

Medicaid Primary Care Rate Increase: Considerations Beyond 2014

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IN BRIEF

The Medicaid primary care rate increase, a provision of the Affordable Care Act, requires Medicaid programs to reimburse primary care providers at Medicare levels for two years – a “bump” that is funded 100 percent by the federal government in 2013 and 2014. The increase was intended to ensure sufficient provider participation as the Medicaid population expands. As the temporary provision enters its final months, a number of state and federal policymakers are considering extending the rate increase into 2015 and beyond.

This brief assesses the policy’s successes and shortcomings, drawing from interviews with policy experts and stakeholders across the country. It examines the rate increase through the provider’s lens; reviews its impact in meeting access and quality goals; and outlines considerations for states interested in extending and strengthening the provision to better meet its goals. This brief was developed through *Leveraging the Medicaid Primary Care Rate Increase*, a CHCS initiative made possible by The Commonwealth Fund.

The Medicaid primary care rate increase, enacted under Section 1202 of the Affordable Care Act (ACA), requires Medicaid programs to reimburse qualified primary care services at Medicare levels in 2013 and 2014. Funded entirely by the federal government, the rate increase was designed to increase access to Medicaid primary care services, both before and during the ACA’s Medicaid expansion.¹ Federal funding for the increase will cease as of December 31, 2014, raising questions about next steps for states at a time when Medicaid programs are growing rapidly, particularly in states that opted to expand coverage.

Prior to the rate increase’s implementation, Medicaid programs paid, on average, 66 percent of Medicare rates for all services and just 58 percent of Medicare rates for primary care services.² Low reimbursement is one of many factors deterring primary care providers (PCPs) from accepting Medicaid, suggesting that higher payment rates might attract more PCPs to the program and encourage Medicaid providers to see more patients.³ A Kaiser Family Foundation survey estimated that the rate increase would boost Medicaid primary care fees by an average of 73 percent in 2013, and at least double rates in states with the lowest Medicaid-to-Medicare fee ratios, including California, Florida, Michigan, New Jersey, New York, and Rhode Island.⁴ As of September 2014, clear evidence linking the rate increase to greater provider participation in Medicaid or patient access to care does not exist—though some believe this is due not to the policy’s ineffectiveness, but its short time horizon.

As the rate increase enters its final months, many are concerned about the implications of taking billions of dollars out of primary care just as Medicaid is dramatically expanding. A July 2014 analysis reported that PCPs in Medicaid expansion states saw the proportion of adult visits from Medicaid patients increase substantially in the months following Medicaid expansion (from 12.3 percent in

December 2013 to 15.6 percent in May 2014), while PCPs in non-expansion states also saw this proportion increase, though by a smaller amount (from 5.9 percent to 6.3 percent).⁵

Both state and federal policymakers are considering extending the increase into 2015 and beyond. The Obama administration included a one-year extension of the rate increase in the president's 2015 budget.⁶ Members of Congress have also proposed legislation to extend the policy: a Senate bill introduced by Senator Sherrod Brown (D-Ohio) would maintain the rate increase for two years,⁷ while a House of Representatives bill sponsored by Rep. John Lewis (D-Georgia) would continue the increase for five years. Both bills were introduced and referred to committee on July 31, 2014.⁸

If the federal government does not extend and fully pay for the rate increase after 2014, six states—Alabama, Colorado, Iowa, Maryland, Mississippi, and New Mexico—and the District of Columbia plan to use state dollars to continue the policy of paying Medicaid PCPs at Medicare rates. States may opt to extend the policy for a variety of reasons, including to: (a) maintain Medicaid beneficiaries' access to care; (b) garner goodwill among providers; and (c) promote development of the Medicaid provider network. The price tag would be relatively low for states that do not currently have a large disparity between Medicaid and Medicare rates and/or those in which the federal government pays a large proportion of Medicaid costs.

