HEALTH POLICY

The New Medicaid Under PPACA What Will it Mean for General Internists?

Colleen M. Grogan, PhD

School of Social Service Administration, Center for Health Administration Studies, University of Chicago, Chicago, IL, USA.

The Patient Protection and Affordable Care Act (ACA) institutionalized Medicaid as a significant and permanent structure in the U.S. health care system. About half of the 32 million Americans expected to gain health insurance coverage under the ACA will be covered under Medicaid. While it is clear general internists will be significantly impacted by Medicaid-related health care reform provisions, its ultimate effect is unclear since these new opportunities also come with some new potential burdens. There are four main areas of impact for general internists to consider: (1) coverage expansions and reimbursement; (2) multiple payers and fragmented coverage; (3) primary care workforce and infrastructure capacity; and (4) delivery model changes.

J Gen Intern Med 26(12):1502–5
DOI: 10.1007/s11606-011-1856-9
© Society of General Internal Medicine 2011

COMMENTARY

More often than not experts and policymakers express concerns about Medicaid: too restrictive (or some argue too generous) eligibility requirements, inadequate access to providers due to low payments, and growing costs. Given these concerns—which have persisted over its 40-plus year history—one might have thought that health care reform would have eliminated the program altogether. Instead, the Patient Protection and Affordable Care Act (ACA) further embeds Medicaid as a significant and permanent structure in the U.S. health care system. About half of the 32 million Americans expected to gain health insurance coverage under the ACA will be covered under Medicaid.¹ While it is clear general internists will be significantly impacted by Medicaid-related health care reform provisions, its ultimate effect is unclear since these new opportunities also come with some new potential burdens. There are four main areas of impact for general internists to consider: (1) coverage expansions and reimbursement; (2)

multiple payers and fragmented coverage; (3) primary care workforce and infrastructure capacity; and (4) delivery model changes.

MEDICAID COVERAGE EXPANSIONS AND PROVIDER REIMBURSEMENT

For the first time since Medicaid was enacted over 45 years ago, the program will provide coverage to *all* low-income Americans (defined as less than 133% of the federal poverty level or \$29,326 annual income for a family of four in 2010).² When Medicaid was first passed, only certain categories of poor people were eligible: families with dependent children, the disabled and elderly, for example. Over time, the federal government mandated expanded coverage for pregnant women and children, and provided financing for states to cover additional optional groups (e.g., single childless adults). In stark contrast to past policy, health care reform largely equalizes Medicaid coverage across the states. After 2014, people who were considered undeserving in many states in the past—single adult males, childless couples, and the homeless, for example—will receive access to public insurance.

Because the state coverage rates varied substantially before reform, the impact of reform similarly varies by state. There will be huge regional effects. Not surprisingly, states with relatively low per capita incomes will realize the most dramatic increases in Medicaid coverage. In particular, physicians practicing in southern states (especially South Carolina, Georgia, Florida, Louisiana, Arkansas, Texas) and the mountain states (North and South Dakota, Montana, Idaho, Nevada) will experience significant increases where new Medicaid enrollees will make up more than 25% of total enrollment.³

The extent to which these coverage expansions will help primary care providers will depend on a number of factors. For general internists practicing in facilities whose mission it is to serve the uninsured (e.g., public hospitals, primary care centers, or federal qualified community health centers—FQHC), the cost structure for these facilities is such that Medicaid cost-based reimbursement has usually been viewed favorably.⁴

However, for physicians practicing in private practice settings, it is unclear that ACA inducements will be sufficient to increase participation in the program. Although there has been remarkable agreement over the years that Medicaid reimbursement is the most salient factor influencing physician participation in the program,^{5–8} state fee increases have unfortunately had relatively little impact on physician participation. Most significant for thinking about the effect of the

Received April 5, 2011

Revised August 9, 2011

Accepted August 17, 2011

Published online September 14, 2011

ACA which increases Medicaid payment rates to primary care physicians to 100% of the Medicare payment rates for two years, was Perloff, Kletke and Fossett (1995) finding that an increase in fees up to the Medicare level would only increase primary care physician participation by about 7.5 percentage points, from 36.4 to 43.9%. They noted further that if states only wanted to reach 50% full participation rate among primary care physicians, Medicaid fees would have to increase to 39% above Medicare fees.⁹ Additional studies of fee increases—including a recent one that looks specifically at fee increases under the ACA—concur that marginal increases to low Medicaid fees, even those up to 100% of Medicare, will not likely result in any measurable increase in physician participation levels.^{10–12}

Although the federal government will assume 100% of the costs associated with the fee increase, the fiscal stress states are currently in makes it highly unlikely that many (if any) states will expand fees above Medicare to really get a significant boost in participation. Moreover, it is extremely important to note that the fee increase provision under the ACA is temporary—as specified in the bill it will only be in effect for a two-year period (2014–2015). Such a temporary provision will likely make physicians even more reluctant to participant knowing that they may experience a decrease in fees two years later.

