MAY 2011

# Ensuring Access to Care in Medicaid under Health Reform
## *Executive Summary*

Under the Patient Protection and Affordable Care Act (ACA), 16 million low-income individuals will gain Medicaid coverage by 2019, and another 16 million people are projected to gain private health coverage through new, state-based health insurance Exchanges. This broad national expansion of coverage, largely to a previously uninsured population, will generate new demands for access in a system already short of adult primary care providers and some specialists**.** Many of the adults gaining Medicaid are expected to be in fair or poor health, have chronic physical and/or mental health conditions, and present with pent-up needs for health care.

To explore and discuss important issues related to ensuring access to care in Medicaid under health reform, the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on December 14, 2010 with a group of federal and state officials and experts. This brief summarizes the key issues identified and discussed by the invited participants.

- **A larger primary care workforce will be needed to meet increased demands for access as Medicaid expands under health reform.** System-wide gaps in primary care access are exacerbated in Medicaid by the geographic maldistribution of the primary care workforce, lack of transportation and other poverty-related barriers to care, and low physician participation in fee-for-service Medicaid. More can be done to optimize existing primary capacity. In particular, removing state, federal, and health plan policy barriers that prevent nurse practitioners from practicing to the full extent of their education and training could increase the availability of primary care to underserved populations, including Medicaid beneficiaries.

- **Access to specialists is a serious and growing concern in Medicaid; difficulty arranging specialist referrals also dampens participation in Medicaid among primary care physicians.** Given the complex health needs of many of the adults who will gain Medicaid beginning in 2014, concerted efforts to improve access to specialty care are needed. ACA does not extend the Medicaid payment boost for primary care physicians to specialists. State Medicaid programs may need to pay specialists more. The trend toward hospital acquisitions of physician practices, including multi-specialty group practices, and the potential emergence of accountable care organizations (ACOs) could improve access to specialists in Medicaid. Telemedicine, e-consultations, digital photography, and other applications of technology could also help bridge gaps in specialist access.

- **Access to mental health care will be a pressing issue as millions of low-income adults, many of them with mental health and substance abuse treatment needs, gain eligibility for Medicaid.** The high prevalence of mental health conditions, including substance abuse disorders, in the newly-eligible Medicaid population sharpens concerns about the mental health system's capacity to serve the population, and about the lack of coordination in Medicaid between physical and mental health services. Increased coordination at both the federal and state levels between Medicaid and mental health agencies is needed to reduce fragmentation of care and capture opportunities for coordination. Models that integrate behavioral health with physical health, co-location of mental health and primary care, and payment mechanisms that foster integration, are all important directions for improving access to mental health care in Medicaid.

- **Adequate payment rates are an important component of efforts to improve provider participation in Medicaid, but strategies that focus strictly on payment as a lever for building capacity may not solve the problem.** Timely payment, reduced administrative burdens, and broader strategies are needed to support the networks of providers who serve Medicaid populations, make Medicaid more attractive to

primary care providers, and build additional capacity in Medicaid. The VA's health system, in which health IT, team-based practice, and other innovations create a high-performing clinical environment, may offer a model. Federal initiatives to promote a public service ethos, development of Medicaid champions in professional societies, and more regulatory approaches, like cap-and-trade or a requirement for some level of Medicaid participation as a condition of Medicare participation for physicians, all hold potential to increase Medicaid provider participation and build capacity.

- **Managed care plans appear likely to be the delivery systems in which an increasing share of the Medicaid population will access care.** Many states are considering expanding managed care to Medicaid beneficiaries with more complex health needs, including people with disabilities, a prospect that heightens concerns about care continuity and network adequacy. There is also uncertainty about the needs and costs of the adults who will become newly-eligible for Medicaid. Enforcement of the federal requirement that states pay actuarially sound rates in Medicaid is important to securing desirable participation by managed care plans and high-quality care for beneficiaries. Given the diverse composition of the Medicaid beneficiary population, different managed care and risk arrangements are likely to be appropriate for different groups. Churning in Medicaid coverage due to short enrollment periods is a key obstacle in managed care. Unstable coverage is incompatible with efforts to manage chronic conditions and causes disruptions in care. Twelve-month continuous eligibility for adults in Medicaid, already permitted for children, could reduce churning.