This brief, made possible by The Commonwealth Fund, assesses the primary care rate increase's successes and shortcomings, drawing from interviews with policy experts and staff from state Medicaid programs, health plans, and provider organizations. It examines the rate increase through the provider's lens and reviews early lessons in meeting access and quality goals. Based on interviewee suggestions, it outlines considerations for extending the increase beyond 2014 and recommendations for strengthening the provision to better meet its goals.

Provider Response

The provider community's response to the rate increase ranged from negative to indifferent to enthusiastic, depending on how the policy was implemented and how quickly. On the one hand, the rate increase tended to generate goodwill among PCPs who received the extra funds on or close to the policy's January 1, 2013 start date. This was more often the case for providers billing under fee-for-service (FFS) Medicaid, as the policy was relatively straightforward to implement in the FFS environment. Providers in states that recently experienced Medicaid payment cuts also expressed appreciation for the funding boost.

PCPs working in states that contract with Medicaid managed care organizations, on the other hand, tended to have a less positive experience with the policy, as these states faced significant implementation challenges and multi-month payment delays while struggling to develop new managed care payment methodologies and contracts. PCPs who expected higher rates in January, but did not see funds until much later, viewed the policy in a decidedly negative light. One health plan decided to pay providers the higher rates beginning January 1, 2013, even though federal funds were not yet available. A representative from this plan stated that fronting the money was a financial risk, but that it greatly improved provider satisfaction. Other providers did not fare as well: nine months after the policy's start date, some or all qualifying PCPs in 14 states had still not seen enhanced payments.⁹

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Finally, there was a sizable cohort of providers who showed indifference toward the policy or were simply unaware of it. States acknowledged a number of factors that negatively impacted participation, including:

1. **Limited outreach about the policy and attestation process.** In many states, efforts to educate PCPs about the payment increase were limited. Additionally, some providers may have known about the policy, but did not know they had to attest to being a PCP to qualify for the enhanced rates.
2. **Reluctance to participate in a time-limited policy.** Providers treating Medicaid patients value funding predictability and stability, so some may have decided not to participate because they knew the policy was slated to end after 2014.
3. **Medicare rates not high enough to prompt participation.** Despite having higher average rates than Medicaid, Medicare underpays for primary care compared with rates for specialty services.¹⁰ For some providers, payment parity with Medicare was not a big enough incentive to participate. Others may have signed up, but did not qualify for a sizable payment increase, because they were already paid at or close to Medicare levels. Some Medicaid managed care organizations, for instance, choose to pay higher rates than FFS Medicaid to sustain a strong provider network.
4. **Administrative complexities and delays in managed care.** Some providers simply did not want to deal with the administrative tasks associated with the policy or were put off by the long payment delays in Medicaid managed care.

Impact on Access and Quality

There are a number of factors to consider when evaluating whether the rate increase was successful at meeting its goal to improve Medicaid beneficiaries' access to primary care. When considering the policy's impact thus far, state officials and national experts have looked to changes in the number of PCPs accepting Medicaid. This metric is somewhat problematic—the policy is too new to accurately measure its effect on provider enrollment trends, and any observable increases in Medicaid participation could be attributable to other factors—yet it is arguably the best proxy for measuring primary care access changes at this time.

Some Medicaid and health plan representatives reported anecdotal findings that Medicaid PCP enrollment increased following the policy's inception. For instance, a California managed care plan saw multiple providers who had previously participated in the Children's Health Insurance Program (CHIP), but not Medicaid, sign on to Medicaid when the rate increase began. A Medicaid official from a different state credits the rate increase with reducing the drop-out rate of physicians from Medicaid, though he noted that he did not see a corresponding increase in new physicians joining. Connecticut Medicaid, meanwhile, experienced one of the most dramatic increases in PCP participation, expanding from 2,370 PCPs in January 2013 to 3,256 in December 2013.¹¹

In each of these cases, however, it is unclear whether higher provider enrollment numbers were a direct result of the enhanced payments, or if other factors were at play. In California, for example, the state migrated CHIP beneficiaries into Medicaid plans around the onset of the rate increase, which could have influenced CHIP physicians' decision to enroll in Medicaid. In Connecticut, the rate increase coincided with program and administrative improvements associated with transitioning from a

managed care model to a self-insured administrative service organization (ASO) model. A health plan representative who witnessed new PCPs join her plan in 2013 and 2014 noted that the influx of physicians was probably the result of a confluence of factors, including better relationship development.

