

medicaid
and the uninsured

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**Increasing Medicaid Primary Care Fees for Certain Physicians in 2013 and 2014:
A Primer on the Health Reform Provision and Final Rule**

Executive Summary

Under the ACA, beginning in 2014, millions of uninsured Americans will gain Medicaid in states that implement the Medicaid expansion. To help ensure access to meet expected higher demands for care in Medicaid, the health reform law requires states to pay certain physicians Medicaid fees at least equal to Medicare's for many primary care services in 2013 and 2014. The idea behind the fee increase is to boost physician participation in Medicaid and to provide increased support for physicians who already participate and who might expand their Medicaid service. The fee increase is federally funded. On November 6, 2012, CMS published a Final Rule outlining how states are to implement the higher fees. This brief explains major elements of the statute and rule.

Key provisions

- **Qualified physicians and services.** Family physicians, internists, and pediatricians, as well as subspecialists, qualify for the higher Medicaid fees if they attest that they are Board-certified, or that at least 60% of the Medicaid codes they billed in the previous year were primary care codes identified in the ACA. The 146 ACA primary care services are visits and other care central to primary care practice. Services furnished by non-physicians under the supervision of a qualified physician also qualify for the higher fees.
- **Minimum Medicaid fees.** In 2013 and 2014, Medicaid fees for the ACA primary care services cannot be less than Medicare fees. The effective date of the provision is January 1, 2013. States can make the higher Medicaid payments as add-ons to their existing rates, or as lump-sum payments.
- **100% federal match.** The federal government will fund the full cost of the fee increase, up to the difference between Medicaid fees as of July 1, 2009 and Medicare fees in 2013 and 2014. The estimated federal costs are \$11.9 billion. States with current fees below their 2009 fees have to fund their regular share of that difference; the 100% federal match applies only to increases over July 1, 2009 rates. By the same token, states whose current fees exceed their 2009 fees will realize savings, estimated to total \$545 million.
- **Managed care.** The ACA requires that qualified physicians in MCOs also receive the full benefit of the fee increase, whether the MCO pays them on a fee-for-service, capitation, or other basis. States have considerable flexibility in implementing this requirement, but they must submit methodologies for identifying what MCO payments to qualified physicians would have been for ACA primary care services as of July 1, 2009, and for identifying the portion of their 2013 and 2014 capitation payments attributable to the fee increase, for which the 100% federal match is available.

- **Dual eligibles.** Most states limit how much of the Medicare 20% coinsurance they pay on behalf of dual eligibles to the amount that brings the total provider payment to the state's Medicaid fee. Thus, physicians serving dual eligibles often lose out on some or all of the 20% coinsurance. Because 2013 and 2014 Medicaid fees for primary care services must at least equal Medicare fees, all qualified physicians serving dual eligibles will receive the full Medicare amount.
- **State plan requirements.** States have to submit a state plan amendment (SPA) to reflect the higher Medicaid fees in 2013 and 2014 unless they already pay at least the Medicare fee for every ACA primary care service. If a state's SPA is not approved by January 1, 2013, the state can increase its fees and wait until the SPA is approved to submit claims for 100% federal matching, or it can pay 2012 fees and make supplemental payments once the SPA is approved.
- **Evaluation.** States are required to provide information to CMS on physician participation in Medicaid and utilization of the ACA primary care codes as of July 1, 2009 and during 2013.

Looking ahead

Bringing Medicaid primary care fees up to Medicare fee levels, and financing the fee increase with federal dollars, will likely have important impacts on qualified physicians, access to care, and the states. In 2013, average Medicaid fees for the ACA primary care services will rise by an estimated 73%. If the Medicaid fee increase succeeds in increasing physician participation in Medicaid, as intended, primary care access for beneficiaries should expand, helping states and the health care system prepare for significantly increased Medicaid enrollment due to the ACA. State data on changes in physician participation and primary care use relative to 2009 will be of keen interest as decision-makers evaluate the fee increase and consider policy beyond 2014.