- **Safety-net hospitals and health centers are a critical source of access to care for Medicaid beneficiaries, and greater safety-net capacity will be needed in key areas to meet the complex demands of the newly insured.** High-Medicaid and safety-net institutions are very vulnerable, especially in the current economy. The loss of disproportionate share hospital (DSH) funds is a worrisome prospect and these funds need to be better-targeted to true safety-net hospitals. Additional, focused effort and resources will be needed to ensure adequate capacity to serve Medicaid beneficiaries and the uninsured. While health centers will help to address the increased demands for access when Medicaid expands, there are limits to what health centers can shoulder. Reliance on health centers is not viable in many rural areas, where needs for access will grow with the expansion of Medicaid, but where few health centers locate. Rural health clinics and critical access hospitals will continue to be a linchpin of the delivery system in rural areas, requiring strong support.

- **Team-based care and integrated service delivery systems can promote better access.** Team-based care, which emphasizes coordination of services and facilitates access to appropriate specialist care, contrasts with the fragmented care than many people, including Medicaid beneficiaries, receive today. Team-based care relies in part on greater use of electronic medical records and other health IT. The provider-based delivery systems emerging today offer promising opportunities for coordinating and integrating care for Medicaid beneficiaries, perhaps especially in rural areas, where resources are scarcer and access challenges more difficult. There is a need for policy to foster integrated service delivery systems within the safety-net as well.

- **Coordination between Medicaid and Exchange coverage will be important to support continuity of coverage and care for low-income people.** Key issues for coordination are how similar the essential health benefits package required for Exchange coverage and the Medicaid benefit package will be, and whether states or Exchange boards will decide that at least one plan must operate in both Medicaid and the Exchange. Important trade-offs are involved in balancing the goals of maximizing coordination and simplicity, preserving Medicaid's comprehensive benefits, and ensuring access to providers and delivery systems that are equipped to serve low-income populations.

## Ensuring Access to Care in Medicaid under Health Reform

### Introduction

The Patient Protection and Affordable Care Act (ACA) expands Medicaid eligibility nationally to nearly all individuals under age 65 below 133% of the federal poverty level (FPL), effective January 1, 2014. As a result, about 16 million people – mostly, uninsured adults – are expected to gain Medicaid coverage by 2019. At the same time, an additional 16 million people are projected to gain private health coverage through new, state-based health insurance Exchanges, with subsidies provided for those up to 400% FPL. This broad national expansion of health coverage, largely to a previously uninsured population, will generate new demands for access to care in a system already short of adult primary care providers and some specialists; one estimate projects a shortage of 91,500 physicians by 2020, split about evenly between primary care physicians and specialists (AAMC Center for Workforce Studies, 2010). The current geographic maldistribution of providers relative to need may also become more pronounced.

While gaps in access are a concern system-wide, access problems have historically been amplified in Medicaid because of low physician participation in fee-for-service Medicaid, the disproportionate representation of Medicaid beneficiaries in federally designated health professional shortage areas, lack of transportation, and other factors related to poverty. Adding to these pressures, many of the newly-eligible low-income adults entering Medicaid are expected to be in fair or poor health, have chronic physical and/or mental health conditions, and present with pent-up needs for health care.

ACA includes numerous provisions aimed at improving access to care in Medicaid as well as more broadly. In particular, the reform law temporarily boosts Medicaid payment rates for primary care physicians. Also, the Medicaid and CHIP Payment and Access Commission, or MACPAC, is charged with reviewing state and federal access and payment policies in the two programs, making recommendations on a wide range of issues, and creating an "early warning system" to identify provider shortage areas as well as other factors that could adversely affect access to care for Medicaid and CHIP beneficiaries. ACA includes significant new funding for the safety-net delivery system on which many underserved communities rely. New support for service delivery and payment reforms that place a greater emphasis on primary care and care coordination may improve access to care as well. Many states appear likely to rely on managed care to serve their newly-eligible, mostly adult, Medicaid beneficiaries.

