⁹⁴

2. Direct the secretary of HHS to work with states and other stakeholders to promote measurement and report of spending on primary care as a percentage of total health care spending.

Investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.⁹⁵ The Primary Care Collaborative, a not-for-profit organization that represents a broad range of stakeholders in promoting and improving primary care, has issued a series of recommendations to promote best practices and increase primary care investment.⁹⁶ Despite current high levels of healthcare spending in the United States, the organization has raised concerns that the proportion spent on primary care is insufficient and advocates for a shift in resources to support greater access to comprehensive, coordinated primary care.⁹⁷ Given the importance of primary care, defining and quantifying these services will further build an evidence base to support additional investment in primary care.⁹⁸

3. Appropriate funding for the Primary Care Extension Program.

The ACA established the Primary Care Extension Program (PCEP) to support primary care practice transformation⁹⁹ by adapting the successful model the U.S. Department of Agriculture used to spread adoption of best farming practices.¹⁰⁰ The program allowed for community-based Health Extension agents and local primary care extension agencies to assist primary care providers in implementing patient-centered medical homes, work with local health departments and community organizations to identify local needs and priorities, address determinants of health, and strengthen local primary care workforces and address health disparities.¹⁰¹ Congress authorized but did not appropriate the \$120 million appropriation to AHRQ.¹⁰²

Despite the lack of funding, AHRQ implemented a pilot PCEP program from 2011 to 2013, the Infrastructure for Maintaining Primary Care Transformation (IMPACT), to demonstrate the efficacy of a national primary care health extension program.¹⁰³ Through IMPACT, four states received grants for quality improvement and practice transformation and worked with three to four partner states to share successful infrastructure models.¹⁰⁴

Drawing from lessons learned from IMPACT, AHRQ established EvidenceNOW, a health extension grant initiative focused on heart health in primary care.¹⁰⁵ Seven regional collaboratives participated in the EvidenceNOW model, which operated starting in 2015 and the last cooperative ending in early 2020.¹⁰⁶ Evidence supports expanding the demonstration as a means of improving primary care transformation and advancing population health.¹⁰⁷ Participating practices have substantially increased their capacity to implement new evidence and quality improvement strategies,¹⁰⁸ and small practices may especially benefit from practice facilitation.¹⁰⁹ AHRQ is seeking to build on EvidenceNOW to assist states with the highest rates of heart disease.¹¹⁰ Collectively, these initiatives have helped develop an evidence base of PCEP's potential for primary care providers¹¹¹ and funding the program will help improve access to quality health care services.

B. IMPROVE ACCESS TO INSURANCE COVERAGE

The lack of access to affordable health insurance and health care services are major barriers to comprehensive primary care. Some factors that contribute to the inability to achieve comprehensive primary care include the lack of coverage or under-insurance of some individuals, discontinuity of coverage, and affordability of care.

Health Insurance Coverage

Health insurance coverage is critical to accessing primary care, yet many Americans lack coverage or if they have coverage, benefits are limited. Studies

have shown that those with health coverage are more likely to receive preventive and screening services from a regular source of care, and insurance that has more extensive coverage of these services results in greater use of appropriate, recommended preventive and screening services.¹¹²

Under the ACA as enacted, states were required to provide Medicaid coverage to individuals with incomes up to 138% of FPL.¹¹³ Those with incomes above 138% of FPL receive subsidies for private health insurance coverage through Marketplaces.¹¹⁴ The Supreme Court decision in *NFIB v. Sibelius* effectively changed the Medicaid expansion from a requirement to a state option, resulting in a group of individuals in non-expansion states whose incomes were too high to qualify for Medicaid and too low to qualify for the premium tax credits.¹¹⁵ Of the 27.9 million nonelderly individuals who were uninsured in 2018,¹¹⁶ 2.3 million people reside in non-expansion states where they earn too much to be eligible for Medicaid, but earn too little to qualify for premium tax credits.¹¹⁷ Another 9.7 million of the 27.9 million individuals were ineligible for financial assistance because their income was too high to qualify for ACA subsidies, they had an offer from their employer to provide coverage, or they were undocumented immigrants.¹¹⁸ The remaining 15.9 million or 57% of all nonelderly uninsured individuals were eligible for financial assistance through Medicaid or through premium tax credits in the Marketplace.¹¹⁹

Medicaid beneficiaries can also lose coverage and continuity of care when they cycle on and off coverage. In Medicaid, intermittent coverage can be attributed to fluctuations in monthly income or failure to meet paperwork requirements for eligibility redeterminations.¹²⁰ According to studies, the cycle of coverage followed by loss of eligibility results in disruptions in the continuity of care and causes individuals to forgo primary and preventive care that can prevent more costly health care utilization.¹²¹ Under current law, states may provide 12 months of continuous coverage to children through Medicaid and the Children's Health Insurance Program (CHIP), even if the family experiences a change in income during the year.¹²² This option is not available for adults in Medicaid, though some states plan to use state-only funding or Section 1115 waivers to provide postpartum care to pregnant women after delivery for 12 months.¹²³ Provision of postpartum benefits among states has varied widely.¹²⁴ Congress has also temporarily required, as a condition of receiving the 6.2% increase in FMAP under the FFCRA, continuous coverage for all Medicaid recipients until the end of the public health emergency related to COVID-19.¹²⁵

Recommendations

To improve access to affordable health insurance coverage, Congress should:

- 1. Permit non-expansion states to expand Medicaid coverage under one of these options:**

- i. Provide coverage to adults with incomes up to 138% of the federal poverty level with 100% Federal Medical Assistance Percentage phased down over five years to 90%.**
- ii. Provide coverage to adults with incomes up to 100% of the federal poverty level with 88% Federal Medical Assistance Percentage, provided they expand coverage within two years of enactment.**

There are strong differences of opinion between Democrats and Republicans as to whether states should receive an enhanced FMAP unless the state extends coverage to those with incomes up to 138% of FPL. Given the unprecedented number of individuals who are filing for unemployment, the anticipated increase in Medicaid eligibility resulting from the pandemic and the simultaneous reduction in state revenues, it is unlikely that non-expansion states will do so at this time.

