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**Medicaid Expansion and the Patient Protection
and Affordable Care Act: Lessons and Hopes for
Implementation of Healthcare Reform**

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Abstract

This study was designed to examine the perspectives and concerns of California healthcare policymakers and stakeholders about the upcoming expansion of Medicaid. Key California stakeholders show general support for the expansion of Medicaid, with concerns about the cost to implement expansion, hopes for increased use of managed care delivery system reform to produce cost savings, worries about provider access and physician payment rates, and support for the recent California Section 1115 Medicaid Waiver “bridge to reform” as a timely measure for the transition to Medicaid expansion. This state-level perspective from California can help to inform state and national preparations for the 2014 implementation of Medicaid expansion.

Keywords: healthcare reform, The Affordable Health Care Act, California healthcare

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Medicaid Expansion and the Patient Protection and Affordable Care Act: Lessons and Hopes for Implementation of Healthcare Reform

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The Patient Protection and Affordable Care Act of 2010 is landmark healthcare legislation with the call to provide healthcare coverage to many millions more Americans. The act includes the unprecedented mandatory expansion of Medicaid to all persons at or below 133% federal poverty level starting in 2014. With the recent passage of this bill and follow-up legislation (ACA), state governments and the entire national healthcare infrastructure are beginning to prepare for the implementation of these new reforms. This implementation comes in the midst of a dramatic and difficult national economic climate. California, with the largest Medicaid program in the country and a massive budget deficit, serves to highlight the concerns and hopes of Medicaid expansion across the nation over the next years.

Currently, Medicaid, called Medi-Cal in California, serves 7.5 million Californians at a cost of \$45 billion/year (Hansen 2011). Healthcare reform expansion will allow 3.6 million additional Californians to enroll in Medicaid (RAND 2011; Lavarreda and Cabezas 2011). Such an increase in coverage is not without a price, with some estimates of up to **\$3–4 billion/year of additional state expenditures** anticipated by 2020 (Hansen 2011; RAND 2011). This expansion comes in the face of a current \$22 billion budget deficit and limitations to the already existing state Medicaid program (Bindman and Schneider 2011). Even more problematical, Medicaid

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expansion is unrolling while the country's economic purse-strings are tightening, and concerns of a possible recession strengthen.

Given this climate in which Medicaid expansion will take place, it is essential to understand the key elements that state healthcare leaders are considering with implementation of the ACA. The aim of our study was to evaluate the California perspective on the ACA's Medicaid expansion. We interviewed 26 key California healthcare stakeholders to address their thoughts, desires, and concerns about the upcoming Medicaid expansion. Informants from across the healthcare arena participated in our study, including Democrats and Republicans, state officials, individuals in both the legislative and executive branches, and numerous association groups representing providers, hospitals, and clinics.

Study Data and Methods

The authors received University of California IRB exempt approval to undertake qualitative interviews with key California healthcare stakeholders. Interviewees were approached by email for participation and sent information sheets and the interview question guide prior to participation in the study. In-person and telephone interviews were conducted by the first author. This author interviewed 26 key California informants including individuals from the Department of Health Care Services, the Department of Health and Human Services, the California Health and Human Services Agency, the California State Senate, the California State Assembly, the California Governor's office, the California Academy of Family Physicians, the California Association of Public Hospitals, the California Hospital Association, the California Primary Care Association, the California Medical Association, the Center on Budget and Policy, and four county government and community health center representatives. Common consensus themes and points of conflict were identified for each question category.

Key Views of California Healthcare Stakeholders

Our analysis uncovered five key findings from California stakeholders: support for Medicaid expansion, concern about the costs of implementation, hope for managed care as a strategy to contain costs, worries about access and physician payment rates, and support of the state's Section 1115 Medicaid waiver as a "bridge for reform."

1. California policymakers and stakeholders agree that Medicaid expansion for low-income, childless adults is a ground-breaking step forward.

With few exceptions, individuals interviewed on both sides of the political aisle in California endorsed the Medicaid expansion of the ACA as a major step forward for coverage of low-income, childless adults. While Republicans in general were very concerned about the costs, no one, including the Republican stakeholders, indicated a desire to repeal Medicaid expansion. Many of the legislative staffers, state employees, and organization leaders agreed with the sentiment that it is “a wonderful opportunity for California,” allowing for coverage of a “population that everyone has struggled to address for decades.” One Republican legislative staffer remarked, “in general, it makes sense.”

