

# **The Precarious State of Medicaid**

by:

**Cherilyn G. Murer, J.D., C.R.A.**

On June 30, 1965 President Lyndon Johnson signed into law the Social Security Act. It was established the same day as Medicare, but with unquestionably different goals. Medicare was fully funded at the federal level, with eligibility based on reaching the age of 65 years old, having a recognized disability, or in end-stage renal disease. Medicaid, on the other hand, is a needs-based social welfare program, not a social insurance program like Medicare. But while enormous attention has been given to the looming financial woes of Medicare, little focus has been on the funding for Medicaid.

As a program that is funded by both State and Federal dollars, Medicaid is regularly hit hard by the one-two punch of reduced Federal Medicaid matching and dwindling state budgets. This drop of in funds strains the State-operated Medicaid offices responsible for reimbursement and authorization of appropriate care. Perhaps most importantly, the increase in Medicaid enrollment with inequitable increase in Medicaid funding, hurts the low-income Americans for whom the program was designed.

## **State and Federal Costs**

The increased cost of Medicare to the Federal Government has been well-documented. However Medicaid costs have also grown as the Federal government trims money available to States. In 2007 Medicaid covered approximately 48 million people, with a total cost of \$350 billion (\$200 billion came from the Federal budget, \$150 billion from States). This is a significant increase when compared to the \$295 billion total cost in 2004, or the \$205 billion in 2000.

While State budgets have been largely cash-strapped in 2008 (over half of all States are anticipating Budget Shortfalls in FY 2009), it would be inaccurate to suggest the Federal Government has failed to supplement State Medicaid spending when necessary. In May 2003 Congress passed and President Bush enacted temporary federal fiscal relief called the "Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) giving State Medicaid programs an additional \$20 billion for 2003-2004. Nevertheless, Medicaid has taken some significant financial hits in the past few years as both the Federal and State governments search for ways to reduce their budgets.

## Decreasing Medicaid Funding

CMS and the Federal Government have implemented and proposed several measures to reduce, or at least hold Medicaid spending levels. The well-publicized fight between the U.S. Congress and President Bush's administration over the State Children's Health Insurance Program ("SCHIP") in 2007 was, at its core, a question of whether federal health care needs to be expanded to insure more of America's children. Although SCHIP is not synonymous with Medicaid, they share a vulnerability for government funding cuts. SCHIP, introduced in 1997, was designed to cover children's insurance for those families with modest incomes, but make too much to qualify for Medicaid. The Democratic-controlled Congress sought to expand the reach of SCHIP, covering an additional 4 million children and costing approximately \$35 billion over five (5) years. President Bush twice vetoed the expansion, sending a clear message that his Administration desires not to increase health care coverage paid for by the U.S. Government. States have begun to fight back against the government's inability to expand the scope of SCHIP. For instance, Indiana, Iowa, and New York have taken steps to increase eligibility for SCHIP for hundreds of thousands of children.

The Federal Government additionally passed legislation reducing Medicaid reimbursement across multiple services. As Medicaid relies on Federal matching dollars combined with State funding, these Federal cuts have taken their toll on State budgets.

At the State level, there have been endless stories about the States with grossly expanding expenses, but disproportionate revenue growth. Large states, like New York, have seen Medicaid costs skyrocket while their budgets and CMS reimbursement remains relatively stagnant. New York, alone, paid \$43.4 billion in 2005 for Medicaid (almost double that of the national average) and the number has since risen. California anticipates spending \$38 billion on Medi-Cal next year, accounting for the second largest State expense, second only to education (George Lauer, "Medicaid Contractions Inspire New State, National Opposition," California Healthline, March 31, 2008). Tennessee Medicaid spending doubled to \$6.5 billion between 1995 and 2006, according to a recent Kaiser Family Foundation report. Overall, there is a crisis throughout the country – not just stabilizing State budgets, but ensuring accessible healthcare to low-income individuals.

The common reaction to the nationwide state budget deficits has been to make cuts in essential government services, such as Medicaid. In 2007 Michigan's Governor and legislature considered significant Medicaid cuts to help cover their \$400 million deficit. Florida is seeking \$1 billion in healthcare cuts, out of the \$16 billion budgeted for healthcare in 2008 (Stephen Nohlgren, "Medicaid a target as Florida seeks \$1 billion in health cuts," St. Petersburg Times, April 20, 2008). Mississippi is short \$90 million in Medicaid funding for the current budget year.

Arkansas is looking to cut Medicaid by up to \$40 million (Doug Smith, "Medicaid is OK, DHS Says," Arkansas Times, April. 17, 2008). There is no end in sight to the tapped State Medicaid budgets and their respective cost-cutting measures.

