# A Decade of Medicaid

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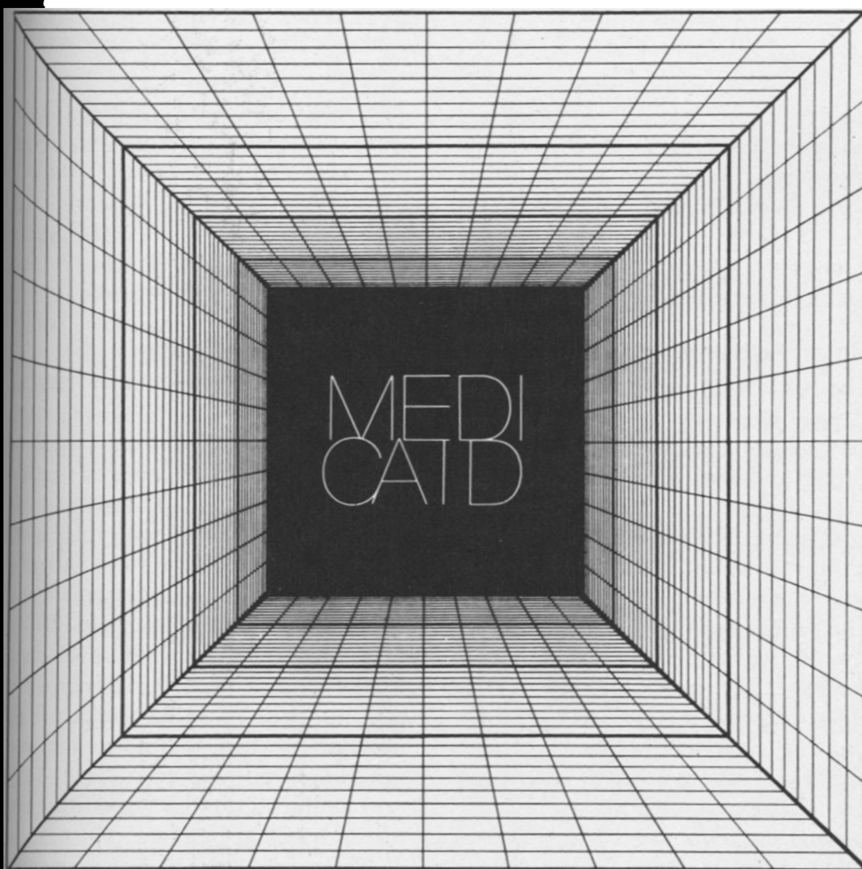


ATION OF MEDICAID and Medi- by enactment of the Social rity Amendments of 1965 blished a major role for the eral Government in financing th care. Medicare, title XVIII the Social Security Act, pro- s health insurance to persons aged 65 years and over who are eligible for social security. Medicaid, title XIX, is a federally assisted State program which offers health benefits to low-income persons on public assistance and, in some States, to those deemed medically needy because their incomes are only slightly above the welfare standards. Depending upon the per capita income of a State's population, the Federal Government pays between 50 and 78 percent of the costs of the State's Medicaid program. Within broad Federal guidelines, the States determine the eligibility of recipients, scope of services, and amounts paid to providers.

Today, 10 years after its inception, Medicaid is assuring financial access to health care services for more than 23 million persons (fig. 1). However, dramatically escalating costs, operational weaknesses, and provider and recipient fraud and abuse have placed the program under increased scrutiny. As the likelihood of replacing Medicaid with a comprehensive national health insurance program has waned, Congress and the President have put forth proposals for redefining the Federal-State partner-

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ship—their respective roles, responsibilities, and resources—in financing health services to the poor.

