

## Will All Health Care Reform Lead Back to Medicaid?

**D**uring the U.S. presidential campaign, the Republican and Democratic candidates proposed health care reform plans that emphasized reducing the number of uninsured Americans—approximately 45 million people younger than 65 years have no health care coverage. Their plans also focused on controlling health care costs, which consume 16% of the nation's gross domestic product, far more than that of any other developed country. The candidates promised to make health care reform a priority.

But what happens if health care reform loses its place on the president's priority list? This is a real possibility, according to Michael Sparer, JD, PhD, professor of health policy and management at Columbia University in New York. Sparer noted that interest group politics, political culture, and institutional dynamics will probably thwart comprehensive national health care reform. "Powerful interest groups could once again derail any move toward major reform. The nation's antigovernment political culture is again going to be a powerful obstacle. And institutionally, the new president is going to have to deal with the number 1 priority, the economy, and the number 2 priority, the war. Health care is going to be a distant third," he said.

Those realities do not mean that the political will for health care reform will go away, just that it might remain stuck at status quo—at the state level and centered on Medicaid expansion. The Kaiser Family Foundation reported that of 42 states planning health coverage expansion in 2007 and 2008, 38 planned to use Medicaid to support these efforts (1). In recent years, Massachusetts, Vermont, and other states have relied largely on Medicaid funds to expand health care coverage. "Since no dramatic health reform programs are likely to be enacted in this kind of environment, Medicaid becomes

even larger and more important. It is really the only path to national health insurance that we have in the United States right now," Sparer said.

For years, states have turned to Medicaid for a way to provide free or low-cost health and long-term care for their neediest citizens. The portion of the U.S. population covered by Medicaid increased from less than 10% in 1975 to 20% in 2005, according to data from the Kaiser Family Foundation. Medicaid's loose structure—featuring broad state flexibility and guaranteed federal matching funds—allowed it to evolve to address emerging needs.

Thanks to recent legislation, states now have greater flexibility than in the past to design their Medicaid programs. The Bush administration and Congress enacted the Deficit Reduction Act of 2005 that led half of the states to change their Medicaid programs, including enrollment expansion and caps, cost sharing, and changes in benefit flexibility and program financing. The policy changes, which include new Medicaid waivers, could lead to profound changes in the entitlement program, and these changes could be carried out relatively easily, according to a report by Stephen Zuckerman, PhD, and Teresa A. Coughlin, MPH, principal research associates in the Health Policy Center of the Urban Institute in Washington, DC. They wrote, "States have not yet fully used this flexibility for their Medicaid programs. However, states may exercise this newly available flexibility if, for example, the nation's health care system is not reformed or an economic downturn creates fiscal pressures on states that must be addressed" (2).

Medicaid offers an established health care model that can be expanded, rather than created from scratch, to cover more people who are uninsured. But changes to Medicaid are complicated for states to

achieve, and expansion comes at a cost. Because of the current economic downturn, ambitious state plans to expand Medicaid coverage are mostly on hold. Budget problems are expected to worsen as states struggle to meet the increased demand for Medicaid that will occur as citizens lose employer-sponsored health coverage. In a recent survey, state Medicaid directors expressed concerns about the likelihood of budget shortfalls but projected that enrollment would remain stable in 2009 (1).

Meanwhile, as the president settles into his new position, states are waiting to learn what will happen with national health care reform. If reform stalls at the national level and if state-based efforts do become the country's fallback path to health care reform, Medicaid could play a key role. However, large-scale expansion of Medicaid raises significant concerns. In particular, states must balance health care costs with other high-priority expenditures, such as education. They must also make sure that increased health care coverage actually translates into improved health for their citizens. Substantial evidence shows that loss of Medicaid coverage is associated with worse health care outcomes. However, proving that expansion leads to better outcomes could be more difficult than expected because the states face an emerging dilemma: As more Medicaid-eligible patients seek care, fewer physicians are agreeing to care for Medicaid patients, a problem compounded by the growing shortage of primary care physicians. Lack of access to primary care threatens the future success of state-based health care reform.

