Medicaid reform: An opportunity for the osteopathic medical profession

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Established in 1965 to provide medical care for the impoverished, the Medicaid program has pitted state governments against the federal government, and made adversaries of the providers. The authors examine the legislative history of the program and the rapid growth of expenditures that have led states to cut benefits, tighten eligibility requirements, and slash payments to providers. The call for comprehensive healthcare reform and universal access put Medicaid at the forefront of proposed changes. The osteopathic medical profession, which already provides a quarter of the care in the program, has an opportunity to lead in innovation to promote program efficiencies, and to affirm the profession’s commitment to serve vulnerable populations.

(Key words: Medicaid, cost containment, universal coverage, healthcare reform)

Although Medicaid has been far from perfect and insures only half of the impoverished population in the United States, it is the health insurer of America’s most vulnerable populations. Osteopathic physicians have historically accepted a major role in caring for our vulnerable populations, and are responsible for 25% of the Medicaid population though they make up fewer than 5% of physicians (AOA President Laurence E. Bouchard, DO; letter to Health Care Financing Administration [HCFA] administrator Bruce Vladeck, Oct 5, 1993). Given the inadequacy of the present Medicaid system to address the dilemma of access versus costs, health reformers all predict changes in the program—changes that are of critical importance to the profession.

How we got here
Medicaid was established in 1965 as an amendment to the Social Security Act of 1935, and became part of the existing federal-state welfare structure to assist the poor. Under Title XIX, Medicaid was enacted to serve as a safety net, providing needed medical care to those persons whose incomes fell below the federal poverty line. The program encompasses those persons eligible to receive cash payments under existing welfare programs. At the time of its inception, the Medicaid program had two primary objectives:

- ensuring that covered persons received adequate medical care, and
- providing a means of payment for that care.

Medicaid now provides assistance to children of Aid to Families with Dependent Children (AFDC) families; and those covered by Supplemental Security Income (SSI), including the aged, the blind, and the permanently and totally disabled. The program established a process for states to receive matching grants from the federal government to address the needs of persons who met state standards for public assistance programs. State standards, linked to welfare eligibility and established within federal guidelines, determine who will be covered, what services will be offered, and what the compensation for those services will be. As a result, monies spent, eligible beneficiaries who receive care, and services rendered have varied greatly from state to state. The tests for income levels, assets, and family composition constitute an uneven patchwork of coverage, creating holes and gaps in the system and leaving a large number of poor persons uncovered by Medicaid. Medicaid, nonetheless, provides a sense of security.

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and needed healthcare for more than 28 million people.1

In 1967, 1 year after the program actually began, the program was serving 9.5 million people. By 1970, the program was providing 14.5 million people with Medicaid assistance, and after 10 years of operation (1976), it was serving 23.2 million people. The increase in expenditures rose at a yearly rate of around 25% through the early 1970s.2 From the period of the mid-1970s through the mid-1980s, expenditures rose at the rate of only around 10% yearly. But within the past 5 years, the rate of growth began to accelerate at an unbridled pace, increasing by 13% in 1989, 19% in 1990, 32% in 1991, an estimated 31% in 1992, and 24% in 1993 for an all-time high of $140 billion. At this rate of growth, Medicaid expenditures are expected to surpass Medicare expenditures (estimated at $148 billion in 1993) before the end of the century.1 Unfortunately, the resources available to provide medical care to the poor are limited. States have addressed the escalating costs of the program by reducing benefits to existing recipients and restricting the number of beneficiaries through stricter requirements (Table).

Where we are

The federal share of Medicaid expenditures is based on each state's per capita income, ranging between a set minimum of 50% for states with high per capita incomes to a maximum of 83% for states with the lowest per capita incomes. As long as the states satisfy the matching fund requirements, there is no set dollar limit on the amount of federal funds that a state can receive. This open-ended policy allowed hospitals and physicians to establish the standards for the "reasonable costs and charges" for the services that they provide based on "customary charges" and "the prevailing charges in the locality."3 By placing this control at the source of care, this qualification in the language of the statute has allowed some physicians and hospitals to overutilize scarce resources and take advantage of the federal blank check. The result has been a continuing escalation of general medical costs, essentially defeating the intent of publicly financed care for the poor at a "reduced" fee-for-service.

