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Medicaid: A view from the front lines

by Gary J. Clarke

Introduction

Twenty-five years after its enactment, the Federal-State Medicaid program has survived amidst constant, conflicting pressures. Different perspectives on the strengths and weaknesses of the program and on the proper directions for reform have created a Medicaid "identity crisis" that makes it difficult to clearly view the program's real—and potential—value in shaping American health policy.

To physicians, hospitals, nursing homes, and other health care providers, Medicaid is the program that pays far too little. Yet for State and Federal legislators, executive officials, and the public, Medicaid is the program that costs way too much.

Advocates for the poor, as well as health care providers, complain that the program has an enormous amount of unnecessary paperwork and a blizzard of byzantine rules. Indeed, one group of welfare-rights attorneys likens explaining the Medicaid program to "draining the Serbonian bog." Yet congressional studies and Federal audits continue to rail at States for being too lax in enforcing a complex set of Federal rules, and particularly for being too lenient in making eligibility determinations and Medicaid payments.

Even the services covered by State Medicaid programs have been alternately criticized as being far in excess of private insurance standards (particularly in the area of long-term care), or else discriminating against the poor for having too many limitations (e.g., Stevens and Stevens, 1974). Indeed, amid all the criticisms by elected officials, professional organizations, and the academic community, it sometimes seems amazing that the Medicaid program has lasted 25 years without some fundamental reform or outright abolition.

Perhaps it was the thought that national health insurance was always lurking just around the corner that stopped a more fundamental look at the Medicaid program. The time has come to re-evaluate the problems and successes of the Medicaid program in a more realistic light.

Successes of the Medicaid program

Medicaid has done much to relieve the health care burdens of the poor and the elderly. The number of physician office visits for the poor, which once badly trailed that of the middle class population, are now at comparable levels (Leicher et al., 1985). Widespread long-term care for the elderly in nursing homes was practically made possible by the Medicaid program, which continues to pay for more than 60 percent of all nursing home patient days nationwide (Hing, Sekecenski, and Strahan, 1989). And the current method of caring for the severely developmentally disabled in small group facilities is almost entirely supported by the Medicaid program. Other innovations in public and even private health policymaking received most of their starts in innovative State Medicaid programs throughout the country. Why then is Medicaid still perceived as the program that falls short of providing access to quality care for our most vulnerable citizens?

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Is the problem Medicaid?

Although there are a host of difficulties with any public or private insurance program, at least four fundamental problems seem to have undermined confidence in the Medicaid program. First, and probably most important, is a classic situation of exorbitant expectations that are not even compatible with the legislative design of the program, much less the practical reality. From the start, Medicaid was never designed to provide all services to all the poor. In fact, designers of the program could hardly have guessed at the kinds of services—particularly nursing home and intermediate care facility for the mentally retarded (ICF/MR) care—that evolved out of the needs of the newly eligible population. With few standards established for payment rates, limitations (or lack thereof) on services, and variation among States in terms of welfare coverage, Medicaid has by design, and from the start, lacked sufficient heterogeneity on a national basis to foster a good national understanding of the program. In 1965, and even today, there is little public understanding of how variable our welfare programs are and, consequently, little understanding about the fiscal and other challenges of making Medicaid truly comprehensive enough to serve all the needs of the poor.

Second, Medicaid has been shaped, in different ways by different States, by the growing financial pressures of health cost inflation. Unlike the Federal Government, when caught in the same fiscal crunch with the Medicare program, State governments have far less elasticity in revenues to help solve the problem. In addition, and just as importantly, there is no strong voting constituency to demand protections for the Medicaid program when State revenues fall short of expected demand. As a result, State-specific controls on program coverage and pricing have been an endemic Medicaid problem almost since the program began.

Third, the cost squeeze itself, by increasing the costs of health insurance, has actually left more working people without health insurance today than there were 25 years ago. Thus, those who are without private means must look for public assistance and find only the Medicaid program to rely on. Not surprisingly, they are frustrated at dealing with an eligibility system designed not for obtaining catastrophic or regular health insurance, but rather for obtaining cash-assistance payments (with all the inherent concerns about potential fraud that are associated with cash payments). Nonetheless, demands are now being placed on the Medicaid program to serve a young, working population that was never envisioned as needing public coverage by the founders of the program. Not surprisingly, the program has been found wanting.