A more recent development that will help shape access to care in Medicaid is a proposed rule on methods for assuring access to covered Medicaid services, issued by CMS on May 6, 2011. The rule sets forth data collection efforts and public processes that all states must implement to demonstrate that they take beneficiary access into account on an ongoing basis and particularly in setting their Medicaid fee-for-service payment rates.

To explore and discuss important issues related to ensuring access to care in Medicaid under health reform, the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on December 14, 2010 with a group of federal and state officials and experts. This brief summarizes the key issues identified and discussed by the invited participants.

### Background: Key Access Provisions in ACA

The ACA outlined a multi-pronged strategy to build capacity in the health care system to meet increased demands for care. The following provisions, especially, may have a significant, positive impact on access to care in Medicaid:

- **Increased Medicaid payment for primary care physicians**. State Medicaid programs must pay 100% of Medicare rates to primary care physicians for specified primary care services in 2013 and 2014 (including in managed care organizations). The rate increase is fully federally financed.
- **Expansion of health centers program**. The ACA provides $11 billion in new, dedicated federal funding for the health centers program over five years, beginning in FY 2011. The lion's share ($9.5 billion) is to enable existing centers to expand their capacity by adding new sites and services (e.g., behavioral health, oral health, pharmacy). The rest is to support construction and renovation.
- **Expansion of National Health Service Corps (NHSC).** The law provides $1.5 billion in new funding for the NHSC over the five-year period FY 2011-2015. This funding adds to the $300 million in supplemental funding for the NHSC provided by the American Reinvestment and Recovery Act (ARRA). The ACA also increases the amounts that can be appropriated for the NHSC annually and permanently authorizes the program.
- **Other workforce training investments.** The ACA provides for new grants to support primary care training programs, traineeships and fellowships, and primary care capacity-building in schools of medicine and osteopathic medicine; a specific allocation is made to physician assistant training programs in primary care. The law also includes a new program of grants to medical schools to recruit and train rural physicians. Other investments are directed to increase the supply of certain pediatric subspecialists, primary care dentists, and geriatricians, and to expand the dental workforce to include alternative dental providers. The law also expands support for nursing student loans and education, including nurse practitioner and midwifery programs, and development of nurse faculty.
- **Nurse-managed health clinics.** The HHS Secretary is required to establish a grant program to fund the operation of nurse-managed health clinics that provide comprehensive primary care and wellness services to vulnerable or underserved populations. In addition to providing access to primary care, the clinics serve as clinical training sites for primary and community health students. $50 million is authorized for FY 2010 and such funds as necessary each year for FY 2011-2014.
- **Expansion of teaching health centers (THC).** THCs are community-based, ambulatory patient care centers that operate a primary care residency program; they include federally qualified health centers, community mental health centers, Rural Health Clinics, Indian health centers, and entities receiving federal family planning program funds. The HHS Secretary is authorized to make grants to THCs to establish new programs or expand existing ones. $25 million is authorized for FY 2010, $50 million for FY 2011 and 2012 and such funds as necessary in later years.
- **Delivery system and payment innovation.** The ACA makes significant investments in the development of innovative care delivery and payment systems. It establishes a new Center for Medicare and Medicaid Innovation (CMMI) in CMS, and specifically calls for demonstrations of care models that emphasize primary care and care coordination, such as the patient-centered medical home, and seek to improve access to care.

### Key issues in ensuring access to care in Medicaid

#### 1. A larger primary care workforce will be needed to meet increased demands for access as Medicaid expands under health reform.

