ventive services. New enrollees will also be offered the opportunity to complete advance directives for end-of-life care when they enroll in Medicaid — part of a broader state initiative to encourage residents to express their preferences regarding end-of-life care.

Fifth, Michigan's new Medicaid law enhances the state's capacity to monitor the costs and quality of health care. The Department of Community Health, which oversees the Medicaid program, will assess opportunities for improving the Medicaid program and make Medicaid data available to outside vendors that can help participating health plans to pursue innovations in the program. The Department of Insurance and Financial Services will evaluate the effect of the Medicaid expansion on private insurance premiums in the state; some reduction in these premiums is anticipated.[3,5] A new Health Care Cost and Quality Advisory Committee will be created to promote greater transparency with respect to the costs and quality of care.

By linking Michigan's Medicaid expansion to market-oriented changes in this federal–state program, the governor and legislature have created a pragmatic pathway to link Republican and Democratic priorities for health care. The key Democratic goal of expanding Medicaid coverage to low-income adults will be implemented in tandem with Republican objectives to control the state's health care costs, increase the role of private health plans, and require some new Medicaid enrollees to contribute toward the costs of their care. In recent years the U.S. Congress has rarely been able to achieve bipartisan agreement on health care or other major issues. Thus, the best prospects for achieving greater efficiency and equity in health care may arise from states such as Michigan that can blend public and private approaches to health care reform, with bipartisan support.

By linking Michigan's Medicaid expansion to market-oriented changes in this federal–state program, the governor and legislature have created a pragmatic pathway to link Republican and Democratic priorities for health care.

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Professionalism and Caring for Medicaid Patients — The 5% Commitment?

Lawrence P. Casalino, M.D., Ph.D.

Medicaid is an important federal–state partnership that provides health insurance for more than one fifth of the U.S. population — 73 million low-income people in 2012. The Affordable Care Act will expand Medicaid coverage to millions more. But 30% of office-based

physicians do not accept new Medicaid patients, and in some specialties, the rate of nonacceptance is much higher — for example, 40% in orthopedics, 44% in general internal medicine, 45% in dermatology, and 56% in psychiatry.[1] Physicians practicing in higher-income areas are less likely to accept new Medicaid patients.[2]

For most office-based physicians, a 5% commitment would mean seeing, on average, one Medicaid patient per day at most. For most surgeons, it would mean, on average, operating on one Medicaid patient every 1 to 2 weeks.

Physicians who do accept new Medicaid patients may use various techniques to severely limit their number — for example, one study of 289 pediatric specialty clinics showed that in the 34% of these clinics that accepted new Medicaid patients, the average waiting time for an appointment was 22 days longer for children on Medicaid than for privately insured children.[3]

Physicians have good reasons for not accepting Medicaid patients, as I learned from direct experience as a member of a nine-physician primary care practice in California. We accepted Medicaid patients, but it was difficult. Medicaid's payment rate was very low — we lost money on each Medicaid visit. When referrals were necessary, we often had to personally ask specialists to accept our patient. Administratively, it was not simple to obtain payment from Medicaid for our services, in part because some patients frequently moved between eligibility and ineligibility for the program. In addition, it was time-consuming for our physicians and staff to deal with the Medicaid pharmaceutical formulary and to obtain prior authorization for Medicaid patients to see specialists and obtain imaging studies.

There are additional reasons — beyond low payment rates, administrative complexity, and problems obtaining specialist care — why physicians may be reluctant to see Medicaid patients. Medicaid patients often have complicated behavioral health, transportation, and social service needs that require physician and staff time.[4] Some physicians believe that Medicaid patients are more likely to initiate malpractice suits, although data suggest that this belief may be incorrect.[5]

Nevertheless, there is a fundamental reason why physicians should strongly consider providing care for at least a reasonable number of Medicaid patients. It is a core professional principle that physicians should put the patient's interest first; refusing to care for vulnerable, socioeconomically disadvantaged Medicaid patients seems incompatible with this principle. Many medical schools ask their students to accept the World Health Organization's Declaration of Geneva (a modified version of the Hippocratic Oath), which states in part that "I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient."

