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

Positions

Position 1: The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of

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]

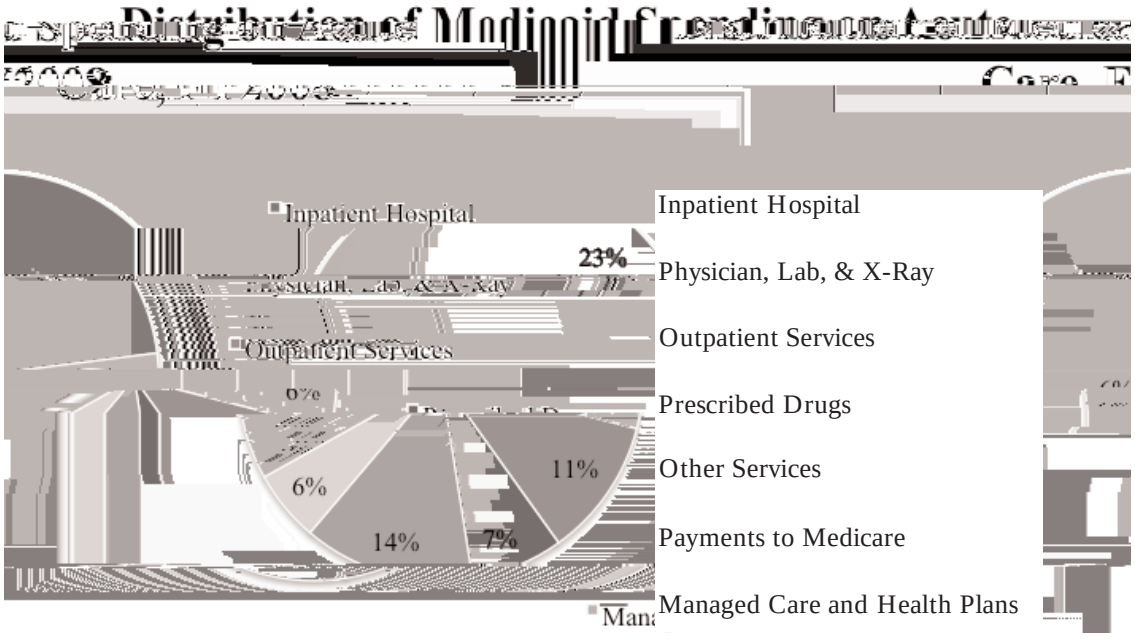
Spending

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,

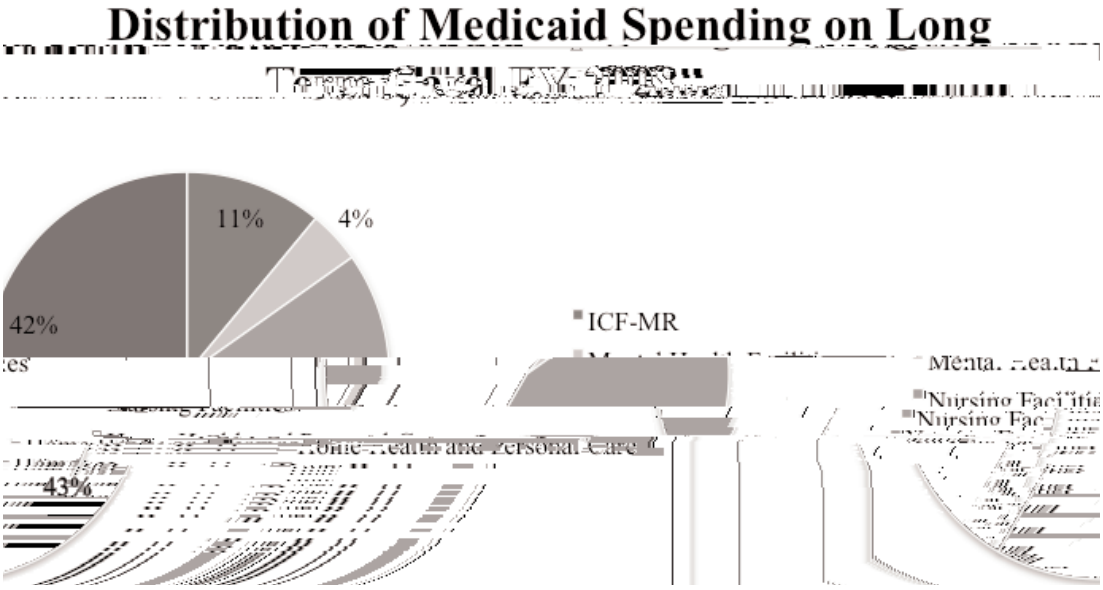
significant temporary increase in the federal reimbursement for state Medicaid programs, providing states a total of $87 billion through December 2010; a smaller reimbursement enhancement was extended to states until June 2011. The legislation stipulated that to receive the money, states could not reduce 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.



