REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-16)
Affordable Care Act Medicaid Expansion
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2015 Annual Meeting, the House of Delegates adopted Policy D-290.976 which asked our American Medical Association (AMA) to "use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low-income adults as specified by the Affordable Care Act (ACA) to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population (b) the quality of health care services provided to those who are part of the Medicaid expansion population (c) the adequacy of provider payments for those services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use."

This report provides background on the ACA Medicaid expansion; summarizes research on the impact of the Medicaid expansion on access to health care, quality of health care, adequacy of provider payments, and ramifications to the health care system as a whole; summarizes AMA policy and advocacy efforts; and discusses strategies to address the impacts of Medicaid expansion.

The Council has reviewed a wide range of research on the Medicaid expansion's impact on access to care, quality of care, physician payment and the health care system as a whole. Throughout the course of its study, the Council experienced a constant influx of new and emerging research, and met with numerous experts regarding Medicaid and the Medicaid expansion.

The Council remains concerned about the current and projected federal costs of Medicaid expansion, which the Congressional Budget Office has estimated at $64 billion in 2016 and $134 billion by 2026. Given the enormous monetary investment in Medicaid expansion, it is unclear if the resulting level of access to health care is due to characteristics of the previously uninsured patient population or the Medicaid program's delivery system. Research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study. Furthermore, since access to care and adequate physician payment are intrinsically linked, mechanisms to ensure adequate provider payment need to be developed. As such, the Council presents a series of recommendations to improve the provision of health care services to beneficiaries of the ACA Medicaid expansion.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-16

Subject: Affordable Care Act Medicaid Expansion

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee A
(Patrice Burgess, MD, Chair)

At the 2015 Annual Meeting, the House of Delegates adopted Policy D-290.976 which states:

> That our American Medical Association (AMA) use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low-income adults as specified by the Affordable Care Act (ACA) to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population (b) the quality of health care services provided to those who are part of the Medicaid expansion population (c) the adequacy of provider payments for those services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use.

The Board of Trustees assigned the requested study to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. This report provides background on the ACA Medicaid expansion; summarizes research on the impact of the Medicaid expansion on access to health care, quality of health care, adequacy of provider payments, and ramifications to the health care system as a whole; summarizes AMA policy and advocacy efforts; discusses avenues to address the impacts of Medicaid expansion; and provides policy recommendations.

For its study, the Council consulted with data analysts and policy experts from a range of perspectives. The Council notes that data on the Medicaid expansion is just now becoming available. Due to normal discrepancies in survey designs and research methods, the data are not yet conclusive on the impact of Medicaid expansion on access to care, quality of care, physician payment or the ramifications on the health care system. In addition, state Medicaid expansion designs are subject to change on an annual basis and according to the state's political climate. As such, this report includes examples of state Medicaid expansions that are current as of the writing of this report.

BACKGROUND

The US spent $3 trillion on health care in 2014, of which 16.4 percent, or $495.8 billion, was spent on Medicaid. The Medicaid expansion increased health care spending by 11 percent from 2013-2014, and its share of health care spending increased from 15.5 to 16.4 percent.[1] As of February 2016, the ACA has resulted in an estimated 20 million uninsured individuals obtaining health insurance. Approximately 14 million obtained health insurance through Medicaid and the Children's Health Insurance Program, and 12.7 million through the health insurance marketplace. The total number is greater than the net gain in health insurance (20 million) because of changes in

health insurance status.[2] The Congressional Budget Office (CBO) estimates that Medicaid expansion will cost the federal government $64 billion in 2016 and increase to $134 billion by 2026. The CBO predicts that the program will cover 11 million beneficiaries in 2016 and about 15 million in 2026 as a result of the Medicaid expansion.[3] Even with these coverage gains, approximately three million uninsured adults in non-expansion states fall into the "coverage gap" of earning too much to qualify for Medicaid in their states, but too little (i.e., less than 100 percent of the federal poverty level) to qualify for subsidies to purchase health insurance through the health insurance marketplace.[4, 5]

States have chosen to expand Medicaid in various ways, which has resulted in vastly different patient access experiences and physician participation rates. Following are two diverse examples.