There was consensus among the roundtable participants that a larger supply of adult-care primary care providers will be needed to meet the increased demand for primary care when both Medicaid and private coverage expand in 2014. The magnitude of the primary care shortage is uncertain and will vary among and within states and local areas. Factors contributing to gaps in primary care access in Medicaid include system-wide inadequacies in the number of new doctors choosing careers in primary care, geographic inequities in the distribution of the primary care workforce, inefficiencies in care delivery, and regulatory barriers facing some health professionals. Low physician participation in Medicaid, attributed most often to inadequate Medicaid payment and administrative hassles, is an exacerbating factor.

Participants underscored that more can be done to optimize existing primary care capacity. One focus of the discussion was the untapped potential of nurse practitioners (NP) and physician assistants (PA) to increase the availability of primary care to underserved populations including Medicaid beneficiaries. Participants pointed to state scope-of-practice regulations and policies in force in some managed care plans that prevent NPs, in particular, from practicing to the full extent of their training and competency, despite strong evidence of high-quality care and patient satisfaction.

The discussion noted the recommendations of the recent Institute of Medicine study on the future of nursing, including the amendment of federal law and policy to permit NPs to practice in Medicare and Medicaid to the full extent of their education and training, regardless of state regulations that restrict their scope-of-practice unnecessarily. The Veterans Administration health system, which has gained attention for its emphasis on primary care and care coordination, and in which NPs are fully integrated as primary care providers, was noted as a model of what is possible. It was also suggested that more education of health plans about NPs, and "carrots" that reward managed care contractors that include them as primary care providers, could help promote NPs' integration in managed care environments. Retail clinics and other front-line access points staffed by NPs and PAs could also expand access to primary care. One participant observed that while fuller deployment of NPs and PAs would help to increase access to primary care where shortages exist, physicians will likely continue to drive utilization, potentially increasing overall system costs.

#### 2. Access to specialists is a serious and growing concern in Medicaid; difficulty arranging specialist referrals also dampens participation in Medicaid among primary care physicians.

Roundtable participants pointed out that while the shortage of primary care physicians has received substantial attention, national shortages of certain pediatric and adult specialists (e.g., pediatric subspecialists, orthopedists), which are particularly acute in Medicaid, are also a large and growing concern. Part of the need for specialist services in Medicaid arises from the fact that primary care physicians are overburdened and often do not have time for complex cases. Thus, some primary care physicians are not practicing "at the top of their license." Inadequate access to specialist care poses particular risks for many in the Medicaid population, including dual eligibles as well as children and a growing number of non-elderly adults with chronic conditions and/or severe disabilities. Given the serious and complex health needs of many of the adults who will become eligible for Medicaid in 2014, concerted efforts to improve access to specialty care are needed.

Payment is one lever for garnering more specialist care in Medicaid. However, the health reform law does not include any targeted increase in Medicaid payment rates for specialists, similar to the temporary boost in rates for primary care physicians. To gain greater specialist participation in Medicaid, it may be necessary in some cases for state Medicaid programs to pay specialists more than Medicare does. Dynamics in the broader health care market could also increase access to specialists in Medicaid. Specifically, the increase in hospital acquisitions of physician practices, including multi-specialty group practices, and the potential emergence of accountable care organizations (ACO), were cited as developments that could improve access to specialists for Medicaid beneficiaries, although the risks if hospitals with substantial leverage withdraw from Medicaid were also noted.

Participants also highlighted the demonstrated potential of telemedicine to increase access to specialist care. Several state examples were cited. In Project ECHO in New Mexico, urban specialists remotely assist and train rural primary care providers in managing complex patients; the project has produced results showing that patient care and outcomes among primary care physicians with training were comparable to those for specialists. In Maine, the single pediatric gastroenterologist in the state provides E-consultations with primary care physicians, eliminating the need for families to travel to obtain that care. Elsewhere, LACare in California uses digital photography to extend access to dermatology services electronically in areas that lack these specialists.

### 3. Access to mental health care will be a pressing issue as millions of low-income adults, many of them with mental health and substance abuse treatment needs, gain eligibility for Medicaid.