## Antecedents of Medicaid

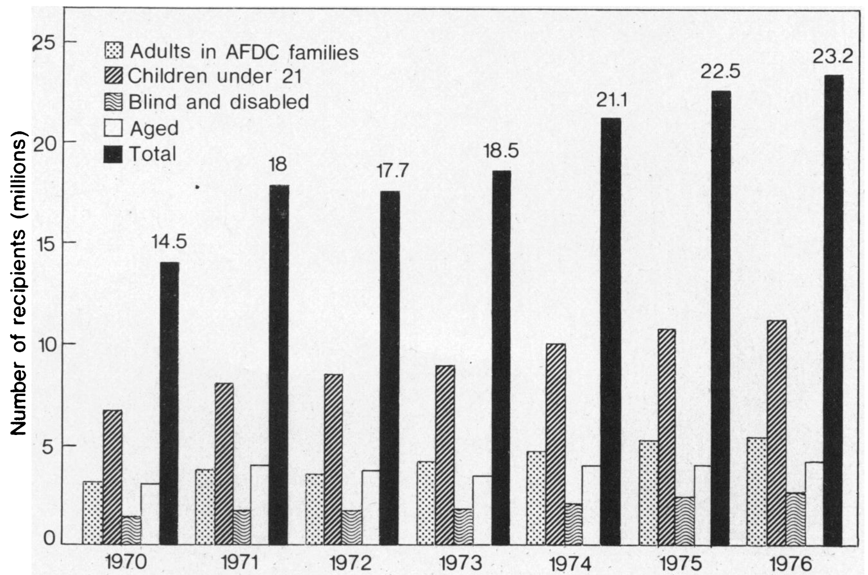
Although the enactment of Medicaid legislation represents the most dramatic commitment, Federal financing of health care for the poor has been part of the State welfare system since the 1930s. Motivated by the depression, the Social Security Act of 1935 marked the beginning of the American social welfare system, which provides government protection from financial calamities for "deserving individuals." From this legislation two concepts of social welfare emerged: social insurance for the working population (unemployment insurance, workmen's compensation, guaranteed pension) and public assistance—direct financial aid provided by the States—for those unable to work.

The Social Security Act established categorical assistance programs for needy aged and blind persons, for one-parent families with children, and later for the disabled. Although the act did not provide medical insurance per se for recipients of categorical assistance, the individual recipient's medical expenses were included in determining the size of the monthly payments, which could be matched by Federal funds. Participation by the States in the Federal categorical programs was, however, optional and, as a result, medical services remained only a small part of welfare assistance.

The Social Security Amendments of 1950 expanded the categories of public assistance and provided for a federally supported program of direct reimbursement—vendor payments—to physicians and hospitals. States were encouraged to take part in the program and, within 10 years, approximately 40 States had plans.

The Kerr-Mills Act of 1960 provided more generous, open-ended Federal matching for all vendor payments and established a new category of public assistance—"medically needy" aged persons who were not receiving cash assistance. By the end of 1965, 50 States and 4 jurisdictions had federally approved vendor payment programs for medical care.

**Figure 1. Number of Medicaid recipients in the United States, fiscal years 1970–76**




## Major Features of Medicaid

The Kerr-Mills program was viewed by many as only a temporary solution to the problem of providing medical care for the aged. Even before the States had fully implemented Kerr-Mills, organized groups of senior citizens questioned why the elderly should be forced into retirement and required to accept welfare to receive health services. The special needs of the elderly coupled with rapidly increasing hospital costs and the plight of impoverished minorities brought strong pressure on the Congress throughout the early sixties to enact a compulsory health insurance program. A myriad of health proposals were introduced, such as subsidized insurance for the aged for physicians' services, hospital insurance for the aged under social security, and larger Federal grants to the States to provide health care services to indigents. Finally, in July 1965 several of the proposals were combined to form Medicare and Medicaid.

Medicaid was the "sleeper" of the 1965 legislation. Congressional debate had focused almost exclusively on Medicare, the program for the elderly. By contrast, Medicaid, which was viewed as an extension and improvement of the Kerr-Mills program and the existing welfare system, was quickly written and hastily passed. Its architects never delineated clear goals or came to grips with the problems endemic to the structure of the welfare programs, particularly the problem of determining eligibility through means tests. Furthermore, as Medicaid began, policymakers had no clear sense of the potential costs of the program or of the impact of pumping vast sums of Federal dollars into the private sector of the medical market.

