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Medicaid and Health Care Reform

American College of Physicians

A Position Paper

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Medicaid and Health Care Reform

A Position Paper of the American College of Physicians

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Executive Summary

In 2005, the American College of Physicians (ACP) published *Redesigning Medicaid During a Time of Budget Deficits*. The paper was released at a time when the Bush Administration and Congress were seeking new ways to limit the accelerated growth of the Medicaid program by permitting states to have more discretion regarding cost-sharing and delivery system reform. Medicaid continues to be an enormous part of states' budgets, and when combined with the Medicare program, makes up 4% of the nation's gross domestic product. The Medicaid system provides vital health services to vulnerable populations, such as the poor and disabled, but like the health care system as a whole, Medicaid needs to be improved to emphasize preventive and primary care. Some of this is occurring now, as states like Vermont experiment with a medical home pilot project and others heighten attention to determining best practices. The need for the program is even more elevated as the country emerges from an economic recession and more people have turned to the Medicaid system for coverage.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and a companion bill that provided further changes. Among other things, the landmark health care reform legislation would expand access to the Medicaid program regardless of categorical eligibility, potentially increasing program enrollment by over 16-18 million by 2019.[1,2] Ten states may see Medicaid enrollment increase by 50%.[3] The law will dramatically alter the landscape of health care coverage and delivery; while more uninsured Americans will have access to coverage under Medicaid, private insurance, and other means, the health care system will probably continue to face challenges involving financing, delivery system reform, and the provider workforce. ACP will continue to focus on analyzing and encouraging effective models to redesign how care is delivered, financed, and reimbursed under Medicaid to 1) provide more value for the services provided; 2) ensure access to physicians; 3) create a more viable long-term financing mechanism; and 4) address how long-term care should be improved and financed. The influx of Medicaid-covered patients into the health care system heightens the need for fundamental changes in health care delivery, financing, and payment policies to sustain the program. Expanding Medicaid will be a daunting task as the program is poised to become one of the largest—if not the largest—payer of health care services. However, this daunting task provides an opportunity to reform the program to emphasize primary care and prevention; transform the delivery system to strengthen evidence-based, patient-centered care; ensure physician participation; reform the long-term care system to allow people to live in their homes and communities; and reduce administrative barriers by promoting health information technology. This paper provides a brief update on changes to the program over the last 3-4 years and makes recommendations on how the Medicaid program can be improved to ensure access and sustainability in the future.

Positions

Position 1: The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis, and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.

Position 2: Medicaid payment rates must be adequate to reimburse physicians and health care facilities for the cost of providing services, to enhance physician and other provider participation, and to ensure access to Medicaid covered services. Policymakers must permanently increase payment for Medicaid primary care and other specialists' services to at least the level of Medicare reimbursement.

Position 3: Medicaid resources must be allocated in a prudent manner that emphasizes evidence-based care and mitigates inefficiencies, waste, and fraud. Efforts to reduce fraud, abuse, and waste under the Medicaid program should not create unnecessary burdens for physicians who do not engage in illegal activities.

Position 4: In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since these services could be less costly and more suitable to the individual's needs. States and the federal government should collaborate to ensure access to home and community-based, long-term care services. Individuals with long-term care needs should be able to supplement their Medicaid coverage with long-term care insurance products.

Position 5: States' efforts to reform their Medicaid programs should not result in reduced access to care for patients. Consumer-driven health care reforms established in Medicaid should be implemented with caution and consider the vulnerable nature of the patients typically served by Medicaid. A core set of comprehensive, evidence-based benefits must be provided to enrollees.

Position 6: Federal and state stakeholders must work together to streamline and improve the Medicaid waiver process, ensuring timely approval or rejection of waiver requests and sufficient transparency to allow for public consideration and comment.

Position 7: Medicaid should be held accountable for adopting policies and projects that improve quality of care and health status, including reducing racial and ethnic disparities and effectively managing chronic disease and mental health.

Position 8: Congress should establish a counter-cyclical funding mechanism for Medicaid, similar to the funding mechanism for unemployment insurance, to increase the amount of federal dollars to the program during economic downturns. Substantial structural changes to Medicaid are necessary if states are to meet the needs of the nation's most vulnerable populations.

Position 9: States and the federal government should reduce barriers to enrollment for Medicaid coverage. Efforts should be made to ease enrollment for all eligible persons, including automatic enrollment based on income. Implementation of citizenship documentation requirements should not impede access to Medicaid and Children's Health Insurance Programs (CHIP) for those who are lawfully eligible. States and the federal government should provide culturally and linguistically competent outreach and education to ensure understanding and enrollment of Medicaid-eligible individuals.

Position 10: States should work to improve the physician and patient experience in dealing with the Medicaid program. Solutions should include reducing administrative barriers and facilitating better communication and prompt pay standards between payers and physicians. Financial assistance should be provided to Medicaid-participating physicians to purchase and implement health information technology.

Position 11: Medicaid programs should ensure access for Medicaid enrollees to innovative delivery system reforms, such as the patient-centered medical home, a team-based care model that emphasizes care coordination, a strong physician-patient relationship, and preventive services.

Position 12: Medicaid program stakeholders should consider alternative financing structures to ensure solvency, high quality of care, and uninterrupted access for beneficiaries, while alleviating the program's financial pressure on states. Particularly, financing and delivery of care for dual-eligible beneficiaries must be reformed.

a. A physician—particularly a primary care physician—should be included among the membership of the Medicaid and CHIP Access Commission.

Background

Currently, states are permitted to operate their Medicaid program within broad parameters established by the federal government. State Medicaid programs are required by federal law to cover certain benefits, like diagnostic screening and related treatment for children, and to provide coverage to certain populations, such as lower-income pregnant women. Adults without dependent children, regardless of income, are generally prohibited by federal law from receiving Medicaid benefits.

States are able to cover optional populations and benefits beyond the mandatory thresholds, such as pregnant women with higher incomes. This flexibility has allowed states to tailor their Medicaid program to the needs of their state but leads to wide variation in the generosity of Medicaid programs across the country. Before enactment of provisions in the PPACA of 2010 that become effective in 2014, the income and categorical exclusions in the program kept many poor and near-poor individuals from receiving Medicaid coverage. In addition to childless adults, low-income parents and legal immigrants have generally been excluded from coverage or face significant barriers to receiving coverage. For instance, in 20 states a parent in a family of four making federal minimum wage earns too much to qualify for Medicaid.[4] States are permitted to seek federal waivers to provide coverage beyond federal guidelines. A number of states, for example, have a federal waiver that permits them to offer Medicaid coverage to childless adults. Much of this will change in 2014, however, as the PPACA will expand Medicaid access to all individuals with incomes below 133% of the federal poverty level (FPL). Eligible individuals and small businesses will be able to access private insurance through state-based health exchanges, and some will be eligible for tax credits to assist in the purchase of exchange-based insurance.

Enrollment

Between 2000 and 2007, total enrollment in Medicaid increased from 31.8 million to 42.3 million. From 2000-2002, the nation was mired in a deep recession, leading Medicaid enrollment to increase and program spending to grow by 12.9% per year.[5] Since the 2005 publication of ACP's *Redesigning Medicaid During Times of Budget Deficits*, the Medicaid program has seen enrollment fluctuate. From 2005-2007 total enrollment in the program stabilized or dropped because of a number of factors, including an improved economy and tightened citizenship documentation requirements.[5,6] As the economy fell into another economic recession in late 2007, total enrollment in the 50 states and the District of Columbia grew again in response to increases in unemployment and lack of access to employer-sponsored health insurance. In June 2009, nearly 3.3 million more people were enrolled in the Medicaid program than in June 2008, the largest one-year enrollment increase since the early days of the program.[7]

Medicaid enrollment numbers do not fully reflect the number of individuals eligible for the program. The Congressional Budget Office (CBO) estimates that at any time in 2009, about 64 million nonelderly people will be eligible for Medicaid or Children's Health Insurance Programs (CHIP) coverage but that only 43 million will be enrolled.[8]

Spending

Medicaid is financed through a combination of federal and state funds. The federal share is determined by a formula called the Federal Medical Assistance Percentage (FMAP), which is generally based on a state's per capita income relative to the national average and cannot fall below a 50% match. Poor states receive more funding—Mississippi, for instance, receives a 76% match.[4] Medicaid is a major source of state spending; about 17% of state revenue is devoted to financing the program.[4]