Roundtable participants highlighted that, with the Medicaid expansion to low-income adults, access to mental and behavioral health services will be a major issue. Data on uninsured adults below 133% FPL indicate that approximately one in six has a severe mental health disorder and many others have mental health service needs for less severe mental health conditions. Thus, new demands on the system for mental and behavioral health care are likely to be great, with many people in need of care, including treatment for substance abuse disorders, that primary care practitioners alone are not equipped to address. This impending demand heightens concerns about mental health system capacity to supply services to the newly-eligible adult Medicaid population. Community health centers are already experiencing increasing demand for behavioral health services, and shortages of mental health providers and the lack of a mental health infrastructure are particularly acute in rural areas. The expected new mental health care needs also sharpen current concerns about the lack of coordination between physical and mental health services in Medicaid.

Participants raised multiple issues related to financing of mental health services. It was pointed out that financing of the mental health system is highly dependent on Medicaid today, and participants expressed concern that state cuts in Medicaid due to state budget pressures threaten to weaken existing capacity. At the same time, they said, a “culture change” will be necessary among many mental health providers who are used to grant-based financing, to adapt to the new coverage-based system for financing care under health reform. A major structural obstacle to rationalizing the mental health system and its financing in many states is that the mental health department and Medicaid are separate agencies that operate on different models and have not historically coordinated with each other, contributing to fragmentation of care and missed opportunities for streamlining and improved efficiency.

Coordination and integration of behavioral health with physical health services also emerged as a key challenge. Behavioral health is carved out of many managed care contracts between state Medicaid programs and plans, posing a major barrier to integration. However, models of integration between primary care and mental health care, in Medicaid managed care plans in some states and in some community health centers, were also cited. Co-location of mental health and primary care services at health centers, and linkages between health centers and emergency departments, were mentioned as mechanisms for improving integration. Payment mechanisms were also cited as an important tool that can be structured to foster integration. Ultimately, while provider-level initiatives can effect improvements and provide models, collaborations at the federal agency level, such as a joint HRSA-SAMHSA effort to integrate behavioral health and primary care, are needed to drive care delivery in this direction and to provide states, communities, and providers with the policy and programmatic tools necessary to support integrated care.

**4. Adequate payment rates are an important component of efforts to improve provider participation in Medicaid, but strategies that focus strictly on payment as a lever for building capacity may not solve the problem.**

It was widely agreed that Medicaid is under-resourced where provider payment is concerned. The federally funded increase in Medicaid payment rates for primary care to Medicare levels in 2013 and 2014 was commended as a helpful policy response to the under-payment of primary care relative to specialist care and as a means of promoting increased physician participation in Medicaid. At the same time, participants expressed concern about the impact of state budget pressures and the prospect of cuts in Medicaid provider payment in the short term. They stressed that it is important for decision-makers weighing difficult rate cuts to consider what choices would least jeopardize capacity in Medicaid. Participants cautioned that recurring controversy over Medicare physician payment rates could harm efforts to cultivate greater physician willingness participate in Medicaid as well.

While low fee-for-service payment rates were acknowledged as an important factor contributing to low Medicaid participation among physicians, the discussion emphasized that raising payment rates alone is not sufficient to attract more providers to Medicaid. Other programmatic improvements, including reduced administrative burden and more timely Medicaid payment are also essential; simplified provider enrollment processes would also lower barriers to participation in the program. Managed care organizations might also play an important role by easing some of the pressure on physicians to find specialist referrals and/or perform administrative duties. Physician incentives, including continuing medical education credits and other perks, could also be used more to promote increased participation.

It was generally agreed that, separate from increased payment and other programmatic improvements, broader strategies are needed to support networks of providers who serve Medicaid populations, to make Medicaid more attractive to primary care providers, and to build additional capacity in Medicaid. Some participants suggested examining the reform of the VA health system as a model, pointing to its aggressive adoption of health IT, team-based practice, and other innovations to create a high-performing clinical environment, and to attract and support physicians and other health professionals.