To encourage expansion, this policy would provide non-expansion states with the option to expand coverage to 138% of FPL and receive full federal funding during the first year, phasing down in the same formula that was available to early expansion states after enactment of the ACA. In some states, however, policymakers have been unwilling to expand coverage beyond 100% of FPL, and the current economic conditions will likely further deter expansion. The second option to cover individuals with incomes up to 100% of FPL and receive a slightly lower match rate creates a one-time opportunity for those states to expand coverage. BPC suggests a window of two years post-enactment, recognizing that some states' legislatures meet every two years. This option would not be available to states that expanded coverage before July 2020.

2. Permit states to auto-enroll individuals eligible for coverage under Medicaid, CHIP, or Marketplace subsidies in the appropriate programs. Marketplace auto-enrollment should only apply if the individual's subsidy meets or exceeds Marketplace premium costs.

Permitting states to auto-enroll eligible individuals will provide access to health insurance coverage at no additional premium cost to the individual. For auto-enrolled individuals, the HHS secretary should be directed to waive federal penalties if income fluctuations result in overpayments. The secretaries of Treasury, HHS, and Agriculture should make income information available at state request to facilitate auto-enrollment.

3. Create a new state option for 12-month continuous Medicaid eligibility for adults.

States would have the option of providing 12 months of continuous Medicaid eligibility without requiring enrollees to reapply or verify income and assets. This change will allow states to provide continuous coverage to low-income individuals, who often experience fluctuations in income, to avoid gaps in coverage and disruptions in care that can result in worse outcomes and higher

costs. This provision is not intended to supersede continuous eligibility requirements included in the FFCRA.

Coverage and Affordability of Preventive Services

Preventive services have potential to reduce disease, prevent medical conditions from worsening, reduce care utilization, and reduce Medicaid spending on chronic disease.^{126,127} Non-elderly adult Medicaid beneficiaries are much more likely than low-income privately insured and uninsured adults to report fair or poor health and suffer from greater rates of chronic conditions and risky health behaviors that may be addressed through preventive care.¹²⁸ As an example, obesity and tobacco use rates are especially high for this population.¹²⁹ The majority of states have not elected to cover all recommended preventive services without cost-sharing for the non-expansion Medicaid population in return for a 1% increase in FMAP they would be eligible to receive.¹³⁰

Lack of insurance coverage and cost-sharing for low-income individuals is associated with delays in care and adverse health outcomes.^{131,132} For high-value services, such as preventive services, individuals should have access to care without delay to reduce the risk for adverse health outcomes. These preventative services include blood pressure screenings, immunization vaccines, and lung cancer screenings for older, high-risk populations, among others.¹³³

Policymakers have encouraged coverage of high-value preventive services at no cost to encourage utilization, however the requirement does not apply in traditional Medicaid. Under current law, private insurers must cover all preventive services recommended by the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices without cost-sharing.¹³⁴ States must cover the same services without cost-sharing for the Medicaid expansion population, who have higher incomes than the traditional Medicaid population.¹³⁵ For children, these services are covered under Early and Periodic Screening, Diagnostic and Treatment.¹³⁶

States are not required to cover preventive services for the traditional Medicaid population.¹³⁷ If states choose to cover these services, they may impose cost-sharing requirements.¹³⁸ Congress did provide an incentive to states to expand preventive services without cost-sharing to the traditional Medicaid population through a 1% increase in FMAP.¹³⁹ Although most states do cover the recommended preventive services, many impose cost-sharing.¹⁴⁰ As of 2017, only nine states covered a list of all federally recommended preventive services without cost-sharing for traditional Medicaid.¹⁴¹ Requiring coverage of preventive services without cost-sharing for the traditional Medicaid population would create uniformity across payers and increase access to preventive services for the most vulnerable Medicaid beneficiaries.¹⁴²

Recommendation

To ensure preventive services are affordable and accessible, Congress should:

4. Require coverage of preventive care services for adults in traditional Medicaid without cost-sharing.

This change will align coverage of preventive services among Medicaid populations. The 1% increase in FMAP would continue for this population.

C. STRENGTHEN THE MEDICAID PRIMARY CARE WORKFORCE

Medicaid coverage alone does not guarantee access to primary care. Medicaid beneficiaries, when compared to privately insured individuals, find it harder to access primary care in a timely fashion, making them more likely to utilize emergency departments as a source of care.¹⁴³ In addition, according to primary care providers participating in Medicaid managed care plans, current policies present challenges to meeting patients' needs and some policies are detrimental to outcomes and quality of care.¹⁴⁴ Barriers preventing a robust primary care workforce within the Medicaid program include low provider reimbursement rates, the lack of data-driven network adequacy requirements in managed care, and the limited capacity of the primary care workforce.