Fourth, an underlying and too often ignored part of the Medicaid problem are changes in the demographic landscape of the United States itself. Even when Medicaid programs pay quickly and adequately, too few health care providers are found where most Medicaid recipients tend to reside—in inner cities or rural areas. Those providers that do serve in these areas are then overwhelmed with the social and health concerns of their patients—problems and concerns their suburban colleagues have left behind. No reform to a system designed after a private insurance model will by itself resolve the health problems associated with poverty, crime, and drug abuse, nor will such a system put health care providers directly where they are most needed.

Understanding the Medicaid program

One of the most serious problems with understanding the Medicaid program is that it is not a single program, but rather an umbrella program that has several components serving vastly different populations that have in common the sole misfortune of having insufficient income to meet their health care needs. Medicaid serves at least four distinct groups. First, for poor persons with Medicare, Medicaid actually serves as a medigap policy, paying coinsurance and deductibles, and covering uncovered services in the Medicare program. Second, for persons of virtually all incomes, Medicaid is the ultimate payer of long stays in nursing homes or ICFs/MR. Long-term care for these recipients accounts for 44 percent of all Medicaid spending, and in at least one State, more than 60 percent of the total (Ruther and Reilly, 1989).

A third group covered by the Medicaid program are persons needing episodic coverage for a variety of problems. For these persons, who are generally not eligible for cash assistance, Medicaid actually provides catastrophic coverage, kicking in after both family cash reserves and private insurance are exhausted. Since 1986, additional groups of needy persons, primarily children and pregnant women, have been added to the list of those for whom Medicaid acts as a major medical insurance policy.

Finally, there is the group for whom Medicaid was originally and explicitly intended, as a kind of regular health insurance policy. Recipients of Aid to Families with Dependent Children (AFDC) and noninstitutionalized recipients of Supplemental Security Income (SSI) comprise more than 70 percent of all Medicaid recipients. Yet spending for this group now accounts for less than one-half of all Medicaid expenditures (National Governors' Association, 1990; Congressional Research Service, 1988). These are the "poor," however, as defined in 1965, for whom Medicaid was intended.

How one judges the Medicaid program really first depends on how Medicaid performs for the particular group in question. And I suggest a final and further division be considered before judgments of the Medicaid program are made. The Medicaid program itself is really part welfare and part health insurance. Those who judge the Medicaid program as too stringent in its eligibility criteria (State AFDC income criteria vary from about 14 to 82 percent of the Federal poverty level; Federal SSI income criteria are set at about 75 to 80 percent of the Federal poverty level), are probably making the right judgment, but about the wrong program. They are judging the welfare side of the public house that, following its own policies, then enrolls individuals and families in the Medicaid program. Despite the incremental reforms in the Omnibus Budget Reconciliation Act (OBRA) of 1986 that severed the connection between cash assistance and Medicaid for

pregnant women and children, Federal and State policymakers have not yet aggressively addressed the health-versus-welfare dichotomy in Medicaid's identity. As a result, the vast majority of recipients continue to be those receiving cash assistance.

Judging the Medicaid program

If one judges the Medicaid program by the basic functions it uniquely performs—claims payment, policy and ratesetting, provider relations, fraud control, and quality assurance, as opposed to eligibility—I think a distinctly different scorecard emerges. Certainly the picture is not always rosy in every area and in every State. But overall, Medicaid programs throughout the country function far better than is frequently portrayed in the popular press or at State and Federal legislative hearings.