Managed care is being pursued by many state Medicaid programs to counter the uncontrolled escalating cost trends. In the present national and state reform climate, it is perceived that continuation of fee-for-service reimbursement produces no incentive to contain increasing costs.

While the federal government can increase the amount of funds needed to match state contributions to Medicaid by adding to the national deficit, the states themselves are required to work within fixed budgets that must be balanced by the end of each fiscal year. According to the National Association of State Budget Offices, Medicaid is growing more rapidly than all other state programs. Continuation of the current trend would double the 1991 expenditures at 14% of state budgets to 28% by 1995.4 This trend is responsible for state slashes in benefits and services.

Some states have resorted to creative formulas for raising revenues to meet federally mandated Medicaid coverage.1 Many states have collected voluntary contributions from providers, or taxes imposed on providers, to generate federal matching funds on a dollar-for-dollar basis. Then the states repay healthcare providers with the same money. The federal government has challenged some state efforts to be creative, and providers have challenged others. When the New York State Legislature sought to impose a ceiling on Medicaid payments to hospitals in 1969, several affected hospitals challenged the move in federal court. As a result, an amendment to the statute in 1972 established that states may establish their own standards of "reasonable costs" for Medicaid purposes.3

In 1981, the Omnibus Budget Reconciliation Act (OBRA) removed the requirement that states reimburse hospitals on a "reasonable cost" basis and allowed them to establish their own reimbursement criteria and payment systems—including prospective payment systems.5 That action led to the 1981 law, the Boren Amendment, which again directed the states to pay economically and efficiently run hospitals and nursing homes rates that are "reasonable and adequate" to meet the costs incurred in caring for Medicaid patients. In June 1990, the US Supreme Court upheld the standing of these institutions to sue states for redress.6

In addition to falling short of ensuring access to medical care for all poor Americans, Medicaid has also been plagued by political infighting between the states and the federal government. Medicaid has long been at the center of a continuing struggle between the states and the federal government over the apportionment of funds in response to steadily rising costs. Not long after the implementation of the program, states sought to curb rising costs in Medicaid spending by making cuts in benefits, tightening eligibility requirements for beneficiaries, and slashing payments.
to providers—moves that have persisted throughout the life of the program. At the same time, the federal government has increased the number of services that must be covered, yet continually calls for caps on federal Medicaid spending. This situation places the states and the federal government in an adversarial position to one another, squabbling over who should foot the bill.

The providers, too, have been placed in an adversarial position with the program, as evidenced by the Boren Amendment. As a result in 1992, one in six beneficiaries (approximately two million adults) was turned away by a physician or a hospital because the providers would not accept Medicaid. The consequence has been that many Medicaid recipients do not have adequate primary care. One in five beneficiaries has had to seek care from an emergency room. Emergency room care is more expensive than primary care, putting a greater drain on already scarce resources, and emer-

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**Table**

**Addition of Eligible Beneficiaries**

**Under Budget Omnibus Bills of the 1980's**

<table>
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<tr>
<th>Year and bill</th>
<th>Mandated</th>
<th>Optional</th>
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<tr>
<td>1984 <strong>Deficit Reduction Act (DEFRA)</strong></td>
<td>First-time pregnant women</td>
<td>Children younger than 5 years in two-parent families</td>
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<td>Two-parent families in which principal wage earner is unemployed</td>
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<td>Children to age 5 years in two-parent families</td>
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<tr>
<td>1985 <strong>Combined Omnibus Budget Reconciliation Act (COBRA)</strong></td>
<td>Two-parent families even when principal wage earner is employed</td>
<td>Disabled widows and widowers</td>
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<td>9 months' transition for beneficiaries losing Medicaid</td>
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<td>1986 <strong>Omnibus Budget Reconciliation Act (OBRA)</strong></td>
<td>Children younger than 7 years in two-parent families</td>
<td>Pregnancy-related services for women below 100% of poverty*</td>
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<td>Severely impaired individuals who work</td>
<td>Infants to age 1 year below 100% of poverty</td>
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<td></td>
<td>Homeless eligible</td>
<td>Phase in to age 5 years below 100% of poverty</td>
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<td>Elderly and disabled below 100% of poverty</td>
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<tr>
<td>1987 <strong>DEFRA</strong></td>
<td>Children to age 7 years in two-parent families</td>
<td>Pregnancy-related services for women below 185% of poverty</td>
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<td>Infants to age 1 year below 185% of poverty</td>
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<td>Children younger than 5 years below 100% of poverty</td>
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<td>Children younger than 8 years below 100% of poverty phased</td>
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<tr>
<td>1988 <strong>Medicaid Catastrophic Coverage Act</strong></td>
<td>Pregnant women below 100% of poverty phased</td>
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<td>Infants younger than 1 year below 100% of poverty phased</td>
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<td>Cost-sharing Medicare recipients below 100% of poverty</td>
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<td>12-month transition, families 100% to 185% of poverty</td>
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<td>Two-parent AFDC† families in which wage earner is employed</td>
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*Based on the federal poverty level.
† AFDC=Aid to Families with Dependent Children.
Addressing the issues