Medicaid's goal, however vague, was ambitious: "to provide the poor with the same access as the rich to mainstream medical care." Each State was encouraged "as far as practicable to provide medical assistance to families with dependent children and to the aged, blind, and permanently and totally dis-

ed individuals whose income and urces are insufficient to meet costs of necessary medical servs." By 1975 the States were to er "comprehensive care for subntially all individuals." Within a tter of months the term "comhensive care" became more mbolic than substantive": A 66 policy interpretation by the partment of Health, Education, d Welfare (DHEW) required ly that the State "show progrese steps in the direction of a comhensive scope of medical care d services" (*1*).

The Medicaid program has these jor features:

- Like the earlier welfare programs, is a Federal-State partnership in ich the Federal Government proes financial support and general idelines, and the States assume ntrol and direction of operations.
- It requires a participating State cover all persons receiving cash istance under the Aid to Families th Dependent Children (AFDC) gram. (Before implementation the Supplemental Security Inme (SSI) program in 1974, ates were also required to cover l aged, blind, and disabled cash istance recipients.)
- It gives a participating State the tion of including medically needy rsons in the following categories: pendent children and their famis, the aged, the blind, and the abled.
- It substitutes a single program of dical assistance for the payments der the categorical programs for h assistance for the aged.
- It offers a higher rate of Federal atching for vendor payments than e Kerr-Mills program.
- It requires a participating State offer under its program the folwing services: inpatient and outtient hospital services, other labratory and X-ray services, skilled ursing services, physicians' servces, home health services, and PSDT. The amount, scope, and uration of the basic services are left o the discretion of the States.
- It allows the States to pay for other specified health care services and receive Federal matching funds for these optional services.
- It emphasizes State responsibility rather than the local responsibility stressed in the earlier welfare programs.
- It retains from the previous welfare structure the concept of vendor payments (payments made directly from the State to health care providers) and expands the concept of the medically needy to include all persons, not just the elderly, whose medical bills are beyond their means but who are not eligible for cash assistance.

Although the States are not required to have a Medicaid program, strong incentives have been provided. After December 1969, no Federal funds were available for medical vendor payments for the categorical-related health assistance programs or for Kerr-Mills programs. Also, Federal matching funds were offered to help States pay for the administration of their programs. By the end of 1966, 29 States had initiated a Medicaid program. Today, 49 States, the District of Columbia, Guam, the Virgin Islands, and Puerto Rico offer Medicaid, and Arizona expects to begin its program in July 1977. Thirty-two programs cover the medically needy in addition to welfare recipients.

## Problems in Management

Problems in management of the Medicaid program developed immediately in implementing the sometimes vague and often confusing legislation. Because Medicaid was the outgrowth of earlier programs, implementation proceeded simultaneously at the Federal and State levels. Manv States with well-organized Kerr-Mills programs began developing State plans as soon as the bill was passed and thus preempted the opportunity for Federal initiative and direction.

Meanwhile, at the Federal level the question of whether Medicaid was an income-maintenance program or a health program created an organizational dilemma. Should the program be administered by DHEW's Welfare Administration or Public Health Service? After lengthy discussion, the task of administering Medicaid was given to the Division of Medical Services in the Bureau of Family Services of the Welfare Administration, which had previously been charged with oversight of the Kerr-Mills programs. Twelve new positions were added to the division's staff of 23, including clerical personnel, as it began interpreting the legislation, preparing guidelines, negotiating with the States and jurisdictions, and administering a budget which within a year totaled $1.6 billion.

By contrast, Medicare's implementation, according to Robert and Rosemary Stevens' history of Medicaid, "had the advantage of being a completely new program, one administered solely from the federal level by a well established, well ordered and well accepted entity in HEW" (*2*). Ample planning time, in which staff were hired and preliminary guidelines prepared, preceded the implementation of that program.

The first congressional attempt to improve the management of Medicaid came with the passage of the Social Security Amendments of 1967. Enacted only 2 years after the bill's passage and only 1 year after most State programs were started, these amendments reflected growing concern by the Federal and State governments with the administration of the program. Federal guidelines were established requiring States to review, on a continuing basis, the cost, administration, and quality of medical care provided in their programs. Stricter standards to insure quality care and periodic reviews to appraise utilization patterns were required for nursing homes.