Telehealth

Although not a covered benefit under Title XIX, CMS guidance permits states to determine whether and how they cover telehealth services, including eligibility, amount, scope, and duration.¹⁴⁵ CMS does not require states to file a state plan amendment (SPA) to cover telehealth services, unless they opt to reimburse at a rate that is less than the comparable office visit, in which case, states must file a SPA to get approval of a separate payment methodology.¹⁴⁶ In response to COVID-19, CMS has released a telehealth toolkit designed to assist states in their efforts to expand use of telehealth in Medicaid.¹⁴⁷

Provider Reimbursement

Across payers, primary care providers are generally reimbursed at lower rates than other providers, which has potential implications for access.¹⁴⁸ The difference in primary care and specialty care is even more pronounced in the Medicaid program. On average, primary care providers are reimbursed at about 66% of Medicare rates.¹⁴⁹ Primary care providers are less likely to accept new Medicaid-covered patients than those with Medicare or private insurance.¹⁵⁰

In 2013 and 2014, the ACA required states to increase Medicaid rates to primary care providers to 100% of Medicare and provided 100% FMAP to cover the cost of the increase for those services.¹⁵¹ As of July 2016, 19 states continued to pay primary care providers at an increased rate, although not all continued

at Medicare rates. Fourteen of those states had Medicaid-to-Medicare primary care fee ratios above 0.80 for eligible providers.¹⁵²

Evaluations of the impact of increased reimbursement on access to care found the increased reimbursement had only a modest effect, if any, on enrollment of new Medicaid providers.^{153,154} However, appointment availability increased among existing Medicaid providers, and availability increased most in states with the largest reimbursement increases, resulting in increased access to care.¹⁵⁵ States and other stakeholders have suggested the short duration of the increased reimbursement may have delayed state implementation of the policy and influenced states' decisions not to increase payment after the bump, resulting in challenges in recruiting new Medicaid providers.¹⁵⁶

Recommendation

To ensure that reimbursement for primary care providers is sufficient to support access to primary care services in Medicaid, Congress should:

1. Increase state Federal Medical Assistance Percentages to 100% for primary care services for states that reimburse at Medicare rates for five years.

The HHS secretary should apply the enhanced match for services provided by all primary care providers. Primary care providers would qualify for the increased payment by self-attesting to an eligible specialty or subspecialty and then attesting to either Board certification or an appropriate claims history—similar to the requirement under the ACA.¹⁵⁷ Enhanced match should apply to office visits and telehealth primary care services. While the ACA limited the Medicaid payment increase to primary care physicians, CMS clarified in regulation that the payment increase applied to non-physician practitioners practicing under the personal supervision of an eligible physician.¹⁵⁸ This policy recommendation would also extend the enhanced match rate to services provided by non-physician practitioners practicing independently, as long as they are practicing within the scope of their state license. This recommendation also extends enhanced match rate for primary care services delivered through telehealth to encourage provider participation in telehealth and improve access to primary care services for Medicaid enrollees. Establishing a five-year policy will provide data to help determine the effectiveness of the policy on access to care.

A national survey of primary care providers, conducted in 2015 by the Kaiser Family Foundation and the Commonwealth Fund, suggested that nurse practitioners and physician assistants are more likely than physicians to accept Medicaid and to accept new Medicaid patients.¹⁵⁹ Evidence also suggests that increasing Medicaid reimbursement for nurse practitioners may increase their participation in primary care and Medicaid acceptance.¹⁶⁰

In February 2020, [BPC's Future of Health Care initiative](#) recommended a similar policy and suggested the cost of the increase in reimbursement could be offset through by reforming Medicaid supplemental payments.¹⁶¹ To help facilitate this policy without jeopardizing access to care, the report recommended Congress direct the HHS secretary to finalize proposed requirements for state reporting of upper payment limit (UPL) supplemental payments, but delay proceeding with other aspects of CMS' proposed Medicaid Fiscal Accountability Regulation (MFAR), pending a review of those reports and the submission of a comprehensive plan to reform these payments while ensuring access to care.^{162,163} The proposed rule takes steps to constrain the financing mechanisms that support supplemental payments, which could have broader implications for state finances and access to care.¹⁶⁴ With projected increases in Medicaid enrollment and strain on state budgets from COVID-19, the proposed MFAR creates uncertainty for states' current financing mechanisms. A proposal from House Democrats included a provision that would have delayed implementation of the MFAR until two years after the public health emergency,¹⁶⁵ but the congressionally passed CARES Act did not include this provision.¹⁶⁶ However, the CARES Act delayed reductions to Medicaid Disproportionate Share Hospital (DSH) payments until December 1, 2020.¹⁶⁷

BPC's report also recommended Congress direct the HHS secretary to review distribution of UPL supplemental payments and submit recommendations to Congress on ways to phase out these payments over five years, while incentivizing states to increase the base rate providers are paid for serving Medicaid patients to ensure the link between payment and access, quality, and value.

Network Adequacy Requirements in Medicaid Managed Care

The 2016 Medicaid Managed Care Final Rule directed states to develop MCO network adequacy requirements based on the time and distance enrollees must travel to access certain providers, including primary care providers.¹⁶⁸ Under the current law standard, states may also use other measures in addition to time and distance to account for other factors impacting provider availability, such as access through telehealth services.¹⁶⁹ A Medicaid and CHIP Payment and Access Commission (MACPAC) review of state oversight of network adequacy and access found that all 14 states reviewed had additional standards beyond current law time and distance standards.¹⁷⁰

In November 2018, CMS proposed eliminating the time and distance standard, and requiring states to set a quantitative minimum access standard.¹⁷¹ The proposed standard is broader than the current law time and distance standard. Quantitative standards that states could elect under the proposed rule, include but are not limited to: minimum provider-to-enrollee ratios; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements

such as extended evening or weekend hours; the current law time and distance standard; or a combinations of these quantitative measures.¹⁷²