MULTIPLE PAYERS AND FRAGMENTED COVERAGE

Besides expanding eligibility, the ACA requires states to streamline Medicaid enrollment by creating automated processes and routine reenrollment procedures so that if a family's income remains the same their Medicaid enrollment is automatically continued. Discontinuous coverage has long been a problem in Medicaid and such bureaucratic inefficiency has often meant uneven care resulting in patient noncompliance and medical regimens left incomplete. Given that the vast majority of states have already created simple application forms and procedures, and 35 states devote funding to enrollment outreach programs, the implementation prospects for this provision look promising.¹³

However, while the ACA requirement for streamlined and coordinated Medicaid enrollment should reduce discontinuous coverage due to paperwork and bureaucratic problems, the creation of state health insurance exchanges under the ACA will increase churning between Medicaid and the state-based private insurance exchanges as their income increases or decreases.¹⁴ Moreover, while ACA substantially expands coverage, there will still be people without health insurance. In most states, legal immigrants are not eligible for Medicaid during their first five years of residency. As patients move between these systems, providers will have to adjust to different reimbursement rates, benefits, and payment procedures. Depending on whether states address coordination issues between these systems, this could create huge administrative burdens for providers.

Some states have created online information systems which operate across multiple platforms. Massachusetts, for example, created a successful electronic application system called a "virtual gateway," which allows providers including hospitals, private clinics and community health centers to enter the same

gateway system—regardless of patient status—to assist in Medicaid and the Exchange enrollment process.¹ There is new federal funding and guidance to help states design and implement information technology similar to the Massachusetts gateway idea where *all* people shopping for insurance would go to one website. The idea, as stated by Joel Ario, director of the Office of Health Insurance Exchanges in CMS, is that "individuals will seek health care coverage without necessarily knowing whether they are looking for an exchange plan, a Medicaid or a CHIP plan."¹⁵ This type of reform should help significantly reduce the potential for high administrative burden under this segmented payer system, but it depends entirely on state willingness to invest in IT infrastructure and almost assuredly on continued federal financial assistance.

PRIMARY CARE WORKFORCE AND INFRASTRUCTURE CAPACITY

While improving access to health insurance coverage is crucially important, it will lack significant meaning for low-income people if access to *care* is not also improved.¹⁶ There is concern that the US does not have an adequate primary care workforce or infrastructure to implement comprehensive primary care reforms. As a result, there are provisions under the ACA to address these issues. First, the bill expands investment in Federally Qualified Community Health Centers (FQHCs) by allocating nine and half billion dollars to build new FQHCs around the country and \$1.5 billion to renovate existing facilities. This increase reflects bi-partisan support for FQHC investment over the past decade; appropriations have totaled \$15.5 billion resulting in a doubling of FQHC patients, from about 10 million in 2001 to 20 million in 2010.¹⁷ While there is evidence of good quality offered at many FQHCs,¹⁸ overcapacity resulting in long waiting times and insufficient access to needed services is a consistent trend as well. Given that FQHCs expanded care to an additional 10 million patients with 15.5 billion and are now expected to increase care to an estimated 40 million in five years with less—\$11 billion—adequate capacity to maintain good quality of care is a concern. While federal commitment to FQHC financing remains unclear in light of the House of Representatives initial vote in 2011 to eliminate health center funding, FQHCs will undoubtedly continue to play a critical role in providing needed primary care: they take care of a large proportion of Medicaid enrollees and¹⁷ and are purposefully located in underserved areas often with high percent minority populations.^{19–20}

Second, provisions in the ACA attempt to increase the supply of primary care doctors (as well as dentists, allied health providers, and some specialists) by providing increased funding for loan repayment programs and inducements to practice in underserved areas.^{21–22} While some inducement to expand the primary care workforce is arguably better nothing, it is important to note that these policies are based on an incentive approach and the amount of financial incentives needed to change physician preferences from specialty care to primary care remains unclear. What is clear is that even if these incentives are effective at increasing the supply of primary care providers, it will not change in the short-term. And, we are facing some serious primary care shortages in many states.