For instance, most Medicaid programs pay a "clean" claim as fast as does private health insurance, and faster than most Medicare claims, which are required to be held for 14 days (Office of the Assistant Secretary for Medicaid, Health, and Rehabilitation Services, 1989). Most Medicaid programs are as automated as private health insurance, and often more so, thanks to favorable Federal matching rates and State and Federal requirements for rebidding private contracts. Many States have utilization review programs that are the envy of private insurance, in terms of both degree of automation and depth and sophistication of review. Because they have to "try harder" (Medicaid is definitely not number one on providers' lists of favorite insurance companies), many States have developed manuals and billing procedures that rival anything private insurance has done in terms of clarity. And finally (albeit as a mixed blessing), Medicaid programs pay hospitals and other providers at such "bargain" rates that private insurers might be able to lower their premiums significantly if they were to use the same methodologies.

In truth, after 25 years of striving, the States and the Federal Government have built Medicaid programs into more-than-adequate enterprises with the capability to manage voluminous and complex health insurance claims as easily and rapidly as any private insurer. The administrative mechanisms and systems owned and controlled by the Federal and State governments are sophisticated and adaptable and could be used for purposes beyond paying for Medicaid claims for the poor.

Difficulties of administration

This result has not come without considerable effort. Administering a program in which both levels of government have huge financial commitments that rise inexorably with health cost inflation can never be easy. Provider reliance on Medicaid revenue, particularly by politically powerful nursing homes and ICFs/MR, pharmacies, inner city hospitals, and other arms of State government, enormously complicate the task. And Federal regulatory oversight is almost all-encompassing.

Federal regulation of the Medicaid program extends to almost every conceivable area. Claims-processing standards, facility certification, utilization review, quality assurance, statewide uniformity, and a whole host of areas (mostly contained in 674 pages of fine print [42 C.F.R. 430]) necessarily engender confrontations between the Federal and State governments. Nonetheless, in general, these standards have led to the creation of units of State government with considerable competence and expertise—if for no other reason than to minimize the potential for Federal sanctions. In fact, it is difficult to identify another large program of State government that is less subject to outright political manipulation than the Medicaid program—despite the fact that it represents the second largest budget item of most States. Indeed, many of the disputes between the States and the Federal Government today are spawned not by laxity in State program management, but rather by increasing State expertise and innovation.

There have been numerous calls to nationalize the Medicaid program over the years. Apparently the theory is that a nationally administered program would be better understood, more efficiently operated, and more fair to the poor than is the present fragmented system. Such pronouncements may be reasonable on face, but too often they ignore the underlying reasons for lack of uniformity in the present system—social policy dynamics that go far beyond the administration of the Medicaid program itself. Even so, some of the more fundamental challenges to the Medicaid program (e.g., determining a uniform poverty level at which coverage begins, establishing minimum benefit requirements), have, to some extent, been recently addressed through both Federal legislation (mandates) and State initiatives and innovations. Surprisingly enough to some critics, Medicaid programs throughout the country have been shown to be readily adaptable to the recent changes mandated by the Omnibus Budget Reconciliation Acts of 1987, 1988, and 1989, as well as the Medicare Catastrophic Coverage Act changes. The State problem with mandates has not been administration, but money.

Advantages for continuing the program

There are a number of advantages to preserving State administration of the Medicaid program. States continue to be the locus of most eligibility systems. In addition, State and local governments serve most Medicaid recipients through a variety of other programs in such areas as aging, mental health, developmental disabilities, crippled children, foster and shelter care for children, public health, and income assistance. These myriad services clearly require coordination and cooperation for appropriate service delivery. So too, States have been quite innovative, most frequently out of economic or regulatory necessity, in designing unique changes to the health care system (e.g., ratesetting, managed care, long-term care, claims payment, utilization review) that would be more difficult (and risky) to experiment with on a nationwide basis.

The two most obvious reasons for continuing with State administration of the Medicaid program are more straightforward—money and administration. States contribute about 45 percent of the cost of their programs, more than $30 billion annually to ensure that Medicaid continues to function (Ruther et al., to be published). It

seems inconceivable that State contributions would continue, particularly at their present growth rate, absent some State control over how the money is spent. Second, Federal practice, even in the Medicare program, is to contract with other parties (intermediaries and carriers) to carry out the national program. Any further national approach seems likely to follow this pattern. State-administered Medicaid programs in the last decade have been shown to be fully capable of carrying out these tasks.