There was discussion that perhaps more could and should be done federally to promote an ethos of public service among physicians. Engagement with professional societies could help develop champions. Some framed the issue of access to care in Medicaid as a fundamentally federal interest, and proposed that more regulatory approaches to ensuring access may be needed and would be justified given the federal government's large role in financing Medicaid. One such approach would be a cap-and-trade system of sorts that would tax providers who do not participate in Medicaid and redistribute the tax

revenues to subsidize those serving Medicaid patients. Another would be to require some level of Medicaid participation as a condition of Medicare participation for physicians.

### 5. Managed care plans appear likely to be the delivery systems in which an increasing share of the Medicaid population will access care.

The discussion highlighted important challenges and opportunities related to expanding access in Medicaid through managed care. Many states are currently considering expanding Medicaid managed care beyond children and parents to more of their Medicaid beneficiaries, including people with disabilities, and both states and industry appear interested in serving the newly-eligible Medicaid adults through managed care plans.

The enrollment of people with more complex health needs raises issues about care continuity and network adequacy. There is uncertainty about the health needs and costs of the adults who will be newly-eligible for Medicaid, but their relatively high rates of physical and behavioral health conditions suggest there will be greater needs for specialists in plan networks. Participants observed that the experience of states that have already expanded Medicaid to low-income adults can inform planning in other states and plans. Lessons from those states related to network adequacy, how to engage new members in care, rate-setting, and other issues will be particularly valuable. The importance of enforcing the federal requirement that states pay plans actuarially sound Medicaid rates was underscored; without this protection, efforts to secure desirable participation by managed care plans and high-quality care for Medicaid enrollees could fall short.

Managed care offers potential to drive improvements in access by aligning payment and care delivery goals. At the same time, it was pointed out that, given the diverse composition of the Medicaid beneficiary population, managed care may work well for some but not others, and that different managed care and risk arrangements may be appropriate for different groups to safeguard access to care, particularly for the most vulnerable people in the program.

Participants cited churning in Medicaid coverage due to short enrollment periods as a key obstacle in managed care. Unstable coverage is incompatible with efforts to manage chronic conditions and causes disruptions in care. It was suggested that 12-month continuous eligibility for adults in Medicaid, already permitted for children, could reduce churning.

### 6. Safety-net hospitals and health centers are a critical source of access to care for Medicaid beneficiaries, and greater safety-net capacity will be needed in key areas to meet the complex demands of the newly insured.

The roundtable participants expressed concern that high-Medicaid and safety-net institutions are very vulnerable, especially in the current economy. Hospitals with a high concentration of Medicaid and uninsured patients lack adequate cross-subsidies from commercially insured patients, and substantial losses in ambulatory care capacity in safety-net hospitals as a result were cited. Many expressed worry about the prospect of losing disproportionate share hospital (DSH) payments and stressed that DSH funds need to be better-targeted to true safety-net institutions. Additional, focused effort and resources will be needed to ensure that safety-net hospitals have adequate capacity to serve Medicaid beneficiaries and the uninsured.

Health centers are also a critical source of access for Medicaid beneficiaries today, and the ACA provides vastly increased federal funding to expand health center sites and services. While health centers will

help to address the increased demands for access when Medicaid expands, it is not clear that they will offer sufficient capacity; some participants emphasized that there are limits to what health centers can shoulder. Several participants also cautioned that reliance on health centers is not viable in many rural areas, where needs for access will grow with the expansion of Medicaid, but where few health centers locate. Rural health clinics and critical access hospitals will continue to be a linchpin of the delivery system in rural areas, requiring strong support.

A question was raised as to whether health centers are pulling in existing resources or creating additional capacity. Also, the need for them to integrate with the rest of the safety-net system rather than operate as "siloes" and compete with it was emphasized. A fundamental question that was posed in the discussion, but not settled, is what balance to strike between efforts to improve access to care in Medicaid by strengthening the safety-net and strategies aimed at integrating the Medicaid beneficiary population into the mainstream health care delivery system.