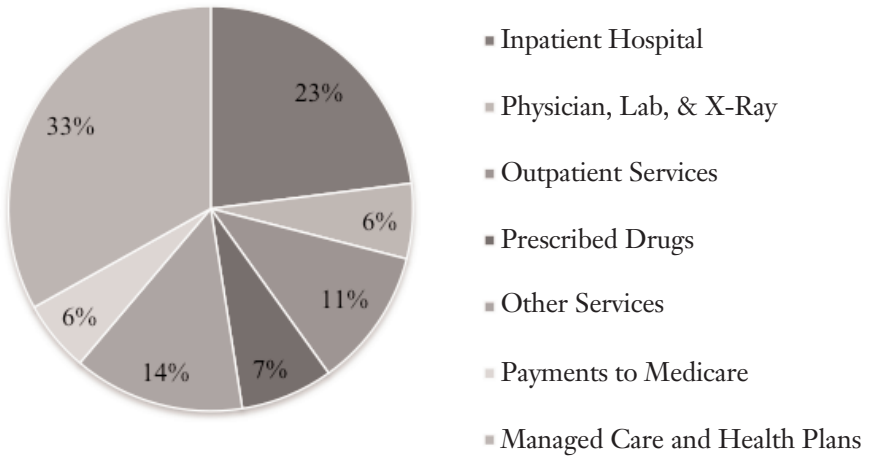
From 2000-2007, Medicaid spending grew slightly faster than national health care spending. This was largely because of flagging economic conditions, which caused Medicaid enrollment to swell. Despite the total growth in the program, Medicaid spending per beneficiary met or had been below growth in Gross Domestic Product (GDP) and other benchmarks. This was partially due to efforts to rein in Medicaid costs through such actions as increased use of managed care, reduced reimbursements to physicians and other providers, transition from an emphasis on institution-based to home and community-based long-term care, and the transfer of dual-eligible prescription drug costs to the Medicare program.[5] In 2007, following a small decline in total enrollment, Medicaid spending increased primarily because of rising acute care spending, rather than enrollment. In 2008, federal Medicaid spending increased by 8.4%, while state spending declined by 0.1%, a result of supplemental Medicaid funding provided by the federal stimulus package (see below).[9]

Economic downturns particularly affect the Medicaid program, since the need for its services grows while state revenues decline during recessions. The Kaiser Family Foundation estimates that a 1% increase in unemployment is met with a 3-4% decline in state revenues, making it difficult for states to fund their portion of Medicaid.[10] Shrinking revenues have forced states to grapple with cuts to their Medicaid programs. New Mexico is facing a $300 million shortfall after increasing enrollment by nearly 10% from June 2007 to June 2008. The state has already capped the amount Medicaid managed care plans can spend on administrative costs and is considering eliminating benefits for optional services.[11] In reaction to the state of the nation's economy, Congress passed the American Recovery and Reinvestment Act (ARRA) of 2009, a legislative initiative intended to strengthen the economy. Included in the stimulus bill was a

significant temporary increase in the federal reimbursement for state Medicaid programs, providing states a total of $87 billion through December 2010; a smaller reimbursement enhancement was extended to states until June 2011. The legislation stipulated that to receive the money, states could not reduce Medicaid enrollment in 2010, forcing cash-strapped states to consider cutting Medicaid provider reimbursement rates and/or optional benefits.[12] Total Medicaid spending is likely to continue to grow as the recession leaves more individuals in need of its coverage.[13] A 2010 survey of Medicaid directors found that many states have been unable to expand their CHIP programs despite the availability of enhanced federal matching funds because of dwindling state revenues.[12]

While the majority of Medicaid spending is directed toward acute care services, a substantial portion is spent on providing long-term care. In FY 2008, nearly 61% of Medicaid spending was directed to acute care while about 34% was spent on long-term care services and 5% was devoted to disproportionate share hospital payments.[16] The following charts illustrate the distribution of Medicaid acute and long-term care funding in FY2008.[14] The data show that 23% of acute care funding is spent on providing inpatient hospital care while only 6% is directed to physician, lab, and X-ray services.

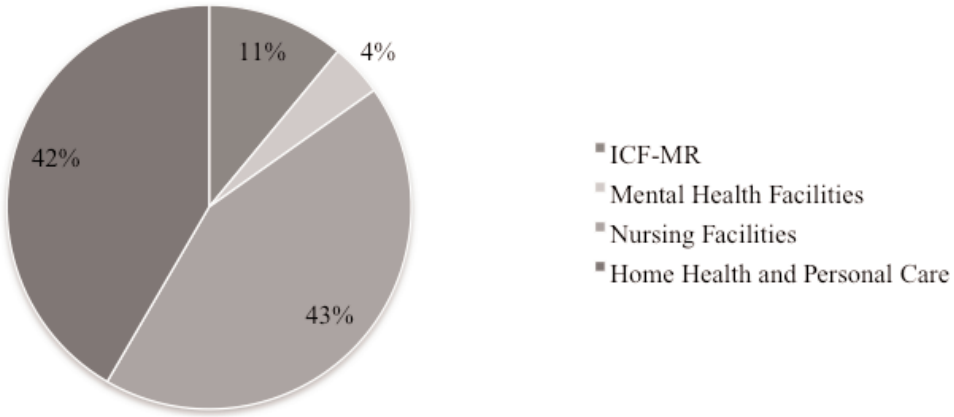
Distribution of Medicaid Spending on Acute Care, FY2008



Definitions(14): *Outpatient Services* includes outpatient hospital and clinic services, as well as payments made to rural health clinics and federally qualified health centers (FQHCs). *Other Services* include dental, other practitioners, abortion, sterilization, transportation, physical and occupational therapy, services for individuals with speech, hearing and language disorders, programs of all-inclusive care for the elderly (PACE), dentures, eyeglasses, prosthetic devices, other diagnostic and rehabilitative services (including EPSDT), and other uncategorized services. *Payments to Medicare* are primarily premiums paid by Medicaid for Medicare enrollees. Medicaid may also pay Medicare cost-sharing for some individuals, but these amounts typically should be reported as payments for other services (e.g., "Inpatient Hospital"). *Managed Care & Health Plans* includes payments to health maintenance organizations (HMOs), prepaid health plans (PHPs), and other health plans, as well as primary care case management (PCCM) fees.

Source: Statehealthfacts.org. Distribution of Medicaid Spending on Acute Care, FY 2008. Kaiser Family Foundation. 2010. Accessed at http://statehealthfacts.org/comparetable.jsp?ind=179&cat=4 on July 21, 2010.

Distribution of Medicaid Spending on Long Term Care, FY 2008



Definitions (14): ICF-MR stands for Intermediate Care Facility for the Mentally Retarded. Mental Health Facilities include inpatient psychiatric services for individuals age 21 and under, and other mental health facilities for people age 65 and older. Home Health & Personal Care includes standard "Home Health Services", "Personal Care", "Targeted Case Management", "Hospice", "Home and Community-Based Care" for the functionally disabled elderly, and services provided under "Home and Community-Based" services waivers.

Source: Statehealthfacts.org. Distribution of Medicaid Spending on Long Term Care, FY 2008. Kaiser Family Foundation. 2010. Access at http://statehealthfacts.org/comparetable.jsp?ind=180&cat=4 on October 14, 2010.

Reimbursement Rates for Physicians and Other Nonphysician Providers

Historically, Medicaid reimbursement rates have lagged behind those of private insurers and Medicare. In 2008, Medicaid physician fees were 72% of Medicare fees.[15] Medicaid reimbursement rates differ wildly among states. In 2008, Wyoming's rates for primary care services were the highest in the nation (excluding Alaska) at 67% above the national average of fee-for-service Medicaid fees, while Rhode Island's rates were the lowest at 57% of the average.[16] Medicaid rates typically increase at a much slower rate than inflation. From 2003-2008, average Medicaid physician rates for a range of services increased by 15.1%; over the same period, the rate of medical inflation (Medical Care Services component of Consumer Price Index) was just over 28%.[15] Over the 5-year period, primary care services rates were increased 20% compared with obstetrics services, which increased 8%.

States have control of Medicaid physician and other provider reimbursements and because of their often precarious budget status, Medicaid payment rates often dip during times of state budget problems. Along with enrollment,

Medicaid reimbursement rates fluctuate based on the health of the economy. In the early 2000s, physician and other provider payment rates were cut to reduce spending during the economic downturn; as the economy improved, many states restored or increased pay rates.[17] The recent recession has forced most states to consider once again cutting Medicaid rates to address deficits. One survey found that in 2004, a total of 21 states had cut reimbursement rates. The California legislature attempted to reduce Medicaid reimbursement rates but was blocked by the Ninth U.S. Circuit Court of Appeals in San Francisco.[18] The Michigan legislature is considering a 12% cut to the state's Medicaid program, most of which may come from reductions in hospital, physician, and nursing home reimbursement rates.[19] Cuts to reimbursement rates in Georgia were averted because of an infusion of stimulus package funds and tobacco settlement–related assistance.(20) As of September 2009, a total of 39 states were cutting or freezing rates for FY 2010.[17] Stimulus funding directed to states during the recession has helped stanch deeper cuts to physician and other provider reimbursement. Additionally, some states increased their Medicaid reimbursement rates to match program expansions. Massachusetts, in enacting its landmark health care reform package, increased its Medicaid rates in 2007 in an effort to encourage participation by physicians and other providers of health care.

State Reform Activity

In reaction to growing fiscal problems or political decisions, a number of states took advantage of changes in federal laws or pursued waivers that permitted them greater flexibility to curb costs, increase beneficiary cost-sharing, and/or reform the Medicaid delivery system. These changes have given states greater flexibility in tailoring their Medicaid programs toward a so-called consumer-directed model.