Arkansas

Arkansas' Medicaid expansion program, the Arkansas Health Care Independence Program, is commonly known as the "private option." The state took an alternative approach to Medicaid expansion by using Medicaid funding to provide premium assistance to nondisabled beneficiaries to allow them to purchase private coverage through the health insurance marketplace. With Medicaid beneficiaries insured by private insurers, physicians are paid exchange rates, experience quick payment turn-around and minimal administrative hassles. Between 2013 and 2014, Arkansas' private option reduced the state's uninsured rate from 27.5 percent to 15.6 percent, increased the number of carriers offering marketplace plans, decreased uncompensated care costs by 55 percent and saved the state $30.8 million.[6] The most recent data available from 2013 reported that 89.8 percent of office-based physicians in Arkansas accepted new Medicaid patients.[7] The majority of physicians reportedly still participate in the program.

California

California's Medicaid program, Medi-Cal, expanded through the Affordable Care Act's traditional Medicaid expansion program. The program's enrollment increased by about 4 million from 2014 through 2015, which was more than expected, primarily due to the expansion. In 2015, about 12 million California residents, or one-third of the state's population, received health care through Medi-Cal. The majority of Medi-Cal beneficiaries, approximately 10.3 million, are enrolled in managed care.[8] In 2016, the state further expanded eligibility to undocumented children.[9] While expanding Medicaid, the state began implementing payment reductions to Medi-Cal providers. The higher-than-expected enrollment in Medi-Cal along with decreasing provider payments has caused immense access to care issues. The most recent data available from 2013 reported that only 54.2 percent of office-based physicians in California accepted new Medicaid patients.[10] It is unclear how many physicians currently participate in the program. When the federal government's financing of the Medicaid expansion decreases from 100 percent to 95 percent in 2017, it is estimated that California's five percent share of the cost will be $385 million every six months.[11]

At the time this report was written, 31 states and the District of Columbia have expanded Medicaid under the ACA with most having done so through their existing Medicaid programs. Six states (AR, IA, IN, MI, MT and NH) have been awarded and are implementing a Section 1115 Demonstration, or "Medicaid waiver" from the US Department of Health and Human Services (HHS). Medicaid waivers give states flexibility to design, demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid eligible; providing services not typically covered by Medicaid; or using innovative service delivery systems that improve care, increase efficiency, and reduce costs.[12] Many experts believe that states that decide to expand Medicaid in the future will do so through a Medicaid waiver.

ACCESS TO HEALTH CARE

Evidence on the impact of Medicaid expansion on access to care is mixed. Obtaining health insurance does not necessarily ensure better access to health care,[13] although recent research has shown improved access in expansion states relative to non-expansion states. Adults with chronic conditions in two expansion states (Arkansas and Kentucky) experienced an 11.6 percent increase in receiving consistent care to manage their conditions compared to a non-expansion state (Texas). Furthermore, unmet health care needs due to costs declined 10.5 percent in the two expansion states.[14] In Michigan, appointment availability increased six percent for new Medicaid patients compared to availability before the expansion and wait times remained stable, at one to two weeks.[15] Additionally, the Government Accountability Office recently reported that some expansion states have increased behavioral health care treatment availability compared to non-expansion states.[16]

Despite some gains, ensuring access to health care remains an enduring challenge for Medicaid programs regardless of a state's decision to expand Medicaid. Two 2014 HHS Office of Inspector General (OIG) reports evaluated the adequacy of access to care for Medicaid managed care beneficiaries. One report found that approximately 50 percent of providers were either not participating in the health plan at the location listed by the health plan or not accepting new patients enrolled in the plan. In addition, wait times for routine appointments were on average two weeks for 50 percent of providers and as much as four weeks or more for 28 percent of providers.[17] The other OIG report found that state standards for access to care varied widely, ranging from requiring one primary care provider for every 100 enrollees to one primary care provider for every 2,500 enrollees.[18]

To improve provider availability, OIG recommended that the Centers for Medicare & Medicaid Services (CMS) work with states to: (1) assess the number of providers offering appointments and improve the accuracy of plan information; (2) ensure that plans' networks adequately meet the needs of their Medicaid managed care enrollees; and (3) ensure that plans are complying with existing state standards and assess whether additional standards are needed.