Medicaid contains a mechanism that allows states to modify the program to satisfy their unique needs—the waiver authority. The waiver authority can create new ways to deliver healthcare services to the poor among providers, thus effectively breaking the traditional ties between welfare and Medicaid eligibility.

Some of the needs of the aged, blind, and disabled populations are covered under Medicare and SSI, but often the funds provided by these programs do not raise incomes above the poverty level. Consequently, the recipient qualifies for Medicaid. The healthcare needs of the aged, the disabled, and the mentally retarded account for nearly two thirds of all Medicaid spending. Most of this money goes to long-term care and nursing home care (Figure).

The HCFA oversees Medicaid at the federal level, and though states have flexibility in the range of services that they may offer to Medicaid recipients, many services are mandated by federal law. The services that the states must offer to qualify for federal matching grants include physicians' services, hospital inpatient and outpatient services, radiology and laboratory services, nursing home care for adults, home healthcare, prenatal care, early and periodic screening, diagnosis and treatment for persons younger than 21 years, and the services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners.

The optional services usually covered by the states include intermediate care in facilities for the mentally retarded, prescription drugs, dental services, podiatry, optometry, prosthetic devices, and eye care.

Rising costs of medical care under Medicaid is just one facet of the growing problem. Another facet of the problem is the growth in eligible beneficiaries to the program. In the 1980s, Rep Henry A. Waxman (D-Calif) managed to build expansions of eligibility into the massive annual omnibus budget-reconciliation bills, expansions that would probably not have been able to survive on their own in the Reagan and Bush administrations. The legislative changes expanded eligibility, primarily for pregnant women and children, and permitted financial standards different from those under the AFDC program, thus effectively breaking the traditional ties between welfare and Medicaid eligibility.

The demonstration waiver is a vehicle for significant departures from program rules; it is currently the "waiver of choice." Most states experimenting with healthcare reform are maintaining the Medicaid infrastructure and using the demonstration waivers to simplify eligibility by breaking categorical linkages, expand coverage to the uninsured, and establish managed care arrangements for delivery and capitated payments. (Capitated payments are per-person payments for health services based on average cost for the defined population.) Though experimentation did occur in the late 1970s and in the 1980s, the emphasis was on cost-containment rather than innovations in delivery and financing. In the late 1980s, faced with increasing Medicaid budget pressures and pursuing voluntary donations and provider taxes to increase federal matching funds, states took the lead in seeking innovations.

In an effort to resolve some of the problems of rising costs and increasing enrollments of Medicaid recipients, states experimented with primary care networks (PCNs) in the early 1980s. These PCNs were designed after the concept of health maintenance organizations (HMOs), altering the conventional way in which physicians, hospitals, and Medicaid beneficiaries provided and received services. The PCNs were composed of general practitioners and pediatricians, organized as groups or practicing individually, who served as primary care physicians and case managers for Medicaid patients. By enrolling these patients in a system that acted as a point of access to care and by guiding them to appropriate healthcare services, a higher continuity of care could be achieved. In addition, by changing the system of reimbursement, from fee-for-service to capitated payments, dedicated to weighing economic efficiency against medical efficacy. There are two types of waiver authorities: program and demonstration.