Florida was provided a Medicaid waiver where enrollees in some counties would be required to select from a variety of private insurance plans offering different provider networks, benefits, and cost-sharing levels. During the 7-month demonstration period, enrollees were informed that they would have to select an insurance plan or one would be provided for them. Plans are required to provide the minimum Medicaid benefit package, but can vary the extent of services by amount, duration, and scope, such as limits on prescription drug coverage. Although this model allowed Medicaid beneficiaries greater choice in health coverage, a survey of participants in 2 counties shows that many enrollees did not realize they had been shifted to a private plan and had difficulties understanding plan information.[21] Given the vulnerable nature of the Medicaid population, such misunderstandings may lead to difficulties accessing appropriate care, and some evidence shows that Florida's Medicaid access problems are worsening since implementation of the reform effort.[22] Some enrollees have reported problems finding a plan that included their doctors in the network.[22] In addition, many doctors have reported dissatisfaction with the program, with 47% describing the reform effort as making the Medicaid program worse (compared with 8% reporting that it had improved the program).[22] Florida physicians also reported issues with the increased administrative burden as well as low reimbursement rates. Many physicians also expressed that the ease of authorizations for needed services had worsened since reform was enacted.[23] In April 2010, Florida's House voted to shift nearly all Medicaid beneficiaries into Medicaid managed care plans. A more modest state Senate proposal would expand the pilot program from 5 to 19 counties.[24]

Missouri also made drastic changes to its Medicaid program. In the early 2000s, the state faced a severe budget crisis and in 2005 made sweeping cuts to the Medicaid system. As a result, 100,000 Medicaid enrollees were removed from the program, physicians and other providers saw reimbursement cuts, and beneficiaries who remained in the system had their cost-sharing increased or their benefits slashed. Between 2004 and 2006, Medicaid and CHIP enrollment dropped by 15.4%, or about 147,000 people.[25] The state eliminated its Medical Assistance for Workers with Disabilities program, which allowed lower-income disabled workers to buy in to the Medicaid program. The reductions led to an increase in the number of uninsured, uncompensated care provided by hospitals, and forced health clinics to seek more funding through donations and patient fees. The reforms enacted by the state failed to reduce costs; however, spending was slowed.[25]

West Virginia initiated a controversial program whereby eligible Medicaid beneficiaries receive "enhanced" benefits if they adhere to a "Medicaid Member Agreement" that requires them to attend regular doctor visits, enroll in preventive and wellness programs, and avoid unnecessary emergency department care. Beneficiaries enrolled in the enhanced benefit program receive unlimited prescription drugs. Those who do not sign up or do not abide by the terms of the agreement receive a "basic" package of curtailed benefits that limits items and services, such as prescription drugs and mental health coverage.[26] The patient's doctors would be required to monitor and report patient compliance to their agreement. In response to criticism of this policy, the state vowed it would begin monitoring HMO claims data to determine patient compliance, but this system has not been implemented as of August 2008 and physicians remain largely confused about their enforcement role.[26, 27]

Since initiation of the program, few beneficiaries have signed up for the enhanced benefits; about 13% of eligible children and 10% of eligible adults are enrolled in the enhanced plan as of February 2009.[27] This is probably due to beneficiary confusion and poor implementation on behalf of the state Medicaid department. Surveys have found that physicians and other health care professionals remain concerned about lack of communication from the state regarding their role in completing member agreements and structuring beneficiary assessments. Physicians and other health care professionals and patient advocates surveyed largely believe that the program as structured will not change the health behaviors of enrollees.[27] In 2008, the West Virginia Medicaid department was the target of a lawsuit that alleged children were being denied crucial benefits because of the reformed Medicaid program.[28]

ACP issued a policy paper developed by its Ethics, Professionalism, and Human Rights Committee regarding West Virginia's Medicaid Redesign program and the concept of influencing patient responsibility in health care. The paper recommends that, "incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control. Incentives to encourage healthy behaviors should be appropriate for the target population. The American College of Physicians supports the use of positive incentives for patients such as programs and services that effectively and justly promote physical and mental health and well-being."[29]

Wisconsin. While many states have been forced to halt proposed expansions or trim certain program benefits, Wisconsin has managed to maintain Medicaid coverage for existing enrollees and expand eligibility to more citizens using federal Medicaid/CHIP matching funds, state general revenue, and

specific state allotments for some newly insured individuals.[30] Even during the economic recession, the state has made it a goal to ensure that 98% of state residents have access to affordable health insurance by expanding its BadgerCare program to all children, adults with no dependent children, and adults on BadgerCare waitlists.[31] By covering all current and newly eligible beneficiaries in one program—BadgerCare Plus—the state has managed to improve program administration and facilitate enrollment.

To improve outreach and increase enrollment, coverage for adults and children is provided through the program and the "welcome mat" message that the program is open to all children has helped reduce the stigma and confusion regarding who qualifies.[32] Additionally, community health center staff is trained to assist eligible people with enrollment. To help ensure program solvency, different coverage levels are offered to different groups. Childless adults below 200% FPL receive a more limited benefit and a higher application fee. Further, most BadgerCare Plus beneficiaries are required to enroll in a managed care plan.[32] However, enrollment of childless adults in the BadgerCare Plus Core plan was suspended in October 2009 and applicants were transferred to a waitlist. Childless adults on the waitlist are eligible for coverage under a limited benefit health plan called BadgerCare Plus Basic Plan until Core Plan enrollment resumes.[33]

Other Activity

States also continue to establish and integrate managed care in their Medicaid programs, particularly for the purpose of quality improvement. In FY 2008, about one third of states expanded their use of Medicaid managed care programs.[10] Similarly, many states have developed pay-for-performance programs chiefly through managed care or primary care case management initiatives. In FY 2009, 37 states expressed that they would establish a pay-for-performance program compared with 20 states in FY 2006.[10,34] Some state Medicaid directors have expressed concern that implementation of pay-for-performance initiatives may cause physicians to leave the program. To encourage participation, some states have offered enhanced reimbursement rates for physicians and other health care professionals who establish a medical home for Medicaid enrollees.[34] In addition, a number of states have required Medicaid health plans to utilize common quality measures and reporting methods to mitigate administrative burden and complexity.[35]

Changes at Federal Level

In 2005 Congress passed the Deficit Reduction Act (DRA), legislation which permitted states to use greater cost-sharing responsibilities on Medicaid enrollees and pursue other program changes to yield cost-savings. The DRA was expected to reduce federal spending on Medicaid by about $10 billion over 10 years.[36] In addition to allowing states to pursue cost-sharing and benefit changes for certain populations through a state plan amendment, savings were garnered by restricting asset transfers for long-term care service qualification and tightening citizenship documentation rules.

Before the DRA, individuals could provide a written declaration of their citizenship without having to show additional proof of immigration status.[37] Undocumented immigrants are prohibited from receiving Medicaid coverage. Under the DRA, those applying for or renewing Medicaid coverage are required to provide proof of their U.S. citizenship and identity. Some groups, such as those receiving Social Security disability benefits, are exempt. Since enactment of the new documentation requirements, a number of states have

reported delays in the eligibility determination process as well as decreased Medicaid enrollment. Further, states have devoted more resources to outreach and education related to the documentation requirements.[37] The Government Accountability Office (GAO) found that because of these cost increases, savings from the provision were likely to be less than initially predicted and only 5 of the 44 states studied by the GAO reported that they expected to see cost-savings because of the provision.[38] To improve the process, some states have established electronic application pilot programs, increased enrollment assistance staff, and heightened attention to retaining experienced enrollment staff.[39]

Under the Bush Administration, the federal government issued a number of regulations that sought to change reimbursement policy for government providers and rehabilitation services. They also targeted Medicaid payments for case management, graduate medical education, and other services. The regulations met significant criticism from members of Congress, states, advocacy groups, and providers, many of whom expressed concern that the federal government was simply shifting costs to states.[10] In response, Congress voted to delay implementation of the regulations until April 2009. In 2009, the Obama Administration rescinded three of the controversial rules and is considering taking action on others.[40]

In an effort to accelerate the nation's economic recovery, President Obama signed the American Recovery and Reinvestment Act of 2009. Among the provisions was targeted funding for state Medicaid programs. The legislation temporarily curbs federal Medicaid cuts that some states would have experienced because of the economic downturn. All states receive a temporary 6.2-percentage point boost in their federal share of Medicaid costs, and states that experienced significant unemployment received additional financial support.[41]

Brief Overview of Changes to Medicaid in Health Care Reform

The landmark health care reform legislation expands Medicaid coverage to nonelderly individuals with incomes up to 133% FPL regardless of categorical eligibility. Nonincome asset and resource tests will not be considered in determining eligibility for most applicants.[42] This expansion of coverage will greatly increase Medicaid coverage among childless adults, a population generally ineligible for Medicaid. The law will provide full federal funding for the expansion population during the years 2014-2016 and then gradually reduce funding to 90% of the expansion population cost in 2020 and subsequent years. The expansion occurs in 2014; however, states can pursue a Medicaid state plan amendment to cover all individuals with incomes up to 133% FPL beginning in 2010. States that already cover adults with incomes up to 100% will also receive an enhanced federal reimbursement to cover nonpregnant, childless adults.[43] The CBO estimates that by 2019, Medicaid and CHIP coverage will be expanded to an additional 16 million people under the law.[44] The law also requires states to maintain coverage of currently Medicaid and CHIP-eligible children until 2019 and Medicaid-eligible adults until 2014.[42] The Medicaid enrollment process is also streamlined as the law would permit hospitals and other providers to make presumptive eligibility determinations for all populations and would require states to coordinate with state insurance exchanges and CHIP.[42]

The law enacts a number of delivery system reforms and changes in the way physicians are paid through Medicaid. To address primary care workforce shortages, the health reform legislation will increase Medicaid reimbursement rates for evaluation and management services and immunizations provided by internists and other primary care physicians in the years 2013 and 2014. Reimbursement rates will be no less than the Medicare rates for such services.

The law will also establish a demonstration project to test medical homes for individuals with chronic disease as well as a bundled payment demonstration in eight states. The scope of the Medicaid and CHIP Payment Access Commission will be expanded to assess adult services provided through Medicaid.[42]

Positions

Position 1: The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis, and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.