To improve state standards for access to care, OIG recommended that CMS work with states to: (1) strengthen its oversight of state standards and ensure that states develop access standards for primary care providers and high-demand specialists; (2) strengthen its oversight of states' methods to assess plan compliance and ensure that states conduct direct tests (e.g., by calling physicians) of access standards; (3) improve states' efforts to identify violations of access standards; and (4) provide technical assistance and share effective practices.

CMS issued the final rule, "*Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*," in November 2015 that addresses many issues identified by the OIG.[19] The final rule mandates that states develop an access monitoring review plan by July 1, 2016, and update it annually. Of note, states must provide a comment period before submitting the plan to CMS. Every three years, states must conduct a separate analysis, by provider type and site of service, for each of the following core services: primary care, specialty, behavioral health care, pre- and post-natal obstetrics (including labor and delivery), and home health. States must include any additional services for which the state or CMS has received a significantly higher than usual volume of access complaints.

The final rule also mandates that states develop mechanisms for ongoing beneficiary and provider input via hotlines, surveys, ombudsmen, reviews of grievance and appeals data, or other equivalent

mechanisms. States must promptly respond to public input with appropriate investigation and maintain a record of data on how the state responded. The record must be available to CMS upon request. When deficiencies in access to care are identified, the state has 90 days to submit a corrective action plan with specific steps and timelines to address those issues.

The final rule only requires access monitoring review plans for services provided by the state Medicaid fee-for-service model, not for Medicaid services provided by managed care organizations, which include about 70 percent of Medicaid patients, or through state waiver programs. In a January 2016 comment letter, as outlined in the advocacy section of this report, the AMA advocated for standardized access standards across all Medicaid delivery systems.

Primary Care Medical Homes/Patient Centered Medical Homes

The Council notes that states have been able to address access concerns, such as with the primary care medical home (PCMH) model either through or independent of an ACA Medicaid expansion program. The ACA created options for states to implement Medicaid health homes or Medicaid PCMHs. As of January 2015, 43 states and the District of Columbia had implemented some type of medical home program for their Medicaid beneficiaries.[20] While North Carolina is not a Medicaid expansion state, Community Care of North Carolina (CCNC) has been successful in using the PCMH model to provide access to quality care for 1.3 million of the state's Medicaid beneficiaries. The Oregon Health Plan, a Medicaid expansion program, provides health care for Medicaid beneficiaries through Coordinated Care Organizations (CCOs) delivering care through Patient-Centered Primary Care Homes (PCPCHs). Enrollment in Oregon's PCPCHs has increased more than 70 percent from 2013 to 2015 due to the state's Medicaid expansion.[21]

Specialty Care

A national comparison of typical payments for general surgeons found that there are wide variations in Medicaid payments between states for the same procedures.[22] Inadequate payment and administrative burdens for physicians are key barriers to accessing specialty care for Medicaid beneficiaries. One study reviewed six innovative models that are successfully delivering appropriate and efficient specialty care to Medicaid beneficiaries. The strategies these models use are implementing telemedicine for specialty consultations, training primary care physicians to manage certain specialty needs and enhancing coordination among primary care providers and specialists through the use of "access coordinators." These models include collaboration between hospitals, primary care and specialty physicians, community health centers and Medicaid agencies.[23]

QUALITY OF HEALTH CARE

Research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study.

For primary care services, one study found that 59 percent of primary care providers reported no change in their ability to provide high-quality care to their Medicaid patients a year after the expansion.[24] Kentucky's Medicaid expansion resulted in more than a 100 percent increase for breast and colon cancer screenings and physical exams, and an 88 percent increase for cervical cancer screenings.[25] Adults with diabetes in Ohio's MetroHealth Care Plus waiver program improved more than 13 percent on the diabetes composite standard than members of the uninsured comparison group.[26] A comparison of three expansion states to neighboring non-expansion states found that Medicaid expansion was significantly associated with a reduction in mortality.[27]

From 2008 to 2009, the Oregon Health Insurance Experiment used random selection to offer a limited amount of uninsured low-income adults health insurance through Medicaid. The researchers concluded that Medicaid coverage increased emergency use by 40 percent, decreased rates of depression and improved feelings of financial security. The study did not find statistically significant improvements in measures of physical health outcomes, specifically blood pressure, cholesterol, or glycated hemoglobin levels. While the study was able to take advantage of random selection, the authors acknowledge limitations in the generalizability of the study's conclusions since it covered a short period of time, the sample size was small and the population covered was relatively homogenous (disproportionately white and urban-dwelling).[28, 29, 30]