Recommendation

To strengthen MCO network adequacy requirements, Congress should:

- 2. Direct the HHS secretary to delay proposed changes to managed care organization network adequacy requirements and direct MACPAC to develop data-driven access standards, taking into account the impact on medically underserved populations, including rural residents. Congress should direct the secretary to promulgate regulations based on the new data-driven standard.**

This policy recommendation would require that changes to Medicaid network adequacy requirements be based on a data-driven standard that accounts for potential impacts to medically underserved populations. CMS states in the proposed rule that a quantitative minimum access standard would be a more effective standard than the current law standard for reflecting provider availability.¹⁷³ But some stakeholders have concerns the proposed, broader standard may result in weaker access measures that less accurately reflect provider availability and contribute to reduced access for underserved populations. A new data-driven standard would ensure a more accurate reflection of provider availability while preserving access for medically underserved populations.

Primary Care Workforce Capacity

Limited accountability and transparency of federal graduate medical education (GME) funding that goes towards supporting the provider workforce, limitations placed in the immigration system for foreign-trained doctors practicing in the United States, and short-term funding for community health centers should all be addressed to increase the number of primary care providers.

HHS agencies administer 72 health workforce programs that include education, training, and payment programs.¹⁷⁴ The U.S. Government Accountability Office (GAO) has found these programs lack comprehensive planning, oversight, and coordination to ensure healthcare workforce needs are met.¹⁷⁵ Included in these programs are education and training programs the federal government funds to support the supply and distribution of providers.¹⁷⁶ GME payments to teaching institutions account for about 90% of those training and education funds, while Health Resources and Services Administration (HRSA) funds to encourage students to train and work in health professional shortage areas account for most of the remaining funds.¹⁷⁷

Federal spending on GME reached \$16.3 billion in 2015¹⁷⁸ and the federal share of Medicaid GME payments was \$2.3 billion.¹⁷⁹ GAO has highlighted the need for increased accountability and transparency of federal GME funding.¹⁸⁰

Medicare is the largest source of federal GME payments (71%), while federal match for Medicaid payments is the second largest (16%).¹⁸¹ Other sources of federal GME payments include the Children’s Hospital GME payment program, Teaching Health Center GME program, and the Veterans Affairs program.¹⁸² While there is no federal requirement for state Medicaid programs to make GME payments to teaching institutions, 45 state Medicaid agencies made GME payments in 2015.¹⁸³

Easing restrictions on foreign-trained doctors practicing in the United States may be another way to meet workforce needs during public health crises. Foreign-trained doctors, or international medical graduates (IMGs), make up more than one out of every four doctors in the United States, and almost one out of every three primary care physicians.¹⁸⁴ Sixty-two percent of all IMGs practicing in the United States are primary care physicians;¹⁸⁵ IMGs are more likely to practice in medically underserved regions, serve higher percentages of minorities,¹⁸⁶ and serve a higher percentage of Medicaid or CHIP-eligible individuals as part of their total patients at 17.6% compared to U.S. medical graduates at 10.2%.¹⁸⁷ However, there are significant barriers and restrictions foreign-trained doctors face in immigrating and practicing medicine in the United States, even as the country faces a worsening shortage problem.¹⁸⁸

The J-1 exchange visa that many of these doctors use to complete residencies in the United States requires them to return to their home country or country of last legal residence for two years before they can apply for certain visas, unless they apply for a waiver that requires them to work in medically underserved areas or with medically underserved patients.¹⁸⁹ Besides waivers granted on the basis of persecution and exceptional hardship, waivers are granted through a “Request by an Interested U.S. Federal Government Agency,” (IGA) and through the Conrad State 30 Program.¹⁹⁰

The Conrad 30 program provides 30 J-1 visa waivers to each state that allows international medical graduates to stay and practice in the United States after their J-1 visa expires for three more years through an H-1B nonimmigrant visa if they commit to practicing in Health Professional Shortage Areas.¹⁹¹ The Conrad 30 program requires regular reauthorizations and is set to expire September 30, 2020.¹⁹²

Community health centers serve a critical role for Medicaid beneficiaries and others, but their reliance on short-term funding creates uncertainty and threatens their ability to operate successfully.¹⁹³ As of February 2019, community health centers served 28 million individuals, including 24.9 low-income and 6.2 million uninsured individuals.¹⁹⁴ Community health centers are required to provide certain health care services, including primary care services, to all individuals in the service area or who are part of its target population, regardless of ability to pay.¹⁹⁵ Primary revenue sources include Medicaid, Medicare, private insurance, self-pay patients, Section 330 grants

awarded through HRSA, the CHCF established by the ACA, and other grants.¹⁹⁶ The largest source of funding for Community Health Centers in 2018 was Medicaid, which provided 45% of revenue, followed by Section 330 grants that accounted for 17%.¹⁹⁷ In some states, however, Section 330 grants exceed Medicaid revenues.¹⁹⁸

Recommendations

To increase primary care workforce capacity by addressing health professional shortages, Congress should:

3. Direct the HHS secretary to establish a comprehensive plan to ensure oversight and coordination of all federal programs that address healthcare workforce needs.

In developing the plan, the secretary should take into account all sources of federal funding including Medicare, Medicaid, programs administered by the Health Resources Services Administration, and the Veterans Affairs program. Oversight and coordination activities should maintain state flexibility in determining Medicaid GME payments. Congress should require states that make supplemental payments to teaching institutions for graduate medical education to identify specialties supported by those payments and demonstrate to the secretary that Medicaid GME payments reflect the state's Medicaid provider workforce needs.