Increasing Medicaid Primary Care Fees for Certain Physicians in 2013 and 2014: A Primer on the Health Reform Provision and Final Rule

Introduction

Under the Affordable Care Act (ACA), 7 million more Americans are projected to gain Medicaid coverage in 2014, as many states implement the Medicaid expansion called for in the health reform law. Increased enrollment due to the expansion is expected to reach 11 million by 2022.¹ Most of the “newly eligible” population will be previously uninsured low-income adults. Many of these adults have substantial unmet and pent-up needs, expected to increase the demand for care in Medicaid significantly. But limited physician participation in Medicaid is a perennial concern. In 2011, 70% of physicians accepted new Medicaid patients, compared to 83% and 82% who accepted new Medicare and privately insured patients, respectively. Among primary care physicians, 66% accepted new Medicaid patients, while 71% accepted new Medicare patients and 81% accepted new privately insured patients.² Research suggests that low payment rates are the main factor deterring physicians from participating in Medicaid.³ A [new study](#) commissioned by the Kaiser Commission on Medicaid and the Uninsured shows that, in 2012, Medicaid fees for primary care services averaged 59% of Medicare fees, down from 66% in 2008; in several states with large Medicaid enrollment, the ratio in 2012 was less than 50%.*

To help ensure that access in Medicaid expands to meet anticipated higher demand for care, the health reform law** requires states to pay certain physicians Medicaid fees in 2013 and 2014 that are at least equal to Medicare’s for a list of 146 primary care services. The idea behind the fee increase is to recruit new physicians to Medicaid, and to increase support for physicians who already participate and improve the prospect that they might expand their Medicaid patient base. As a result of the new requirement, average Medicaid fees paid to certain physicians for primary care services will increase an estimated 73% in 2013.⁴ A national Medicaid fee increase of this magnitude is unprecedented. Under the ACA, the cost of the fee increase is fully federally funded, up to the difference between states’ Medicaid fees in July 2009 and Medicare fees in 2013 and 2014.

The primary care fee increase takes effect on January 1, 2013, and all states must implement the policy change, regardless of their choices on other aspects of the health reform law. On November 6, 2012, CMS published a [Final Rule](#) (77 Fed. Reg. 66670, November 6, 2012) elaborating how these provisions are to be implemented. In particular, the rule defines in greater detail which physicians and services qualify for the enhanced Medicaid payment rates, the required minimum payment rates, and the amount for which 100% federal matching funds are available. It also outlines what states must do to implement the fee increase in the Medicaid managed care context.

* Zuckerman S and D Goin, “How Much will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees.” Kaiser Commission on Medicaid and the Uninsured (December 2012).

** The Medicaid fee increase for primary care is in section 1202 of the Health Care and Education Reconciliation Act of 2010 (HCERA), enacted on March 30, 2010. HCERA amended the Social Security Act, the Public Health Service Act and the Internal Revenue Code, as those were amended by the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. In this paper, “ACA” and “health reform law” are used interchangeably.

This brief reviews the new provision and explains the major elements of the Final Rule. It also discusses implications and policy issues associated with the increase in Medicaid primary care fees for physicians who qualify for the higher rates. National and state-by-state estimates of the magnitude of the increase in Medicaid fees for primary care are available in the [brief](#) mentioned earlier.

Key parameters of the Medicaid fee increase

I. Who qualifies for the higher Medicaid fees for primary care services?

Physicians. The health reform law states that physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine qualify for the higher Medicaid rates for the Evaluation and Management (E&M) services (e.g., office visits, hospital visit for a new patient) and other primary care services identified in the law (see next section). The statute provides no flexibility to extend the primary care fee increase to physicians outside the designated specialties. Therefore, for example, obstetrician/gynecologists do not qualify, even though they are major providers of primary care in Medicaid. The statute expressly requires that qualified physicians who provide care in Medicaid managed care organizations (MCO) also receive the full benefit of the higher fees, whether the health plan pays them on a fee-for-service (FFS), capitation, or other basis. Finally, the preamble to the November 6 rule clarifies that the higher Medicaid fees also apply in CHIP programs structured as Medicaid expansions.⁵