For specialty care, one evaluation of the quality of cancer care by source of health insurance has concluded that there are significant disparities in cancer survival and quality of care among individuals having different sources of health insurance, with some of the greatest deficiencies in care found among Medicaid beneficiaries.[31] Another study found that Medicaid beneficiaries had a higher rate of mortality when undergoing major surgical operations.[32] Researchers acknowledge that Medicaid beneficiaries tend to be diagnosed at a later stage and have worse overall survival rates compared to privately insured individuals.[33, 34] Contributing to poorer outcomes may be a lack of access to high-volume centers for complex surgical procedures.[35] The literature recognizes the need for additional studies to determine factors that could account for poorer outcomes for Medicaid beneficiaries compared to privately insured individuals.

When analyzing the quality of care provided by Medicaid, factors such as the severity and length of illnesses, complexity of coexisting illnesses, stage at diagnoses, inconsistencies in obtaining health care, degree of access to high-quality care, level of health literacy, and availability of social supports should all be taken into consideration. The complexity of the Medicaid population requires extensive, longitudinal and risk-adjusted research to determine the program's impact on quality of care.

ADEQUACY OF PROVIDER PAYMENTS

Section 1902(a)(30)(A) of the Social Security Act, also known as the "equal access" provision of Medicaid, requires that states have procedures in place to ensure that provider payment rates are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." It recognizes that "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program."

In the past, Medicaid providers have sued state Medicaid agencies to enforce the equal access requirement. However, in March 2015, the Supreme Court ruled in *Armstrong v. Exceptional Child Center Inc.*, that the Medicaid statute does not provide a private right of action for providers to enforce state compliance in federal court. The Court ruled that enforcement of the law falls to CMS.

In a January 2016 comment letter to CMS on the final rule, *Methods for Assuring Access to Covered Medicaid Services,*[36] as outlined in the Advocacy section of this report, the AMA emphasized that it is incumbent upon CMS to aggressively protect beneficiaries' access to care and ensure that physicians receive fair and adequate payment, especially given the *Armstrong v. Exceptional Child Center Inc.,* ruling. Specifically, the AMA advocated that CMS should provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access

necessary services in a timely manner. The AMA also advocated that CMS should create a mechanism for providers to challenge payment rates directly to CMS.

Increased physician payments

The ACA increased Medicaid primary care payment rates to be equal to Medicare rates for 2013 and 2014 to encourage more primary care physicians to participate in Medicaid and increase access to care. Even though the federally funded increase was temporary, it encouraged some states to continue paying at the higher rate. For 2016, 13 states have kept primary care rates at 100 percent of Medicare rates and 11 states have increased Medicaid rates to be closer to Medicare levels.

With respect to the Medicaid expansion, some states are experiencing decreases in expenses for state-funded health care services for low-income residents, which is resulting in budget savings available for other purposes. For example, Medicaid expansion in New Jersey has resulted in a 44.3 percent drop in uncompensated care costs since 2013, which saved the state $453 million.[37] As a result of the savings, the 2016 New Jersey Governor's budget called for a redirection of a portion of the existing uncompensated care costs ($15 million state share/$45 million total) to physician payments in the state's Medicaid expansion program, NJ FamilyCare. A recent memo to New Jersey physicians explained that the redistribution of health care funding is intended to support a continuing effort by the Division of Medical Assistance and Health Services to encourage physician participation in the NJ FamilyCare program, expand beneficiaries' use of primary care services and reduce episodic non-emergent emergency department (ED) visits.[38] The increased payment rate went into effect on January 1, 2016.