### **Medicaid Rehabilitation Services Option**

In his 2007 Budget Proposal, President Bush took affirmative steps to reduce federal Medicaid costs when his Administration sought to cut \$13 billion from Medicaid over five (5) years. Of particular note, the Medicaid cuts included restrictions on the coverage of the Medicaid Rehabilitation Services Option. The Rehabilitation Services Option covers "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." (Social Security Act, Sec. 1905(a)(13)). States have traditionally used this federal funding for innovative and much-needed mental health programs treating mental illness, with 47 participating states and approximately 1.5 million people enrolled.

The White House proposal to narrow the applicability of the Rehab Option comes amidst consistent growth of States utilizing this Medicaid resource for patient care services. The broad definition of the Rehab Option has allowed flexibility for States in their treatment programs, but the ambiguity is believed by the Bush Administration to be a root of increased Medicaid costs. Specifically, the proposal restricted the definitions for the Rehab Option with the intent to limit the opportunity for States to be reimbursed for these services. The changes would prohibit the Rehabilitation Services Option from applying in mostly unconventional settings, would require measurable goals and outcomes when such results are often unattainable, and require the Rehab Services be prescribed and provided by, or under the direction of a physician or licensed practitioner. To be fair, the basis for these provisions is, at least in part, to counter the presumption of State manipulation of Medicaid matching regulations by the Federal Government. Regardless of the merits of these changes, it is clear these initiatives were introduced solely as cost-cutting measures. It is equally clear that there would be a detrimental impact on the Medicaid-eligible individuals now covered by the Rehab Option.

Despite the President's proposals and CMS' rules, Congress had other plans: Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). This legislation covered multiple health care venues, but also places a six-month moratorium on several CMS initiatives, including the cuts to the Rehabilitation Services Option, until June 30, 2008. As of the writing of this article, the moratorium has not been extended by the U.S. Congress. However the U.S. House of Representatives passed an extension of the moratorium on April 23, 2008. The Medicaid Safety Net Act of 2008 would extend the

moratorium until April 1, 2009, but has not yet been passed by the U.S. Senate, and President Bush has promised a veto. Unless the moratorium is continued, Medicaid programs in all States will need to trim their budgets and prepare for more narrow federal matching allowances.

### **Impact on Americans**

The incessant back-and-forth between the States and the Federal Government regarding responsibility for health care challenges bellies the impact on the average American. In particular, Medicaid has caused turmoil in states from California to New York, failing to reimburse enrollees on a timely basis, challenging medical necessity, and sometimes freezing payments altogether. The direct impacts have been highly publicized - Beginning June 18, 2008, California Medicaid payments will be delayed until the State government can reach a consensus regarding the current budget impasse. Temporarily freezing Medicaid benefits has occurred in other states as well, such as Kentucky in 2007. Illinois Medicaid is presently experiencing average payment delays of 100 days, and the Governor is considering further Medicaid delays. In addition, the current and potential future cuts to Medicaid have forced states to drastically reduce staff at their local Medicaid offices. Ohio has announced 550 Medicaid employee layoffs, and in the event of the full implementation of President Bush's Medicaid cuts Colorado predicts 3,500 layoffs and Michigan anticipates 15,000 lost jobs.

None of this data, however, speaks to the day-to-day impact on the average American citizen supported by Medicaid. The vast majority of Americans have private health insurance, followed next by those covered by Medicaid, then Medicare. For those with low-incomes that qualify for Medicaid, they are already challenged with the quickly rising costs of living – everything from gasoline, to a loaf of bread. Squeezing those with Medicaid by not paying their benefits in a timely manner, not staffing local Medicaid offices as necessary to assist those with eligibility questions and issues, and reducing Medicaid coverage for those who need it most, chips away at the foundation of our democracy. To fail to provide the adequate health insurance necessary for our poverty-stricken citizens – young and old – is to fail to fulfill the dream of America. We can do better.