Notwithstanding the statute's more narrowly drawn definition of physicians who qualify for the fee increase, the regulation sets forth a broader definition that includes not only physicians in the three designated primary care specialties, but also physicians in a subspecialty recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties.⁶ The preamble suggests that only subspecialties within the three primary care specialties qualify for the higher fees, but the regulatory text does not delimit the recognized subspecialties.⁷ To receive Medicare fee amounts for Medicaid primary care services in 2013 and 2014, physicians must attest that they are Board-certified in one of the designated primary care specialties or a recognized subspecialty, or that at least 60% of the Medicaid codes they billed in the previous calendar year are among the primary care codes identified in the ACA. For new physicians, the 60% threshold applies to codes billed to Medicaid in the prior month. At the end of 2013 and 2014, states must audit a statistically valid sample of physicians who received the higher fees to check that they were qualified to receive them. CMS expects that states that rely on Medicaid managed care will work with health plans to establish a verification method.

Non-physicians. The rule defines the primary care services that qualify for the payment increase as those furnished by "or under the personal supervision of" (emphasis added) a qualified physician.⁸ Thus, services provided by advance practice clinicians (e.g., nurse practitioners (NP), certified nurse midwives, physician assistants (PA)) may qualify for the fee increase, but only if the practitioner operates under a (qualified) physician's supervision. The services do not have to be billed under the physician's Medicaid number, but the physician must oversee or have professional responsibility for them.⁹ Neither pharmacists nor independently practicing NPs or other non-physicians qualify for the fee increase.

II. Which services qualify for the Medicaid fee increase?

The ACA defines the services to which Medicare fees apply as E&M codes 99201 through 99449 in the Healthcare Common Procedure Coding System (HCPCS), and certain vaccine administration codes or their successors. The November 6 rule clarifies that the E&M code range specified in the law includes

the following primary care services that are important in Medicaid though not reimbursed by Medicare:¹⁰

- New Patient/Initial Comprehensive Preventive Medicine (99381-99387)
- Established Patient/Periodic Comprehensive Preventive Medicine (99391-99397)
- Counseling Risk Factor Reduction and Behavior Change Intervention (99401-99404, 99408-99409, 99411-99412, 99420, and 99429)
- E&M/Non Face-to-Face Physician Service (99441-99444)

E&M services provided under the “physicians’ services” benefit in Medicaid qualify for the enhanced payment rates. However, E&M services provided by qualified physicians in federally qualified health centers (FQHC), rural health centers (RHC), and other settings where payment is made to the facility rather than the physician do not qualify for the fee increase. (FQHCs and RHCS already receive enhanced rates under a prospective payment system.)

States that do not currently cover all the ACA primary care services are not required to begin covering them. Nor do states have to amend managed care contracts to require coverage of previously non-covered services. However, if states do choose to cover, or to require MCOs to cover, a currently non-covered ACA service, the federal government will finance the entire cost of the service in 2013 and 2014 when provided by a qualified physician.

III. What is the minimum Medicaid payment rate for the ACA primary care services?

The ACA establishes Medicare fee schedule amounts as the minimum Medicaid payment rates for ACA-designated primary care services in 2013 and 2014. Medicare fee schedule amounts are the product of three factors: 1) the relative value units (RVU) associated with a given service, which may vary based on the site in which the service is delivered; 2) the Medicare conversion factor for the year, which is a dollar amount; and 3) an index that reflects geographic variation in practice costs.

The minimum Medicaid payment rate for the ACA primary care services in 2013 and 2014 will be the Medicare fee schedule amounts in effect or, if greater, the amounts that would result using the 2009 Medicare conversion factor.^{***} For example:

VFC maximum vaccine administration fees are also updated

In addition to raising Medicaid physician fees for primary care services in 2013 and 2014, the health reform law also updated the regional maximum fees that providers may charge for the administration of pediatric vaccines to children eligible for the Vaccines for Children (VFC) program. This update in regional maximum fees is the first since the VFC program was established in 1994.

The updated maximum fees for vaccine administration interact with the Medicaid primary care fee increase. The CMS Final Rule provides the updated regional maximum fees by state (77 Fed. Reg. 66690), and it also incorporates in Medicaid regulations the statutory requirement that states provide for a program for the purchase and distribution of pediatric vaccines to registered providers for the immunization of vaccine-eligible children, including children enrolled in Medicaid (42 CFR 441 Subpart L).