RAMIFICATIONS TO THE HEALTH CARE SYSTEM

Many states report Medicaid enrollment has surpassed expectations. The uninsured rate has decreased 52.5 percent in expansion states and 30.6 percent in non-expansion states.[39] Expansion states are experiencing a greater increase in health care sector employment than non-expansion states.[40] Hospitals in expansion states report decreased uncompensated care costs and increased revenues,[41] whereas rural hospitals in non-expansion states are becoming financially vulnerable since they are not benefiting from federal Medicaid funds to offset uncompensated care costs.[42] Expansion states have experienced decreased expenses for state-funded health care services for low-income residents, such as behavioral health care services, hospitalizations for incarcerated individuals, and uncompensated care, and also experienced increased revenue from expansion funding.[43] States are increasingly enrolling their Medicaid populations in managed care to reduce financial risk, outsource administration, and allow for a more predictable state expense. Some health insurers are experiencing higher-than-expected revenues due to an increase in Medicaid enrollees.[44] There is limited empirical evidence of additional cost-shifting prior to or since Medicaid expansion.[45]

Regarding ED use, research conclusions on the impact of the Medicaid expansion have been mixed. One Portland-area study concluded that ED use increased by about 40 percent from 2008-2009 for newly enrolled Medicaid beneficiaries,[46] while a state-wide study found that ED use decreased by about 23 percent from 2011-2015 for Medicaid beneficiaries enrolled in Oregon's Medicaid expansion program, attributed in part to the use of ED navigators.[47] An American College of Emergency Physicians (ACEP) member poll suggests that Medicaid expansion is associated with an increase in ED use,[48] although a National Center for Health Statistics survey did not find a significant change in the percentage of Medicaid beneficiaries using the ED or the frequency of their use between 2013 and 2014.[49]

A Washington state-wide program, "ER is for Emergencies," was developed in 2012 by a coalition of stakeholders including ACEP's Washington Chapter, the Washington State Medical Association, the Washington State Hospital Association and the Washington State Health Care Authority. Medicaid ED use decreased by about 10 percent in the first year of the program resulting in a savings of approximately $34 million. The program attributes its success to implementing the following best practices: using electronic health information; providing patient education; identifying frequent ED users and developing patient care plans; following statewide standards for prescribing opioids; monitoring prescriptions; and using feedback information.[50]

PREVIOUS COUNCIL REPORTS

The Council addressed access to health care for patients with low incomes in Council Report 1-I-03, "Medical Care for Patients with Low Incomes" and Council Report 1-A-12, "Medicaid Financing Reform," which established and updated Policy H-165.855, respectively. The Council notes that some states with Medicaid waivers are experimenting with implementing components of Policy H-165.855, which include encouraging state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance; assuring continuity of care; using presumptive eligibility; allowing for retroactive coverage; offering a choice of coverage; and continuing to provide some non-medical benefits for at least a transitional period of time, such as non-emergency medical transportation.

In addition, the Council addressed Medicaid expansion alternatives in Council Report 5-I-14, "Medicaid Expansion Options and Alternatives," which established Policy H-290.966 encouraging the development of coverage options, including through state waivers, for adults in non-expansion states who do not qualify for either Medicaid or exchange subsidies. The policy also urged CMS to review Medicaid expansion waiver requests in a timely manner and to exercise broad authority in approving such waivers. The report also highlighted the variety of waivers that were being considered at that time.

AMA POLICY

In general, AMA policy supports a preference for using Medicaid funds to purchase private health insurance with income-adjusted premiums and minimal, if any, copays, rather than public sector expansion (Policies H-165.920, H-165.855 and H-290.982). AMA policy encourages the development of coverage options, notably through state waiver demonstrations, for low income adults living between their state's Medicaid income eligibility and 138% FPL (Policies H-290.966, H-165.855; D-165.966, H-290.987 and D-290.979) and advocates for coverage that allows individual choice of health plans and benefits (Policies H-165.845, H-165.855, H-290.985, H-165.852, H-290.972 and H-290.984). The AMA supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured (Policy H-160.923).

AMA Policy H-165.855 supports continuous eligibility, presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person sought medical care. For enrollees subsidized through the exchange, the AMA advocates that plans be required to notify physicians of their patients' grace period status upon an eligibility verification (Policy H-185.938). The AMA supports improvements in Medicaid that will reduce administrative burdens (Policy D-290.979).

Long-standing AMA policy advocates that Medicaid should pay physicians at minimum 100 percent of Medicare rates (Policies H-385.921 and H-290.976) and supports reinstatement of Medicaid primary care payments that are equal to Medicare rates (Policy D-290.977). Key

elements of an adequate network are outlined in Policy H-285.908 and health plans should educate enrollees on the continuum of available health care services and the appropriate use of the ED (Policies H-130.970 and H-290.985).