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.



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]

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

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

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.

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

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 pre-

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

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

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

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.

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,

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

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.

References

1. **Foster RS.** Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009. CMS Office of Chief Actuary. January 10, 2010. Accessed at www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf on April 5, 2010.
2. **Congressional Budget Office.** H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). CBO. March 20, 2010. Accessed at www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf on January 24, 2011.
3. **Norman J.** Report: Medicaid Enrollment to Climb by More Than 50 Percent in 10 States. CQ Today. April 15, 2010. Accessed at www.cq.com/display.do?docid=3641821&productId=5&binderName=healthbeat-20100415 on April 16, 2010.
4. **Kaiser Family Foundation.** Medicaid: A Primer. Kaiser Family Foundation, 2009. Accessed at www.kff.org/medicaid/upload/7334-03.pdf on October 6, 2009
5. **Holahan J, Yermane A.** Enrollment Is Driving Medicaid Costs-But Two Targets Can Yield Savings. Health Affairs. 2009;28(5):1453. Accessed at http://content.healthaffairs.org/content/28/5/1453.full on February 2, 2011.
6. **Ellis E et al.** Medicaid Enrollment in 50 States: June 2008 Data Update. Kaiser Family Foundation, September 2009. Accessed at www.kff.org/medicaid/upload/7606-04.pdf on September 22, 2009.
7. **Kaiser Family Foundation.** Annual Change in Medicaid Enrollment in 50 States and DC, June 2000 to June 2009. Presentation Slide. Accessed at http://slides.kff.org/chart.aspx?ch=1365 on February 24, 2010.
8. **Congressional Budget Office.** Key Issues in Analyzing Major Health Insurance Proposals. CBO. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf on March 5, 2010.
9. **Hartman M et al.** Health Spending Growth At A Historic Low in 2008. Health Affairs. 2010;29(1):147.
10. **Smith V et al.** Headed for a Crunch: An Update on Medicaid Spending , Coverage and Policy Heading into an Economic Downturn: Results from a 50-State Medicaid Budget survey for state fiscal Years 2008-2009. Kaiser Family Foundation, September 2008. Accessed at www.kff.org/medicaid/upload/7815.pdf on September 22, 2009.
11. **Jennings T.** New Mexico looks to other states for idea on Medicaid fix. New Mexico Independent. September 19, 2009. Accessed at http://newmexicoindependent.com/36818/medicaid-crisis-doesnt-have-silver-bullet-fix-lawmakers-told on September 22, 2009.
12. **Smith V, Rosenstein S.** Medicaid's Continuing Crunch in the Recession: A Mid-Year Update for State FY 2010 and Preview for FY 2011. Kaiser Commission on Medicaid and the Uninsured. February 2010. Accessed at www.kff.org/medicaid/upload/8049.pdf on February 2, 2011.
13. **Holahan, J, Yemane A, Rousseau D.** Medicaid Expenditures Increased by 5.3% in 2007, Led By Acute Care Spending Growth. Kaiser Family Foundation, September 2009. Accessed at http://kff.org/medicaid/upload/7978.pdf on September 22, 2009.
14. **Statehealthfacts.org.** Distribution of Medicaid Spending by Service, FY2008. Kaiser Family Foundation. Accessed at http://statehealthfacts.org/comparetable.jsp?ind=178&cat=4 on August 9, 2010.
15. **Zuckerman S et al.** Trends in Medicaid Physician Fees, 2003-2008. Health Affairs. 2009;w510. Accessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.28.3.w510v1?ijkey=FtFdm/8MJTtuk&keytype=ref&siteid=healthaff on April 8, 2010.
16. **Statehealthfacts.org.** Medicaid Physician Fee Index, 2008. Accessed at http://statehealthfacts.org/comparetable.jsp?ind=195&cat=4 on September 22, 2009.
17. **Smith V et al.** The Crunch Continues: Medicaid Spending, Coverage and policy in the Midst of a Recession. Kaiser Family Foundation. September 2009. Accessed at www.kff.org/medicaid/upload/7985.pdf on April 6, 2010.