- **Program waivers** allow the states greater flexibility in tailoring alternative delivery and financing strategies, and in creating home- and community-based long-term care. Program waivers are often referred to as "freedom of choice" waivers because the beneficiaries' freedom to choose a provider is waived in lieu of state dictates.

- **Demonstration waivers** are designed to permit experimentation and research, and give states the authority to depart from federal Medicaid requirements. These waivers are time-limited and subject to evaluation by HCFA's Office of Research and Demonstrations.

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cost-effective incentives resulted in greater efficiencies in the utilization of resources. 9

The authority to establish PCNs came from the OBRA of 1981. The Act allowed states to obtain waivers from federal regulations to limit a Medicaid recipient's free choice of provider. By limiting the choice of provider, the states could design PCNs and channel Medicaid recipients into a system of competing healthcare plans.

The 1981 Budget Act also allowed states to develop different methods of reimbursing providers under Medicaid, and the 1982 Tax Equity and Fiscal Responsibility Act allowed states to require AFDC and other categorically eligible persons to make copayments for mandatory Medicaid services. 9

Congressionally mandated, federally qualified health centers (FQHCs) are now emerging as a preferred contender for the provision of Medicaid services. These centers build on the original neighborhood health center program that began in the 1960s as part of the Johnson Administration's War on Poverty. Commonly referred to as community health centers (CHCs), these clinics and other public and nonprofit primary care clinics have provided comprehensive, family-oriented healthcare to medically underserved communities for more than 25 years.

As originally envisioned, neighborhood health centers (NHCs) were to provide an alternative to hospital-based medical care for the entire population; but pressure from private interests, those private practitioners who feared competition from NHCs, established income as the qualifying criteria for NHC services. This move effectively drew the line between government medicine for the poor and private medicine for the rest of the population. Because many of the people served by these programs had no healthcare insurance or were covered by low fee-for-service reimbursement under Medicaid, substantial financial burden was placed on the publicly financed primary care delivery system. With congressional mandates establishing reasonable cost payments for FQHC services under Medicaid, many of these primary care clinics are likely to become more viable participants in the evolving healthcare arena.

For states constantly under pressure to trim budget items, especially entitlement programs for the poor—the FQHC program represents yet another federal mandate to expand Medicaid services, raise Medicaid rates, and increase state dollars that help to fund Medicaid. The states are particularly concerned about identifying how many clinics will be eligible to operate under FQHC cost reimbursement. 10

What does the future hold?
A 1991 General Accounting Office (GAO) report stated that comprehensive healthcare reform is necessary to achieve universal access and cost-containment. The report was issued after the GAO did a detailed comparison of other countries' health-

Figure. Medicaid per capita expenditures (real dollars)—combined state and federal.
care plans and their provisions. The recommendations in the report make a useful yardstick against which to measure the six comprehensive reform proposals currently before Congress in relation to the cost and access dilemma of the Medicaid program. After examining the strategies that have been successful in other countries that offer a broad range of services to all their citizens at a substantially less-per-capita cost than the United States, the GAO recommended:

- Insure everyone;
- Establish policies and procedures for provider reimbursement so that all payers—public and private—follow uniform rules; and
- Cap total expenditures for major categories and services (including physicians, hospitals, and new technology).

Six proposals for comprehensive healthcare reform have been introduced in the House and Senate by President Clinton, Sen John H. Chafee (D-RI), Sen Phil Gramm (R-Tex), Rep Jim Cooper (D-Tenn), Rep Jim McDermott (D-Wash), and Rep Robert H. Michel (R-IL).

The bill proposed by Representative McDermott and Sen Paul D. Wellstone (D-Minn), HR 1200/S 491, directly addresses the Medicaid program in its comprehensive reform recommendations. Under its conditions, Medicaid would be absorbed into a single national plan with streamlined claims processing and comprehensive benefits financed by new taxes. This single-payer healthcare system would be regulated at the federal level.