Medicaid GME costs may be reimbursed as an add-on adjustment to the state's provider payment rates or as a lump sum supplemental payment through UPL supplemental payments, DSH payments, or as part of an uncompensated care pool authorized by an 1115 waiver.¹⁹⁹ CMS requires states that make Medicaid GME payments to report on the aggregate GME supplemental payments, but does not require reporting on payments at the provider level, amount of add-on adjustments to the payment rate for GME, or how these payments support GME training.²⁰⁰ States can establish their own additional reporting requirements, but only 20 of the 45 states that made Medicaid GME payments required recipients to report on the number or characteristics of residents supported by Medicaid GME payments.²⁰¹ States may also restrict Medicaid GME payments to the training of certain types of physicians.²⁰² According to GAO, four states (Alabama, Montana, New Mexico, and South Dakota) have restricted Medicaid GME payments to the training of primary care physicians only, and nine states required that the funding recipient have a primary care residency program.²⁰³

Greater accountability is needed for how Medicaid GME payments are meeting Medicaid provider workforce needs. States should begin exercising their existing authority to both direct Medicaid GME payments and require recipients of Medicaid GME payments to report on the residents supported by those payments, in order to demonstrate that Medicaid GME payments reflect

the state's Medicaid provider workforce needs. According to the Association of American Medical Colleges, three states (Michigan, New Jersey, and Virginia) already have similar state level requirements to document and report the impact of Medicaid GME payments on their state's health care workforce.²⁰⁴ This policy recommendation would create accountability for Medicaid GME payments across states.

4. Reauthorize the Conrad 30 program and expand the number of J-1 Visa Waivers each state receives through the program from 30 to 50, with priority given to those in rural areas.

In April 2020, BPC's Rural Health Task Force released a [report](#) addressing the health care needs of rural America.²⁰⁵ To address workforce shortages, the report recommended reauthorizing the Conrad 30 Waiver program and increasing the number of J-1 visas for IMGs from 30 to 50 per state.²⁰⁶ The task force recommended a priority for placement should be in rural areas.²⁰⁷ The report highlighted S.948, The Conrad State 30 & Physician Access Reauthorization Act introduced by Senator Amy Klobuchar (D-MN).²⁰⁸ The bill would reauthorize the Conrad 30 Waiver program until 2021, increase the number of waivers each state can offer to IMGs to more than 30 if demand rises high enough, and establish other changes that would make it easier for IMGs to better provide care in the country.²⁰⁹ The bill has 15 co-sponsors and the support of the American Medical Association, the American Hospital Association, and the Association of American Medical Colleges.²¹⁰ A companion bill has been introduced in the House of Representatives by Rep. Bradley Schneider (D-IL).²¹¹

A survey of 33 states found about half use all of their waivers while half do not.²¹² States have, however, used more waiver slots as physician shortages have gotten worse.²¹³ Increasing the number of slots would give states that have used all of their slots more options to serve the needs of their residents²¹⁴ without requiring more federal funding.²¹⁵

5. During a public health emergency, revise restrictions on international medical graduates on H-1B visas to permit an employer to deploy an international medical graduate from an assigned site of service to another within the health system and permit an international medical graduate to provide telehealth services outside that location.

To obtain an H-1B visa allowing an international medical graduate to work, employers have to specify, among other things, the location of work; 2015 guidance from U.S. Citizenship and Immigration Services (USCIS) clarified that changes to that location require submission of a new application.²¹⁶ A bipartisan group of members of Congress have stated this specification and difficulty in changing it have made it impossible for physicians holding H-1B visas to transfer to work at overwhelmed hospitals and facilities or those with staff shortages.²¹⁷ These restrictions also prevent these physicians from

providing telehealth services to areas of need.²¹⁸

USCIS has temporarily waived visa restrictions with regards to the practice of telehealth outside approved locations for IMGs who have received a J-1 waiver.²¹⁹ USCIS noted in the same waiver there was no previous statutory or regulatory guidance on whether Conrad State 30 or IGA international medical graduates could meet their service requirement through provision of telehealth services, and they and the State Department have decided to interpret the relevant authorities to allow them to do so during the emergency.²²⁰ This recommendation would waive restrictions during a public health emergency without a need for agency action. It would also allow IMGs to be deployed to other sites of service to provide needed in-person services in places of high demand. These relaxed telehealth restrictions will not preempt state telehealth or federal payer telehealth laws.

6. Reauthorize federal funding for the Community Health Center Fund at the current level of \$5.6 billion annually, including both mandatory and appropriated funding.

While the Bipartisan Budget Act of 2018 authorized a longer two-year extension of the CHCF that expired in September 2019,²²¹ community health centers have since had to rely on short-term extensions.²²² Congress recently extended the CHCF through the end of November 2020 and appropriated \$1.32 billion under the CARES Act.²²³ However, community health centers need additional stable, long-term funding to ensure continued access to care for the vulnerable populations they serve.²²⁴

D. ADDRESS RACIAL, ETHNIC, AND ECONOMIC DISPARITIES IN MEDICAID

Medicaid provides health insurance to individuals from all racial and ethnic groups.²²⁵ For 2018, 44.9% of nonelderly adult Medicaid beneficiaries were White, non-Hispanic, 24.7% were Hispanic, 21.5% were Black, non-Hispanic, and 8.9% were other non-white, non-Hispanic.²²⁶ Additionally, many beneficiaries qualify for Medicaid based on their disability status.²²⁷ While adults with Medicaid coverage fare better on access to care and quality of care measures compared to uninsured individuals, they fare worse when compared to those with private insurance.²²⁸ Individuals with low incomes up to 100% FPL experience significant disparities in access to care compared to those with higher incomes at or above 400% FPL.²²⁹