ACP's 2008 paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists, Updated 2008* established the College's recommendation that states should have the option of expanding Medicaid eligibility to all individuals with incomes at or below 100% FPL regardless of categorical eligibility. The College iterated that the additional cost of a coverage expansion should be financed by a dollar-to-dollar FMAP increase. The PPACA, signed into law on March 23, 2010, as well as its companion reconciliation legislation, largely reflect the College's policy on Medicaid expansion by increasing Medicaid eligibility to all individuals with incomes at or below 133% FPL and providing federal financing for nearly all of the expansion's cost. At this early stage it is unknown whether major revisions to the Medicaid program will occur in the future. Some opponents of the legislation have expressed their intention to repeal or modify the law.[45] The College believes that the Medicaid program should remain the foundation of health coverage for low-income individuals and families. Any future efforts to alter the program should not endanger the coverage of those most in need.

While the College continues to support broad Medicaid coverage expansions, policymakers must provide the needed funding to state governments to ensure that coverage expansions do not create deficits in state budgets. During the first 2 years of health care reform implementation, the federal government will provide all funding for newly eligible individuals; after that, the federal share of funding will gradually decrease and states will ultimately have to fund 10% of the expansion population's coverage cost. States have expressed significant concern that the Medicaid coverage expansion enacted in the health care reform legislation will place great financial strain on state budgets and be particularly harmful as the nation struggles to stabilize during the economic recession.[46] Further, the federal government may need to provide additional funds to states that experience a marked increase in Medicaid enrollment of individuals currently eligible for the program. Tennessee, for instance, predicts that over 60,000 individuals currently eligible for the state's TennCare program will enroll between 2014 and 2019, potentially costing the state $913 million.[47] ACP reiterates its position that Medicaid coverage expansions not result in an unfunded mandate to states and that any expansion be fully financed by the federal government.

Position 2: Medicaid payment rates must be adequate to reimburse physicians and health care facilities for the cost of providing services, to enhance physician and other provider participation, and to ensure access to Medicaid covered services. Policymakers must permanently increase payment for Medicaid primary care and other specialists' services to at least the level of Medicare reimbursement.

ACP strongly supports ensuring that all legal residents have access to quality health coverage, but increases in coverage must be met with a focused effort to expand the number of physicians — particularly primary care physicians—to meet the health care demands of the currently and newly insured. Although evidence shows that Medicaid beneficiaries are just as able to access primary and preventive care as those with private insurance, some health policy stakeholders have expressed concern that Medicaid's provider infrastructure may not be able to absorb an immense coverage expansion.[48-50] Further, low Medicaid and private payer reimbursement rates for primary and preventive care services have helped to exacerbate the shortage of primary care physicians.[51] A 2008 survey of primary care physicians found declining reimbursement to be the most "significant impediment to patient care delivery in today's practice environment by a large margin."[52] The survey also found that more than one third had stopped accepting Medicaid patients and two thirds indicated that Medicaid reimbursement payments did not cover the cost of providing care.[52] A survey of physicians conducted by the Center for Studying Health System Change indicated that in 2008, 53% of physicians reported accepting all or most new Medicaid patients and 28% stated they were accepting no new Medicaid patients. Comparatively, the same survey found that 87% reported accepting all or most new patients with private insurance and 74% accepted all or most Medicare patients.[53] Sixty-seven percent of primary care physicians believe that the Medicaid program will struggle to meet the increased demand for primary care services initiated by the PPACA Medicaid expansion.[54]

The situation in Massachusetts may shed light on the deleterious impact of inadequate Medicaid reimbursement. When Massachusetts reformed its health care system to require all citizens to have health coverage, the primary care infrastructure was unable to meet the increased patient demand and delays in care occurred in some areas.[55] A 2009 Massachusetts Medical Society physician survey categorized the commonwealth's internist shortage as "severe" and found that only 44% of internists in Massachusetts were taking new patients, down from 58% in 2008.[56,57] Further, the survey found that the number of Massachusetts internists accepting Medicaid patients had declined. Only 60% of internists accepted Medicaid beneficiaries in 2009 compared with 79% in 2005.[57]

The CBO estimates that implementation of the health care reform law will result in an additional 16 million enrollees receiving Medicaid or CHIP coverage.[2] One estimate suggests that more than 17 million nonelderly, uninsured adults have incomes at or below 133% FPL, making them potentially eligible for Medicaid coverage under the health reform law.[58] Further, 1 in 3 individuals in this income category is diagnosed with a chronic condition, and many more may have an undiagnosed chronic condition.[58] This major infusion of adults into the health care system could potentially be problematic if physician participation in the Medicaid program is insubstantial. With this enormous influx of new patients, the supply of internists and other primary care physicians will need to be increased. As the Medicaid program is expanded to cover more of the uninsured, stakeholders must strengthen efforts to boost reimbursement rates and reduce the onerous administrative burdens that exist in Medicaid to encourage

participation among physicians.[59,60] Evidence shows that low reimbursement rates are among the reasons physicians elect to not participate in Medicaid or limit their participation.[61] Physician acceptance of new Medicaid patients is higher in states with Medicaid payment rates that are closest to Medicare levels, compared with states where Medicaid payment is low relative to Medicare.[62]

Medicaid payment rates are abjectly low compared with Medicare and private insurance. Typically, Medicaid primary care payments are 66% of Medicare reimbursement rates.[63] In 2008, Massachusetts' Medicaid reimbursement rates for primary care services were 78% of Medicare rates, above the national average, illustrating that even when Medicaid payments are above the national average, shortages can still occur.[15] However, stable Medicaid payments may help influence growth in some specialties. The workforce situation for Massachusetts neurosurgeons improved as recruitment and retention data were positive compared with past years' evidence that indicated that noncompetitive salaries threatened the commonwealth's neurosurgery workforce. Medicaid reimbursement for neurosurgery services in the commonwealth remained stable, potentially bolstering the workforce projection.[57] A UnitedHealth survey of physicians determined that half of primary care physicians would increase their Medicaid case load if Medicaid reimbursement rates were brought up to the level of Medicare rates.[54]

To address this important concern, the health care reform law provides an increase in Medicaid reimbursement for evaluation and management services provided by internists and other primary care physicians.[64] In 2013 and 2014, payment for such services will be increased to Medicare levels. The increase will be applied to Medicaid fee-for-service and managed care plans. Additionally, the health reform law enhances funding for safety-net providers like community health centers, a crucial part of Medicaid's safety net.[65] Such a payment enhancement is an important step toward balancing the bias against primary and prevention-based, patient-centered care, but it is not enough. At a minimum, Medicaid payment rates for primary and preventive care services should be permanently brought up to the level of Medicare to encourage physician participation. The 2-year increase provided in the health care reform law has been criticized as potentially being insufficient to compel physicians to participate in the expanded Medicaid program.[66] An abrupt reduction in Medicaid physician reimbursement rates may endanger patient access to care, and state Medicaid programs are hesitant to trim Medicaid physician payments because of this concern.[67] Again, Massachusetts offers evidence of the effect of insubstantial reimbursement rates; the health care reform effort initially boosted Medicaid reimbursement, but the increase ended after only 2 years because of budget pressures.[68] Additionally, with a dramatic expansion of Medicaid coverage to those with incomes up to 133% FPL, federal and state governments must also work to strengthen access to services provided by specialists. While the nation faces a dearth of primary care physicians, it also faces shortages in a number of specialists accepting Medicaid. In 2008, Medicaid paid only 72% of Medicare reimbursement for all services.[69]

Position 3: Medicaid resources must be allocated in a prudent manner that emphasizes evidence-based care and mitigates inefficiencies, waste, and fraud. Efforts to reduce fraud, abuse, and waste under the Medicaid program should not create unnecessary burdens for physicians who do not engage in illegal activities.

The Medicaid program is a significant component of federal and state budgets. With the impending program expansion initiated by the PPACA, the Medicaid

program will continue to grow and policymakers and stakeholders will have to work together to ensure that Medicaid funds are spent wisely. As noted elsewhere in this paper, the College supports reforming the health care delivery system to emphasize the patient-centered medical home for Medicaid recipients, promote preventive rather than reactive care, and dramatically improve access to home and community-based long-term care. However, a number of other efforts should be made to help guarantee program solvency for future generations; specifically, the Medicaid program must crack down on fraud, waste, and improper payments and must prioritize use of health care services that are known to result in positive health outcomes.