Another consideration for state and federal officials is whether or not the rate increase enhanced PCPs' ability to provide higher quality care. While it is extremely difficult to tease out exactly how providers spent the extra funding, anecdotal evidence suggests some providers used the money to offset the impact of recent payment cuts, while others were able to invest in quality improvement initiatives. A member of a provider organization believed the rate increase gave practices "more breathing room to improve." He noted pediatric providers reported using the funding to offer new services or enhance existing infrastructure, such as providing lactation consultations, contracting with a nutritionist, updating office technology, and adding more services to pediatric medical homes.

If the policy is extended into the future, states may wish to examine changes in additional primary care access and quality measures to better assess the policy's impact, such as average wait times for Medicaid PCP appointments, the statewide patient-to-Medicaid PCP ratio, and the ratio of PCPs accepting new Medicaid patients to the total number of PCPs in the state.¹²

Rationale for Expanding the Increase

As the rate increase nears its December 31, 2014 end date, many are wondering if the provision will be extended, and if so, whether an extension is a sound policy decision. One health plan representative was uncertain whether her organization would advocate for an extension, explaining it would be difficult to back a policy without concrete evidence of its efficacy.

Interestingly, other individuals support extending the policy precisely *because* there is no clear evidence yet of its effectiveness. They note that a two-year timeframe is too short to measure meaningful changes in Medicaid provider participation and patient access—and due to roll-out delays, the two-year period was significantly shortened for many. Maintaining the rate increase past 2014 will enable states to collect more complete, accurate, and long-range data about the policy's impacts.

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A common argument for extending the rate increase is to minimize the negative repercussions of taking money away from providers. Most providers would experience this loss of funding as more detrimental than the benefits they experienced with the funding gain, as explained by the behavioral economic theory of loss aversion, which suggests that individuals prefer avoiding losses to acquiring gains. In states like Rhode Island, New York, and New Jersey—those that saw the most dramatic rate increases in 2013—providers would see payments cut by more than 50 percent.¹³ These rate cuts would be significantly higher than the Medicare Sustainable Growth Rate (SGR) cuts put forward each year (in 2014, the proposed SGR cut was 24 percent), but as of yet, never implemented, thanks in part to strong provider lobbying.¹⁴

Many also worry that ending the rate increase will cancel out any gains made in Medicaid provider enrollment and retention over the past two years, resulting in PCPs dropping Medicaid patients or leaving the program altogether. Health plans could also suffer negative consequences if the policy ends, as providers may believe it was the plan—not the federal government—that reduced their

funding, leading providers to drop out of their networks. One health plan representative estimated 25 – 30 percent of the plan’s providers would be significantly impacted by the policy’s elimination.

Finally, interviewees noted the potentially harmful effects that terminating the policy could have on Medicaid beneficiaries and the health care system as a whole, leading to longer appointment wait times, more emergency department (ED) usage, and worse health outcomes, at a time when millions more individuals are signing up for coverage. A state like California, which has a low Medicaid-to-Medicare fee ratio (51 percent in fiscal year 2012) and the largest influx of new Medicaid enrollees following the ACA’s first open enrollment period (2.2 million sign-ups between January and August 2014),¹⁵ could be especially hard hit. Even states that did not expand Medicaid are experiencing increased enrollment due to the “woodwork” effect, as previously eligible but un-enrolled individuals enroll in coverage. Of the 24 non-Medicaid expansion states, at least 19 saw Medicaid enrollments increase between October 2013 and April 2014.¹⁶ It should be noted, however, that not all newly-enrolled Medicaid beneficiaries are seeking care from office-based PCPs eligible for the rate increase; many are accessing services at federally-qualified health centers, which do not qualify for the increase because they already received enhanced Medicaid payments for their services.