Medicaid plays a critical role in serving individuals with disproportionately lower incomes, including racial and ethnic minority groups, the elderly, and individuals with disabilities, limited English proficiency, complex conditions,

or disparate access to care, such as rural populations.²³⁰ According to the CDC, residents in minority communities experience lower socioeconomic status, greater barriers to accessing care, and higher risk for disease compared to the general population in the same county or state.²³¹ As a result, Medicaid is particularly suited to address health equity.²³² Recommendations to maintain language access, provide guidance on the use of community health workers, protect individuals with disabilities from discrimination, and cover certain non-medical services that address social needs for certain populations will all contribute to reducing disparities in Medicaid.

Language Access

In 2014, a study found that approximately 6.4 million individuals enrolled in Medicaid, or 10%, have Limited English Proficiency.²³³ Under Title VI of the Civil Rights Act²³⁴ and Section 403 of the Rehab Act of 1973,²³⁵ health care providers receiving reimbursement under federal programs, including Medicaid and CHIP must make language services available to those with limited English proficiency.²³⁶ While translation and related services are not a mandatory benefit under Medicaid or CHIP, states may consider these costs in the regular rate of reimbursement for direct service through claiming Medicaid reimbursement for interpretation services as medical-assistance by increasing provider rates or as administrative-related expenditure at a rate that is higher than the state's regular administrative match.²³⁷ As of February 2017, 15 states directly reimburse providers for language services.²³⁸

The ACA included provisions designed to limit discrimination in the provision of health services. Section 1557 extended nondiscrimination protections to individuals participating in any HHS-funded health program or activity, required states to post taglines—short non-English statements that indicate the availability of free language assistance services—²³⁹ in the top 15 languages spoken by individuals with limited English proficiency in that state, and encouraged states to develop and implement language access plans.²⁴⁰ The ACA also allowed Medicaid expansion states to receive enhanced reimbursement for language services provided to expansion populations at 90% FMAP in CY 2020 and beyond.²⁴¹

Community-level Solutions to Address Disparities in Medicaid

One strategy to address disparities in Medicaid has been the use of Community Health Workers (CHWs). Also referred to as community health advisors, outreach workers, peer counselors, and patient navigators, CHWs are public health workers who are trusted members of a community or have close understanding of the communities in which they serve.²⁴² CHWs serve as a link or liaison between underserved communities and the hospitals and clinics located within them.²⁴³ According to CDC, CHWs have improved health, reduced disparities, and enhanced health equities in minority and underserved

communities.²⁴⁴ Studies have shown CHWs improve outcomes for underserved populations in the areas of prevention and control of chronic disease, including asthma management and increasing cancer screening.²⁴⁵

CHWs have also demonstrated net-savings in some areas. For example, in west Baltimore, using CHWs as part of the care team resulted in cost-savings savings of \$2,000 per enrollee with diabetes and \$2.6 million net savings through outreach to those in need of home and community-based services.²⁴⁶ While there is no national standard for training, certification, and licensure for CHWs, some states have established their own training and certification requirements to support reimbursement through Medicaid.²⁴⁷

CHW services are not directly financed as Medicaid-covered services, though states can pay for these services through managed care, state plan amendments utilizing CHWs as part of health homes, and by including CHWs in the state preventive service and targeted case management benefits.²⁴⁸ About half of states with managed care require MCOs to employ CHWs.²⁴⁹ States have also financed CHWs through 1115 waivers and through grant funding.²⁵⁰

CMS has provided guidance to states on the role and reimbursement of peer specialists in treatment of mental illness and substance use disorder.²⁵¹ While CHWs and peer specialists share a similar peer status, differences exist in their typical role.²⁵² Peer support providers are self-identified consumers who are in recovery from mental illness and substance use disorder. They are trained to deliver services that include supervision and care coordination as core components. ASPE has found peer support services effective for promoting recovery-based outcomes for those with behavioral health conditions, but notes the inherent challenges in evaluating health outcomes due to differences in training and certification standards, coverage and reimbursement levels, and service models.²⁵³ A study examining the literature suggests peer support workers are more successful than professionally qualified staff in promoting hope and belief in the possibility of recovery, empowerment, increased self-esteem, self-efficacy, self-management of difficulties and social inclusion, engagement, and increased social networks.²⁵⁴

Recommendations

To prevent discrimination and to encourage states to address disparities in Medicaid, Congress should:

- 1. Block implementation of the June 2020 final rule eliminating non-discrimination provisions and direct GAO to determine the impact of the rule.**

In June 2020, HHS finalized a rule that changes the agency's 2016 interpretation of the anti-discrimination provisions in Section 1557 of the ACA.²⁵⁵ The new rule eliminates and weakens several non-discrimination provisions in federal programs.²⁵⁶ Specifically, the final rule eliminates the requirement for covered

entities to send notices and taglines, in at least the top 15 languages spoken by individuals with LEP, with all significant communications.²⁵⁷ Covered entities, under the final rule, are now only required to provide taglines when they are necessary to ensure meaningful access for individuals with LEP.²⁵⁸ In response to comments, HHS reasoned that “the financial burden on covered entities was not justified by the protections or benefits it provided to LEP individuals.”²⁵⁹ In the proposed rule, however, HHS acknowledged that repealing the notice and tagline requirements would decrease access to and utilization of health care for non-English speakers.²⁶⁰ The agency characterized this impact as negligible.²⁶¹ To confirm the accuracy of this assessment and the scope of the proposed rule’s impacts on access to care, a more detailed evaluation should be conducted by GAO.