AMA ADVOCACY

The AMA continues to advocate for access to care and adequate physician payment in the Medicaid program.

Access to Medicaid Services

In July 2011 and January 2016, the AMA submitted comment letters[51] on the proposed and final rule, *Methods for Assuring Access to Covered Medicaid Services.*[52] The final rule requires states to submit to CMS an access monitoring review plan to document that provider payment rates are sufficient to enlist enough providers to serve the Medicaid population. The AMA advocated for the following:

- States should be required by CMS to use uniform data elements, such as cost studies as part of their access review plan.
- States should use consistent standards to measure access to care regardless of whether care is provided on a fee-for-service basis, through a managed care entity or by a waiver program.
- CMS should provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner.
- CMS should create a mechanism for providers to challenge payment rates directly to CMS.
- CMS should develop a rule for assuring access to covered Medicaid services for Medicaid managed care plans as expeditiously as possible.

Medicaid Managed Care

In July 2015, the AMA submitted a comment letter[53] on the proposed rule, *Medicaid Managed Care,*[54] which advocated for the following:

- State regulators should be established as the primary enforcer of network adequacy requirements.
- Managed care entities should be required to publish their provider selection standards.
- Provider directories should provide comprehensive, accurate and up-to-date information; paper forms should be updated monthly and electronic versions within three days.
- CMS should require all states to impose a minimum medical loss ratio of 85 percent and require managed care plans to remit a portion of their capitation payment if they do not comply.
- Physician payment rates should be based on realistic costs of care and should be an essential element of the capitation rate-setting process.
- As part of their access review, CMS should require states to submit cost studies, physician payment rates, the number of physicians accepting new Medicaid patients, and an analysis of access in Medicaid compared to those in private group plans and Medicare, and to make the information publicly available.
- CMS should ensure standardization and harmonization of quality measures and methodologies across reporting programs to reduce administrative burdens and simplify compliance.

The final rule, *Medicaid Managed Care*, was released in April 2016, and requires states to create network adequacy standards for private Medicaid plans; applies a medical loss ratio standard of at least 85 percent to Medicaid managed care plans; and provides the opportunity to expand access to behavioral health care by easing restrictions on reimbursements at certain facilities for short-term stays. CMS will develop a quality rating system for private Medicaid and CHIP plans. In addition, CMS will prohibit states from making certain supplemental payments to hospitals and other providers that serve Medicaid managed care enrollees. Instead, states and Medicaid plans must transition to a payment structure linked to delivered services or quality of care.

DISCUSSION

The Council has reviewed a wide range of research on the impact of Medicaid expansion on access to care, quality of care, physician payment and the health care system as a whole. Throughout the course of its study, the Council experienced a constant influx of new and emerging research, and met with experts regarding Medicaid and the Medicaid expansion.

The Council remains concerned about the current and projected federal costs of Medicaid expansion, which the Congressional Budget Office has estimated at $64 billion in 2016 and $134 billion by 2026. Given the enormous monetary investment in Medicaid expansion, it is unclear if the resulting level of access to health care is due to characteristics of the previously uninsured patient population or the Medicaid program's delivery system. Research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study. Furthermore, since access to care and adequate physician payment are intrinsically linked, mechanisms to ensure adequate provider payment need to be developed. As such, the Council presents recommendations to improve the provision of health care services through Medicaid expansion programs.

Access to Care

Results of states that have expanded Medicaid vary widely, although compared to other states, Arkansas' expansion model has been successful in providing access to quality care, and adequate provider payment. It has also had a positive impact on the health care industry as a whole by reducing the uninsured rate, increasing choice of coverage through marketplace plans, and decreasing physician and hospital uncompensated care costs. It is highly consistent with AMA Policy H-165.855, which encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance. The policy also encourages states to support a Medicaid Physician Advisory Committee to evaluate and monitor access to care in the state Medicaid program. Accordingly, the Council recommends that Policy H-165.855 be reaffirmed.

Despite the early stage of data collection, the Council is concerned about the level of access to quality care for patients in the Medicaid program, which coincides with low physician payment rates. To encourage states to take responsibility for providing access to quality care to their Medicaid populations, the Council recommends reaffirming Policy H-290.966, which advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on state Medicaid web sites.