Reducing Fraud and Abuse

According to the GAO, the Medicaid program is rife with fraud and waste, resulting in billions of dollars in improper payments made throughout the health care system. In FY 2008, Health and Human Services (HHS) reported that over $18 billion in federal funds were directed to improper payments in the Medicaid system, the largest amount for any federal program reported for that fiscal year.[70] Examples of improper payments and fraudulent activities include incorrect coding, payment for medically unnecessary services, false cost reports, and payment for a service for which a third-party is responsible.[71] For instance, Medicaid programs in 4 of 5 states reviewed reimbursed for more than 24 hours worth of care in a single day.[72] In an effort to protect the integrity of the Medicaid system, a number of federal and state agencies are tasked with investigating and eliminating fraud and abuse in the Medicaid program. The HHS' Office of Inspector General, Center for Medicare & Medicaid (CMS), state-based Medicaid Fraud Control Units and other entities often collaborate to address fraud and abuse charges throughout the various Medicaid programs. Despite the attention of federal and state stakeholders, the dual financing nature of the Medicaid program complicates investigation and enforcement efforts, as administrative barriers and program variation from state to state impede the collaborative process.[70] Further, financial resources for fraud and abuse reduction efforts have been generally insufficient.[73]

Recently the federal government has strengthened its focus to address improper payments by increasing funding for efforts in fraud and abuse elimination, establishing protections for whistleblowers who report false claims, and improving agency coordination. For instance, the health care reform bill establishes within CMS the Office of Program Integrity to prevent, rather than react to, fraud and abuse in the Medicare and Medicaid systems.[73] Existing antifraud initiatives, such as the collaborative work of the U.S. Attorney General and HHS under the Health Care Fraud and Abuse Control program, have been successful in reducing fraudulent activity in Medicaid and other federal health care programs. Not only do such initiatives protect the integrity of the Medicaid program, they also yield substantial financial benefit. The HHS Office of Inspector General reported that from FY 2006 to FY 2008, Medicare and Medicaid-related expected audit disallowables and investigative receivables yielded a return of $17 for every $1 invested in oversight.[74] While the College strongly supports efforts to address fraud and abuse in the Medicaid program and encourages adequate funding for such activities, it reiterates its position that law-abiding physicians and other health practitioners participating in the Medicaid program should not be subject to onerous administrative barriers related to antifraud activities.

Comparative Effectiveness Research

Medicaid programs could also improve resource utilization by implementing comparative effectiveness research recommendations. Comparative effectiveness research assesses the efficacy, safety, and cost of similar medical procedures, drugs, and medical devices to treat an illness or condition. According to the Medicare Payment Advisory Commission (MedPAC), "effectiveness implies 'real world' performance of clinically relevant alternatives provided to patients with diverse clinical characteristics in a wide variety of practice settings."[75] Comparative effectiveness strategies are essential to promoting evidence-based care and helping physicians and other health care providers decide which procedures and treatments will result in the best outcomes for their patients; however, the nation's health care system has been slow to conduct and disseminate such research. There currently exists a patchwork of public and private entities, including the Agency for Healthcare Research and Quality (a division of HHS), and private sector entities, such as Blue Cross Blue Shield Evaluation Center, which do not usually consider cost in their comparative clinical effectiveness research.[75] Federal entities conducting such evaluations are severely underfunded and are vulnerable to fluctuations in the availability of financial resources as well as to political pressure.[76]

A number of Medicaid programs use comparative effectiveness research to assist in coverage decisions. The Oregon Health and Science University established the Drug Effectiveness Review Program (DERP) to evaluate and compare the clinical effectiveness of a variety of drugs to help create a preferred drug list for the Oregon Medicaid program.[77] In cases where two drugs are deemed to be equally effective, cost is considered. While the program provides objective information about the relative effectiveness of drugs, it does not provide a recommendation or rating system, resulting in varied interpretations of the evidence.[78,76] The Missouri Medicaid program saved $4 million a year after switching most patients from an expensive brand-name cholesterol-lowering drug to its generic equivalent, based on the DERP recommendation.[79] Physicians of patients who do not respond positively to the generic drug are permitted to prescribe an alternate treatment, including the brand-name drug. Currently, 11 states are partnered with the DERP, and AARP and the Consumers Union have adapted the program's data for consumer use.[80,81]

Starting in 2006, Washington State began a health technology assessment program that evaluates new medical technology, diagnostic tests, imaging procedures, and drugs to determine their safety and clinical and cost-effectiveness.[82] If a device, such as an upright MRI scanner, is deemed not to yield a substantial health benefit, the state's health care programs—including fee-for-service Medicaid plans—will not cover it. The Washington State program also uses the DERP recommendations in determining preferred drugs.[83] Such decisions are made by a group of health practitioners from across the health care spectrum.[82] By establishing an objective team of practitioners shielded from outside influence, decisions can be made based on independent scientific evidence rather than political or other concerns. While it is difficult to determine the long-term cost-savings generated from the health technology assessment program, one estimate predicts that the program would have resulted in first-year savings of $21 million, at a cost of $1 million.[84, 85]

The subject of comparative effectiveness research generates significant controversy. However, physicians and other health practitioners should be equipped with objective research to provide effective care. Not only is such research an essential part of reducing wasteful spending in the bloated health care system,

but it is a crucial step toward ensuring that all patients receive the best care possible. In ACP's position paper *Improved Availability of Comparative Effectiveness Information*, the College expressed its strong support for efforts to improve access to information comparing clinical management strategies and the formation of an adequately funded, independent entity to sponsor and/or produce trusted research on comparative effectiveness of health care services. Further, the College recommended that all payers, including Medicaid, employ both comparative clinical and cost-effectiveness information as factors to be explicitly considered in their evaluation of a clinical intervention. However, the College also notes that cost should never be used as the sole criterion for evaluating a clinical intervention and should be considered along with the comparative effectiveness of the intervention.[86]

In recognition of its potential benefits, the federal government has increased attention and resources on comparative effectiveness research. In 2009, the Obama Administration directed over $1 billion toward comparative effectiveness research efforts and the health reform law established the Patient-Centered Outcomes Research Institute to provide independent clinical comparative effectiveness research for the Medicare program; however, the Institute is unable to consider cost in its evaluation process.[79, 87]

It is vital that Medicaid programs aggressively target fraud and abuse to preserve the integrity and ensure the solvency of the Medicaid system. Programs must also use comparative effectiveness research when determining benefit packages so beneficiaries have access to the best possible evidence-based care.

Position 4: In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since these services could be less costly and more suitable to the individual's needs. States and the federal government should collaborate to ensure access to home and community-based long-term care services. Individuals with long-term care needs should be able to supplement their Medicaid coverage with long-term care insurance products.

Medicaid is the primary payer of long-term care services, providing for 40% of long-term care funding in 2006.[88] The demand for long-term care services is expected to double by 2040, and the Medicaid system will need to be fundamentally changed to meet this need.[89] In addition to traditional nursing home care, home health care is also reliant on public programs, as 80% of total home health care spending in 2008 was provided by public insurers including Medicaid and Medicare.[9] Although Medicaid is required to cover institutional services for qualifying beneficiaries, home and community-based services (HCBS) are optional through a waiver or state plan amendment, although all state Medicaid programs provide some level of coverage for such services. Since home and community-based services are established through the Medicaid waiver process, coverage varies throughout the country; some states target HCBS only to certain geographic areas or beneficiaries and a complex assortment of income and asset requirements further complicate access to such benefits. Funding for HCBS varies significantly across states: North Dakota devotes only 5% of Medicaid long-term care funding for the elderly and adults with disabilities to HCBS, while Washington State spends over half of its Medicaid long-term care budget for that population on HCBS.[90]

The number of Medicaid beneficiaries receiving HCBS has risen steadily over the last decade, as more state programs elect to provide a more cost-effective

and beneficiary-preferred alternative to traditional institutional care.[5] HCBS spending has risen 95% since 1999, totaling $41.8 billion in 2007.[91] Evidence shows that following initial investment, HCBS are more cost-effective and have higher beneficiary-reported satisfaction rates compared to institutional care.[91,92] Further, states face growing demand for such services. According to AARP, 84% of individuals aged 50 and older report that they would prefer to age in their homes.[93] Reflecting this need, 38 states reported having waiver waiting lists totaling approximately 400,000 people.[91]

Despite the increasing need for HCBS, Medicaid long-term care remains biased toward institution-based services and support. Beneficiaries who qualify for long-term care services are guaranteed access to institutional care but may not have access to HCBS services due to the fragmented nature of coverage and funding. A number of proposals aim to balance this institutional bias by either mandating that states offer certain HCBS to various populations or by providing financial inducements for establishment and/or expansion of such services. One way to incentivize HCBS is to increase the federal Medicaid reimbursement rate while reducing the rate for nursing home services. For instance, the federal Medicaid reimbursement for HCBS services would increase 5%, while the rate for nursing home services would decrease by that amount. Similar incentives were established in the Deficit Reduction Act of 2005 to encourage the Money Follows the Person program.[94] To qualify for an FMAP increase, states would have to meet certain requirements, potentially including establishment of single access points to facilitate enrollment and improved service coordination.[94] Such a policy would potentially enable states to strengthen their underfinanced HCBS programs, ensuring that Medicaid beneficiaries are able to choose among the care setting appropriate to their needs.[95]

In ACP's 2005 position paper on Medicaid reform, the College expressed its support for permitting Medicaid beneficiaries to purchase supplemental long-term care insurance policies. A number of states have established Partnership for Long-Term Care (LTC) programs, which protect beneficiaries who have bought private LTC insurance from being forced to spend-down assets to qualify for Medicaid benefits. While this is one option to help beneficiaries maintain coverage, it may not lead to reductions in Medicaid spending.[96] Proposals that seek to partner Medicaid long-term coverage with supplemental private long-term care insurance must provide strong consumer protections such as inflation protection and premium stabilization to shield beneficiaries from insurance market volatility.[97] The health care reform law would establish or extend a number of innovative programs that may improve access to effective home and community-based services for those with long-term care needs. The legislation creates the Community Living Assistance Services and Supports (CLASS) program, a voluntary federal long-term care insurance program. Under the CLASS program, active workers who pay into the program for five years and require assistance performing certain daily activities would receive financial assistance to pay for community-based services providing for such needs.[98] Since the CLASS program may alleviate the need for Medicaid LTC services, the CBO estimates that Medicaid could save $2 billion from 2010-2019.[98] Medicaid beneficiaries also eligible for CLASS program benefits will be able to use CLASS funding to help supplement services designed to improve independence in an HCBS setting or help offset the cost of nursing home care.[99] The law would further address Medicaid LTC services by establishing the Community First Choice Option. The program would permit states to provide community-based attendant services to disabled individuals with incomes up to 150% FPL who would otherwise require institutional-level services. An enhanced federal reimbursement would be granted to states that implement the option.[42]