### PARTICIPATION DWINDLES

Often described as disorganized, inefficient, and administratively onerous, Medicaid is certainly imperfect, and physicians have historically disliked the program's low fees and burdensome paperwork. But studies have made 1 thing clear: Medicaid improves

people's lives. Research has demonstrated that people with Medicaid coverage have improved individual access to care compared with those who have no coverage. They are also more likely to have a medical home. A retrospective cohort study published in the 16 December 2008 issue of *Annals* provided some context: The authors found an association between interruptions in Medicaid coverage and a higher rate of hospitalization for such conditions as heart failure, diabetes, and chronic obstructive pulmonary disease (3). "Having Medicaid is an enormous benefit over being uninsured," said lead author Andrew B. Bindman, MD, professor of medicine, health policy, epidemiology, and biostatistics at University of California, San Francisco, and chief of the division of general internal medicine at San Francisco General Hospital.

But whether Medicaid will continue to carry such value depends largely on patients' continued ability to access needed care. Bindman has witnessed declining participation among his colleagues and has documented it through official surveys of physicians in California (4). "There is no question that access is inadequate for many Medicaid patients in California," he said. At about 50%, the Medicaid program in California (Medi-Cal) has among the lowest rates of physician participation in the country.

The growing trend away from Medicaid participation is happening not only in California but also throughout the United States. The Center for Studying Health System Change reported that 14.6% of physicians did not accept Medicaid patients in 2004–2005, up from 12.9% in 1996–1997, and 21.0% of physicians did not accept new Medicaid patients in 2004–2005, up from 19.4% in 1996–1997 (5). The rate of physicians who do not accept new Medicaid patients was 6 times higher than the rate for Medicare patients and 5 times higher than the rate for privately insured patients, according to the report.

Dwindling access to primary care providers is particularly prob-

lematic. According to the findings, 30.5% of general internists and 27.3% of family practice physicians closed their doors to new Medicaid patients in 2004–2005, up from 27.0% and 25.5% in 1996–1997. However, Medicaid experts said that access problems are worst among specialties like orthopedic surgery and cardiovascular surgery, for which the discrepancy between their charges and actual fees paid by Medicaid is greater than for primary care.

### THE PAYMENT PROBLEM

Physicians decline Medicaid participation for various reasons, including complicated billing requirements, delayed payments, and a high rate of no-shows for office visits. But the main reason is that Medicaid pays physicians less than any other payer.

In California, which has one of the lowest reimbursement rates, Medi-Cal pays about \$24 for a primary care office visit, whereas private insurance pays approximately \$70 (6). In the past 20 years, the state has enacted just 1 across-the-board reimbursement increase, even though the cost of providing care has soared, according to a report from the California Medical Association. A decision by the California State Legislature to cut 10% from current physician reimbursement (a court stay has put the decision in political limbo) could drive away even more physicians. "Even if this is not enacted, it sends a disheartening message to providers. And once you lose physicians because of frustrations with the program, it's hard to get them to come back later to try it again," Bindman said.

Although most states pay more than California, average Medicaid rates are just 70% of Medicare rates, according to Zuckerman. For physicians who have a small percentage of Medicaid patients, reimbursement fluctuations of 5% either way have little effect on how much these physicians are paid. But for physicians who do have a large percentage of Medicaid patients, small

changes in payment rates can make a big difference.

Internist Charles Hofmann, MD, runs a primary care practice in Baker City, Oregon. The population in this frontier territory is primarily older and poorer, and among his 3300 patients, 40% have Medicaid coverage, 60% have Medicare, and some are dual-eligible. Until a few years ago, Hofmann shared a practice with 2 other internists, but reimbursements were so low that "it got to the point where we said we can't do it anymore," Hofmann said. After the 2 partners left the practice and moved away, he added 2 physician assistants, but finances remained unsustainable.

Finally, he applied to become the sole proprietor of a rural health clinic, a designation saved for clinics located in nonurban areas with current health care shortages. This designation resulted in higher Medicaid and Medicare reimbursement rates and a stabilized practice. "This saved us. We couldn't do it otherwise. We'd be working for nothing," Hofmann said.