In attempting to improve administration of the Medicaid program, the 1967 amendments also greatly expanded the Federal responsibil-

ity. Concerned with the health of children in low-income families, the Congress mandated, for persons under 21 years eligible for Medicaid, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to "ascertain their physical and mental defects and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered . . . ." Thus, not only is child health now a major program priority, but the States are expected to administer and the Federal Government is expected to oversee a program for the direct provision of health care services.

In 1970, a Senate Finance Committee report (*3*) and an independent DHEW task force (McNerney report) (*4*) underscored the need for better management of the Medicaid program. The Division of Medical Services, which had been given bureau status and renamed the Medical Services Administration in 1967, was given 80 new positions, bringing its total to 160. Two management themes were stressed: improving management information systems in the States and strengthening procedures for developing policy guidelines and regulations.

The Social Security Amendments of 1972 reflected the continued disenchantment of the Congress with the program. In an effort to improve State compliance, penalty provisions were enacted which allowed Federal funds to be withheld from States for failure to implement the utilization review and EPSDT programs mandated by the Congress. In addition, the amendments established professional standards review organizations composed of practicing physicians in local areas to undertake a comprehensive and ongoing review of services under Medicaid and Medicare to determine if they are "medically necessary" and in accordance with professional standards.

A major shift in the Federal posture has occurred in the last few years. As the Medicaid program has matured, the Federal focus has shifted from encouraging expansion of State programs to assuring their integrity. The Federal Government has developed a number of measures designed to assure that appropriate and high quality care is delivered only to eligible recipients by qualified providers and is currently undertaking in-depth review of several aspects of the programs.

*Medicaid's eligibility quality control program* is designed to insure that all Medicaid recipients are actually eligible for the benefits. This activity complements the AFDC eligibility quality control program and the Social Security Administration quality assurance program covering Medicaid recipients whose eligibility is determined by the Social Security Administration.

*Provider fraud and abuse* is being attacked through evaluation and monitoring of the States' fraud and abuse surveillance activities. The Federal program is designed to document and highlight a State's capability to identify and prosecute providers who are benefiting unfairly from treating Medicaid patients. Once a State shows that it can detect and take action on fraudulent or abusive practices, the incidence of these practices rapidly declines.

*Financial reviews* are Federal studies which evaluate the effectiveness of State operations and the appropriateness of Federal reimbursement for State claimed expenses for these operations. As many as 12 different reviews can be made in each State to identify weaknesses, provide technical assistance, and save Federal funds.

## High Costs

It was apparent almost from the start that costs of the Medicaid program would exceed projections. Budgeters with little reliable actuarial data on which to base their estimates had anticipated that Medicaid would add $250 million to the $1.3 billion in vendor payments for Kerr-Mills programs in 1965. By 1967 program costs had already passed $2 billion and were rising steadily. (All figures in this paper are for fiscal years.)

The Social Security Amendments of 1967 instituted a limited definition of "medically needy" in an effort to control program costs. By 1969, however, the payments to providers of health services had increased to $4.4 billion (fig. 2), and Congress stated that the goal of having a "comprehensive" Medicaid program in all States could be postponed until July 1, 1977, and that the States could drop optional services if they faced serious budget constraints.

