Recent Medicaid policy discussions have focused on coverage issues because millions of beneficiaries have been disenrolled during the unwinding of COVID-19 pandemic-era eligibility protections. But access to care during a person's enrollment in Medicaid is an equally important issue, and one that is particularly thorny to measure and address.

Policies extending Medicaid to previously uninsured people improve access to care, with a range of positive downstream health and economic outcomes.1,2 However, programmatic choices need to be made beyond who gets covered, and policymakers need better information to guide decisions (1) regarding state Section 1115 waiver demonstration projects, (2) when measuring Medicaid program and plan quality, and (3) in determining reimbursement rates and the adequacy of clinician networks.

Medicaid policy includes federal and state oversight designed to ensure access to care for enrollees. Federal standards require that policies are “sufficient so that care and services” in Medicaid are similar to those available “to the general population.” Within these federal guidelines (and ongoing regulatory updates), state Medicaid agencies set reimbursement rates, participation requirements, and approaches for monitoring clinician networks. States may set standards based on several factors, including clinician-to-enrollee ratios, distance, or wait times.

Currently more than 70% of Medicaid enrollees receive care through managed care organizations (MCOs), which create their own clinician networks and negotiate payment rates with Medicaid agencies. States have flexibility in how they enforce access standards, including how they define the adequacy of MCO networks and monitor enrollee access to care. With different Medicaid programs in 56 states and territories (and numerous MCOs operating within them), variability is the norm.

Medicaid's complexity makes measuring the concept of “access” challenging. Perhaps the most cited metric is the share of physicians who accept new Medicaid patients. For instance, a former Secretary of the US Department of Health and Human Services observed in 2017 that “one-third of the physicians in this nation…are not seeing Medicaid patients,” and critics of the program often compare this statistic unfavorably to the share of physicians (82%-90%, depending on the study) who report accepting private insurance.3,4

But this common framing of access in Medicaid is not particularly useful because measuring access to care should be centered on the patient and not the clinician. Knowing the percentage of physicians who treat new Medicaid patients is only loosely connected to patients' experiences for several reasons. First, absolute numbers often matter more than percentages. For instance, based on the percentage of physicians accepting new Medicaid patients, Wyoming ranks first among states at 99%; but when factoring in the state's relative shortage of clinicians, the state ranks 33rd in physicians per capita accepting Medicaid. In contrast, after shifting from percentages to numbers of physicians, New York goes from 46th to eighth.5

Second, comparisons with private insurance are not meaningful. There is no monolithic private insurance in the US. Almost all individuals with private insurance plans have limited networks that are specific to their plans. Although some plans have generous networks, substantial numbers of individuals have narrow network private plans covering fewer than one-quarter of area physicians. One study found that, on average, Affordable Care Act Health Insurance Marketplace plans covered...
just 31% of area physicians, and only half of employers described their private health insurance plans in 2020 as offering "very broad" provider networks.

Third, measuring access by acceptance rates for new patients obscures the fact that most Medicaid beneficiaries already have established relationships with clinicians. The more relevant question for many is how easily and promptly they can be seen by their clinicians.

Better measures of access should be meaningful to patients. Alternative metrics exist, such as appointment availability and wait times, often assessed using secret shopper (aka audit) studies. The Centers for Medicare & Medicaid Services recently proposed requiring states to use this method to assess patient access in Medicaid MCOs. Time and distance standards (ie, how far away and how long a beneficiary has to travel for an appointment) can also be useful patient-centered information, though if states do not estimate travel times based on public transit, they may underestimate the actual burden on beneficiaries who do not drive.

Patient surveys can directly elicit whether beneficiaries are struggling to obtain timely care. An ideal data source would be an annual national survey of Medicaid beneficiaries akin to the Medicare Current Beneficiary Survey. A Medicaid-focused survey of this type was conducted in 2015, but it has not been repeated. Other existing surveys are either not specific to Medicaid or are conducted in an inconsistent manner across states or MCOs. However, individual state surveys can provide valuable information focused on state-specific policies.

Actual patterns of health care use reflect access to care. Even though the quality of Medicaid claims collected and reported by states has improved in recent years, the data they provide are not always comparable across states or with other payers; research using all-payer claims databases can put Medicaid use patterns in context with other types of insurance.

More meaningful metrics are the first step to identify access shortfalls and develop related policy solutions. To maintain and improve access to care for Medicaid enrollees, policies need to be tailored to the states, including consideration of the supply and distribution of clinicians and the degree of managed care penetration. In states with fewer clinicians per capita, such as Alaska or Wyoming, most physicians already accept Medicaid through fee-for-service arrangements, but rural areas lack sufficient numbers of clinicians. Efforts to ensure access in these areas need to focus on the overall number and distribution of the workforce, rather than Medicaid acceptance rates. In contrast, states with a relative abundance of clinicians, such as Massachusetts and Pennsylvania, may need additional incentives to persuade clinicians to provide care to patients with Medicaid.

Increasing clinician reimbursement to match Medicare or private insurance rates is often cited as a policy solution to boost access for Medicaid enrollees. However, higher reimbursement would have minimal effects in rural states where nearly all physicians already accept Medicaid or in states where most clinicians are paid via rates set by managed care arrangements. Prior research shows a positive, but modest, relationship between paying clinicians more and increased patient access in Medicaid. Several nonfinancial factors are also important in clinicians’ decision-making about participating in Medicaid, including availability of specialists who accept Medicaid and concerns about having adequate resources to care for patients with complex psychosocial and medical needs.

Thus, policy tools beyond reimbursement are needed. In areas with substantial MCO penetration, Medicaid agencies could prioritize contracting or set the MCOs with broader networks or shorter wait times as the default plans for beneficiaries. These policies would incentivize plans to address both financial and nonfinancial barriers to clinician participation. Increased funding for federally qualified health centers that offer wraparound services for behavioral and social needs can help address concerns about patient complexity.

Equally important are policies to promote an adequate, diverse workforce in health professional shortage areas, including rural regions. Studies show that advanced practice clinicians (such as nurse practitioners and physician assistants) who are Asian, Black, female, or Hispanic are more likely to serve Medicaid patients and that clinicians with rural backgrounds are more likely to return to rural areas to practice. Thus, expanded scope of practice for advanced practice clinicians and programs...
that recruit trainees who are underrepresented in health care may improve access for Medicaid beneficiaries.

More than 80 million people rely on the Medicaid program for health insurance coverage. To maintain and improve access to care, patient-centered metrics and consideration of the number and distribution of clinicians should be emphasized. Equipped with better metrics, policymakers can develop better policies that are built on the existing strengths of the Medicaid program to guarantee meaningful access to care for beneficiaries across the country.

REFERENCES