

imagination.” Might opening this possibility defeat the purpose of the vaccine court and again potentially jeopardize market stability and vaccine availability? The Supreme Court noted that in place of litigation, the NCVIA “provides many means of improving vaccine design.”<sup>5</sup> Among those listed were oversight by the FDA, voluntary reporting and monitoring of adverse events (both of

which are known to be imperfect means of detecting risk and ensuring safety), and the National Vaccine Program. Amendments to the NCVIA may be required to provide additional regulatory support, because these systems are now operating without one important safety net.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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4. Joint appendix, *Bruesewitz v. Wyeth*, No. 09-152 (May 24, 2010).
5. *Bruesewitz v. Wyeth*, 562 U.S. \_\_\_\_ (2011). Copyright © 2011 Massachusetts Medical Society.

## Catching a Wave — Implementing Health Care Reform in California

Andrew B. Bindman, M.D., and Andreas G. Schneider, J.D.

The Affordable Care Act (ACA) has launched a wave of federal funding and policy changes that will extend health insurance coverage to 32 million Americans beginning in 2014. Many states have been resisting this wave by asking the federal courts to strike down the ACA on constitutional grounds. Others are preparing to catch it. Among the latter states is California, where despite a 12.3% unemployment rate and major budget problems, implementation is under way.

The stakes for Californians and their physicians are enormous. The state is expected to have more newly insured people than any other state: approximately 3.4 million.<sup>1</sup> Whether that expanded coverage will improve access to needed care and lead to better population health will depend in large part on how effectively physicians are engaged in implementation.

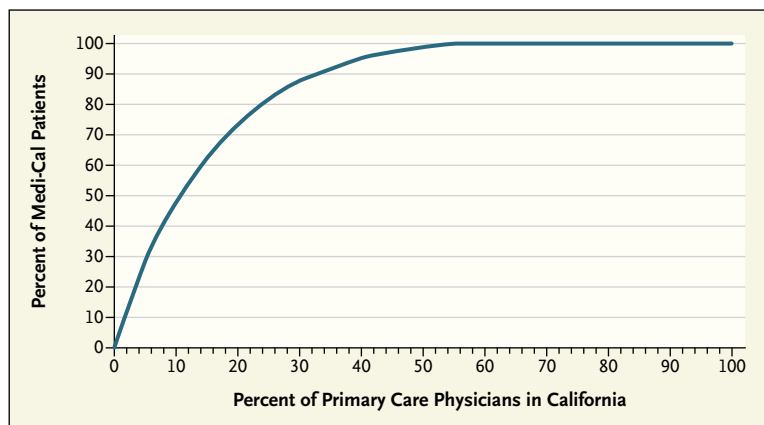
Some early signs are promising. California was one of the first states to enact enabling legislation for a new health in-

surance exchange from which people will be able to purchase coverage regardless of whether they have preexisting conditions. In addition, the secretary of health and human services has granted California a 5-year, \$8 billion Medicaid demonstration waiver to enable it to prepare for the coverage expansion in 2014; such waivers permit states greater administrative flexibility in using the anticipated federal share of Medicaid funds to meet their program’s goals. With the federal funding and this flexibility, California is pursuing three main implementation strategies.

First, the state plans to expand coverage to the uninsured before 2014 on a county-by-county basis. Several California counties, most notably San Francisco County through its Healthy San Francisco program,<sup>2</sup> have developed coverage initiatives that provide a defined health care benefit for low-income, childless adults — the group that’s not currently eligible for the tradi-

tional Medicaid program but will be in 2014. Under the waiver, more counties will launch such initiatives, in which covered benefits will be increased to approximate those available through Medi-Cal, California’s Medicaid program.

Second, California will use federal resources available under the waiver to invest in its public safety-net hospitals. Nineteen of California’s acute care public hospitals (6% of all the state’s acute care hospitals) currently account for approximately half of the state’s hospitalizations of uninsured people each year. Most of these facilities also operate robust ambulatory care services that provide more than 10 million primary care and specialty visits for uninsured people and Medi-Cal beneficiaries annually. California aims to increase these institutions’ capacity to care for their traditional patient populations, because even after health care reform is implemented, there are expected to be more than 3 million uninsured people in the state.



Distribution of Medi-Cal Visits across Primary Care Physicians, 2008.

Finally, California will expand its use of Medicaid managed care by mandating the enrollment of approximately 320,000 elderly and disabled people. The hope is that a managed-care delivery model meeting rigorous standards for network adequacy and public accountability will improve care coordination for these high-cost beneficiaries. If the transition of the elderly and disabled population into managed care is successful, it can pave the way for enrolling newly eligible Medi-Cal beneficiaries into managed care in 2014.