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Recommendations for Improvement

Interviewees made a variety of recommendations for improving the primary care rate increase, should it be extended. While some recommendations are more applicable to the continuation of the increase at the federal level, others are relevant to states wishing to extend the policy on their own. Some interviewees made suggestions for improving the policy’s implementation process in response to challenges states experienced with regulation delays, unclear sub-regulatory guidance, and rate setting difficulties. This brief, however, will focus specifically on recommendations to improve the policy itself, not how it was implemented.

Following are recommendations for: (1) identifying eligible providers; (2) promoting value-based payment; (3) defining primary care providers; (4) identifying the primary care services covered; and (5) implementing the rate increase in managed care.

1. Identifying Eligible Providers

To qualify for the rate increase, physicians must self-attest either that: (a) they are board certified in primary care; or (b) at least 60 percent of their paid claims are for approved evaluation and management (E&M) codes, including vaccine administration codes. The self-attestation process departs from the initially-proposed requirement for states to verify provider eligibility. While removal of the state verification requirement was intended to ease states’ administrative burdens, some state officials would like to introduce a state-based verification system, because of numerous difficulties with the self-attestation process. Challenges included: (a) confusion about whether providers can retroactively attest after the sign-up deadline (they can); (b) a lack of understanding about the need for providers to attest; and (c) confusion about how to calculate the 60 percent threshold.

RECOMMENDATION: Provide states the option to assume control of the provider verification process by using existing data sources (e.g., board certification records, claims data, and/or health plan physician enrollment data) to confirm providers' primary care credentials.

2. Promoting Value-Based Payments

States and health plans looking to adopt or expand value-based Medicaid models were discouraged that the primary care rate increase is an inherently FFS-oriented reimbursement policy, paying enhanced rates for every service provided. By reinvesting money in a volume-based model, the policy conflicts with many Medicaid programs' payment goals to promote quality over quantity.

While CMS developed models to implement the policy in managed care, which covers 74 percent of all Medicaid beneficiaries,¹⁷ some health plans believed shoehorning a FFS-based policy into a managed care system would be an exceedingly difficult undertaking. As a result, these plans decided to transition from a sub-capitation provider payment model to a FFS model to reduce administrative burdens and promote payment transparency. Thus, a CMS-led policy may actually be leading to more care being provided under FFS, which runs counter to the ACA's broader delivery system reform goals.

RECOMMENDATION: Enable states to use value-based payment models to implement the rate increase. States could either incorporate the increase into existing payment methodologies or use the additional funding to begin the transition to value-based models. The federal government could facilitate this by providing the funds in a block grant, or via some other unrestricted manner, that offers states more discretion in how the money is allocated – so long as it continues to promote PCP participation and primary care access through higher PCP payments.

3. Defining Primary Care Providers

■ Qualifying Physician Specialties

Interviewee opinions differed as to whether the primary care rate increase was too restrictive or too expansive regarding which physician specialties should qualify for enhanced funding. Some interviewees believed the increase should be extended to additional providers who can positively impact health outcomes and promote more holistic care, such as behavioral health specialists and complementary medicine providers.

Others advocated for obstetricians and gynecologists (OB-GYNs) to be included in the rate increase if 60 percent of their billable codes are for primary care, noting that OB-GYNs serve as de facto PCPs for many women. A June 2014 letter to Congress from 21 provider organizations and health systems advocated both for the continuation of the rate increase and the inclusion of OB-GYNs, highlighting the fact that Medicaid programs in 34 states and the District of Columbia recognize OB-GYNs as PCPs.¹⁸

Finally, some believe the policy should simply be expanded to most, if not all, Medicaid specialties. A physician organization representative noted Medicaid-enrolled children have a harder time accessing pediatric sub-specialists (such as surgeons and neurologists) than general pediatricians, indicating resources may be better spent enhancing children's access to specialty care. Others argue that low-income populations have difficulty accessing both primary and specialty care and believe all Medicaid physicians should be paid at 100 percent of Medicare levels.