In addition to the CLASS program and the Community First Choice Option, the law extends the Money Follows the Person demonstration project; improves the HCBS state plan amendment option; and establishes the State Balancing Initiative Program, which will provide an enhanced FMAP to qualifying states that accelerate access to noninstitution-based LTC services.[42]

Stakeholders must work toward comprehensively reforming the nation's long-term care structure. Primarily, prevention and care coordination must be integrated into the health care delivery system to reduce the need for complex institution-based care. Reforming the long-term care system may require addressing issues in Medicare (particularly post-acute care coverage), housing, transportation, caregivers, and the long-term care workforce. As the baby boom generation ages, the health care system may be faced with an immense burden that could strain the long-term care infrastructure. Most people would prefer to spend their elder years in their homes and communities, and the transition to HCBS must be aggressively pursued by strengthening financial incentives and providing states the flexibility needed to transform their long-term care system.

Position 5: States' efforts to reform their Medicaid programs should not result in reduced access to care for patients. Consumer-driven health care reforms established in Medicaid should be implemented with caution and consider the vulnerable nature of the patients typically served by Medicaid. A core set of comprehensive, evidence-based benefits must be provided to enrollees.

Although the Florida Medicaid Reform pilot intends to steer patients toward preventive services while reducing overall costs to the program, many patients have found their access to care restricted. Tightened prescription drug formularies, poor implementation, and limited provider networks have forced many patients to go without adequate care. The increased complexity of the program has been a burden to patient and provider alike.[22] In addition, Missouri's efforts to drop or restrict care for hundreds of thousands of patients failed to have the intended effect of reducing overall program spending growth.[25] Evidence shows that increasing the cost-sharing levels on Medicaid enrollees may force those with little or no income out of the program. For instance, a study of the Oregon Health Plan efforts to increase cost-sharing led many individuals to leave the program. Those who left because of the cost-sharing burden reported "inferior access to care, used primary care less often, and used hospital emergency rooms more often than those who left [the program] for other reasons."[100] Given the financial vulnerability of Medicaid beneficiaries, efforts to expose enrollees to a higher level of cost-sharing needs to be done with caution and should not reduce access to care or force beneficiaries to forgo care because of cost. Consumer-driven health plans—particularly those with very high deductibles—may create particular challenges for the Medicaid population, which already places most enrollees in managed care plans that aggressively control use of services.[101] States often cap the amount of cost-sharing that Medicaid enrollees are required to yield; however, more needs to be done to develop and enforce these rules.[102] Some evidence suggests that the need for preventive care services provided through Medicaid is exacerbated as patients with high-deductible plans are unable to afford the cost of care. In 2010, the New Hampshire Medicaid program primarily enrolled children of parents who had either lost their employer-based health plans or had an unaffordable health plan with a high-deductible, and among this population, the need for preventive services had increased.[12]

States facing harsh budget projections should focus on improving the delivery of health care services rather than simply transferring the financial burden of coverage to poor beneficiaries. ACP strongly supports improving care coordination, emphasizing preventive services, and strengthening chronic disease management for Medicaid beneficiaries. As stated under Position 11, innovative, evidence-based, delivery system reforms, such as the patient-centered medical home, have helped reduce health care costs while improving health outcomes of patients.

Additionally, the health reform law provides a benchmark or benchmark-equivalent package of benefits for newly eligible adult enrollees. This package will provide, at a minimum, the same level of benefits as those provided by Exchange-based plans and states may have the option of providing additional benefits beyond the core set of services.[103] While this benefits package may be sufficient for the majority of newly eligible adult beneficiaries, some Medicaid enrollees, particularly the indigent and homeless population or those with complex mental health needs, may need additional benefits not included in the minimum package. The Medicaid program must ensure that these vulnerable people have access to comprehensive, effective care that suits their needs.[104]

Position 6: Federal and state stakeholders must work together to streamline and improve the Medicaid waiver process, ensuring timely approval or rejection of waiver requests and sufficient transparency to allow for public consideration and comment.

ACP maintains its position that the Medicaid waiver process should be streamlined to facilitate establishment of approved plans, encourage public input, and improve coordination between federal and state agencies. While the DRA allowed certain aspects of the Medicaid program to be altered through the state plan amendment process, waivers may remain an option for states seeking to expand Medicaid coverage and/or reduce costs. Since the Medicaid waiver process can have far-reaching consequences and sometimes lead to negative outcomes for vulnerable individuals, the College reiterates that the waiver process should be more transparent and allow for significant public input from stakeholders – including patients, physicians and other health care professionals. To facilitate public interaction, HHS should, at a minimum, widely disseminate waiver notices and other information by publishing in the Federal Register and allow a minimum 30-day comment period before approving or disapproving a waiver.[105] States should also communicate Medicaid waiver intentions through a variety of media and public hearings to ensure that stakeholders are made aware of proposals and have a chance to offer comments.

The health care reform law includes a provision that makes progress toward meeting this goal. The PPACA requires the Secretary of HHS to issue regulations that mandate the process for publication and public comment related to Medicaid 1115 waivers.

Position 7: Medicaid should be held accountable for adopting policies and projects that improve quality of care and health status, including reducing racial and ethnic disparities and effectively managing chronic disease and mental health.

Medicaid is particularly important to racial and ethnic minorities, providing a vital safety-net for low-income and disabled individuals. According to 2007 U.S. Census statistics, half of the nation's nearly 40 million Medicaid enrollees were racial and ethnic minorities.[106] Racial and ethnic minorities often have

complex health care needs and often have higher rates of chronic disease than whites.[107] Further, individuals with low socioeconomic status are often in poorer health than those in higher levels, potentially due to elevated exposure to adverse environmental conditions and limited access to affordable and accessible quality health care, among other factors.[108] ACP steadfastly maintains that all patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, or religion, deserve high-quality health care and that the Medicaid program is crucial to delivering such care. Eliminating racial and ethnic disparities is a moral and fiscal imperative: Disparities between African American and white Medicaid beneficiaries result in over $2 billion in excess Medicaid costs.[109] The College strongly supports reforming the Medicaid delivery system to emphasize patient-centered care, specifically by establishing patient-centered medical homes for Medicaid beneficiaries. A Commonwealth Fund survey found that access disparities among whites and racial and ethnic minorities are lessened when care is received through the medical home model; according to the survey, three fourths of white, non-Latinos; African Americans; and Latinos with medical home access reported getting the care they needed when they needed it.[110] The same survey found that only 38% of adults (including white, non-Latinos; African American; and Latino patients) with no regular source of care or provider were able to access care on a timely basis. Additionally, Medicaid managed care plans have also implemented programs to improve patient-physician interaction, culturally sensitive patient education, and data tracking to determine causes and potential solutions of health disparities.[111]

Position 8: Congress should establish a counter-cyclical funding mechanism for Medicaid, similar to the funding mechanism for unemployment insurance, to increase the amount of federal dollars to the program during economic downturns. Substantial structural changes to Medicaid are necessary if states are to meet the needs of the nation's most vulnerable populations.

The Medicaid program is particularly vulnerable during economic downturns, as states with budget problems curb coverage and decrease enrollment despite increasing need. For instance, a 1 percentage point rise in the unemployment rate would increase Medicaid and CHIP enrollment by 1 million.[112] Despite the greater need for public health programs in times of economic distress, it is predicted that states needing to balance their budgets would be forced to reduce Medicaid and CHIP spending by 3 to 4% for every 1% increase in unemployment.[113]

The American Recovery and Reinvestment Act of 2009 provided vital federal funding to state Medicaid programs to help them preserve enrollment and access to crucial services. A study of 2008 health care sector spending showed that stimulus funding shifted Medicaid costs to the federal government in the last quarter of 2008, saving states $7 billion in Medicaid spending.[9] To receive the boost in federal Medicaid funding, states were required to maintain existing Medicaid eligibility and mandatory benefit standards; however, states were permitted to trim costs as needed, and many states have cut or have considered cutting reimbursements for Medicaid providers or optional benefits like dental services. The boost in federal Medicaid funding is temporary and unless Congress provides an extension, the stimulus funding will end in June 2011. A survey of Medicaid directors found that most believe the federal government must maintain an enhanced funding boost for a significant period,

to be phased down as the economy stabilizes. The maintenance of increased funding may help Medicaid programs maintain their current eligibility standards while accommodating new enrollees who are unable to access health insurance through other means.

To maintain and strengthen the Medicaid program during times of economic stress, the federal government should provide a counter-cyclical funding mechanism substantial enough to accommodate the increased need for Medicaid as unemployment increases (and access to employer-based health coverage decreases) while allowing states to meet budget stabilization requirements. A number of Medicaid directors have expressed concern that implementation of Medicaid reform and eligibility expansion will place an additional strain on state Medicaid departments, many of whom have been forced to trim or furlough experienced staff or forgo equipment upgrades because of dwindling budgets.[12,114] To ensure a smooth program transition in 2014, it is an imperative that resources are made available to accommodate the enormous influx of currently and newly eligible Medicaid beneficiaries.

