primary care and obstetrics. Altman notes that "... one way to begin to address this problem without substantial new expenditures (is to) get serious about expanding managed care."

Finally, all respondents emphasize the difficulties confronting both the States and the Federal Government in addressing Medicaid policy issues alone. The growing demands placed on Medicaid resources in the coming years require a strengthened State-Federal partnership to marshal program resources effectively within current Federal and State fiscal realities. Tallon's article, in particular, outlines the multiple views currently under debate for repositioning Medicaid in the search for solutions. Whether program changes are incremental or systemic, and occur slowly or rapidly, Clarke emphasizes the need to build on the States' Medicaid management expertise, their demonstrated capacity for innovation, and their ability to work directly with local agencies and providers in balancing State and Federal fiscal and policymaking responsibilities.

Perspectives on the Medicaid program

by Drew Altman and Dennis F. Beatrice

Introduction

Viewed from one vantage point, Medicaid has been one of the most successful social programs this country has launched. It represents a dramatic achievement in providing access to care for low-income people and stands in sharp contrast not only to the situation that existed prior to the passage of the Medicaid program, but also to the plight of the uninsured today. Medicaid also serves some of the Nation's neediest and most vulnerable groups, especially low-income women and children, the elderly, and the blind and disabled. It provides coverage to more than 25 million people, many of whom would otherwise be added to the ranks of the uninsured.

Yet, despite its important contributions to access to health care for the poor, Medicaid has never been a popular program. Indeed, it is the health care program everyone loves to hate. Governors and State administrators see it as the "Pac Man" of State budgets, eating up a substantial share of available increases every year. Providers believe Medicaid pays them too little and too slowly. Federal executives see a constant stream of State Medicaid waiver requests, with tortuous arguments for budget neutrality, that seek to raid the Federal treasury. And clients view Medicaid as a mixed blessing: It offers a vital health benefits life line, but they view it as stigmatizing, and obtaining care is often frustrating.

Both sides of the ideological aisle also have their reasons to dislike the Medicaid program. Liberals view Medicaid as diverting the Nation's attention from the need for national health insurance. They are troubled by the fact that the program covers less than one-half the Nation's poor and that there are substantial variations in State Medicaid programs. Conservatives view Medicaid as "just another welfare program," this time hiding in health care clothes. Their view is that welfare programs, including Medicaid, have caused more harm than good by promoting dependency and using taxpayer dollars unwisely.

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Not surprisingly, given these perceptions, Medicaid has not built a strong constituency and has received only a fraction of the analytical attention devoted to Medicare. Another reason for this lack of affection and focus is the complexity and diversity of the program. As is well known by the readership of this journal, Medicaid is really three programs in one: a program for low-income women and children; a program for the blind and the disabled; and a program—really a catastrophic insurance program—for the elderly in need of long-term care. Remembering that each of these 3 programs looks a little different in every State, one realizes that Medicaid is really 150 different programs spread across the 50 States. It is difficult to comprehend, analyze, or mobilize support for a program this diverse. The result is that Medicaid plays its role as payer of last resort and provides care to the most vulnerable populations without much fanfare or support.

As Human Services Commissioner and Associate Commissioner in New Jersey, and long-time advocates for Medicaid, we sometimes even found ourselves losing our affection for the Medicaid program, as annual Medicaid increases consumed funds needed for other priority areas. In any given year, the increase in Medicaid necessary just to maintain current services consumed about one-half of all the new funds available for our department. This left the homeless, the mentally ill, the elderly, the developmentally disabled, veterans, welfare recipients, and other needy groups to fight for the leftovers after Medicaid had taken its share.

The last 10 years

In recent years, Medicaid has gone through some important changes. With State and national economies faltering, the early eighties saw a period of cost containment in the Medicaid program. During this time, the States and the Federal Government faced a common challenge: how to control Medicaid expenditures without hurting needy clients. The specific challenge Medicaid faced was how to limit expenditures without resorting to the traditional, quick-fix Medicaid cuts—reducing eligibility, eliminating benefits, or reducing payments to providers. Although Federal policy changes in the early eighties reduced Medicaid eligibility for some groups (Omnibus Budget Reconciliation Act of 1981, Public Law 97-35), by and large, States worked hard to avoid

draconian measures, and out of this period came an interest in new financing and service alternatives.

Spurred by the need for cost containment and by the search for alternatives to harmful cuts, many Medicaid agencies began slowly to change in character. Once large agencies that simply paid bills, Medicaid administrators began to take more initiative, using their control over reimbursement as a mechanism to try to improve the health care system for their clients. In effect, many Medicaid programs became laboratories for change. They also became more active purchasers, seeking to use their buying power to achieve savings. During this time, important experiments were launched in prepaid managed health care, utilization review, case management, diagnosis-related groups (DRGs), negotiated rates, home and community-based services for the elderly, disabled, and persons with acquired immunodeficiency syndrome (AIDS), and other forms of payment reform.

As State economies improved in the mid-eighties, Congress moved to expand Medicaid coverage. Thus, Medicaid moved from an era of cost containment to one of careful and selective expansion. It was during this time that the historical step was taken of breaking the link between Medicaid and welfare eligibility. This resulted in a series of significant expansions of Medicaid, particularly for low-income women and children, and laid the basis for a potentially much broader and very different program in the future.