^{***} The requirement to use the Medicare fee schedule amount based on the 2009 Medicare conversion factor, if greater, was designed to ensure that, if Medicare physician fees are sharply reduced in 2013 or 2014 by application of the Medicare Sustainable Growth Rate (SGR) factor, the Medicaid fee increase will not be adversely affected.

In 2012, the mean Medicaid physician fee for an Office Visit, New Patient, 30 Minutes (99203) was about \$65.¹¹ In 2013, the Medicare fee for this code is slated to be about \$110. Thus, a state now paying the mean Medicaid fee (or any fee less than the 2013 Medicare fee) for this service must increase its Medicaid fee for qualified physicians to \$110 on January 1, 2013.

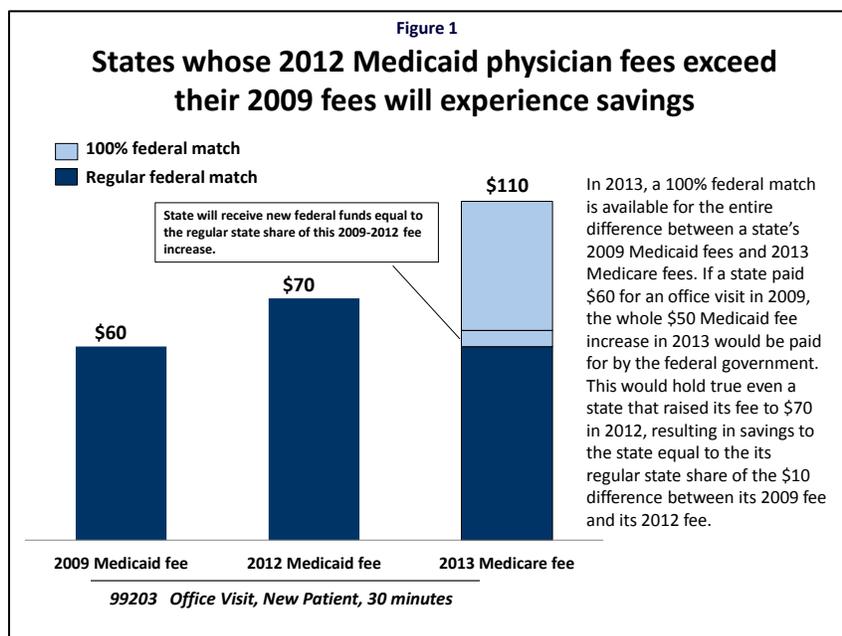
For purposes of establishing the minimum Medicaid payment rates in 2013 and 2014, the Medicare fees do not include the 10% increase for primary care in Medicare authorized under Section 5501 of the ACA.¹² For services unique to Medicaid (i.e., not reimbursed by Medicare), the minimum Medicaid payment rate will be equal to the product of the Medicare conversion factor in 2013 and 2014 (or 2009, if higher) and the 2013 and 2014 RVUs for the services.¹³

States have considerable flexibility on a number of implementation issues. They can provide the fee increases as add-ons to their existing rates, or as lump-sum payments if provided at least quarterly. Also, states can pay the site-specific Medicare fee amount for a service or, instead, always pay the Medicare office rate regardless of the actual site of service. States can adopt all the geographic adjustments made by Medicare, or pay rates that reflect the mean across all counties for each E&M code. States will also determine whether and how often to update their rates to reflect periodic adjustments and updates that may occur in the annual Medicare fee schedule during the year.

IV. How is the payment differential that qualifies for 100% federal matching defined?

E&M services. States can claim the 100% federal match for the amount equal to the difference between the Medicaid fee for a service under the state plan in effect on July 1, 2009, and the Medicare fee schedule amount for that service in 2013 and 2014 (or, if greater, the amount that would result if the 2009 Medicare conversion factor were used). The regulation specifies that the 2009 base rates exclude incentive, bonus, and performance-based payments (e.g., supplements that many states now pay physicians associated with academic medical centers so that their rates are comparable to commercial insurance rates). However, volume-based payments are included in the 2009 base rates.¹⁴ For codes added to the ACA-defined E&M range since 2009, and codes reimbursed by a state in 2013 or 2014 but not in 2009, the 2009 base rate is considered to be \$0. Thus, the federal government will provide states with 100% matching funds for the entire Medicare fee schedule amount when the service is provided by a qualified physician.