Willingness to care for Medicaid patients would be a service to a physician's colleagues as well as to patients. Emergency departments and physicians who care for Medicaid patients would not have to spend time trying to obtain specialist care for patients who need it. Patients would not have to endure long and potentially dangerous waits for care. And if all physicians cared for Medicaid patients, all would have a reason to care about the Medicaid program, so that more pressure could be brought to bear on the program to provide reasonable payment rates and reduce administrative burdens.

Physicians who are reluctant to provide care for Medicaid patients can argue, with justice, that policymakers are trying to make medicine as market-driven as possible, that physicians are increasingly expected to respond to market incentives and market constraints, and that no business in other sectors of the economy is asked to provide a service that loses money year after year. Many physicians, however, earn very high incomes, and some of the highest-paid specialties are the least willing to care for Medicaid patients.[1] Would it be reasonable to ask all physicians to commit to providing care for enough Medicaid enrollees so that at least 5% of each physician's practice consisted of Medicaid patients (assuming sufficient demand)? For most office-based physicians, such a commitment would mean seeing, on average, one Medicaid patient per day at most. For most surgeons, it would mean, on average,

operating on one Medicaid patient every 1 to 2 weeks.

The model for a 5% commitment proposal could come from the Choosing Wisely campaign, an initiative of the American Board of Internal Medicine (ABIM) Foundation. To date, 54 specialty societies participating in this campaign have released lists of more than 150 potentially unnecessary tests and treatments that physicians may want to avoid except in unusual clinical circumstances. Perhaps the ABIM Foundation and other specialty societies could consider making the case for caring for Medicaid patients and asking their members to voluntarily commit to accepting a minimum of 5% (or even 3%?) of Medicaid patients into their practices.

We live in an era in which, for better or for worse, market-based solutions are dominant and policymakers tend to view physicians as self-interested actors. Little or no attention is paid to physician professionalism or to the possible effects of policies on professionalism. Policies that are based on this view may be justifiable if many physicians are indeed seeking to maximize their incomes and refusing to accept even a slight reduction in income as the price for helping to provide care to the most vulnerable patients in our society. A 5%-commitment campaign would be a meaningful, highly visible demonstration of physician professionalism — of putting patients first.

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The Word That Shall Not Be Spoken

Thomas H. Lee, M.D.

During the years when I worked in an academic integrated delivery system, my colleagues and I would frequently discuss patients' experiences and ways to improve our management of their pain and reduce their confusion as they navigated our complex organization. We knew that anxiety is inevitable for patients facing health issues, but we also knew that there is anxiety, and there is *unnecessary* anxiety — caused, for example, by the uncertainty that weighs on patients and their families while they await a consultation for a potentially serious diagnosis, or the confusion induced when clinicians give conflicting information. We worked hard to reduce these problems. From a business perspective, it was a smart strategy; from a clinician's perspective, it was obviously the right thing to do.

So it was a pleasant surprise when I studied the business strategy of a company that assesses patients' experiences and found that it was based on "helping health care providers reduce suffering." This strategic framework divided suffering into three types: suffering from disease (e.g., pain), suffering from treatment (e.g., complications), and suffering induced by dysfunction of the delivery system (e.g., chaos, confusion, delays). The company was recruiting me for a senior management role, and my first reaction was that they were interested in the same things as my colleagues and I were.

My second reaction was that the word "suffering" would take some getting used to. I couldn't remember the last time that my colleagues and I had used that word. "Suffering" made me uncomfortable. I wondered whether it was a tad sensational, a bit too emotional. But on reflection, how could I object to its use? After all, from the perspective of patients, that is what's going on.

I soon learned that my colleagues and I were not the only ones who avoided the word. As a matter of policy, it doesn't often appear in our academic journals or textbooks, at least in reference to particular patients. The widely used *AMA Manual of Style* says, "Avoid describing persons as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from,