Medicaid: Can it Survive?

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Introduction

The health care gauntlet has dropped, the jury is sequestered, and the populous patiently waits. No matter what the decision, someone won't be happy. How did we get to this point?

In 1928 my dad, Charles Davenport, was born in a one-room cabin located on the northern plains of Montana. There was no doctor, nurse, medications, or sterile environment. Three months later, his 38-year-old father died from influenza and in 1942 his 16-year-old brother succumbed to strep throat. Both died without any provider on site or modern medical intervention. Back then, medical care consisted of mustard plaster wraps for colds, Vinegar and honey drinks for a sore throat, and mist tents made from blankets, furniture, and a pan of hot water for bronchitis. Dad talks of a time when neighbors helped each other and medical charity came from the county hospital that was ran by local government not federal. Preventive medicine simply wasn't done.

In 1966, at 38, my Dad enrolled in his first insurance plan. Although his employer offered the program, he was expected to pay the whole premium. Prior to that he paid cash for any medical care his family received. This included the birth of three children, a hysterectomy, and a hospital admission for a child who overdosed on aspirin. The costs were high but he managed to pay the bills and still provide for his family.

As medicine evolved so did cost and demand. In 1965 the federal government created the Medicaid program as a way of helping the indigent population ("Medicaid: a program overview," 2009). Unlike Medicare which is run by the federal government and targets the elderly, Medicaid was state based and focused on low income families with children and individuals with disabilities (De Lew, 2006). "Prior to the passage of this law [Medicaid], health care services for the indigent were provided primarily through a patchwork of programs

sponsored by state and local governments, charities, and community hospitals" ("Medicaid: a program overview," 2009, p. 1).

At the time, Medicaid was a good idea and perhaps a precursor to the present health care reform concepts. The intent of this article is to look at the history of Medicaid, its present state, and how it fits into the future of health care.

Discussion

Medicaid: The Beginning

In 1965, the Medicaid and Medicare programs were created. Medicare was to be financed and ran by the federal government. Medicaid, however, would be state ran and funded by a combination of state and federal funds. As a minimum, state Medicaid insurance programs had to cover all pregnant women and children below age 6 with a household income below 133 percent of the federal poverty level, all other children with household incomes below 100 percent of the poverty level, Social Security Income (SSI) recipients, children in foster care, and low income Medicare beneficiaries ("Medicaid: a program overview," 2009). Each state had to provide Medicaid participants with non-emergency transportation and most screenings, test, and treatments that are approved by the Federal Drug Administration (FDA). Although prescription coverage was not required, most plans covered this cost too (Jones, 2006).

Optional candidates for Medicaid include pregnant women and infants with a family income up to 185 percent of the federal poverty level, individuals with medical costs that reduce their income below a state established guideline, individuals who receive state subsidized income, individuals in long term care with income below 300 percent of an SSI payment, and the working disabled who make to much to qualify for Medicaid.

To pay for this program, the federal government allots matching funds up to $0.83 for every $1 the state spends based on the state's poverty and per capita income. To determine the level of these funds, each state submits their plan to the Centers for Medicare and Medicaid Services (CMS) addressing "… the number of individuals who will receive care, the services that will be provided, the cost of providing those services, and statistical documentation for the delivery of healthcare services" (Jones, 2006, p. 52). Today, the cost of Medicaid is higher than Medicare and "Medicaid is the single largest payer for mental health services in the United States" ("Mental Health Services," 2009, p. 1).

Medicaid: Today and Tomorrow

In 2007, total Medicaid costs were $333.2 billion. This cost was shared between the federal and state governments with the federal government paying $190.6 billion (57%) and the states covering the remaining $142.6 billion (Truffer, Klemm, Hoffman, & Wolfe, 2008). "Federal spending for Medicaid accounted for 7.0 percent of the entire Federal budget in 2007 and is projected to account for 8.4 percent by 2013" (Truffer, et al., 2008, p. iii). Truffer, et al. (2008), predicts Medicaid programs will cost $673.7 billion by 2017. This report was done before the current recession arrived and may not be a true reflection of what the future holds.

According to Trapp (2009), "Medicaid enrollment grew by 5.4% in fiscal 2009 -- the highest rate in six years -- while total program spending increased by 7.9%, the fastest pace in five years" (p. 1). In addition, Trapp (2009) points out that "tax collections dropped by 16.6% in the 12 months leading up to June 2009, according to U.S. Census Bureau statistics. This contributed to a 6.3% decline in the state portion of Medicaid spending" (p. 1). This amount would have been much higher if not for the recent $28.1 billion federal stimulus package, which runs out in December 31, 2010 (*The effects of state fiscal relief*, 2009). Without additional

funding or an economic turnaround, Medicaid programs risk a financial crisis by January 1, 2011.