18. **Egelko B.** State can't cut Medi-Cal payments to hospitals. San Francisco Chronicle. March 4, 2010. Accessed at www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/03/03/BAIO1CAG36.DTL on March 12, 2010.
19. **Greene J.** "Michigan's hospitals, doctors, nursing homes brace for Medicaid budget cuts. Crain's Detroit Business. September 21, 2009. Accessed at www.crainsdetroit.com/article/20090921/FREE/909219978 on September 22, 2009.
20. **Sweeney T.** Overview of the Department of Community Health's FY 2010 Budget. Georgia Budget and Policy Institute, June 2009. Accessed at www.gbpi.org/documents/20090629dch.pdf on September 22, 2009.
21. **Coughlin T et al.** Florida's Medicaid Reform: Informed Consumer Choice? Health Affairs. 2008;27(6):w523. Accessed at http://content.healthaffairs.org/content/27/6/w523.full on February 2, 2011.
22. **Alker J et al.** Florida's Experience with Medicaid Reform: What has been learned in the first two years? Jessie Ball DuPont Fund, October 2008. Accessed at http://hpi.georgetown.edu/floridamedicaid/pdfs/briefing7.pdf on September 23, 2009.
23. **Alker J and Hoadley J.** Waving Cautionary Flags: Initial reactions from doctors and patients to Florida's Medicaid changes. Jessie Ball DuPont Fund. May 2007. Accessed at http://hpi.georgetown.edu/floridamedicaid/pdfs/briefing2.pdf on September 23, 2009.
24. **Saunders J.** House passed Medicaid overhaul. Health News Florida. April 19, 2010. Accessed at www.healthnewsflorida.org/index.cfm/go/public.articleView/article/17224 on April 20, 2010.
25. **Zuckerman S et al.** Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees and Providers? Health Affairs. 2009;28(2):w335. Accessed at http://content.healthaffairs.org/content/28/2/w335.full?sid=7e6b2e19-6fe1-4ff1-91f6-ea37cb5ffeb4 on February 2, 2011.
26. **Alker J.** West Virginia's Medicaid Redesign: What is the Impact on Children? Georgetown University Health Policy Institute Center for Children and Families. August 2008. Accessed at http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/state-specific/wv%20factsheet%202008.pdf on October 6, 2009
27. **Hendryx M et al.** Evaluation of Mountain Health Choices: Implementation, Challenges, and Recommendations. Institute for Health Policy Research, West Virginia University. March 2009. Accessed at www.hsc.wvu.edu/wvhealthpolicy/reports/RWJ%20Policy%20Brief%20FINAL%2003.27.09.pdf on October 6, 2009
28. **Eyre E.** State Medicaid office target of lawsuit. Charleston Gazette. December 16, 2008. Accessed at www.wvgazette.com/News/200812150661 on October 6, 2009
29. **American College of Physicians.** Ethical Considerations for the Use of Patient Incentives to Promote Personal Responsibility for Health: West Virginia Medicaid and Beyond. Philadelphia: American College of Physicians; 2010. Position Paper. Accessed at www.acponline.org/running_practice/ethics/issues/policy/personal_incentives.pdf on February 2, 2011.
30. **Napel ST et al.** State of the States. Robert Wood Johnson Foundation website, January 2010. Accessed at www.rwjf.org/files/research/55308.pdf on March 3, 2010.
31. **Helgerson JA.** BadgerCarePlus: Governor Jim Doyle's Roadmap to Universal Access to Health Care for All Wisconsinites Even During Difficult Economic Times. PowerPoint Presentation. February 22, 2010. Accessed at www.allhealth.org/BriefingMaterials/JasonHelgerson-1715.pp on February 2, 2011.
32. **Witgert KE.** BadgerCare Plus: Medicaid and Subsidies Under One Umbrella. Robert Wood Johnson Foundation Issue Brief. August 2009. Accessed at www.rwjf.org/files/research/47472brief.pdf on February 2, 2011.
33. **Wisconsin Department of Health Services.** Core Plan – Health Care for Adults with No Dependent Children. WDHS. July 12, 2010. Accessed at www.dhs.wisconsin.gov/badgercareplus/core/index.htm on August 9, 2010.