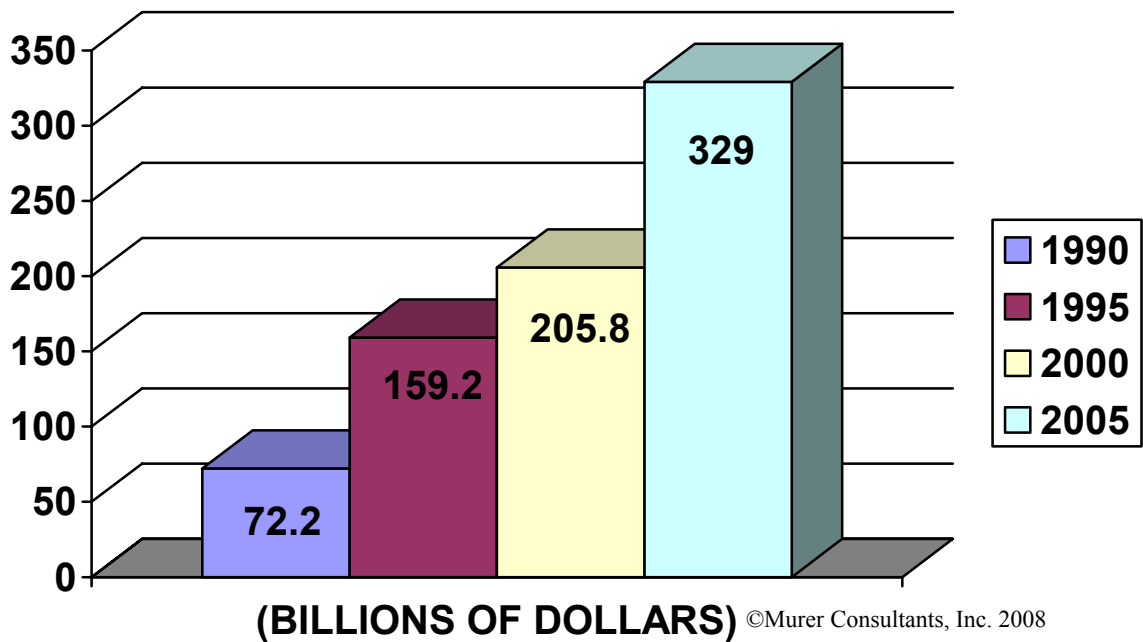
### **Next Generation of Medicaid**

As the 2008 Presidential Election continues, all remaining candidates have introduced substantial health care plans with the goal of improving our health care system to better serve the country. No one disputes the fiscal challenges looming for Medicare and Medicaid, and with fast-growing enrollment and eligibility, it is even more disconcerting to learn that 1 in 4 uninsured (12 million people) are eligible for public health insurance but not yet enrolled (National Institute for Health Care Management Foundation, April 25, 2008). The Federal Government should not whittle down the Medicaid program by limiting its scope,

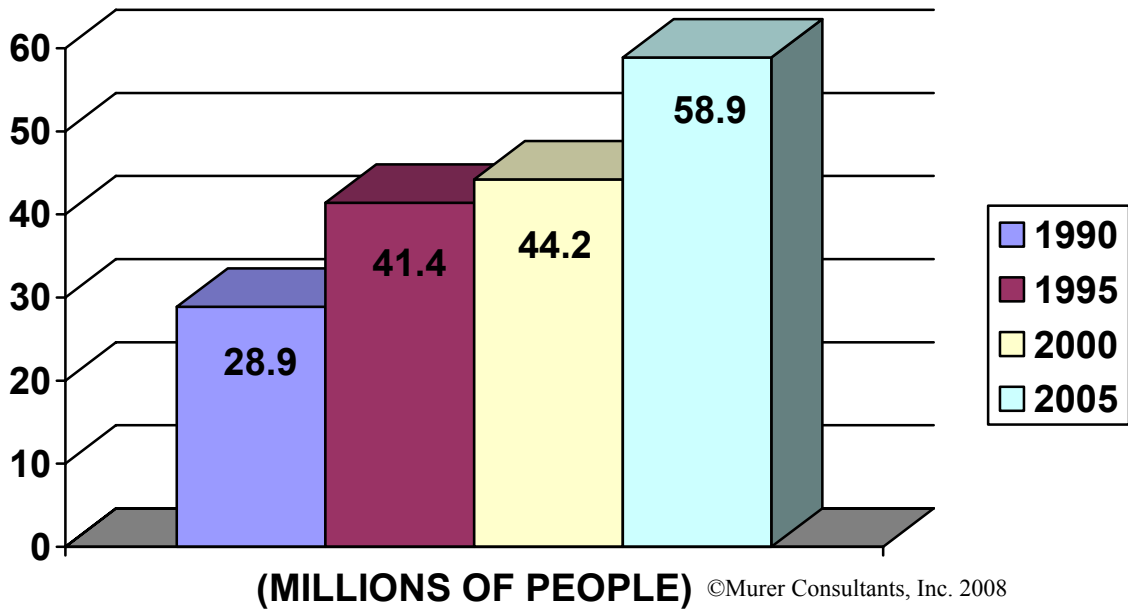
but nor will the status quo support the increasing need for public health insurance.

As more and more Americans, and particularly children, become uninsured, Congress and State governments need to find new, innovative, and cost-effective ways to cover the uninsured. Some programs are already taking shape to fill this void, including States expanding SCHIP eligibility, Federally Qualified Health Centers, and the Federal 340B Drug Pricing Program. More needs to be done, and expect a more thorough discussion of these potential solutions in the next column.

### TOTAL COST OF MEDICAID



## MEDICAID ENROLLMENT



### About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based healthcare management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on her web site: <http://www.murer.com>