The next decade

What then, is the future of the Medicaid program? The history of incrementalism in American politics, the need for cash to finance existing health care programs, much less new ones, and the Federal practice of operating through subsidiaries, rather than directly, indicate that some form of the current Medicaid program should persist into the next century.

In the future, some division of the Medicaid program along patient functional lines seems inevitable. The problems and solutions to long-term care, whether for the aged or the developmentally disabled, are only partly health care related. Expecting a program that was designed to pay medical bills to also finance these other programs requires either that the programs turn on their heads, or that State governments (and here's a new and increasingly popular word) "Medicate" every social, therapeutic, and housing service necessary for these individuals. The result is unnecessarily costly for society and inappropriate for patients and their families. An entire reworking of the Medicaid program in this area seems appropriate.

For the poor elderly, it seemed inevitable that Medicare would eventually become as comprehensive a program as Medicaid. The unfortunate repeal of the Medicare Catastrophic Coverage Act forces the continuation of (at best) an awkward system for providers and patients alike. Under this system, coinsurance, deductibles, and uncovered services are run through an entirely separate Medicaid system, frequently only to ensure payment for Medicare services to Medicare patients. It also continues an ironic Federal policy that requires State subsidization of Federal policies and patients. The future evolution of the Medicare program will be a critical factor in reshaping and redefining Medicaid and the Federal-State partnership.

For the non-elderly poor, continuation of the Medicaid program as a State-run program seems a good bet. The extension of standardization of benefits (essentially already mandated for children by OBRA 1989) also seems likely in the future. And States will undoubtedly continue to be the administrative arm for means-testing for cash-assistance programs.

But what about the working poor and the categorically ineligible who require health insurance coverage? Certainly, State Medicaid programs could administratively adapt to cover these groups and pay their claims. But who would collect premiums? (State workers and unemployment compensation bureaus, and revenue departments have expertise in this area, but not Medicaid agencies). And how would employees be means-tested, if at all? Would private insurers, particularly the Blues, who also have the ability to pay claims, easily let go of this market? While the various health insurance reform proposals are beginning to clarify and confront these questions, the answers seem unclear at the present time.

Conclusion

For State officials working in the Medicaid program, the past 5 years of Federal legislation and State adaption have been some of the most dynamic and exciting in the 25-year history of the Medicaid program. The problems of dealing with a Federal partner governed by conflicting pressures—social policy pressures for expansion and leniency on the one hand, and fiscal pressures for expenditure control and stringency on the other—can be frustrating. To some extent, these difficulties seem rooted in a kind of Federal paternalism toward the States.

Mostly, however, State and Federal difficulties with the Medicaid program—where they exist—seem rooted in two problems. First, the practical realities of running a health insurance-welfare program in which two different levels of government have different fiscal means, even where policy goals are the same, will always make for different points of view.

Second, there are a number of practical problems surrounding the administration of Federal rules that were originally designed to ensure that States created something that looked like traditional health insurance for middle-class patients in a fee-for-service medical economy. Not only has the medical economy changed, but the needs of the Medicaid population are far more profound, and the need to work with other arms of State and local government are far greater, than the original legislative scheme ever envisioned. Unless the scheme itself changes for these special-needs patients (e.g., the aged, the developmentally disabled, chemically dependent mothers and their children), future conflict on these issues also seems inevitable.

These difficulties pale, however, compared with the more urgent clash between health cost inflation and Federal mandates, and the much slower growth of State revenues. No State has a revenue growth rate sufficient to keep up with the current combination of mandates and health cost inflation. In Florida, for instance, overall Medicaid expenditures have increased about 27 percent per year for the last 4 years (39 percent in 1990), while State revenues have grown at about 10 percent per year in the same time (Office of the Assistant Secretary for Medicaid, Health, and Rehabilitative Services, 1990). But the Federal Government simply cannot afford at this time to let the States walk away from their current financial and managerial commitment to the optional Medicaid program. The immediate challenge, and the catalyst for future fundamental reforms, is the need to establish a more constructive balance between Federal and State financial responsibilities, while building on State Medicaid management expertise, their demonstrated capacity for innovation, and their ability to more easily work with State and local agencies and providers.

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