34. **Kuhmerker K, Hartman T.** Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs. Commonwealth Fund. April 12, 2007. Accessed at www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Apr/Pay-for-Performance-in-State-Medicaid-Programs—A-Survey-of-State-Medicaid-Directors-and-Programs.aspx on September 24, 2009.

35. **Hasselman D.** Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care. Center for Health Care Strategies, Inc. March 2009. Accessed at www.chcs.org/usr_doc/P4P_Resource_Paper.pdf on September 24, 2009.

36.

50. **Tumulty K.** Medicaid and the States: Health-Care Reform's Next Hurdle. TIME. July 21, 2009. Accessed at www.time.com/time/politics/article/0,8599,1911856,00.html on March 29, 2010.
51. **Rowland D et al.** Medicaid As A Platform for Broader Health reform: Supporting High-Need and Low-Income Populations. Kaiser Family Foundation. May 2009. Accessed at www.kff.org/medicaid/upload/7898.pdf on April 6, 2010.
52. **Merritt Hawkins & Associates.** The Physicians' Perspective: Medical Practice in 2008. The Physicians' Foundation. October 2008. Accessed at www.mayorswellnesscampaign.org/wp-content/uploads/2009/05/merritt-hawkins-survey.pdf on April 8, 2010.
53. **Boukus E et al.** A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Study Physician Survey. Center for Studying Health System Change. September 2009. Accessed at www.hschange.com/CONTENT/1078/ on April 5, 2010.
54. **UnitedHealth.** Coverage for Consumers, Savings for States: Options for Modernizing Medicaid. UnitedHealth Center for Health Reform & Modernization. April 2010. Accessed at www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf on April 16, 2010.
55. **KHN Staff.** True or False: Seven Concerns About the New Health Law. Kaiser Health News. April 6, 2010. Accessed at www.kaiserhealthnews.org/Stories/2010/March/31/fears-health-reform-true-false.aspx on April 20, 2010.
56. **Mertens M.** Primary Care Shortage Could Crimp Overhaul. Kaiserhealthnews.org. March 22, 2010. Accessed at www.kaiserhealthnews.org/Stories/2010/March/22/Primary-Care-Shortage-Could-Crimp-Overhaul.aspx on March 26, 2010.
57. **Massachusetts Medical Society.** Physician Workforce Study. Massachusetts Medical Society. September 2009. Accessed at www.massmed.org/AM/Template.cfm?Section=Home6&CONTENTID=31511&TEMPLATE=/CM/ContentDisplay.cfm on April 7, 2010.
58. **Kaiser Family Foundation.** Expanding Medicaid Under Health Reform: A Look at Adults at or Below 133% of Poverty. Kaiser Family Foundation. April 2010. Accessed at http://kff.org/healthreform/upload/8052-02.pdf on April 30, 2010.
59. **Shen Y, Zuckerman S.** The Effect of Medicaid Payment Generosity on Access and Use Among Beneficiaries. HSR: Health Services Research. 2005;40:3. Accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC1361165/ on February 2, 2011.
60. **Cunningham P, May J.** Medicaid Patients Increasingly Concentrated Among Physicians. Center for Studying Health System Change. Tracking Report No. 16, August 2006. Accessed at www.hschange.com/CONTENT/866/ on September 25, 2009.
61. **Perloff JD et al.** Which physicians limit their Medicaid participation, and why. Health Serve Res. 1995;30(1):7-26. Accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC1070348/ on March 29, 2010.
62. **Zuckerman S et al.** Changes in Medicaid Physicians Fees, 1998-2003: Implications for Physician Participation. Health Affairs. 2004; W4:384. Accessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1?ijkey=96484c3d6eb3e57b058ac20190a1ee1a528f25c8 on March 29, 2010.
63. **Simmons J.** Doctors Demand Better Medicaid Reimbursements. Health Leaders Media. January 13, 2010. Accessed at www.healthleadersmedia.com/content/PHY-244849/Doctors-Demand-Better-Medicaid-Reimbursements
64. **Baumrucker EP et al.** Medicaid and CHIP: Changes Made by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) to the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). Congressional Research Services. April 1, 2010. Accessed at www.ncsl.org/documents/health/MACHIPchgs.pdf on April 20, 2010.
65. **Adashi EY et al.** Health Care Reform and Primary Care – the Growing Importance of the Community Health Center. NEJM (serial online).April 28, 2010. Accessed at http://healthcarereform.nejm.org/?p=3377&query=TOC on April 30, 2010.
66. **Trapp D.** New Medicaid patients will lack access, most doctors say. American Medical News. May 3, 2010. Accessed at www.ama-assn.org/amednews/2010/05/03/gvsb0503.htm on October 27, 2010.