Position 9: States and the federal government should reduce barriers to enrollment for Medicaid coverage. Efforts should be made to ease enrollment for all eligible persons, including automatic enrollment based on income. Implementation of citizenship documentation requirements should not impede access to Medicaid and CHIP for those who are lawfully eligible. States and the federal government should provide culturally and linguistically competent outreach and education to ensure understanding and enrollment of Medicaid-eligible individuals.

ACP supports providing health coverage to all legal residents. However, millions of people who are eligible for Medicaid and CHIP are not enrolled and do not receive benefits. It is unclear why some eligible individuals fail to enroll in the Medicaid program. Eligible individuals may not realize that they qualify for the program, may be deterred by a perceived stigma associated with the program, and/or may have difficulty navigating the enrollment process.[8] Many states apply arbitrary tests and rules that complicate the process, reviewing an applicant's assets, disability status, and household composition, among others.[115] Efforts must be made to simplify the enrollment process and eliminate inefficiencies and redundancies that needlessly hinder access to Medicaid while protecting applicant privacy. In the College's 2009 monograph *Individual Mandates in Health Insurance Reform,* ACP expressed its support for an individual mandate providing that, among other requirements, federal and state stakeholders monitor and enforce a mandate through efficient and effective means, such as data matching.[116] Data matching processes are used in the Medicare Part D program; when the Social Security Administration determines that a Medicare beneficiary has also received Medicaid or Supplemental Security Income assistance, they are automatically enrolled in the low-income subsidies program, which provides financial assistance for the prescription drug benefit.[117] This streamlined process has helped to enroll most eligible beneficiaries. In February 2009, 81% of eligible beneficiaries received Part D financial assistance and only 12% had filled out application forms for the benefit.[117] Other examples of eligibility determination based on government data include the Massachusetts Commonwealth Care program, the National School Lunch Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children.[117] Similar data-matching concepts should be applied to

the Medicaid program so eligible people are integrated into the program with their consent.

Under PPACA, qualified health insurance plans, CHIP, and Medicaid must use the same universal, standard enrollment application form and applicants will be able to apply for coverage through Medicaid, qualified health plans, and CHIP through a Web site operated by the state. The standard application form may be filed online, by mail, telephone, or in person. The eligibility screening process ensures that individuals applying for Exchange-based coverage who qualify for Medicaid or CHIP will be directed to those programs and limits unnecessary paperwork. The law also requires states to establish data-matching systems with adequate privacy and data security safeguards to determine enrollment. While this is an encouraging step toward integrating advanced application and enrollment procedures, states should be permitted to enroll individuals based on information they already have, such as income and asset information, eliminating the need for an individual to submit an enrollment application. The 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) included a provision establishing an "express lane" eligibility process option that determines CHIP eligibility based on existing federal government records; eligible people are alerted by the program of their eligibility status (and may also be enrolled or reenrolled pending consent) without having to apply.[118] ACP has supported automatic enrollment procedures in a reformed health care system that ensures availability of affordable, regulated, and comprehensive health insurance.

Given the fact that many Medicaid beneficiaries have limited health literacy and many have limited proficiency in the English language, education and outreach initiatives should be made in a culturally and linguistically competent manner. In rolling out their health reform effort, Massachusetts encouraged stakeholders, such as hospitals, health plans, and businesses, to assist in public awareness campaigns that were presented in a culturally competent, multilingual manner.[119] The Commonwealth Connector also teamed up with the Boston Red Sox to help with the effort. Federal and state resources should be allocated to attend to this need. One example of a successful culturally competent outreach and enrollment initiative is the Latino Health Insurance Program, which utilized Spanish-speaking community outreach workers to visit potentially eligible individuals and provide counsel on health plan availability. The program also assisted people with obtaining a primary care physician and other providers. A review of the program found that over 70% of adults signed up for health coverage after educational sessions and 100% of eligible children were enrolled in appropriate plans.[120] Most of the adults who did not sign up were ineligible for coverage but were directed to other health services. The PPACA requires states to establish procedures for outreach to vulnerable and underserved populations to educate them about potential eligibility in Medicaid and CHIP. States must consider the complex needs of such individuals and tailor messaging accordingly. Likewise, citizenship documentation requirements must be coupled with efforts to educate and inform current and potential Medicaid enrollees of changes to the eligibility determination process.

Position 10: States should work to improve the physician and patient experience in dealing with the Medicaid program. Solutions should include reducing administrative barriers, and facilitating better communication and prompt pay standards between payers and physicians. Financial assistance should be provided to Medicaid-participating physicians to purchase and implement health information technology.

Along with relatively low reimbursement levels, another significant factor that plagues physicians who participate in Medicaid is the substantial administrative hassle and slow payment turnaround. One survey found that 70% of Medicaid-participating physicians cited billing requirements and paperwork as reasons for not accepting new Medicaid patients.[60] Payment delays, claims rejection, and preauthorization requirements all add to the growing administrative burden faced by physicians who participate in Medicaid. One study suggests that the benefits of increased reimbursement may not be enough to balance the administrative difficulties physicians face and that because of the administrative burden, states with high reimbursement rates often have similar participation levels of states with low rates. For instance, physicians in states with significant reimbursement delays were less likely to accept new patients.[121] Further, inefficient claims processing and other spending due to administrative errors significantly drains the health care budget. It is estimated that such inefficiencies cost the health care system up to $210 billion.[122] Increased use of electronic claims processing should be encouraged to reduce the administrative burden faced by Medicaid-participating physicians.

To achieve a smoother transaction of medical records between physicians and payers, such as Medicaid, federal and state governments must accelerate investment and implementation of a health information technology infrastructure. Not only can health information technology systems improve quality, but they can be a vital tool in reducing the administrative burden facing physicians and other health care professionals and payers. Physicians and other providers who utilize health information technology claims processing systems may achieve a 50 to 75% reduction in transaction costs, as well as savings garnered from reduced processing time and paper use.[123] Electronic claims processing systems that utilize electronic data interchange ensures physicians are paid faster than through traditional paper processing. Transitioning from a paper to electronic remittance process would yield significant savings for physician and other providers; however, much work needs to be done to expand use of electronic claim activity, as only 20% of physician practices filed all claims through such systems in 2008.[123] The federal government has experience implementing innovative payment systems. The Medicare program already utilizes electronic fund transfers, enabling payments to be directly deposited.[124] Federal and state governments should work to provide such a system for all Medicaid payments.

Realizing the potential for health information technology to improve health care quality and reduce inefficiency, the American Recovery and Reinvestment Act of 2009 included a provision providing funds for investment in health information technology. Physicians and other health care professionals who serve a high volume of Medicaid patients will receive federal funding to assist with the purchase, implementation, and operation of health information technology infrastructure.[125] To qualify for funds under this provision, physicians must demonstrate that their health information technology is for "meaningful use." The College supports Medicaid assistance for health information technology and urges that subsidies be substantial to promote viable physician participation and encourage adoption. However, the funding provided for health information technology activities may not be enough, particularly for independent private physicians.[114] Given the significant investment required of physicians and other health care providers to purchase and implement health information technology, it is important that the Medicaid program provide continued assistance and resources to establish a viable, comprehensive, interoperable information technology infrastructure that will help improve the delivery of quality care and reduce onerous administrative hassles.

Position 11: Medicaid programs should ensure access for Medicaid enrollees to innovative delivery system reforms such as the patient-centered medical home, a team-based care model that emphasizes care coordination, a strong physician-patient relationship, and preventive services.

In the ACP white paper titled *Controlling Health Care Costs While Promoting the Best Possible Health Outcomes*, ACP recommended, "Public and private health insurers should encourage preventive health care by providing full coverage, with no cost-sharing, for preventive services recommended by an expert advisory group, such as the U.S. Preventive Services Task Force." However, a recent GAO study found that access to preventive services of eligible adults under the Medicaid program varied widely. The agency reviewed whether states covered eight recommended preventive services, such as colorectal cancer screening and blood pressure measurement. The GAO recommended that HHS increase guidance to states to expand obesity-prevention services to children, and similar guidance on providing preventive services, with an emphasis on obesity-related services, for adults.[126] The study also found that only 62% of managed care-based Medicaid programs and about half of fee-for-service programs promoted medical home initiatives. States, such as Illinois, Pennsylvania, and Arizona, have recently developed medical homes for improving primary care access and care coordination for specific populations of Medicaid beneficiaries. Increased efforts to improve the coordinated care of dual-eligible patients are also needed.

