

MEDICAID 101: HISTORY, CHALLENGES, AND OPPORTUNITIES

Based on presentation by Warren A. Jones, MD at the Fifth Annual Primary Care and Prevention Conference and Health Policy Summit, September 22, 2005; Atlanta, Georgia.

This report contains information from the Health Policy Summit, held in conjunction with the Fifth Annual Primary Care Conference and the Tenth Annual HeLa Women's Health Conference. During this Summit's presentation, Warren A. Jones, MD provided information on the Medicaid system and the challenges facing administrators at the state level, specifically those in Mississippi and calls for an improved Medicaid system that will: provide a better definition of benefits; remember the children; offer a humane system of care for the elderly; eliminate fraud; and use a synergistic team of leadership to deliver the program. (*Ethn Dis.* 2006;16[suppl 3]:S3-52-S3-53)

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INTRODUCTION

The Medicaid program is a complex, mysterious system to many Americans who do not know how the program is structured, how it was devised, and how to access its benefits. Unlike Medicare, the Medicaid program does not have clearly defined goals and benefits. Instead, it was created in the 1960s as an afterthought, or safety net, for healthcare needs not being met by Medicare.

Medicaid is a partnership between the federal government and 50 state governments. Each state develops its own program and none is alike. States receive matching funds from the government based on the state's level of poverty and its per capita income. Mississippi, which has the lowest per capita income and the highest level of poverty in the nation, currently receives \$.76 per \$1 from the federal Medicaid program. In previous years, the total has been \$.83 per \$1 (the federal government's highest allowable amount).

Federal assistance is allocated after review of each state's Medicaid plan, which policymakers develop to address healthcare issues within the state. The plan, submitted to the Centers for Medicare and Medicaid Services (CMS) for approval, must clearly delineate 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.

The primary goal of Medicaid, an insurance plan rather than a managed care organization, is to pay for services. To illustrate the severity of the problem in some states, consider that the eligibility rate in Mississippi has been as high as one in four individuals. If every eligible person in the state needed health care at the same time, the cost of care would far exceed resources.

CHALLENGES WITH THE MEDICAID SYSTEM

The federal Medicaid program defines eligibility and service requirements for each state. State Medicaid programs must cover children and women living below the federal poverty level, pregnant women, the elderly, and individuals with disabilities. Some requirements are paradoxical. For example, the states are required to provide non-emergency transportation, but have the option of providing medications. In addition, states are not obliged to cover all healthcare screenings/tests and treatments that a patient may need unless the procedures are approved by the Federal Drug Administration (FDA) or deemed non-experimental.

One challenge facing Medicaid is a stigma that remains from the time when the program was a “welfare” program. Originally, Medicaid was linked to the Aid to Families with Dependent Children (AFDC) program of the US Department of Health and Human Services, but that connection no longer exists. Across the country, many medical practices will schedule Medicaid patients for visits on certain days of the week only, causing a very visible division between those who receive services from Medicaid and those who receive coverage from other sources. Indeed, this type of process can only contribute to inequitable treatment and widen the gap in health disparities.

The cost of Medicaid now surpasses the cost of Medicare. As a result, states are required to take action to curtail costs, yet must provide health care to a growing number of individuals who rank below the state’s poverty level. This stipulation means that the state’s roster of eligible individuals (and the matching dollars that the state is expected to contribute to the program) can increase from year to year. For example, the number of individuals enrolled in Medicaid in Mississippi grew from 542,000 to 780,000 in June 2005. Uncertainty in the number of individuals that a state will need to serve and the amount of services that it will need to deliver has made the current course of Medicaid difficult to administer.

States are allowed to design their own modifications to Medicaid, but few state add-on services are dictated by science and/or evidence. Additional services usually originate when policymakers seek to meet the needs of their constituents. Unfortunately, these constituents are seldom individuals with specialized diseases; more often, they are vendors wanting to increase their companies’ share of the Medicaid budget. For example, when state Medicaid leaders sought to bring services into alignment with medical evidence and outcomes and to

reduce Medicaid expenditures, the objectors were not Medicaid recipients; they were lobbyists representing companies that make an average of \$10 million per year from Medicaid in Mississippi. While funds have been allocated to these industry lobbyists, improvements are not taking place in health status, longevity, or quality of life for a population that is living longer.

HOW TO IMPROVE MEDICAID

In summary, Jones believes several things need to occur to ensure that Medicaid operates efficiently and effectively to improve health and health care:

- 1) Define Medicaid benefits on the basis of evidence and science with population health outcomes in mind.
- 2) Remember the children. The State Children’s Health Insurance Program (SCHIP) needs to be funded appropriately, and every child needs to be encouraged to take advantage of the services. School physical education programs are important, but children need regular checkups so that they will be well enough to participate.
- 3) Develop a humane and systematic way to provide health care to the elderly population.
- 4) Make sure the Medicaid program serves the “needy” and not the “greedy.” Eliminate fraud on the part of recipients and providers. Electronic health records will assist in combating dishonesty in the program.
- 5) Create teams of elected officials, Medicaid officials, and healthcare providers to deliver the program and promote its success.