All states whose physician fees for primary care services are below Medicare fees in 2013 and 2014 must raise their fees to Medicare levels for qualified physicians. States whose current fees are below their July 1, 2009 fees will not get the 100% federal match for the entire 2013 and 2014 rate increase; rather, they will have to finance their regular share of the difference between their current fees and their July 2009 fees, and the 100% federal match will apply to the difference between the 2009 fees and Medicare fees in 2013 and 2014. At the same time, states whose current fees for primary care services exceed their 2009 fees will realize savings, because the 100% federal match applies to the entire difference between states' July 2009 fees and Medicare fees in 2013 and 2014 (Figure 1).



V. How will the Medicaid primary care increase be implemented in managed care arrangements?

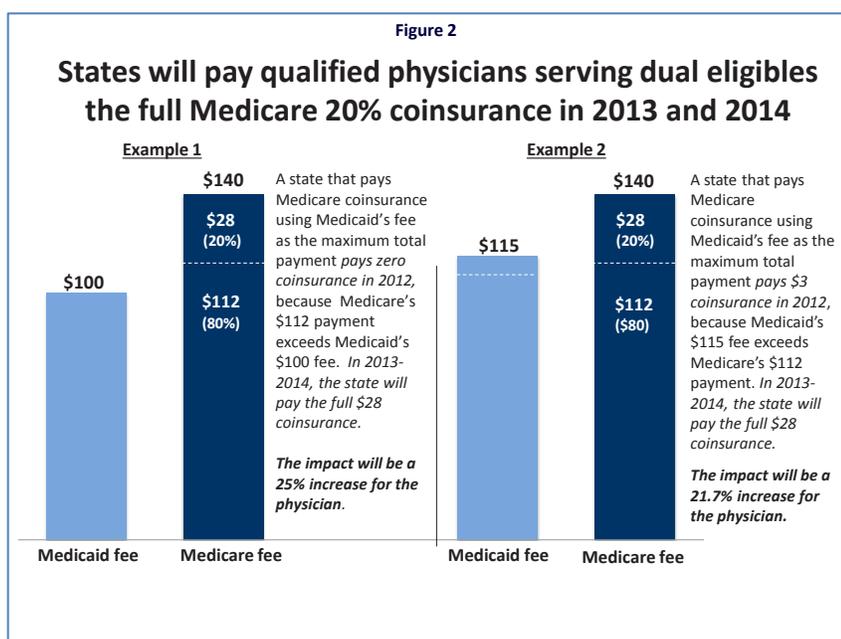
Balancing state accountability and flexibility. Citing diverse state methods of physician specialty identification, managed care arrangements, rate-setting procedures, and plan reporting practices, CMS did not prescribe a uniform approach that all states must use to implement the fee increase in the managed care environment. Instead, states are required to submit “reasonable methodologies” for: 1) identifying what MCOs’ payments to qualified physicians would have been for the ACA primary care services as of July 1, 2009; and 2) identifying the differential between those 2009 baseline provider payments and the amount needed to comply with the fee increase. The 100% federal match is available for the portion of a state’s capitation payments in 2013 and 2014 that is associated with the differential just described.

Both methodologies, which states are required to submit by March 31, 2013 for CMS review and approval, must be based on “rational and documented data and assumptions,” and can consider data availability, administrative burden, and costs, but should “produce a reliable and accurate result to the fullest extent possible.”¹⁵ CMS will provide a framework for states to use in developing the methodologies, and CMS will use the approved methodologies in the review and approval of MCO contracts and rates.¹⁶

MCO contracts. The law specifically requires that qualified physicians in MCOs receive the full benefit of the enhanced primary care rates. The regulation requires that state contracts with MCOs must require the plans to pay qualified physicians the enhanced rates, whether directly or through a capitated arrangement, and to provide sufficient documentation to enable the state and CMS to ensure that the physicians receive the enhanced rates.¹⁷ The preamble provides that states will determine what documentation they require in this regard.

