Editor's Note

The United States has struggled with how to adequately provide health care for its poor and middle class for a long time. The Affordable Care Act (ACA) seeks to lessen that struggle but clearly does not resolve it. When Medicare and Medicaid were passed in 1965, many clearly also believed that the struggle would be relieved or eventually resolved. And, the passage of Medicare has gone a long way toward alleviating the problems of illness-induced poverty among the elderly. Many believed that along with helping this single group, Medicare was also part of a longer-term incremental goal to eventually pass national health insurance. In other words, Medicare for the elderly was viewed by its proponents as a stepping-stone to universal coverage.

Fifty years later it is clear that Medicare has not played that role. Surprisingly, the residual stepchild to Medicare (as it was viewed at the time)—Medicaid, our means-tested target program for America's poor, elderly, and disabled—has been much more expansionary over the years. Ironically, the ACA's Medicaid expansion serves to further broaden the program and to solidify Medicaid's institutionalized role within America's health care system. Yet, while it solidifies Medicaid's role, it does not resolve the struggle over how best to cover America's poor and middle class. This is clearly evident in the fact that only slightly more than half the states have adopted the Medicaid expansion. Medicaid is often labeled derisively as a public welfare program that offers poor quality of care. While these claims are launched against the program, states will at the same time accept funding from the federal government to invest in electronic

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medical records and leverage federal funds (rather than spend state-only money) to expand services for persons with substance abuse problems while claiming the program inadequate for others. Indeed, many states have a love-hate relationship with Medicaid. Although state politicians are quick to criticize the program, every state relies heavily on Medicaid to provide services for many different vulnerable groups, as well as low-income working families who are not sick but are one step away from impoverishment if they do fall ill. Thus, not only are Medicaid policies a bowlful of contradictions, so is political rhetoric about the program. These contradictions and struggles are on full display in the articles to follow.

Though many scholars have explained and analyzed Medicaid's expansion, few have looked at how the program has expanded for persons with mental health and substance abuse needs. Scott Allard and Steven Smith's article, "Unforeseen Consequences: Medicaid and the Funding of Nonprofit Service Organizations," serves to fill that gap. Using survey data of more than a thousand nonprofit social service agencies in seven urban and rural communities, Allard and Smith are able to document that about a quarter of these organizations receive Medicaid reimbursement. Larger secular nonprofit organizations located in more affluent and predominantly white communities are more likely to receive Medicaid funding compared to smaller nonprofit organizations and faith-based organizations located in areas with concentrations of black or Hispanic residents. Analyzing these findings further, they demonstrate mismatches between service need and location of service delivery, which raises important questions about Medicaid's reliance on an increasingly decentralized social service safety net, and discuss what this means for all the new efforts to implement coordinated care across the service continuum in many states.

Nonetheless, because Medicaid coverage is so important—in many expansion states Medicaid coverage will extend to more than 25 percent of the state's population by 2019—states are heavily focused on encouraging delivery model reforms with an attempt to improve the quality of and access to care for Medicaid enrollees. Joanna Bisgaier, Karin Rhodes, and Daniel Polsky's study, "Factors Associated with Increased Specialty Care Access in an Urban Area: The Roles of Local Workforce Capacity and Practice Location," provides another strong rationale for such reforms. Based on an audit study of 273 practices across seven medical specialties serving children in Cook County, Illinois, they find that as local workforce capacity for particular specialty groups increases, discriminatory denials of public insurance decrease. Their findings also support the long-standing

conclusion in the literature that payment rates are the strongest driver in decisions to service publicly insured patients.

Partly to address some of the access problems identified by Bisgaier, Rhodes, and Polsky and the quality problems that arise from the lack of access, many states are experimenting with accountable care organizations (ACOs) for Medicaid recipients. Joel Cantor, Sujoy Chakravarty, Jian Tong, Michael Yedidia, Oliver Lontok, and Derek DeLia look at New Jersey's ACO demonstration project in 2011. In "The New Jersey Medicaid ACO Demonstration Project: Seeking Opportunities for Better Care and Lower Costs among Complex Low-Income Patients," they find that across the study population, there is substantial variation in the share of hospital patients who are high users, and there are high rates of avoidable utilization among these patients. Based on these findings, they conclude that potential savings could be considerable, but they appropriately emphasize that this is contingent on Medicaid ACOs successfully managing the high burden of chronic illness and behavioral health conditions that are prevalent in the Medicaid "high user" population.

Finally, in "State Variation in Health Care Spending and the Politics of State Medicaid Policy," Gideon Lukens looks more broadly across all fifty states and thinks anew about why eligibility and payment policies vary so drastically from state to state. Controlling for the importance of ideology and other political variables, he finds that rising state-level health care costs negatively impact state generosity levels.

In this issue we have two special sections. The first section, Report on Health Reform Implementation, includes two essays. In "First Impressions: Geographic Variation in Media Messages during the First Phase of ACA Implementation," Sarah Gollust, Colleen Barry, Jeff Niederdeppe, Laura Baum, and Erika Fowler examine geographic variation in the volume and content of mass media coverage of the ACA during the first two weeks of open enrollment, starting in October 2013. They look across 210 media markets and find substantial variation in the volume and tone of coverage. This article is an important first step in the documentation of such large variations—especially in news coverage—however, an equally important next step is to understand how the exposure to media messages affects the public's perception of the ACA and their own health care options.

The next essay in this section, "To Extend or Not to Extend the Primary Care 'Fee Bump' in Medicaid?" by Adam Wilk and David Jones, examines how states have responded to the ACA requirement to expand the Medicaid payment levels to 100 percent of Medicare for primary care services. Wilk and Jones make clear that this seemingly simple policy requirement

is exceedingly complex for many reasons. First, the financial implication of this federal requirement varies drastically across the states, depending on the state's current fee levels. Although the federal government will pay the difference for the first two years, states are supposed to assume the fee increase burden after this period. Second, the vast majority of states have implemented managed care in their Medicaid programs, making the implementation of this policy completely unclear since it is managed care organizations that actually set the primary care fees in these states. There are many more complicating factors that Wilk and Jones detail as well. An extremely important conclusion to draw is that though delivery model reforms may improve quality for Medicaid recipients, fee increases to expand access for Medicaid enrollees are increasingly complex for states to implement. Thus, states and the federal government may have to consider alternative policy approaches that are consistent with new delivery model reforms to expand access to primary care.

The second special section is *JHPPL*'s Report from the States, where you will find "Arkansas's Novel Approach to Expanding Health Care Coverage," an essay by Joseph Thompson, Craig Wilson, Andrew Allison, and Mike Beebe, the current governor of Arkansas. As a complement to the topic of this themed issue, they detail why Arkansas decided to pursue the so-called private option and describe the details of Arkansas's program design, the plans for evaluation, and anticipated political conflicts going forward. Their article makes clear how important the discourse of private innovation was for the state to even enter into a conversation about drawing down federal Medicaid funding. This, again, highlights the continued struggle in the United States with how to adequately provide health care for its poor and middle class. In Arkansas, more than 30 percent of the population will fall below the Medicaid coverage level of 138 percent of the federal poverty level in 2019. This figure helps to underline why the positioning of what kind of program this is—public or private—for a third of that state's population is so important.

—Colleen M. Grogan