The final rule also weakens requirements for serving individuals with LEP. The previous regulations focused on individual protections by requiring that covered entities provide meaningful access to “each individual” with LEP “eligible to be served or likely to be encountered.”²⁶² The new rule shifts the focus from protecting each individual to requiring any entity operating or administering a health program or activity to take “reasonable steps to ensure meaningful access to such programs or activities by limited English proficient individuals.”²⁶³ The new rule also changes how compliance with this meaningful access requirement is evaluated. Specifically, previous regulations directed the evaluator to give “substantial weight” to the nature and importance of the health program and the communication at issue to the individual, while also considering relevant factors such as implementation of a language access plan.²⁶⁴ The new rule, however, replaces that standard with a four-factor test that allows the Director of the Office for Civil Rights to assess how the entity balances (1) the number or proportion of limited English proficient individuals eligible to be served or likely to be encountered in the eligible service population; (2) the frequency with which LEP individuals come in contact with the entity’s health program, activity, or service; (3) the nature and importance of the entity’s health program, activity, or service; and (4) the resources available to the entity and costs.²⁶⁵ Under this new standard, the resources available or cost of providing meaningful access for individuals with LEP could outweigh the needs of these individuals and negatively impact access to care. A detailed evaluation from GAO would help determine how the new meaningful access requirements will impact access to care.

Other changes under the rule that could impact access to care include: requiring application of the four-factor test to assess whether video remote interpreting services must be provided to individuals with LEP; changes to the definition of “auxiliary aids and services” relating to effective communication for individuals with disabilities; changes to the regulatory definition of “electronic and information technology;” eliminating regulations that prohibit specific discriminatory insurance practices, including discriminatory insurance marketing practices or benefit designs; and eliminating protections against sex-based discrimination, including

discrimination related to gender identity and sex stereotyping.²⁶⁶

Congress should block implementation of the final rule pending a GAO evaluation to determine the impact of the rule on access to care. If the evaluation concludes that access to care would likely be harmed under the rule, then Congress should block implementation.

2. Direct the secretary of HHS to provide CMS guidance to states on defining and reimbursing community health workers, where evidence has demonstrated improved outcomes for those with chronic conditions.

Coverage of CHWs has proven to be effective in addressing health care disparities in minority and underserved communities, improving outcomes, and reducing Medicaid costs for some populations and conditions. In developing guidance, the HHS secretary should take into account the numerous studies to determine how best to include CHW services as part of a comprehensive primary care model.

Nondiscrimination of Individuals with Disabilities

Despite federal requirements under Titles II and III of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, individuals with disabilities continue to face challenges with physical accessibility of providers' offices and facilities and with effective communication.²⁶⁷ This creates barriers to accessing services and limits choice of providers for individuals with disabilities.²⁶⁸ In fact, adults with disabilities are almost twice as likely as other adults to report unmet health care needs due to problems with accessibility of a doctor's office or clinic.²⁶⁹ There is a desire among stakeholders and advocates to see state Medicaid agencies taking greater accountability and proactive measures to ensure their provider networks are meeting these federal requirements.²⁷⁰ Currently, states generally require MCOs and providers to meet these federal requirements through their contracts, but states need to establish monitoring and enforcement mechanisms to ensure these requirements are met.²⁷¹

Recommendation

To increase accountability for ensuring nondiscrimination and access to Medicaid benefits for individuals with disabilities, Congress should:

3. Direct the HHS secretary to require states to establish monitoring and enforcement mechanisms that ensure providers who receive Medicaid and CHIP funding comply with laws prohibiting discrimination against individuals with disabilities.

States should be required to establish monitoring and enforcement plans that include a schedule for routine audits of Medicaid entities to verify individuals with disabilities have equal access to health care services, including physical access and access to effective communication. Factors impacting physical access may include room size, exam table height, lifts, x-ray equipment, and

other physical accommodations. Access to effective communication may be determined by factors such as availability of a language interpreter, availability of consent forms in braille for those with blindness, and similar requirements that address barriers to effective communication. The secretary should assure coordination between the Office for Civil Rights and other appropriate federal agencies in the implementation of this requirement.

Pathway to Address Individual-Level Social Needs in Medicaid

The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, live, work and age.”²⁷² These determinants include, among other factors, housing and food insecurity and are responsible for up to 80% of population health outcomes.²⁷³ There is a growing recognition this needs to be addressed as part of value-based care transformation.²⁷⁴ Medicaid beneficiaries often have the most serious needs that lead to poor outcomes and higher Medicaid expenditures.²⁷⁵

Generally, states may only seek FMAP payments for Medicaid-covered services.²⁷⁶ This includes both mandatory and optional Medicaid services.²⁷⁷ Unless the state seeks a waiver, it may not use Medicaid funding for non-covered services.²⁷⁸ Federal law prohibits Medicaid from covering the cost of room and board except in a “facility,” as part of institutional long-term care.^{d,279}

Medicaid managed care plans receive a per member per month (PMPM) payment from the state, which represents the plan’s cost of providing the full range of Medicaid benefits.²⁸⁰ States may receive federal matching dollars for expenditures for Medicaid-covered services including the PMPM payments to managed care plans.²⁸¹ As an exception to the prohibition against claiming federal matching funds for non-covered services, managed care plans may offer benefits “in-lieu-of” a Medicaid-covered service, subject to state approval.²⁸² Those benefits must be included in the state plan, and the cost of the service provided in-lieu of a covered Medicaid benefit is included in the PMPM payment to the plan.²⁸³ Under this exception, services that are neither mandatory nor optional Medicaid benefits are eligible for FMAP without a federal waiver. An example of one of these services is home nurse visits to new mothers in lieu of requiring them to receive services in a provider’s office or cab fare in lieu of non-emergency medical transportation.