VI. Why is the fee increase important for physicians serving dual eligibles?

An important impact of the primary care fee increase will be felt by qualified physicians who serve “dual eligibles” – Medicaid enrollees who are also enrolled in Medicare. When dual eligibles receive physicians’ services, Medicare is the primary payer, but Medicaid pays Medicare 20% coinsurance on behalf of the beneficiary. Most states – all but 11 – limit the coinsurance they will pay to the amount that brings the total payment to the physician to the state’s Medicaid fee for the service.¹⁸ As illustrated in the first example in Figure 2, if a dual eligible receives a physician’s service for which the Medicare fee is \$140 but the state’s fee is \$100, most states today would pay none of the coinsurance to the physician, because Medicare’s 80% payment – in this case, \$112 – exceeds the Medicaid fee. In the second example, where the Medicaid fee for the service is \$115, the state would typically pay only \$3 of the \$28 coinsurance. In both scenarios, the same physician serving a Medicare enrollee who is *not* a dual eligible would be able to charge the full \$28 coinsurance to the patient.



Because states must pay qualified physicians at least Medicare fees for most primary care services in 2013 and 2014, physicians serving dual eligibles will receive the full amount of these fees in all states, and the current financial disadvantage associated with caring for poor seniors and individuals with severe disabilities will be eliminated. As outlined earlier, the increased Medicaid payments for Medicare coinsurance are fully federally funded.

VII. What state plan actions are necessary?

States have to submit a state plan amendment (SPA) to reflect the higher Medicaid payment rates in 2013 and 2014 unless they already pay at least the Medicare rate for every eligible primary care code. The SPA must identify all the codes the state will reimburse at the Medicare rate, as well as all the codes the state did not reimburse as of July 1, 2009. It must also document the state’s choices about site-of-service and locality adjustments. States that decide to pay rates that, for each E&M code, reflect the mean Medicare rate across all counties, must provide their formula for determining the mean rates. CMS will be providing an SPA template to assist states. CMS will provide a template for the SPA.

If a state's SPA is not approved by January 1, 2013, the state can make the higher payments to qualified physicians and wait until the SPA is approved to submit claims for federal matching, or it can pay these physicians at 2012 rates and make supplemental payments once the SPA is approved. In the latter case, plans are required to pay the enhancement to qualified physicians "without any effort from the provider."¹⁹ Existing regulations governing the SPA process require states to notify physicians of the payment changes.

VIII. *What are the federal and state costs?*

The federal cost of the fee increase is estimated to be \$11.9 billion over 2013 and 2014.²⁰ States whose 2012 Medicaid fees are lower than they were on July 1, 2009 will have to finance their regular state share of that differential. States whose 2012 fees are higher than they were on July 1, 2009 can claim a 100% federal match for the difference and are projected to save \$545 million over the two years.

IX. *How will the impact be evaluated?*

The Final Rule requires states to provide information to CMS on physician participation in Medicaid and utilization of the ACA primary care codes, as of July 1, 2009 and during 2013.²¹ CMS must post the data online as soon as possible. This information will provide a foundation for assessing the impact of the fee increase and informing policy on Medicaid fees beyond 2014.

Looking ahead

In the states that elect to go forward, the ACA expansion of Medicaid will bring health coverage to millions of low-income Americans who now lack insurance. The Medicaid physician fee increase for primary care services for 2013 and 2014, along with full federal financing, will help to ensure that the coverage expansion translates into actual access to care. In 2013, average Medicaid physician fees for the ACA primary care services will rise by an estimated 73%. If Medicaid's more competitive fees serve to boost physician participation in Medicaid, as intended, access should begin to expand just as enrollment in Medicaid due to the expansion ramps up. One nuance of the fee increase that has received less attention is the benefit it will have for qualified physicians serving dual eligibles; better payment for these physicians aligns well with broader efforts to improve care for this high-need, high-cost population.