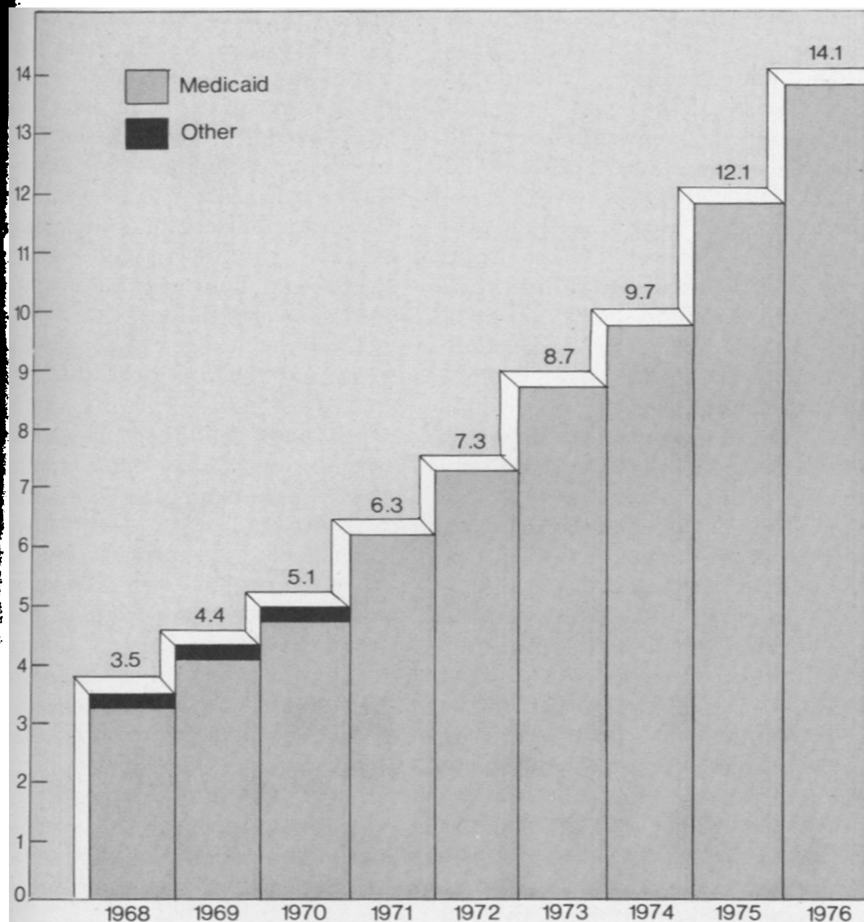
The 1972 amendments to the Social Security Act, passed after program costs had increased 91 percent between 1969 and 1972, from $4.4 billion to $7.3 billion, made significant changes in the program. The requirement that States move to "comprehensive care" was eliminated. States were permitted to control costs by requiring cost sharing for the medically needy and for optional services used by categorical recipients.

## Basic Difficulties

In spite of all the amendments, inadequate program management and high costs have persisted. The reasons are undoubtedly many and interrelated, but perhaps the major shortcoming of the amendments is their failure to attack basic problems. Efforts to improve program management never attempted to deal with the basic difficulty of implementing complicated legislation, particularly that concerning eligibility. Eligibility criteria are so complex that, for example, 500 caseworkers are needed to determine eligibility for patients in the Los Angeles County hospital alone, a fact discovered in a 1975 review of California's program by the Medical Services Administration.

Nor have the amendments eliminated the confusion over where accountability and program control rest in the Federal-State partner-

ure 2. **Medicaid and related program payments to providers of health care, al years 1968–76**




[1] Payments to intermediate care facilities are included in the totals for fiscal years 1969–72 even though they were administered under the cash assistance program until Jan. 1, 1972, when they were transferred to title XIX.

ship. As Federal expenditures for Medicaid have risen, so has the Federal concern over how well the money is being spent.

From an initial posture of monitoring and advising, the Federal role has grown to include the function of oversight. Target areas for oversight have been identified: long-term care, management information systems, fraud and abuse, and control of utilization. Yet despite the increased expectations for Federal oversight of the 53 programs, the Federal "presence," or capability, has remained small. Thus the amendments added increased responsibility without adding commensurate resources and control.

Similarly, efforts to control program costs have focused on eliminating services, instituting cost sharing, and reducing unnecessary utilization without ever tackling the inflationary aspects of the legislation —the provisions for "reasonable cost reimbursement" to providers and open-ended Federal matching. Furthermore, there has been little recognition that Medicare's incomplete coverage for long-term care would require Medicaid to devote approximately 40 percent of its funds to long-term care.

One other problem for which Medicaid has been harshly and justifiably criticized, but which has received little attention from the Congress, is its inequity among the States, a criticism particularly valid since the program is more than 55 percent federally funded. As a result of variations in eligibility requirements, persons who would receive benefits in one State may not be eligible in another State. Thus, Medicaid does not cover all the poor, by any means. In 17 States for example, fewer than one-third of the poor received medical benefits from Medicaid in 1970.

## Accomplishments

During its 10 years, the Medicaid program has produced two major accomplishments: It has improved dramatically the financial access of the poor to medical services, and it has provided experience that is proving valuable in considerations of national health insurance.