2. General support for Medicaid expansion is tempered by anxiety about the financial burden to the state.

Under the ACA, the federal government will initially provide 100% of the costs of new enrollees, a share that incrementally decreases to 90% by 2020. However, there was widespread agreement among California stakeholders that new enrollees will still incur additional costs to the state. Many interviewees believe that substantial indirect costs will be required to run a larger Medicaid system. Additionally, many anticipate increased real-dollar expenditures for new enrollees eligible for Medicaid under current policies, but who are falling through enrollment cracks that tighten with the new regulations; the federal match for these beneficiaries will be at the current rate of approximately 50% (The Kaiser Family Foundation 2010).

As one state official remarked, Medicaid expansion under the ACA is “big, bold, and expensive.” Recent analyses by both the state Medicaid program and the independent RAND corporation estimate that annual new costs to the state could approach \$3–4 billion come 2020 (Hansen 2011; RAND 2011). Amidst an already heavy climate of budget cuts and deficit conversations at the California state level, the thought of possible billion-dollar expenditures above and beyond current Medicaid expenditures was a priority concern, with many asking “how will we pay for it?”

Whether the additional costs to California will approach the projections or will be a more modest sum is a point of controversy among stakeholders. Some interviewees believe that health delivery reforms and redesign can produce savings to offset the costs of the expansion; others think that such savings, if ever realized, will not occur until many years after the initial money is needed. Many discussed the necessity for “smart rationing” and managed care initiatives to keep costs down.

Ideas for payment sources to support expansion were numerous and varied, including general funds, fees, realignment monies from counties back to the state government, new taxes, and provider, hospital, or beneficiary contributions. As one interviewee summed it up, “the state will have to figure out where the money can

come from . . . that will be someone's problem." One respondent suggested that a full-scale "cost-analysis" be undertaken by the state, to give policymakers and state officials a better idea of California's likely Medicaid expansion costs.

3. California stakeholders count on building on California's track record in Medicaid managed care to help control Medicaid expenditures.

For decades, HMOs and other managed care health plans have been a prominent feature of the California healthcare market. Since 1996, the state has required that all nondisabled, nonaged Medicaid beneficiaries in large urban counties enroll in a Medi-Cal managed care plan (Bindman et al. 2000). California counties are integral to this process, with some of the largest counties supporting a county-operated quasi-public, nonprofit health plan. Forty-eight percent of Medi-Cal beneficiaries are currently enrolled in managed care, and policymakers have credited this strategy with lowering the rate of rise of Medicaid expenditures, in part by decreasing rates of hospitalization (California Association of Health Plans 2009; Bindman et al. 2005). However, the most expensive and medically complex populations, seniors and persons with disabilities (SPD), have remained in fee-for-service Medicaid (California Health Care Foundation 2009).

The state's **recently renegotiated Medicaid Section 1115 Waiver makes substantial changes in Medicaid**; beginning June 1, 2011, seniors and persons with disabilities must also enroll in Medi-Cal managed care plans. Most interviewees believe that Medicaid managed care will become even more important under the ACA coverage expansion, with hopes that the move towards managed care under the Section 1115 Waiver will prove that high-user, medically complex patients can be served well under such a model and produce cost-savings. As one state official summed it up, "managed care is here to stay." Legislative staffers remarked that the upcoming years will be an "opportunity to shine," noting that managed care plans are a "cost-effective solution . . . [that] do a good job with money." As a Republican staffer remarked, managed care is ideally suited for health reform, with its emphasis on "medical homes, network requirements, and physician referral requirements."

However, stakeholders representing physicians and patients expressed concern about the ability of California managed care plans to provide high-quality care to indigent populations, who may have a vast array of medical, mental health, and social services needs, questioning whether "the plans are skilled at complementary services that the patients need." Others noted that the regulatory interplay between Medicaid and the upcoming exchange, where individuals above 133% can purchase private insurance plans with government subsidies, will be an important step in determining exactly what role managed care will play at both the state and national level.

4. Concerns abound that new Medicaid beneficiaries will lack adequate access to medical providers, secondary to both a provider shortage as well as poor physician payment rates.

Access to physicians is a key concern of California stakeholders across all healthcare arenas. An interviewee remarked “having a card that says you have coverage does not mean that you will have a physician,” and another, “having insurance isn’t healthcare, it’s just insurance.” Adequate physician networks and payment rates were highlighted as key factors creating access problems for new Medicaid enrollees.