Plans may also offer additional non-medical benefits provided at plans’ discretion.²⁸⁴ These “value-added services” might include such items as a portable crib to assure that a newborn has a safe place to sleep. These value-added services, unlike services provided in lieu of a covered benefit may not be

d Medicaid requires coverage of non-Institution for Mental Disease nursing facility services for those age 21 and older, and can optionally cover intermediate care facilities for individuals with intellectual disability and services in Institutions for Mental Disease for those age 65 and older. Most states have elected to cover the latter two benefits.

claimed for the purposes of federal matching dollars.²⁸⁵

Incentives to offer or refrain from offering additional services are driven by medical loss ratios. A medical loss ratio (MLR) is the ratio of payments that a managed care plan makes for Medicaid-covered services provided to a covered enrollee.²⁸⁶ Similar to the MLR for Medicare Advantage and qualified health plans offered through insurance marketplaces, the MLR is set at 85%.²⁸⁷ As such, 85% of their premium revenue must be used to pay for services or cover the cost of quality improvement or fraud prevention activities.²⁸⁸ Only benefits provided “in lieu of” a covered service may be included in the calculation of the MLR.²⁸⁹ As a result, spending on value-added services must be provided out of the 15% of revenue that plans use for marketing, administration, and other costs.

Policymakers at the state and federal level have taken additional steps to make it easier to address social needs in Medicaid. In response to extensive research demonstrating the strong impact housing has on improving health and well-being, CMS issued guidance that stopped short of allowing for housing, but permits coverage of housing-related supports, such as minor home modifications.²⁹⁰ More recently, HHS secretary Alex Azar announced steps to provide more state flexibility under the Medicaid program to address social determinants.²⁹¹ The movement by policymakers has also extended to Medicare. Through the Bipartisan Budget Act of 2018, Congress enacted legislation to permit Medicare Advantage plans to offer certain non-medical services to patients with multiple chronic conditions, provided the services had a reasonable expectation of improving health or function.²⁹²

At the state level, North Carolina is implementing a section 1115 waiver that permits reimbursement of non-medical interventions that target certain social determinants of health: housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress.²⁹³ The state will use standardized screening questions to identify and assist Medicaid enrollees with unmet health-related resource needs.²⁹⁴ The North Carolina waiver is limited in scope and impact, serving only 1% to 2% of Medicaid enrollees in the state across two to four regions.²⁹⁵ Stakeholders believe CMS is taking a wait-and-see approach with similar state waiver submissions. The State of Oregon found that individuals placed in stable and affordable housing had increased primary care visits and decreased emergency department visitations, resulting in reduced Medicaid expenditures.²⁹⁶

Recommendation

To improve the financing and coverage of proven cost-effective interventions to address social needs for high-risk populations, Congress should:

4. Provide the HHS secretary with the authority to approve Medicaid

coverage of non-medical services that address social needs if the secretary certifies the following:

- i. Peer-reviewed evidence demonstrates the benefit improves or maintains health or function for the targeted population.**
- ii. The CMS Office of the Actuary certifies coverage of the defined benefit for the defined population would result in no net increase in Medicaid spending over the long-term.**
- iii. Additional benefits apply only to patients who are enrolled in Medicaid managed care or other health care payment and delivery models that include a comprehensive team-based approach to care management.**

The evidence base for these targeted services is very limited, however data collected from the North Carolina waiver and similar efforts could help expand the data base to inform coverage. To determine the potential for savings in Medicare, BPC commissioned a [study](#) in 2019 that examined the potential for reduced hospital readmissions and ER visits for Medicare beneficiaries with specific chronic conditions.²⁹⁷ The report found the potential for reductions in ER visits and readmissions if patients were provided two weeks of medically-tailored home-delivered meals immediately following hospital discharge; for every dollar spent on providing medically tailored meals to eligible beneficiaries led to \$1.57 in savings from reduced hospitalizations and health care utilization.²⁹⁸

Targeting services to specific populations will require strong care management to identify patients and have a comprehensive picture of their care needs. At the same time, providers will need a screening tool to determine which patients meet the criteria for these services. For example, the SCAN Foundation and multiple partners developed the My Care, My Choice online tool that asks individuals questions about their care needs and preferences and then provides the “best fit” coverage options based on those responses.²⁹⁹ The HHS secretary should be directed to create a model set of social needs screening questions to identify patients. Once approved by the secretary as an added service and if adopted by the state, these services should be included in the Medical Loss Ratio as “incurred claims,” but not included in the capitation rate for payment to plans.

Conclusion

A strong case can be made to invest in and promote a more comprehensive approach to primary care. Federal policy limits the spread and scale of comprehensive primary care. Strong leadership at the state and federal levels are needed to address barriers. Policymakers should enact and implement policies to accomplish the following:

- Develop a comprehensive framework for transformation of primary care.
- Invest in primary care providers.
- Support evidence-based care models.
- Address disparities.
- Improve access to health care.

COVID-19 has only amplified barriers across our health care system. While stakeholders have made significant progress in improving primary care in Medicaid, we hope these recommendations can provide a roadmap for next steps. But these recommendations are not comprehensive. More can and should be done to identify barriers and promote primary care across programs and payers.

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