Most concerning is those same states—primarily in the Southern and Mountain regions—that will experience the most dramatic increases in Medicaid enrollments, are also suffering from the most severe shortages in primary care providers.¹²

DELIVERY MODEL CHANGES

In response to large deficits, states are eager to control Medicaid costs. Aside from fighting on the legal front for outright repeal of the ACA,²³ the main cost control policy leaver states have used in the past is to either reduce eligibility, lower reimbursement rates, or eliminate coverage of optional benefits (e.g., prescription drugs for the nonelderly, dental care). While states can eliminate important optional benefits, the easy “quick-fix” policy leavers are significantly restricted under the ACA maintenance of effort requirements. Instead, states are asked to make long-term investments to create cost-effective incentives in the delivery system. Two main models have been tried in the states and are further encouraged under the ACA: (1) contracting with managed care plans, and (2) the creation of medical homes.

Since 2006 more than 30 states have advanced the medical home concept within Medicaid and CHIP. At the same time many states have contracts with Managed Care Organizations (MCOs) and are using these contracts to also require use of the medical home idea.²⁴ As has been well documented in this journal, the medical home is an enhanced model of primary care that provides a team approach to comprehensive and coordinated patient-centered care.²⁵ The ACA’s Medicaid State Plan Option provides enhanced federal matching rates for states that designate a primary care provider to Medicaid enrollees as their health home. Under this program services should include: comprehensive care management, core coordination and health promotion, comprehensive transitional care and community and social support services.²⁶ There are also Medicaid demonstration projects with incentive payments for medical homes. This means that if providers are motivated to create comprehensive medical homes, there is additional funding under the ACA to implement such delivery model reforms.

Studies to date suggest efficiency and quality of care gains from the use of medical homes, but also point to significant implementation difficulties in converting small, independent primary care practices into patient-centered medical homes.^{24–27} No provision in the ACA requires or mandates that medical homes are adopted. Given the implementation problems identified in converting to this model, the slower, incentive-based approach of ACA may be wise, but it also means that the most promising step for improved quality and cost-savings may be slow in coming.

SUMMARY

There are many commendable aspects of the ACA—perhaps most importantly the extension of financial protection to millions of low-income families to protect them from impoverishment when sickness occurs.^{28–29} While there is hope that

ACA provisions to increase Medicaid reimbursement will entice private primary care providers to participate in Medicaid, past evidence suggests the increase will result in minor changes. Unfortunately, then, for those primary care providers who already participate they will be asked to do more without a commensurate expansion in capacity, at least in the short-term.

Acknowledgements: I would like to acknowledge the helpful comments and feedback of JGIM Editor Caleb Alexander and two anonymous reviewers.

Conflict of Interest: None disclosed.

Corresponding Author: Colleen M. Grogan, PhD; School of Social Service Administration, Center for Health Administration Studies, University of Chicago, 969 E. 60th Street, Chicago, IL 60637, USA (e-mail: cgrogan@uchicago.edu).