Prior to the ACA, a national workforce shortage of between 35,000–44,000 primary care physicians was projected by 2025; California may face a statewide shortage of 5,000–17,000 primary care providers by 2040 (Colwell et al., 2008; Forte et al., 2004). Furthermore, in 2008 only 57% of California physicians reported that they accept new Medicaid patients, compared with 90% of physicians accepting privately insured new patients. As a result, only one-quarter of California physicians provide the care for 80% of all California Medicaid beneficiaries (Bindman et al., 2010).

With the addition of millions more enrollees into Medicaid, there is concern that this supply-demand mismatch will worsen. Furthermore, the Section 1115 Waiver has strict regulatory requirements and access standards, for instance a requirement that patients seeking primary care should wait fewer than 30 days for new patient appointments (Department of Public Health 2011). Many interviewees noted the need for updated statewide projections of workforce supply given the changing demand expected by the Medicaid expansion.

Many stakeholders also expressed concern that low Medicaid physician fees in California will not entice new providers to join the system. California Medicaid pays only 56% of Medicare rates, having the fourth lowest Medicaid physician payment rates in the country (Zuckerman et al., 2009). Though the ACA mandates a two-year increase in primary care physician rates to equal 100% of Medicare fees, interviewees were doubtful that this will do anything more than persuade current Medicaid providers to remain within the system (The Commonwealth Fund 2011). Many stakeholders, representing providers and care delivery systems, desire an analysis of how different rates could affect uptake and retention of providers within the Medicaid system.

Access to hospitals was also a source of worry for half of the stakeholders, with payment sources and utilization mix between public and private hospitals of concern. For the approximately 120 disproportionate-share hospitals (DSH) in California that care for a large proportion of Medicaid patients, funding will be cut through the ACA, under the assumption that with insurance coverage for all pa-

tients, hospitals will be able to make up lost uncompensated care revenues (Kaiser Family Foundation Fact Sheet). Whether this new revenue will be able to make up for the DSH funding cuts is a question. Additionally, interviewees noted that public hospitals will now need to show that they are high-quality alternatives for care when compared to their private counterparts.

5. California’s Medicaid Section 1115 Waiver provides a timely “bridge to reform” and is essential for successful implementation of upcoming healthcare reform.

All interviewed felt that the state’s 2010 renewal of its Section 1115 Waiver from the Centers for Medicare and Medicaid Services is an integral “building block” for the state, allowing for the early expansion of coverage for low-income adults with the use of federal funds. This “bridge to reform” waiver has three key components that position the state to move forward with some of the preparatory work for ACA implementation.

First, through the waiver, individuals eligible for Medicaid expansion in 2014 are able to be enrolled starting this year into the county-administered Low Income Health Program, with federal monetary support to existing county-operated programs. By providing for federal matching funds to county expenditures at a 50/50 match, the waiver becomes a feasible avenue for beginning the process of Medicaid expansion. Second, as noted above, the waiver expands on California’s already robust managed care climate, by mandatorily moving SPD beneficiaries in fee-for-service Medicaid into Medicaid managed care with the expectation of reducing costs. Third, the waiver provides additional funding to assist California safety net hospitals and clinics to redesign their care delivery models to provide higher-quality care at a lower cost (California Department of Health Care Services 2010).¹⁷

California stakeholders believe these components allow the waiver to serve as the “foundation” for national reform, allowing the state to “develop infrastructure,” “maximize enrollment” of eligible populations, and address “acute [medical] needs of the population . . . sooner.” **The waiver serves as a model for other states contemplating similar projects to prepare for their Medicaid expansion.**

Conclusion

With the recent passage of the Patient Protection and Affordable Care Act of 2010, the nation is beginning preparations for the massive expansion of Medicaid in 2014. While the act provides for an impressive number of newly insured individuals, these implementation efforts are taking place during difficult economic times in our nation. Our study examined the perspective of a spectrum of California

healthcare stakeholders regarding the ACA and Medicaid expansion, in order to inform policymakers in California and in other states about preparation for the implementation of national reform. Key California stakeholders show general support for the expansion of Medicaid, with concerns about the cost to implement expansion, hopes for amplified use of managed care delivery system reform to produce cost-savings, worries about provider access and physician payment rates, and appreciation of the timely value of the state's newly renegotiated Section 1115 Waiver "bridge to reform."

In California, work is already underway with the Section 1115 Waiver, which is initiating enrollment of the most expensive Medicaid beneficiaries into managed care in the summer of 2011. As California and other states across the nation move steadily forward towards the start of ACA reform in 2014, policymakers, healthcare stakeholders, and the public must consider issues of cost, access, provider payment rates and delivery system reforms. State engagement in these issues will be critical for the successful implementation of Medicaid expansion and the other ambitious elements of national health reform.

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