In thinking about how to improve access to care in Medicaid, it is important to bear in mind the influence of important factors beyond Medicaid's control. The supply and distribution of the health care workforce are major systems-level challenges. In the same states where physician shortages are already most acute, growth in Medicaid enrollment attributable to the ACA is projected to be great (if the states implement the Medicaid expansion).²² Because these states already pay relatively high Medicaid rates to garner access, the primary care fee increase probably has more limited potential to "move the needle" on participation and access; additional strategies will also be needed. Especially in underserved communities, NPs and PAs have expanded the supply of high-quality primary care. States that pay NPs, PAs, or others a reduced percentage of Medicaid physician fees now have an opportunity to pay these providers Medicare fee amounts, at no additional state cost in 2013 and 2014, as long as they are supervised by a qualified physician. However, the exclusion of independently practicing non-physicians from the fee increase is out of step with ACA investments that specifically increase support for these important providers of primary care.

Important market unknowns could also alter access in Medicaid. States' decisions about whether to take up the Medicaid expansion, the expansion of private coverage alongside Medicaid, and the response of providers, plans, and insurers to the emerging new Medicaid market, introduce new variables that may influence Medicaid's ability to compete for physicians. Delivery system reforms and new provider alignments such as ACOs could also affect physician participation behavior.

Moving forward, the future of the fee increase after 2014 will be a major issue. Longstanding Medicaid law requires that states "assure that payments 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 May 2011, CMS issued a proposed rule that, for the first time, provided guidance on what states must do to demonstrate compliance with this standard; a final rule has not yet been issued. Also, in October 2011, the Supreme Court took up the question of whether beneficiaries and providers have a right to sue states in federal court over Medicaid payment levels that harm access.²³ The Court did not decide the issue; it sent the case back to the Ninth Circuit Court of Appeals to consider in light of an intervening CMS decision to approve the state statutes being challenged.

If sufficient Medicaid payment rates were not temporary, but assured as the law requires, physician participation in Medicaid would almost certainly be more robust and stable. As the expanded role for Medicaid envisioned in the ACA approaches, the impact of the Medicaid fee increase will provide an important test of this strategy as a means to improve Medicaid's ability to secure access to care for its beneficiaries.

Endnotes

¹ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, Congressional Budget Office, July 2012 (Table 1).

² Decker S, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs* 31:8, August 2012.

³ Cunningham P and L Nichols, "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective," *Medical Care Research and Review* 62(6). 2005.

⁴ Zuckerman S and D Goin, "How Much will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Kaiser Commission on Medicaid and the Uninsured (December 2012).

⁵ 77 Fed. Reg. 66672

⁶ 42 CFR 447.400(a)

⁷ 77 Fed. Reg. 66675

⁸ Ibid.

⁹ 77 Fed. Reg. 66677

¹⁰ Ibid.

¹¹ Op cit., Zuckerman and Goin.

¹² 77 Fed. Reg. 66679

¹³ 42 CFR 447.405(a)

¹⁴ 42 CFR 447.415

¹⁵ 42 CFR 438.804

¹⁶ 42 CFR 438.804

¹⁷ 42 CFR 438.6 (c)(5)(vi)

¹⁸ "Medicaid Today; Preparing for Tomorrow -- A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013," Kaiser Commission on Medicaid and the Uninsured (October 2012).

¹⁹ 77 Fed. Reg. 66687

²⁰ The preamble clarifies that the cost estimate does not reflect any impact related to the Medicaid expansion under the ACA. Expected costs related to the rule would be greater in 2014 as enrollment increases due to the eligibility expansion, outreach efforts, and efforts to simplify enrollment. (77 Fed. Reg. 66696)

²¹ 42 CFR 447.400(d)

²² 2012 data on Primary Care Health Professional Shortage Areas (HPSAs). Available at:

<http://www.statehealthfacts.org/comparemapreport.jsp?rep=112&cat=8>

²³ "Explaining Douglas v. Independent Living Center: Questions about the Upcoming United States Supreme Court Case Regarding Medicaid Beneficiaries and Providers' Ability to Enforce the Medicaid Act," Kaiser Commission on Medicaid and the Uninsured (September 2011).

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