Meanwhile, other early signs in California are worrisome. The state faces daunting budget challenges that threaten not only the current performance of Medi-Cal, but also the ability to improve access to care for an additional 1.7 million beneficiaries in 2014. In January, newly elected Governor Jerry Brown proposed \$1.7 billion in cuts to Medi-Cal as part of a plan to close a \$22 billion shortfall in the state budget. Among the proposed cuts is a 10% decrease in payments to physicians and clinics. A similar proposal advanced by Governor Arnold Schwarzenegger in 2008

has been blocked by the federal courts; the U.S. Supreme Court recently agreed to review this litigation.

Even without these cuts, California ranks 47th among the states in its Medicaid physician-payment rate — and therefore has one of the country's lowest rates of physician participation in Medicaid.<sup>3</sup> On average, there is one primary care physician for every 1700 people in the state; for Medi-Cal, the ratio is one for every 2000 beneficiaries.<sup>4</sup> Expanding coverage through Medi-Cal will strain the program's capacity to translate coverage into access. Although the uninsured are already receiving some health care services, gaining coverage is expected to increase their demand for health care by approximately 70%.<sup>5</sup> If demand does increase that much and the availability of primary care physicians in the Medi-Cal program doesn't change, California will need to recruit the equivalent of 350 new physicians to provide primary care to Medicaid beneficiaries full time. This workforce addition would represent an increase of more than 10% from the estimated 3379 full-time-equiva-

lent Medi-Cal primary care physicians in the state.

Addressing this shortfall will be very difficult. There's not enough time between now and 2014 to train and deploy sufficient new primary care physicians. In addition, Medi-Cal patients are now highly concentrated among a relatively small percentage of providers: approximately 25% of primary care physicians provide more than 80% of the visits for Medi-Cal beneficiaries (see graph). Thus, much of this needed capacity will have to be developed from among physicians who now have little or no involvement with Medi-Cal patients.

It's not clear how eager physicians will be to collaborate with the state in implementing the ACA. Since the Medicaid demonstration waiver provides little in the way of new direct resources to help physicians prepare for reform, California's primary care physicians may be unwilling to increase their role in coordinating care for Medi-Cal patients. California physicians may also take a pass on caring for people who become insured through the exchange if the physician-payment rates from exchange plans are closer to current Medi-Cal rates than to those now offered by private plans.

The ACA includes a provision requiring state Medicaid programs to pay primary care physicians at least 100% of Medicare's rates for comparable services in 2013 and 2014; the incremental costs to states will be financed entirely by the federal government. In addition, this year California and other states will begin distributing federal funds for purchasing certified electronic health record technology to physicians

with substantial Medicaid case-loads. These incentives should increase primary care physicians' willingness to care for Medicaid patients. However, the uncertainty regarding payments to such physicians before 2013 and after 2014, compounded by physicians' frustration over Congress's inability to create a permanent fix for Medicare's sustainable growth rate formula for calculating payment levels, could undermine these policies.

There are other uncertainties as well. The House of Representatives has recently voted to repeal the ACA, opponents have promised to deny the Department of Health and Human Services the funds needed to implement it, and to date, two federal district courts have ruled the individual mandate unconstitutional (three have upheld it). If any of these efforts succeed, California's ability to improve access and population health could be compromised.

Many of the lessons from California have yet to be learned. But it's clear that states and physicians could benefit by recognizing that they need one another. States, through their administration of health insurance exchanges and expanded Medicaid programs, will control the allocation of a substantially larger segment of health care financing. Physicians, however, will largely determine whether coverage expansions translate into access to care and improved population health. Without an effective partnership between states and physicians, the wave of new resources could end up being spent on unnecessary hospitalizations and emergency department visits rather than more cost-efficient, patient-centered, effective care in the community. Missing this opportunity to collaborate on improving the population's health could result in a wipeout of epic proportions.

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## Medicaid and Access to the Courts

Sara Rosenbaum, J.D.

The Medicaid program is grounded in a statute that is one of the most complex of all federal laws. An insurer of more than 60 million people — and poised to begin serving 16 million more by 2019 — Medicaid will be reexamined this year, in all its legal complexities, by the U.S. Supreme Court, which has agreed to hear California's appeal in the case *Maxwell-Jolly v. Independent Living Center of Southern California*. The Court's ruling could fundamentally alter states' accountability to beneficiaries and providers when their official con-

duct allegedly violates Medicaid's essential federal requirements.

The *Maxwell-Jolly* case was precipitated by a series of deep cuts to provider payments that were enacted by the California legislature and aimed at services used predominantly by the state's most severely disabled beneficiaries. The payment reductions were halted by the U.S. Court of Appeals for the Ninth Circuit, but this action by no means ended the dispute. Indeed, the question before the Supreme Court is of far greater consequence than that of specific provider payments: it

is whether beneficiaries and providers have the right to seek judicial redress when they allege that state conduct abridges federal law and threatens health and safety.

The statute regulating Medicaid, unlike that underlying Medicare, does not expressly address the question of whether private persons deserve access to the courts in order to prevent harm arising from potentially unlawful state conduct. Virtually since Medicaid's inception,<sup>1</sup> states have disputed the ability of beneficiaries and providers to hold Medi-