CMS requires that states develop an access monitoring review plan by July 1, 2016, and update it annually. States must provide a comment period before the review plan goes into effect and develop mechanisms to receive ongoing provider input. The Council recommends that state

medical associations participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.

An access monitoring review plan does not apply to Medicaid services provided by managed care organizations, which include about 70 percent of Medicaid patients, or through state waiver programs. It is only required for services provided by the state Medicaid fee-for-service model. The Council recommends that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.

The HHS OIG's reports evaluating the adequacy of access to care for Medicaid managed care beneficiaries concluded that the findings demonstrate a significant vulnerability in provider availability and raise serious questions about the ability of plans, states and CMS to ensure that access to care standards are met. The Council concurs with these concerns and recommends that the AMA support efforts to monitor CMS' progress on the OIG's recommendations to improve access to care for Medicaid beneficiaries.

Poor access to specialty care is a serious barrier for Medicaid patients. The Council recommends that CMS ensure that mechanisms are in place to provide robust access to specialty care for Medicaid beneficiaries.

Quality of Care

Comprehensive research is needed to determine the quality of care that Medicaid beneficiaries are receiving through Medicaid expansion programs. The Council recommends that independent researchers perform longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.

Physician Payment

Physician practices cannot remain economically viable if they lose money on the care they provide. The Council recommends that adequate physician payment should be an explicit objective of state Medicaid expansion programs.

Some states are reporting significant budget savings and increased revenue as a result of their Medicaid expansions. The Council believes that physician payment rates should be considered in any redistribution of funds in Medicaid expansion states experiencing budget savings in order to encourage physician participation and increase patient access to care.

Access to care and adequate physician payment are intrinsically linked. The Council recommends that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner. In addition, CMS should develop a mechanism for physicians to challenge payment rates directly to CMS.

Medicaid Expansion Funding

For states that choose to expand Medicaid eligibility in the future under the ACA, the Council suggests extending to states the three years of 100 percent federal funding for Medicaid expansion programs that are implemented beyond 2016.

To address state concerns that the federal government will discontinue the 90 percent contribution for Medicaid expansions after 2020, the Council recommends supporting maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the ACA's Medicaid expansion exists.

Ramifications to the Health Care System

State Medicaid expansion programs are in different stages of development, implementation and assessment. As such, the ramifications these programs are having on the health care system are still becoming apparent. The Council recommends that the AMA support improved communication among states to share successes and challenges of their respective Medicaid expansion approaches. Regarding ED use, the Council recommends implementing evidenced-based best practices for reducing inappropriate ED use such as employing ED navigators; using electronic health information; providing patient education; identifying frequent ED users; developing care plans; monitoring prescriptions; and using feedback information.

Future AMA Activity

Finally, the Council recommends rescinding Policy D-290.976, which calls for the study that has been accomplished by the development of this report. The Council will continue to study the impact of the Medicaid expansion on access to quality care, the level of provider payment rates and the ramifications on the health care system, and report back to the House of Delegates as necessary.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-165.855, which encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance, and encourages states to support a Medicaid Physician Advisory Committee to evaluate and monitor access to care in the state Medicaid program. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.966, which advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. (Reaffirm HOD Policy)

3. That our AMA encourage state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access. (New HOD Policy)

4. That our AMA continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models. (New HOD Policy)

5. That our AMA support efforts to monitor the progress of the Centers for Medicare & Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries. (New HOD Policy)

6. That our AMA advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents. (New HOD Policy)

7. That our AMA support independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care. (New HOD Policy)

8. That our AMA support adequate physician payment as an explicit objective of state Medicaid expansion programs. (New HOD Policy)

9. That our AMA support increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care. (New HOD Policy)

10. That our AMA continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services. (New HOD Policy)

11. That our AMA continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS. (New HOD Policy)

12. That our AMA support extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. (New HOD Policy)

13. That our AMA support maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. (New HOD Policy)

14. That our AMA support improved communication among states to share successes and challenges of their respective Medicaid expansion approaches. (New HOD Policy)

15. That our AMA support the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits. (New HOD Policy)

16. That our AMA rescind Policy D-290.976, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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