67. **Grovum J.** How Wisconsin made big Medicaid cuts with little controversy. Stateline.org. August 5, 2010. Accessed at www.stateline.org/live/details/story?contentId=503421 on October 27, 2010.

68. **Vock D.** Are there enough docs for the newly insured? Stateline.org. April 27, 2010. Accessed at www.stateline.org/live/details/story?contentId=480074 on April 30, 2010.

69. **Trapp D.** Medicaid safety net: Strong enough to hold? Amednews.com. February 1, 2010. Accessed at www.ama-assn.org/amednews/2010/02/01/gvsa0201.htm on April 20, 2010.

70. **GAO.** Improper Payments: Progress Made but challenges Remain in Estimating and Reducing Improper Payments. GAO. April 22, 2009. Accessed at www.gao.gov/new.items/d09628t.pdf on July 2, 2010.

71. **HHS.** Fiscal Year 2009 Office of the Inspector General Medicaid Integrity Report. HHS Office of the Inspector General. March 2010. Accessed at http://oig.hhs.gov/publications/medicaid_integrity/files/medicaid_integrity_reportFY09.pdf on July 2, 2010.

72. **HHS.**

85. **Meyer H.** Washington State takes a hard look at new treatments and tests. Kaiser Health News. June 4, 2009. Accessed at www.kaiserhealthnews.org/Stories/2009/June/04/Compare.aspx on July 9, 2010.

86. **American College of Physicians.** Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High-Quality and Efficient United States Health Care System. Philadelphia: American College of Physicians; 2008: Position Paper. Accessed at https://www.ecri.org/Documents/CERC/ACP_Improved_Availability_of_Comparative_Effectiveness_Information.pdf on February 2, 2011.

87. American College of Physicians. An Internist's Practical Guide to Understanding Health System Reform; June 2010. Accessed at www.acponline.org/advocacy/where_we_stand/access/int_prac_guide.pdf on February 2, 2011.

88. **Kaiser Family Foundation.** Medicaid and Long-Term Care Services and Supports. Kaiser Commission on Medicaid and the Uninsured. February 2009. Accessed at www.kff.org/medicaid/upload/2186_06.pdf on March 29, 2010.

89. **Kaye et al.** Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much? Health Affairs. 2010;29(1):11. Accessed at http://content.healthaffairs.org/cgi/reprint/29/1/11?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=medicaid+long-term+care+insurance&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT on March 29, 2010.