Three of the bills propose managed competition approaches that would fold some of the Medicaid populations into regional alliances or purchasing pools. Significantly, however, all three bills allow considerable flexibility for states to move to managed care systems of their own devising. In fact, independent of reform, Clinton is encouraging states to begin work on their own solutions through the current Medicaid waiver provisions and has already speeded the process of application to aid them. Under the Clinton plan, Medicaid would be separately pooled for premium setting and all beneficiaries could choose a plan through the regional alliance just as other beneficiaries would. Representative Cooper's HR 3222 would not guarantee coverage but would improve access by folding Medicaid into the purchasing cooperative pools and providing a full subsidy for all the poor. Senator Chafee's plan would use tighter budgeting to reduce Medicaid spending and encourage the use of purchasing cooperatives or managed care, or both. He would phase in government subsidies for the poor.

The least dramatic changes to Medicaid are represented in the proposals of Representative Michel and Senator Gramm, which would allow states to expand managed care in their Medicaid programs.

All proposals would limit the spending for Medicaid in one way or another, through market competition, regulation, or caps on spending. The dilemma of providing access to needy populations, while controlling the increase in costs, remains at the heart of the debate, and Medicaid's future depends on the resolution.

What Medicaid reform means for the osteopathic medical profession

The recent Medicaid certification battle graphically illustrates the need for the osteopathic medical profession to take an informed and proactive role in Medicaid policy formation. The OBRA of 1990 required that physicians providing services to pregnant women and children under the Medicaid program be certified in family practice, pediatrics, or obstetrics and gynecology. Unfortunately, statutory language listed only the American Board of Medical Specialists as the certifying board. In early 1991, the American Osteopathic Association (AOA) began to investigate with the HCFA how the regulation could be modified to add recognition of osteopathic medical certifying boards. The HCFA, however, does not have the authority to simply insert excluded language into the regulation; it requires an act of Congress. The HCFA has extended the deadline for compliance with OBRA 1990 until December 31, 1994, to facilitate change.

The AOA staff worked with sympathetic congressmen in 1991 and 1992 to amend a budget bill or introduce a technical correction. Even though there clearly was no opposition to the change, the AOA was unsuccessful. Finally, on November 17, 1993, Senate Finance Committee Chairman Daniel Patrick Moynihan (D-NY) introduced S 1668, which contains language providing for recognition of osteopathic medical specialty-board-certified physicians when furnishing Medicaid services to children younger than 21 years and pregnant women. The measure is expected to move early in 1994 as part of a noncontroversial technical corrections bill, but the AOA staff continues to work to ensure that a backup plan is in place.

All the incremental expansions, regulatory
controls, escalating program costs, low fee-for-service reimbursement rates, unavailable services for eligible individuals, the administrative bureaucracy, and state program variations have created a program structure that cannot be easily viewed as a whole. In a nation that has historically rationed healthcare services by insurance or categoric entitlements, it is not surprising that the Medicaid program has been most frequently used as the mechanism to address compromised access to healthcare services.

It is a complicated feat to determine where the program has been—let alone where it is going (or should be going) in the future. But what is very clear is that the Medicaid program's future direction is important to the osteopathic medical profession. The AOA has released figures indicating that 25% of the care to presently Medicaid-insured patients is provided by osteopathic physicians. In addition, a conservative estimate is that less than 50% of the poor are covered by Medicaid. Any policy expansions under healthcare reform that support President Clinton's conceptual goal of universal access will have significant impact on the Medicaid program. We osteopathic physicians are, without a doubt, significant stakeholders in this policy formulation process.

States are, and will continue to be, the laboratories for the transition to universal access. It is important that we look at Medicaid as a viable vehicle to influence state-level planning. The planning processes offer us an opportunity to address historic provider concerns related to reasonable costs, perceived malpractice risks, and complicated administrative bureaucracy.

Managed care is the access and cost strategy of choice. States are being encouraged through the Medicaid waiver process to experiment with the structure of their programs to address their unique population needs. Active participation by osteopathic physicians in this process is critical. The profession's level of experience and expertise as providers in underserved rural and urban inner-city areas presents a strong and clear rationale for our participation in the delivery design of the future. We must seize this opportunity to proactively influence the development of managed care systems. Involvement in the evolutionary process will facilitate the profession's ability to accommodate an expanding patient base (over and above the 25% Medicaid population presently served), and affirm our continued commitment to the nation's most health-vulnerable population.

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