The College is a strong supporter of promoting the patient-centered medical home, which emphasizes preventive care, patient-physician engagement, and better collaboration and care coordination among providers and payers across the health care delivery system. A number of states have successfully implemented patient-centered medical home models.[127] Community Care of North Carolina (CCNC), a medical home program for the state's Medicaid population, has achieved improvements in the quality of care and cost-savings. In fiscal year 2006, it was estimated that the program saved $150 to $175 million compared with the state's Primary Care Case Management program.[128] The core elements of the CCNC program include establishing primary care providers as a patient's medical home; enhanced reimbursement for care management services; and an emphasis on disease management, care coordination, and quality improvement. The program is centered on local networks of physicians, case managers, hospitals, social service agencies that collaborate and coordinate enrollee care and system navigation. A statewide CCNC clinical advisory board and state CCNC office also provide support.[128]

In February 2010, the Florida Medicaid Medical Home Task Force released a report outlining recommendations for a Medicaid medical home proposal. The Task Force recommended that the proposal focus on Medicaid beneficiaries in areas with a high concentration of uncoordinated care, ensure that beneficiaries have access to a readily available primary care provider to coordinate care, and provide sufficient reimbursement that incorporates health information technology and possibly case management and pay for performance/incentive payments. The Task Force report estimates that a medical home pilot will yield cost-savings over time, despite the initial investment.[127] As an alternative to the mandatory managed care legislation pushed in the Florida House, the Florida Medical Association released a white paper suggesting that expanding the medical home concept to all Medicaid enrollees would limit cost increases and maintain access to care better than mandatory managed care, which, the paper maintains, would provide cost-savings at the expense of access to care.[129]

Massachusetts has also worked to emphasize primary care and counter workforce shortages by testing a patient-centered medical home model. The medical home initiative has brought together various stakeholders, including primary care practices and major commercial and Medicaid payers in the commonwealth. A report issued by the Massachusetts Patient-Centered Medical Home Initiative Council noted that "there is growing evidence that transforming primary care into a medical home model improves access, quality, and patient experience, and reduces costs."[130]

Federal initiatives, such as the medical home demonstration project in the health reform law, are encouraging. The law facilitates the establishment of medical homes for Medicaid beneficiaries with complex health needs by providing a state plan option where beneficiaries with chronic conditions and/or a mental health need can designate a health home.[131] A number of Medicaid programs, private insurers, and Medicare are participating in the Multi-payer Advanced Primary Care Practice Initiative, a collaborative effort among various payers to test the patient-centered medical home model. According to HHS the demonstration will evaluate whether medical homes are able to improve safety, patient decision-making, and delivery of quality care.[132] The health care reform law also provides enhanced federal funds to state Medicaid programs that cover without cost-sharing preventive services that have in effect a rating of "A" or "B" from the U.S. Preventive Services Task Force. While these are positive steps toward improving access to crucial, coordinated health care services, ACP supports efforts to include all Medicaid beneficiaries in medical home projects.

Position 12: Medicaid program stakeholders should consider alternative financing structures to ensure solvency, high quality of care, and uninterrupted access for beneficiaries, while alleviating the program's financial pressure on states. Particularly, financing and delivery of care for dual eligible beneficiaries must be reformed.

a. A physician—particularly a primary care physician—should be included among the membership of the Medicaid and CHIP Access Commission.

Medicaid spending is a significant part of most state budgets.[133] As the impact of the economic recession continues and employer-sponsored health insurance availability declines, more individuals will seek health insurance coverage through public programs, such as Medicaid. In the face of rising unemployment, balanced budget requirements, and dwindling revenue, many states have been forced to consider cutting payment rates for physicians and other health care professionals and/or ancillary benefits, such as dental and vision services.[12] Many state Medicaid directors, while supportive of the idea of a Medicaid expansion through the federal health reform law, have expressed concern that it will have a deleterious effect on state budgets.[30] While temporary enhancements in federal Medicaid funding have been a crucial component in maintaining existing program enrollment and will probably be required in the future to mitigate disruption in the delivery of services, a more permanent solution to state Medicaid funding issues may be needed.

Dual eligible beneficiaries—elderly and/or disabled individuals eligible for Medicare and Medicaid—are a small yet costly segment of the nation's public health insurance system. More than half of this population has an annual income less than $10,000, a cognitive or mental impairment, and less than a

high school education.[134] In 2005, annual per-patient spending for dual eligibles was five times that of regular Medicare patients.[134] A large portion of state Medicaid spending is devoted to caring for dual eligibles. North Dakota, for instance, directs a staggering 59% of its Medicaid dollars to caring for such patients. Across all states, dual eligibles make up 39% of state Medicaid spending.[135] Dual eligible persons are largely cared for through the Medicare program, while Medicaid typically provides financial assistance for cost-sharing and some services not covered by Medicare, such as long-term care and vision and dental services. Additionally, Medicaid provides coverage to disabled individuals during the Medicare 24-month waiting period. Since states and the federal government share responsibility for dual eligible care, opportunities for effective care management and efficient administration of services are limited, particularly due to the disconnect between Medicare's acute care services and Medicaid's long-term care benefits. According to the MedPAC, current dual eligible policy incentivizes cost-shifting, poor care coordination and cooperation, and prevents access to care.[136]

States have long argued that care of dual eligibles should be the responsibility of the federal government.[137] Among the rationale for such a shift, state governors maintain that better care coordination will be possible if dual eligibles were cared for solely by Medicare and that the federal government is more able to shoulder the financial burden of dual eligibles.[138] Another argument is that states do not have control over the delivery of acute care services under Medicare but are required to provide cost-sharing assistance for such services.[139] Since the federal government is not mandated to balance its budget and is better able to absorb the cost of caring for patients with complex health care needs, the federal government should assume a larger share of responsibility for the care of dual-eligible persons.

States would save a significant amount if the federal government assumed the responsibility of cost sharing and premium support for Medicare acute care services. Such a policy already exists for Medicare's drug benefit, where the federal government provides premium assistance for low-income beneficiaries. Transferring long-term care services and financing for dual eligibles from Medicaid to Medicare would probably provide the most financial relief for cash-strapped states. Under this scenario, Medicare would be responsible for acute and long-term care services, potentially incentivizing and facilitating delivery system reform that improves effective chronic disease management and care coordination, although uniform long-term care standards and coordination requirements may have to be established to achieve such goals.[139] Shifting this responsibility to Medicare, along with establishing evidence-based care coordination, may improve patient health and reduce overall costs while eliminating cost-shifting between payers.[139]

An alternate means of integrating dual eligible care and creating cost-savings is to direct Medicare and Medicaid funding to states to provide care through a medical home model. Dual eligible care would be managed through the state Medicaid program to ensure better care coordination.[140] Conversely, another solution would be to allow Medicaid to share in Medicare savings derived from care coordination. Currently, if a state's Medicaid program established a care coordination program that reduced the number and/or intensity of Medicare acute care services, the Medicaid program would not absorb savings. Policy could be altered to ensure that Medicare directs at least a portion of its savings derived from a reduction in acute care episodes connected to effective state Medicaid care coordination programs.[94]

The health reform law requires the establishment of the Federal

Coordinated Health Care Office, a new federal entity charged with improving cooperation among payers and physicians and other health care professionals serving dual eligibles. Specifically, the office will support state efforts to coordinate and align acute and long-term care services with other Medicare items and services available to dual eligibles. Other goals include eliminating cost-shifting between physicians and other health care professionals and between the Medicaid and Medicare programs, simplifying access to services, and improving care continuity and transitions and the quality of acute and long-term care available to dual eligibles.

Care of dual eligible beneficiaries places a significant financial burden on state budgets. The fragmented, uncoordinated nature of dual eligible care hinders the delivery of preventive services and complicates cooperation among physicians and other health care professionals. Policymakers may want to consider an alternate means of financing the Medicaid program by requiring the federal government to cover the financial costs of dual eligible care and/or enhancing the federal reimbursement to states that establish effective, evidence-based care coordination for vulnerable Medicaid beneficiaries.

The health reform law also expands the scope of the Medicaid and CHIP Payment and Access Commission to include oversight of adults. This new entity will be charged with issuing recommendations on coverage, quality of care, and dual eligible issues.[42] Given internists' substantial role in delivering care to patients who will be insured through Medicaid under PPACA, it is crucial that the commission include a physician—particularly one practicing primary care—among its membership.

Conclusion

The Medicaid program faces significant changes in the next few years as millions of current and newly eligible people will receive Medicaid coverage. With this challenge comes the opportunity to reform Medicaid to ensure its future sustainability and solvency. A reformed program must put coordinated primary care at the forefront, must emphasize quality care over volume-based care, and must provide beneficiaries with more options to meet their long-term care needs. Primary care physicians will assume a major role in providing care to Medicaid beneficiaries, but the program must do more to ensure that physicians can afford to provide care, that information can be shared across the health care infrastructure, and that administrative burdens are mitigated to allow physicians more time to care for patients.

Appendix. Medicaid-to-Medicare Primary Care Services Fee Index, 2008

State	Fee Index	State	Fee Index	State	Fee Index
US Avg.	**0.66**	**US Avg.**	**0.66**	**US Avg.**	**0.66**
AL	0.78	KY	0.8	ND	1.01
AK	1.4	LA	0.9	OH	0.66
AZ	0.97	ME	0.53	OK	1
AR	0.78	MD	0.82	OR	0.78
CA	0.47	MA	0.78	PA	0.62
CO	0.87	MI	0.59	RI	0.36
CT	0.78	MN	0.58	SC	0.86
DE	1	MS	0.84	SD	0.85
DC	0.47	MO	0.65	TX	0.68
FL	0.55	MT	0.96	UT	0.76
GA	0.86	NE	0.82	VT	0.91
HI	0.64	NV	0.93	VA	0.88
ID	1.03	NH	0.67	WA	0.92
IL	0.57	NJ	0.41	WV	0.77
IN	0.61	NM	0.98	WI	0.67
IA	0.89	NY	0.36	WY	1.17
KS	0.94	NC	0.95		

Source[15]**:** Zuckerman S et al. Trends in Medicaid Physician Fees, 2003-2008. Health Affairs. 2009;28(3):w510-519.

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