### STATES ARE STUCK

State officials are aware that physicians have problems with Medicaid reimbursement. Before the recent financial turmoil, many states took actions to boost provider payment rates and increase provider participation, according to Robin Rudowitz, MPA, principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured. "But then the whole economic downturn threw a wrench in these plans," she said.

States cannot afford significant increases in reimbursement. The overall cost for Medicaid has already spiraled. The average annual growth rate for Medicaid spending was 10.9% from 1990–2001, 9.4% from 2001–2004, and 2.8% from 2004–2006, according to data from Kaiser Family Foundation's statehealthfacts.org Web site. Enrollment increases spurred the increase in expenditures, which are affected by the overall in-

creasing health care costs and especially by prescription drug costs.

Medicaid consumes approximately 20% of state budgets and is the fastest-growing component of state spending (7). Tennessee and Missouri have faced Medicaid costs that consumed up to 30% of the budget. “States reach a point where they just cannot have 30% of their budget wrapped up into Medicaid. Because then it is crowding out other priorities,” said Dennis G. Smith, senior fellow in health care reform at the Heritage Foundation in Washington, DC.

One option for reducing costs is cutting physician fees, even though they are already low. California and other states have recently considered fee reductions as a quick way to help balance the state budget. “States typically have 3 choices for dealing with rising Medicaid costs: Cut the providers pay, cut patient benefits, or reduce eligibility. These are all difficult to do, but cutting the providers’ [pay] is the easiest,” Smith said.

A less damaging and more effective long-term solution could be improving the management of 2 patient populations that are particularly costly to insure—the disabled and the elderly. Research shows that disabled and elderly persons make up about 25% of the Medicaid population but account for about 70% of Medicaid spending on services. An even smaller portion of enrollees—the 4% with costs greater than \$25 000—accounted for 48% of total Medicaid spending. The higher per capita expenditures for these beneficiaries reflected their intensive use of acute and long-term care services.

“Congress should give states more tools for dealing with those populations, such as the ability to use more managed care for them. These individuals and their families should also have greater ability to self-direct their long-term care, such as with the cash and counseling program,” which

allows enrollees who receive personal assistance to hire whomever they want to provide their care and assistance in planning their budgets,” Smith said.

### FEDERAL HELP FOR THE STATES

Congress may not have specific tools to help the states, but a new economic stimulus package that could include additional funding of up to \$6 billion to state Medicaid programs is being considered. As of December, it was still unclear whether the stimulus bill would come to a vote during the lame-duck session of Congress or be delayed for a new Congress. The additional federal funding could help to prevent cuts in Medicaid programs due to state budget shortfalls.

“States find the Medicaid budget very hard to manage, and this makes it the source of a lot of concern and unhappiness. They certainly can cut spending by cutting services, but that is not the first choice,” said Alan R. Weil, JD, MPP, the executive director of the National Academy for State Health Policy in Washington, DC. The goal for states should really be to become more efficient and to cut spending without cutting services, he said. Federal-level assistance to state Medicaid programs—in the form of policy changes that increase federal matching on long-term care or acute care services or that shift all costs of dual-eligible patients to the federal government—could help a great deal in stabilizing Medicaid costs. Moreover, funding changes that would allow states to increase physician fees as needed, perhaps closer to Medicare rates, might encourage physicians to accept Medicaid patients.

Finally, states should not overlook the fact that many of the difficulties facing Medicaid correspond to those facing all of health care, including rising costs and a declining primary care workforce, Weil added.

Fixing the overall health care system will help to fix Medicaid.

Such changes, including curbing unnecessary procedures and improving long-term care management, could be critical to ensuring Medicaid’s sustainability and success—and ultimately, they may be critical to continued health care reform. “Medicaid is the cornerstone to every state’s efforts to expand health insurance coverage,” Weil said. “It’s the platform on which you build.”

—Jennifer Fisher Wilson  
Science Reporter, *Annals of Internal Medicine*

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None disclosed.

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