### 7. Team-based care and integrated service delivery systems can promote better access.

Substantial discussion was devoted to the potential of team-based care, such as patient-centered medical homes, and integrated service delivery systems to improve access to care in Medicaid. Team-based care emphasizes coordination of the array of services and supports an individual may need and facilitates access to appropriate specialist care. It contrasts with the fragmented care that many consumers receive today. One participant observed that by facilitating consultation with specialists, team-based care can enhance primary care physicians' ability to practice "at the top of their license," thereby building capacity.

Team-based care relies in part on greater use of electronic medical records and other health information technology, and there is growing evidence of the gains that are possible in patient care quality and efficiency. One participant made the point that to establish the team model most effectively, the training to deliver care in this way needs to begin in medical school.

Participants noted that integrated service delivery systems harness the benefits of a *system* – increased capability to provide access to the right care in the right setting at the right time, and alignment of payment incentives with care goals and increased accountability. They observed that the provider-based delivery systems that are emerging today offer promising opportunities for coordinating and integrating care for Medicaid beneficiaries. Some suggested that rural areas, where resources are scarcer and access challenges more difficult, may stand to benefit particularly. A need for policy to foster integrated delivery systems within the safety-net was noted. Participants counted as genuine integrated service delivery systems those that go beyond integrating behavioral and primary care to include a more comprehensive spectrum of services and providers involved in serving Medicaid patients.

### 8. Coordination between Medicaid and Exchange coverage will be important to support continuity of coverage and care for low-income people.

Particularly because low-income households experience considerable income volatility, potentially leading to frequent transitions between Medicaid and subsidized Exchange coverage, tight coordination between Medicaid and the Exchanges will be necessary to prevent coverage and access gaps for this population. One participant believed that churning between the two could be worse in rural areas.

Key issues for coordination are how similar the essential health benefits package required for Exchange coverage and the Medicaid benefit package will be, and whether states or Exchange boards will decide that at least one plan must operate in both Medicaid and the Exchange. There was discussion of the trade-offs involved in balancing the goals of maximizing coordination and simplicity, preserving

Medicaid's comprehensive benefits, and ensuring access to providers and delivery systems that are equipped to serve low-income populations. Similar benefit packages would ease transitions between the two coverage programs, but might require sacrificing Medicaid's unique coverage of some services that are unlikely to be included in the definition of essential health benefits. Health plans that primarily serve Medicaid may need a transition period to meet the Exchange's reserve or accreditation requirements, and commercial plans interested in being offered on the Exchanges may lack some features (e.g., enabling services and supports, traditional safety-net providers) important to ensuring access for low-income consumers. One participant suggested that the Exchanges will provide transparency regarding each network, helping to ensure that plans provide adequate access and coverage for enrollees.

The Basic Health Plan may better align coverage for low-income people, smoothing transitions between programs when household income fluctuates, providing consistent health plan choices when members of a family qualify for different public programs, and potentially offering coverage options with lower cost-sharing.

## Conclusion

The health reform law expands Medicaid coverage to reach millions of low-income uninsured Americans and, recognizing current serious gaps in access to care system-wide, also takes significant steps to build capacity and help ensure that that coverage translates into access to needed services. Major ACA investments in the safety-net and in the health care workforce, and support for service delivery models that emphasize primary care and care coordination lay the groundwork for a system better-geared to meet the needs of the population generally, and the needs of low-income Medicaid beneficiaries, in particular.

The roundtable discussion highlighted opportunities to more fully realize existing capacity in our system and to improve care through new, more integrated approaches to organizing and delivering services. It also identified important gaps in access to care in Medicaid and some policy steps that could help to close them. The discussion generated ideas about strategies in addition to adequate payment that might elicit more robust provider participation in Medicaid. Participants also identified key issues as states consider extending managed care to newly-eligible Medicaid adults. Finally, the discussion revisited longstanding questions about the relative strengths and advantages for Medicaid beneficiaries of care provided by a robust safety-net system and "mainstream" care, respectively. This issue assumes new significance in the context of ACA's vision of a system in which transitions between Medicaid and Exchange coverage and care are essentially seamless.

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