90. **Kassner E et al.** A Balancing Act: State Long-Term Care Reform. AARP Public Policy Institute. July 2008. Accessed at http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf on March 24, 2010.

91. **Ng T et al.** Medicare and Medicaid Long-Term Care. Health Affairs. 2010;29(1):22-28. Accessed at http://content.healthaffairs.org/content/29/1/22.full on February 2, 2011.

92. **Kaye et al.** Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending? Health Affairs. 2009;28(1):262-272. Accessed at http://content.healthaffairs.org/content/28/1/262.full on February 2, 2011.

93. **Long-Term Care Reform Leadership Project.** Shifting the Balance: State Long-Term Care Reform Initiatives. AARP and National Conference of State Legislatures. Issue Brief No. 1. February 2009. Accessed at www.ncsl.org/documents/health/shiftingbalance.pdf on March 24, 2010.

94. **Schwartz S et al.** Ideas for Managing Costs and Improving Care Delivery for High-Cost Medicaid Beneficiaries. National Academy for State Health Policy. January 2007. Accessed at www.nashp.org/sites/default/files/HighCost_Medicaid_Beneficiaries.pdf on March 25, 2010.

95. **Congressional Budget Office.** Budget Options, Volume 1: Health Care. CBO. December 2008. Accessed at http://cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf on March 24, 2010.

96. **Government Accountability Office.** Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings. GAO. May 2007. Accessed at www.gao.gov/new.items/d07231.pdf on March 30, 2010.

97. **AARP.** AARP Public Policies 2009-2010 – Long-Term Care Services and Supports. AARP. Accessed at http://assets.aarp.org/www.aarp.org_/articles/legpolicy/2008/Chapter8.pdf on November 2, 2010.

98. **Congressional Budget Office.** Patient protection and Affordable Care Act: Additional information on the budgetary effects of proposals to establish the Community Living Assistance Services and Supports (CLASS) Program. Congressional Budget Office. November 25, 2009. Accessed at http://cbo.gov/ftpdocs/107xx/doc10768/CLASS_Additional_Information_Harkin_Letter.pdf on March 17, 2010.

99. **Watts MO.** The Community Living Assistance Services and Supports Act. Kaiser Family Foundation. October 2009. Accessed at www.kff.org/healthreform/upload/7996.pdf on March 29, 2010.

100. **Wright B et al.** The Impact of Increased Cost Sharing on Medicaid Enrollees. Health Affairs. 2005;24(4):1106. Accessed at http://content.healthaffairs.org/content/24/4/1106.full on February 2, 2011.

101. **Holahan J, Weil A.** Toward Real Medicaid Reform. Health Affairs. 2007;26(2):w254. Accessed at http://content.healthaffairs.org/cgi/reprint/26/2/w254?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=holahan+medicaid&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT on April 20, 2010.

102. **Selden et al.** Cost-Sharing In Medicaid and CHIP: How Does It Affect Out-of Pocket Spending? Health Affairs. 2009;28(4):w607. Accessed at http://content.healthaffairs.org/content/28/4/w607.full on February 2, 2011.

103. **Kaiser Family Foundation.** Explaining Health Care Reform: Questions About Medicaid's Role. Kaiser Family Foundation. April 2010. Accessed at http://kff.org/healthreform/upload/7920-02.pdf on June 17, 2010.

104. **Ku L.** Ready, Set, Plan, Implement: Executing the Expansion of Medicaid. Health Affairs. 2010; 29(6):1173-1177. Accessed at http://content.healthaffairs.org/content/29/6/1173.full on February 2, 2011.

105. **Government Accountability Office.** Medicaid Demonstration Waivers: Lack of Opportunity for public Input during Federal Approval Process Still a Concern. GAO. July 24, 2007. Accessed at www.gao.gov/new.items/d07694r.pdf on March 30, 2010.

106. **Families USA.** Health Coverage in Communities of Color: Talking about the New Census numbers. September 2008. Accessed at www.familiesusa.org/assets/pdfs/minority-health-and-the-census-numbers.pdf on March 30, 2010.