**Access to health care.** Without question, Medicaid has extended health care to low-income persons who otherwise would not have received services. According to DHEW's recent report on health trends in the United States (*5*), in 1964 approximately 28 percent of the poor had not seen a physician in the previous 2 years; by 1974 that figure had dropped to 17 percent.

It is estimated that one in every five Americans has received some medical care through the Medicaid program. In 1974 alone, more than 21 million persons received at least one service reimbursed under the Medicaid program.

Currently, the poor are using health services at about the same rate as the nonpoor. In fiscal year 1973 the average health care bill was $384 for all Americans, compared with $432 for Medicaid welfare recipients and $749 for the medically needy and institutionalized Medicaid recipients (*6*).

**Lessons for national health insurance.** As the largest and most direct Federal program for provision of health care services to a broad range of recipients, Medicaid has provided experience that may

prove valuable in considering the effects of a national health insurance program. It has afforded States the opportunity to influence and shape their health delivery systems—to test various administrative mechanisms and to deal with such items as size and structure of benefits, cost sharing, alternative approaches to long-term care, rate regulations, and health maintenance organizations. The mushrooming cost of the Medicaid program, due primarily to the large increase in recipients and inflation in health care costs, has hastened concern and caution among policymakers about the possible harmful effects of enacting a comprehensive national health insurance program.

Experience with Medicaid shows clearly that a successful national health insurance program is possible only if the operational problems of a large public program for financing health services are solved first. Solution of these problems requires high-level commitment in the legislative and executive branches of both Federal and State governments. It also requires managers who are not only strong and tough but also compassionate and sensitive. Any legislation aiming toward national health insurance must address public policy issues such as equity of benefits, as well as existing operational problems.

## Conclusions

Recent events, including Medicaid cutbacks in many States and documentation by the General Accounting Office, the media, Congressional committees, and DHEW of extensive operational weaknesses in the Medicaid program, have produced a consensus that the obstacles to an equitable and comprehensive health care program for the poor must be eliminated. Either the Federal presence—staff, accountability, and authority—must be increased multifold to allow effective and efficient management of the 53 separate State Medicaid programs, or the States should be made clearly accountable for providing health care to the poor, with a concomitant decline in Federal oversight.

President Ford, in the Financial Assistance for Health Care Act (H.R. 12233, introduced March 2, 1976, and S. 3137, introduced March 15, 1976), has proposed realigning the responsibilities and resources so that the States would be held accountable for management of their programs. The proposal would consolidate Medicaid and 15 categorical health programs into a $10 billion block grant to the States. To achieve a more equitable distribution of Federal dollars among States, the funds would be distributed on the basis of the number of low-income persons in a State. States would not be bound by categorical restrictions but could determine the low-income population they would serve. Besides targeting the funds on the low-income population, the only other restrictions on the use of funds would be that 90 percent be spent on personal health services, 5 percent on community and environmental health activities, and 5 percent on other health activities including health planning and rate regulation.

Proponents of increasing the Federal presence include Senators Russell Long, Abraham Ribicoff, and Herman Talmadge. In the proposed Catastrophic Health Insurance and Medical Assistance Reform Act of 1975 (S. 2470, introduced October 3, 1975), Senators Long and Ribicoff recommend replacing Medicaid with a uniform national program of medical benefits for 35 million low-income persons administered by the Social Security Administration. Senator Talmadge's legislation, the Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205, introduced March 25, 1976) would tighten the requirements on the States for eligibility determination and claims processing and increase the Federal responsibility for monitoring State performance. Annual DHEW assessments of State programs would be undertaken to determine compliance with uniform Federal standards, which are specified in the bill. The Federal contribution to a State's administrative costs would be decreased or withheld from States not in compliance, whereas those States with exemplary practices would be reimbursed for a higher percentage of their administrative costs. Likewise, performance-based reimbursement would reward efficient hospitals and nursing homes and limit reimbursement to inefficient institutions.

Over the next few years, the Congress and the President will determine how health care for the Nation's poor shall be financed and administered. The basic administrative issue is whether the Federal Government or the State governments will have primary responsibility for the system. The experience with the first decade of Medicare and Medicaid will influence the decision on this issue and will provide the knowledge needed for a successful implementation of the decision.

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