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On the other hand, other interviewees noted that if the overriding goal of the policy is to improve Medicaid beneficiaries' access to primary care – not to all health care services – a counterargument can be made that the current policy is overly broad and includes some specialists whose services do not match up with the definition of primary care. Board-certified specialists and subspecialists in family medicine, general internal medicine, and pediatric medicine—including physicians practicing in fields like interventional cardiology, transplant hepatology, and critical care—are automatically eligible for the rate increase, though may provide very specialized care to individuals who already have PCPs.

RECOMMENDATION: As Medicaid beneficiaries' access to both primary and specialty care varies significantly across different regions of the country, states could assume greater flexibility in determining which specialties qualify for the rate increase. This would allow states to target resources to the highest need provider specialty areas, whether that is "traditional" primary care or a mix of primary and specialty care.

■ *Physician Extender Eligibility*

The final primary care rate increase rule specifies that physician extenders like physician assistants (PAs) and nurse practitioners (NPs) qualify for the rate increase if they practice under the supervision of a qualifying physician and bill primary care claims to this physician. Services provided by physician extenders practicing independently do not qualify for the increase.

Many believe that because PAs, NPs, and other advanced practice nurses provide a sizable percentage of the primary care in this country, they should be eligible for the rate increase without having to practice under a physician (NPs are currently able to practice independently in 18 states and the District of Columbia).¹⁹ At least one state felt strongly enough about including unsupervised physician extenders that it explored paying these practitioners the enhanced rate using state-only dollars. The state ultimately decided against this because of the cost. The Obama administration's policy extension would identify independently practicing physician extenders as qualifying providers.

Notably, even physician organizations are not opposed to including independently-practicing, mid-level providers in a rate increase extension. A physician representative stated his organization was not advocating for or against including physician extenders in the policy, but believed that if physician extenders were to qualify as independent providers, they should be subject to the 60 percent E&M billing criteria and paid no more than established Medicare levels (e.g., if Medicare pays a nurse practitioner 85 percent of a physician's rate, that same ratio should hold for the increase).

RECOMMENDATION: The federal government should consider allowing states the ability to determine which health professionals can qualify for the increase, irrespective of physician oversight.

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4. Identifying the Primary Care Services Covered

Much like the debate about which specialties should be included in this policy, stakeholders tend to either believe that: (a) the current code set eligible for the increase is too narrow and should be expanded to ensure access to a wider array of services; or (b) it is too broad and does not adequately focus on primary care.

On the one hand, a subset of individuals and organizations interviewed would like to see all Medicaid codes paid at parity with Medicare for across-the-board equity. Others had specific recommendations for primary care codes that were left out of the final rule. For example, a pediatric provider representative advocated for inclusion of the vaccine code 90461, which pays for multi-component vaccines and enables providers to vaccinate children with fewer shots. This is in contrast to the vaccine code 90460, included in the rule, which covers one vaccine at a time and may encourage providers to administer more injections than necessary. A health plan representative noted a state-specific omission: his state's EPSDT program, which offers health assessments and preventive services to Medicaid-eligible children, did not qualify for the increase because of coding issues. He argued this exclusion went against the spirit of the policy and asserted that any future iteration should include all states' complete EPSDT benefit packages.

On the other hand, some believed codes relating to hospital, ED, and nursing facility visits did not belong in this policy. In fact, the president's proposal to extend the increase excludes some currently eligible ED codes beginning in 2015. One state Medicaid official applauded this proposed policy change, noting ED codes are often reimbursed at close to Medicare rates, and paying enhanced rates for ED visits was not consistent with efforts to reduce unnecessary ED use. Others, however, argued that because primary care services are provided in EDs, the code should remain in place.

RECOMMENDATION: Provide states more flexibility in determining which codes can qualify for the increase.