107. **CDC.** Eliminating Racial and Ethnic Health disparities. CDC Office of Minority Health and Health Disparities. March 17, 2009. Accessed at www.cdc.gov/omhd/about/disparities.htm#3 on March 30, 2010.

108. **Adler N, Newman K.** Socioeconomic Disparities in Health: Pathways and Policies. Health Affairs. 2002;21(2):60-76. Accessed at www.sph.umich.edu/sep/downloads/Adler_Newman_Socioeconomic_Disparities_in_Health.pdf on October 28, 2010.

109. **Waidmann T.** Estimating the Cost of Racial and Ethnic Health Disparities. The Urban Institute. September 2009. Accessed at www.urban.org/uploadedpdf/411962_health_disparities.pdf on March 30, 2010.

110. **A.** C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007 Accessed at www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Jun/Closing%20the%20Divide%20%20How%20Medical%20Homes%20Promote%20Equity%20in%20Health%20Care%20%20Results%20From%20The%20Commonwealth%20F/1035_Beal_closing_divide_medical_homes%20pdf.pdf on March 30, 2010.

111. **Martin C.** Reducing Racial and Ethnic Disparities: A Quality Improvement Initiative in Medicaid Managed Care. Center for Health Care Strategies. January 2007. Accessed atu1slth Care5c()pdf on March 30, 20
K

i

116. **American College of Physicians.** Individual Mandates in Health Insurance Reform. Philadelphia: American College of Physicians; 2009: Policy Monograph. Accessed at www.acponline.org/advocacy/where_we_stand/policy/health_reform_individual.pdf on February 2, 2011.

117. **Dorn S.** Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform. Urban Institute. December 2009. Accessed at www.urban.org/uploadedpdf/411985_national_health_care_reform.pdf on February 2, 2011.

118. **Morrow B, Artiga S.** Putting Children on the Express Lane to Health Insurance. Kaiser Family Foundation and the Children's Partnership. August 2009. Accessed at www.kff.org/medicaid/upload/8043.pdf on February 2, 2011.

119. **McDonough J et al.** Massachusetts Health Reform Implementation: Major Progress and Future Challenges. Health Affairs. 2008;27(4):w285. Accessed at http://content.healthaffairs.org/cgi/reprint/27/4/w285 on April 15, 2010.

120. **Abreau M, Hynes HP.** The Latino Health Insurance Program: A Pilot Intervention for Enrolling Latino Families in Health Insurance Programs, East Boston, Massachusetts, 2006-2007. Prev Chronic Dis. 2009;6(4):A129. Accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC2774643/on April 15, 2010.

121. **Cunningham P, O'Malley A.** Do Reimbursement Delays Discourage Medicaid Participation By Physicians? Health Affairs. 2009;28(1):w17. Accessed at http://content.healthaffairs.org/content/28/1/w17.full on February 2, 2011.

122. **American Medical Association.** Administrative Simplification White Paper. AMA Practice Management Center. December 23, 2008. Accessed at www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-whitepaper.pdf on April 16, 2010.

123. **UnitedHealth.** Health Care Cost Containment – How Technology Can Cut Red Tape and Simplify Health Care Administration. UnitedHealth Center for Health Reform & Modernization Working Paper 2. June 2009. Accessed at www.unitedhealthgroup.com/hrm/unh_workingpaper2.pdf on April 16, 2010.

124. **CMS.** Electronic Funds Transfer Electronic Billing & EDI Transactions. December 14, 2005. Accessed at www.cms.gov/ElectronicBillingEDITrans/13_EFT.asp on April 16, 2010.

125. **CMS.** Fact Sheets: Details for: Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act. CMS. June 16, 2009. Accessed at https://www.cms.gov/apps/media/press/factsheet.asp?Counter=3466&intNumPerPage=10&check Dc.jnterT1Key=&srchITDca=&key_wodIT
hkNewsIT1249(er)0(r=&ye(r=&descjntboOrode=ndatp onMay 36, 2010.)]TJ -2.15 -1.5 TD -.0002 Tc 0 Tw (167.)Tj

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