REFERENCES

1. Ku L. Ready, set, plan, implement: Executing the expansion of Medicaid. *Health Aff.* 2010;29(6):1173.
2. Key Questions about Medicaid and its Role in State/Federal Budgets and Health Reform [Internet]. Washington DC: The Henry J. Kaiser Family Foundation; c2011 [cited 2011 March 18]. Available from: <http://www.kff.org/Medicaid/upload/8139.pdf>.
3. Buettgens M, Holahan J, Carroll C. Health reform across the states: Increased insurance coverage and federal spending on the exchanges and Medicaid. Robert Wood Johnson Foundation: State Coverage Initiatives; 2011.
4. Primary Care: What is a health center? [Internet] July, 2011]. Available from: <http://bphc.hrsa.gov/about/>.
5. Sloan F, Mitchell J, Cromwell J. Physician participation in state Medicaid programs. *Journal of Human Resources.* 1978;13(suppl):211–45.
6. Hadley J. Physician participation in Medicaid: Evidence from California. *Health Serv Res.* 1979;14(4):266–80.
7. Davidson SM. Medicaid reform. *Health Soc Work.* 1982;7(2):85–7.
8. Mitchell JB. Physician participation in Medicaid revisited. *Medical Care.* 1991;29(7):645–53.
9. Perloff JD, Kletke PR, Fossett JW. Which physicians limit their Medicaid participation and why. *Health Services Research.* 1995;30(1):7–26.
10. Fanning T, de Alteris M. The limits of marginal economic incentives in the Medicaid participation among pediatricians. *Pediatrics.* 1993;72(4):552–59.
11. Baker LC, Royalty AB. Medicaid policy, physician behavior, and health care for the low-income population. *The Journal of Human Resources* 2000;XXXV(3):480–502.
12. Cunningham PJ. Research brief: State variation in primary care physician supply: Implications for health reform Medicaid expansions. Center for Studying Health System Change (HSC), Robert Wood Johnson Foundation; 2011 March 17. Report nr 19.
13. CHIP Enrollment June 2009: An Update on Current Enrollment and Policy Directions [Internet] Washington DC: The Henry J. Kaiser Family Foundation; c2010 [cited 2011 March 18]. Available from: <http://www.kff.org/Medicaid/upload/7642-04.pdf>.
14. Sommers BD, Rosenbaum S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Aff Project Hope.* 2011;30(2):228–36.
15. News Release: HHS announces new federal support for states to develop and upgrade Medicaid IT systems and systems for enrollment in state exchanges [Internet] Washington DC: U.S. Department of Health and Human Services; c2011 [cited 2011 March 18]. Available from: <http://www.hhs.gov/news/press/2010pres/11/20101103a.html>.
16. Kullgren JT, McLaughlin CG. Beyond affordability: The impact of nonfinancial barriers on access for uninsured adults in three diverse communities. *J Community Health.* 2010;35(3):240–8.

17. **Iglehart JK.** Health centers fill critical gap, enjoy support. *Health Aff Project Hope*. 2010;29(3):343–5.
18. **Rothkopf J, Brookler K, Wadhwa S, Sajovetz M.** Medicaid patients seen at federally qualified health centers use hospital services less than those seen by private providers. *Health Aff Project Hope*. 2011;30(7):1335–42.
19. **Fossett JW, Peterson JA.** Physician supply and Medicaid participation the causes of market failure. *Med Care*. 1989;27(4):386–96.
20. **Adams EK.** Effect of increased Medicaid fees on physician participation and enrollee service utilization in Tennessee, 1985–1988. *Inquiry*. 1995;31(2):173–87.
21. Summary Of The Health Workforce Provisions In The Patient Protection And Affordable Care Act: H.R. 3590 [Internet] Washington DC: National Conference of State Legislatures; c2010 [cited 2011 March 18]. Available from: <http://www.ncsl.org/documents/health/HlthWrkrfceProvHR3590.pdf>.
22. **Rieselbach RE, Crouse BJ, Frohna JG.** Teaching primary care in community health centers: Addressing the workforce crisis for the underserved. *Ann Intern Med*. 2010;152(2):118.
23. **Kelsh R.** Health reform: The politics of implementation. *JHPPL* 2011;36(3).
24. Building Medical Homes in State Medicaid and CHIP Programs [Internet] Washington DC: The National Academy for State Health Policy; c2009 [cited 2011 March 18]. Available from: http://www.nashp.org/sites/default/files/medicalhomesfinal_revised.pdf.
25. **Blue Ribbon Panel of the Society of General Internal Medicine.** Redesigning the practice model for general internal medicine a proposal for coordinated care: A policy monograph of the society of general internal medicine. *J Gen Intern Med*. 2007;22(3):400–9.
26. Safety Net Medical Home Initiative. Health Reform and the Patient-Centered Medical Home: Policy Provisions and Expectations of the Patient Protection and Affordable Care Act [Internet] Seattle, WA: Qualis Health and Bailit Health Purchasing; c2010 [cited 2011 March 18]. Available from: http://www.qhmedicalhome.org/safety-net/upload/SNMHI_PolicyBrief_Issue2.pdf.
27. **Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart E, Jaén C.** Transforming physician practices to patient-centered medical homes: Lessons from the national demonstration project. *Health Aff Project Hope*. 2011;30(3):439–45.
28. **Grogan C. M.** In Morone J., Litman T. and Robins L. (Eds.), *Medicaid: Health care for you and me!*. (2nd Edition) New York: Delmar Thompson. 2012 (forthcoming).
29. **Thompson F.** The medicaid platform: Can the termites be kept at bay? *Journal of Health, Politics, Policy and Law*. 2011;36(3).