Many states are looking at a reduction in services and cost sharing as a means of decreasing expenses. For some the process has already begun. In fact, Senior Journal.com provided the following summation of current trends:

> 19 states have lowered payments to hospitals and nursing homes, eliminated coverage for some treatments and excluded some beneficiaries from the program completely. Eighteen of these states, as well as six others, are considering additional reductions for fiscal year 2010 in preparation for the possibility that additional money will not be available. Many states are suspending coverage for services not required by the federal government, such as physical therapy, eyeglasses, hearing aids and hospice care, and a few states are requiring that beneficiaries pay a larger portion of the cost of their care. ("Medicaid news," 2009, p. 1)

In California, for example, Governor Schwarzenegger has written congress asking why his state is reimbursed at 50% of Medicaid costs while Mississippi receives 75%, New Mexico 71%, and Arizona 65% (Thompson, 2010). Schwarzenegger plans to cut $750 million in California's 2010-11 Medicaid program and is threatening to cancel the state run children health insurance program unless the federal government provides a 7% increase in its matching funds (KHN, 2010).

Oregon is considering a significant reduction in provider reimbursement. This will most likely result in a decrease of providers who accept Medicaid and an increase in Medicaid patients using the ER for non-emergent and primary care concerns. Unlike the primary care provider, the ER cannot turn a patient away based on their insurance. Emergency Medical Labor and

Treatment Act of 1986 (EMTALA) requires emergency departments to perform a screening exam and stabilize any patient that presents to the ER regardless of their ability to pay (Hsia, MacIsaac, & Baker, 2008). Once in a room, the patient expects complete care and often the screening exam leads to diagnosis and treatment. If the situation is more serious, the work up must be done to include blood work, radiographs, and other diagnostic procedures.

In Nebraska, Senator Ben Nelson has managed to protect his state from upcoming Medicaid changes. The federal government has agreed to pay the whole cost of any Nebraska Medicaid beneficiaries who join the program after the health care reform bill passes. According to the Christian Science Monitor, "South Carolina Attorney General Henry McMaster is threatening to file a constitutional challenge to Congress's healthcare reform effort unless a special provision favoring Nebraska at the expense of all other states is stripped from the law" (Richey, 2010).

State Governors are very concerned about how the presently debated health care reform bill might change Medicaid. One proposal being discussed is to increase Medicaid eligibility from 100% of the poverty level to 150% (Hitt & Adamy, 2009). That comes to $16,245 a year for a family of one, $21,855 for a family of two, and $33,075 for a family of four. Funding this increase has not been dealt with.

The solution to Medicaid’s problems is complicated. The federal government mandates that each state provide a Medicaid program but has failed to adequately address the cost.

Summary

The Medicaid program is deeply entrenched in our country and even with health care reform looming, it is doubtful it will go away. In order to survive, states are cutting services and looking for additional federal funding. The present system is fractionated and fails to provide

any continuity of care or cost containment. Increasing services without addressing these issues is like putting a band-aid on an abscess. It only hides the problem for a little while but given time the crisis will come to a head and explode.

Recommendations

The concept of Medicaid is respectable and provides a good service if ran as intended. The cost, however, is too high and states are frantically trying to figure out ways to stay within their budget. If business continues as is, Medicaid will cut more services and provider reimbursement. To date, that has not solved the problem. It is time to step back and look at other remedies.

There is no simple solution, but perhaps the Veteran's Administration (VA) or Kaiser Permanente (KP) provides the best options. For the most part, KP and the VA are closed systems that deal with all primary care and mental health needs of those enrolled. Patients are assigned to a pod that often includes a primary care provider, nurse coordinator, mental health professional, dentist, optometrist, audiologist, dietician, and a clinical pharmacist. The facilities have a pharmacy, lab, and x-ray on site. E-mail and telephone communication and electronic surveillance of daily glucose, blood pressure, and pulse help keep the pod abreast of the patients status at times when face to face visits aren't needed. Computerized records allow for continuity of care even when the PCP isn't available. Administrative support, technicians, nurses, providers, and others are employees of the organization.

Creating a self contained system helps decrease cost in many ways. It provides the continuity that stops repetitive tests between one provider and another, it reduces ER visits (via access to primary care), and it takes away the motive for fraudulent claims. More important, it provides continuity of care and open communication from the nurse care coordinator to the

primary care provider to the mental health counselor. This continuity creates optimal outcome for the patient and the system.

In addition to the pod format, the federal government should set a percentage match for basic services only. For example, each state should get 57% federal match for every $1 they spend. The percentage match must be based only on the basic required Medicaid coverage. States can continue to provide services beyond the basics if they like, however, there will be no federal match for those services until all state Medicaid costs have been met.

Medicaid is a good service and helps the indigent and those with special needs. Its original concept still applies today. For it to continue, however, cost containment, continuity of care, and fraud prevention must be addressed. The above remedies provide the foundation on which the steps of a successful and financially viable program can be built.

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