State Medicaid Eligibility and Care Delayed Because of Cost

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can Physicians and Surgeons showing that 93.7% of respondents voted to abolish MOC requirements. In its place, Mandel proposes a limited trial to test the value of MOC secure examinations, an exercise that would leave in limbo some 450,000 physicians who are actively involved in MOC through 24 specialty boards. Our article quotes Wachter, who makes a valid argument that, in the face of multiple competing efforts to judge physician performance, such a vacuum would be risky because if MOC went away, “it would be quickly replaced by more regulatory external bodies that ultimately would be more burdensome to physicians” and would not be led by them. To some extent, three varying views of MOC published in the *Journal* reinforce Wachter’s opinion. One editorial said: “The experts for and against MOC agree that the concept of recertification is sound — what they disagree about is the process.”¹

As Norris and Nora emphasize, the ABMS is mindful of the criticisms of the current MOC and is committed, along with its specialty boards,

to ongoing improvement of MOC as outlined in a 2012–2015 strategic plan approved by the board of the ABMS.² The plan calls for more extensive researching of the impact of MOC on the quality of care, increasing the value of MOC to participating physicians, and integrating MOC more effectively into the practice environment. To this end, the boards plan to solicit direct feedback from physicians on MOC and implement a program that would engage physicians in local improvement projects to satisfy MOC practice-assessment requirements.

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Since publication of their article, the authors report no further potential conflict of interest.

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2. ABMS 2012-2015 strategic plan as approved by the ABMS board of directors. Chicago: American Board of Medical Specialties, September 20, 2011.

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State Medicaid Eligibility and Care Delayed Because of Cost

TO THE EDITOR: Provisions of the Patient Protection and Affordable Care Act (ACA) are expected to reduce the number of adults who delay seeking needed medical care because of cost.¹ Reforms are expected to improve the ability to obtain care, in part, by extending Medicaid access to adults with incomes at or below 133% of the federal poverty line.² A recent Supreme Court ruling gave greater latitude to state approaches to Medicaid expansion.³ Various state strategies for implementing reforms may amplify geographic variation in the prevalence of delayed care. Estimating the existing variation in and correlates of delayed care may assist states that are planning to improve access within and beyond the framework provided by the ACA.

We examined county-level geographic variation in the prevalence of care delayed because of cost among 289,333 adults who were 18 to 64 years of age in the 2010 Behavioral Risk Factor Surveillance System (BRFSS) survey, a state-based telephone survey of health care access and health status. We calculated smoothed county-level prev-

alence estimates of delayed care using generalized linear mixed models.⁴ We examined the relationship between Medicaid eligibility thresholds for working adults with children and the odds that the BRFSS survey participants would delay seeking care. Statistical models were adjusted for the participants’ sociodemographic and clinical characteristics and for the characteristics of the state and local health care infrastructure.⁵

As shown in Figure 1, the county-level prevalence of delayed care ranged from 6.5% in Norfolk, Massachusetts, to 40.6% in Hidalgo, Texas. More restrictive Medicaid eligibility criteria were associated with a higher prevalence of delayed care than that observed when eligibility criteria were set at or above 133% of the federal poverty line. For example, the increased odds of delayed care was 16% as high among persons with incomes between 67 and 127% of the federal poverty line and 42% as high among persons with incomes between 17 and 44% of the federal poverty line. In addition, a higher concentration

Figure 1. County-Level Smoothed Prevalence of Delayed Care Due to Cost among Adults between the Ages of 18 and 64 Years.

Data are from the 2010 Behavioral Risk Factor Surveillance System survey.

of primary care doctors was associated with a lower prevalence of delayed care (see Table 1 in the Supplementary Appendix, available with the full text of this letter at NEJM.org). We reviewed data on the prevalence of delayed care in six counties in areas with different strategies for management of the health care infrastructure. Table 2 in the Supplementary Appendix shows that populations in counties with the highest prevalence of delayed care were more likely to be Hispanic and have low incomes and a high prevalence of chronic disease, and these areas had a relatively late history of state Medicaid expansion.

Our results suggest stark geographic differences in the prevalence of care delayed because of cost. Particularly vulnerable areas were in the South, including Texas and Florida. States and counties with a high prevalence of delayed care had a weaker health care infrastructure than states with a lower prevalence of delayed care.

Since states determine strategies for implementing the ACA, areas with a high prevalence of delayed care should monitor their progress with the use of the BRFSS survey and other data sources. These states may require additional investments to “catch up” to places with a stronger infrastructure.

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2. Connors EE, Gostin LO. Health care reform — a historic moment in US social policy. *JAMA* 2010;303:2521-2.
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CORRECTION

Endovascular Therapy after Intravenous t-PA versus t-PA Alone for Stroke (March 7, 2013;368:893-903). At the top of Figure 2 (page 899), "Relative Risk (95% CI)" should have been "Relative Risk (99% CI)." The article is correct at NEJM.org.

NOTICES

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The workshop will be held in Batavia, NY, May 1–4. It is sponsored by the University of Rochester Department of Family Medicine and Center for Experiential Learning.

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Contact the Society of Laparoendoscopic Surgeons, 7330 SW 62nd Place, Suite 410, Miami, FL 33143; or call (305) 665-9959; or fax (305) 667-4123; or see <http://www.sls.org>.

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Contact the Mayo School of Continuous Professional Development, 200 First St. SW, Rochester, MN 55905; or call (800) 323-2688 or (507) 284-2509; or fax (507) 284-0532; or see <http://www.mayo.edu/cme>; or e-mail cme@mayo.edu.

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Contact Dana Johnston, IDWeek, 1300 Wilson Blvd., Suite 300, Arlington, VA 22209; or call (703) 740-4961; or e-mail info@idweek.org; or see <http://www.idweek.org>.

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