5. Implementing the Rate Increase in Managed Care

As noted above, the rate increase was particularly challenging to implement in Medicaid managed care, as it was written through a FFS lens, with payment increases based on the use of specific primary care codes. Converting a FFS policy into a non-FFS system required states to undertake lengthy preparation and ramp-up periods, as well as drawn-out negotiations with the Centers for Medicare & Medicaid Services (CMS). As plans were not obligated to pay out the increase until they had the funds, many providers did not receive enhanced payments until the fall of 2013, almost a year late.

■ Rate Setting

One of the most labor-intensive and difficult aspects of implementing the rate increase in managed care was the rate-setting process. CMS offered states flexibility in determining a payment model, providing examples of three "reasonable and acceptable" options: (1) full-risk prospective capitation; (2) prospective capitation with risk-sharing and retrospective reconciliation (either via a risk corridor or "100 percent true-up" to reflect actual utilization experience); and (3) non-risk reconciled payments.²⁰ States tended to choose one of these three "pre-approved" options, as opposed to creating a new methodology from scratch. Plans and providers, however, noted shortcomings with each choice and often had conflicting views about which methodology to select. Some supported the first option to promote faster payment, while others backed the third option to ensure they received full funding.

Once a risk model was chosen, Medicaid agencies had to conduct plan-specific data requests and amend existing managed care contracts. States that chose the "100 percent true-up" option had to conduct intensive, claim-by-claim analyses to determine retroactive payment levels. States with sub-

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capitation—in which capitation payments flow all the way down to providers—also faced additional challenges, as the rate increase had to be incorporated into contracts between both the state and health plans, and between health plans and provider groups. One state that pays a prospective capitation rate, but is implementing the rate increase through a reconciliation process, noted its Medicaid Management Information System (MMIS) was unable to process the retroactive adjustment. As a result, Medicaid staff had to manually enter data for nine months. Another Medicaid official commented that the reconciliation process was so tedious that he would have preferred if plans were removed entirely from the process. He suggested states should create FFS-like rate codes for managed care, with the payment differential built in; providers would then be responsible for billing the codes directly.

RECOMMENDATION: Provide states the flexibility to incorporate the enhanced funding into existing managed care capitation payments—or establish new, simplified payment methodologies—to better align with state goals and minimize administrative burdens. State actuaries could then devise their own rate-setting methods that align with the state’s managed care environment, instead of looking to the federal government for guidance. CMS could offer one default, full-risk option for any state that does not wish to create its own methodology.

■ *Transparency*

The final rule does not require states to dictate how health plans reimburse their providers, and both policy experts and provider representatives questioned whether states should have more oversight over how health plans allocate provider payments. While states are required to collect and report on data related to the policy’s impact on physician participation in Medicaid, there is no requirement for states to audit or measure how payments flow between plans and providers and how the payments are ultimately spent. There is also no requirement for states to educate PCPs about how and why they are receiving enhanced payments, meaning some providers may not attribute their higher rates to the policy and fail to change their behavior in response.

RECOMMENDATION: Require states to determine the most efficient way for Medicaid agencies and health plans to address the need for communicating openly about the rate increase, so that all stakeholders are aware of its intent and can assess its impact.

Conclusion

With roughly 65 million Americans currently enrolled in Medicaid, including more than 7.2 million individuals newly signed up for the program since October 2013,²¹ there is an imperative to ensure access to quality primary care services. The Medicaid primary care rate increase aims to promote primary care access by attracting and retaining more PCPs in Medicaid through higher payment rates. While states and providers encountered a number of hurdles during the policy’s initial roll-out, many believe establishing parity between Medicaid and Medicare primary care rates remains an important objective that should not be abandoned after two years. If the rate increase is continued, policymakers should consider making a number of key changes to the policy. This will enable states and providers to implement and benefit from the rate increase more easily, and help the policy achieve its goals of improving Medicaid beneficiaries’ access to primary care.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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