With the passage of welfare reform in 1987, another subtle but important change was made in the Medicaid program. Medicaid came to be viewed as part of a broader strategy to address the problem of poverty in America. Welfare recipients almost always cite the fear of losing health insurance as a major disincentive to leaving welfare and going to work. But through the Family Support Act as part of a package of services including job training, education, child care, and case management, the 1-year guarantee of Medicaid eligibility for people who leave welfare because of employment has become a cornerstone of the welfare reform effort. The use of a Medicaid extension in welfare reform relieves a woman on public assistance of the need to make a Hobbesian choice between taking an entry-level job that would leave her children without health insurance and remaining on public assistance.

Medicaid has evolved substantially in the last decade, moving from cost control, through innovation, to expansion. The important question is which strands of this recent history will dominate in the decade ahead.

The challenge ahead

As we move into the nineties, the Medicaid program will have to confront several realities if we are to sustain the accomplishments of the past and do better in the future. First, we are once again entering a period, like the early eighties, of fiscal constraints at the State level. Governors are once again eyeing their Medicaid budgets with suspicion. In the recent proclamation from the Nation's governors—"no new money ... no new mandates"—they expressed the view that States cannot absorb new service requirements without increased revenues (National Governors' Association, 1989). This sentiment is captured even more eloquently in a recent statement made by a member of the Senate Appropriations Committee of the New Jersey State legislature who, exasperated by the rate of increase in Medicaid expenditures, referred to it as "the program that ate New Jersey" (McNamara, 1989). Nothing shapes the development of Medicaid policy at the State level more than the health of the State budget. And once again, we are entering a period when State budgets are shaky at best. Healthy State economies have permitted the States to pick up the slack as Federal spending, constrained by the deficit, slowed. With State deficits re-emerging, the ability of States to maintain the safety net—and a growing Medicaid program—will weaken.

Without new resources, it may be that the laboratories of the eighties, the States, are running out of gas. The standard menu of Medicaid reforms may be played out. There are only so many ways to case manage or prepay your way around problems like a low Medicaid fee for a basic office visit, the fact that many obstetricians will not see Medicaid patients, or that 15 percent of a State's population is uninsured. In the eighties, Medicaid agencies made existing resources go further. But Medicaid is not a magic act; it cannot maintain services in the absence of both State and Federal resources. New approaches being discussed, such as the Oregon plan to "ration" services, present a controversial prescription to control costs and make primary care services more widely available. It is our sense that it is better to work to reduce inappropriate services and develop financing alternatives than to eliminate coverage of particular services, as Oregon is attempting to do. In any event, explicit service limitations present a new and unexplored face of the Medicaid debate.

Second, like building a house on a beach that is washing away, we have been expanding the Medicaid program while the foundation of the program deteriorates before our eyes. As the participation of physicians and other health professionals in Medicaid wanes, the access we are providing to those covered by Medicaid is increasingly access only to a hospital emergency room or Medicaid mill. When it comes to providing primary care, emergency rooms make poor family doctors. Moreover, primary care provided in the emergency room is inordinately expensive, costing substantially more than a visit to a physician's office. We see the same problem in home health care and other in-home services, where needs are growing tremendously, but low payment levels have produced an industry with high yearly turnover rates and a pool of personnel unequipped to meet the Nation's health care needs. Some States have added bells and whistles to Medicaid while the program's infrastructure has been left unattended. It makes little sense, for example, to expand Medicaid coverage for pregnant women, if there is no obstetrician within 50 miles willing to provide prenatal care or to deliver her baby.

With so many of today's health care problems linked to poverty and risk-taking behaviors such as substance abuse, it will become increasingly important to break down the barriers between Medicaid and other education and social services programs. This is being done now, for example, where Medicaid financing is part of

comprehensive school-based service programs. Increasingly, today's health care problems transcend the traditional boundaries of medical practice and cannot be resolved through health care intervention alone. Although some observers of the Medicaid scene argue for separating Medicaid from welfare programs in order to bolster Medicaid's political image, practitioners in the field have been working to better integrate Medicaid, welfare, and other social services programs. We can expect increased tension between two views of Medicaid: as a health insurance program, isolated from welfare and a potential base for broader coverage of the uninsured, and as an integral part of a comprehensive set of social and health services to assist individuals and families.

Finally, as our population ages and the needs of the disabled grow, women and children will continue to struggle for a share of Medicaid's resources. Women and children represent almost 70 percent of Medicaid recipients, but less than 25 percent of Medicaid expenditures (Congressional Research Service, 1988). As the population continues to age, we can expect even more pressure for Medicaid resources to be expended on behalf of those needing long-term care services. This is a persistent problem in Medicaid and one that remains very real.

All these stresses and cross-pressures play out in an environment where the problems that Medicaid must address are getting worse rather than better. The problems of the uninsured, the elderly, the urban poor, and, in some States, the devastation of crack and AIDS, are growing, while resources are static. We sometimes forget that two of our biggest problems, AIDS and crack, did not exist 10 years ago. This tension between capacity and need is the major challenge faced not only by Medicaid, but by the entire health care system in the nineties. Particularly hard hit are the Nation's urban and public hospitals. These institutions are on the front lines, and they are disproportionately dependent on the Medicaid program.

Future directions

It is unlikely that the problems faced by Medicaid will be dealt with comprehensively. We seldom solve social problems in our country through bold single strokes. Just as it is likely that we will address the overall health insurance problem by building in increments on what we have, it is also likely we will strengthen the Medicaid program through a series of incremental steps.

If we are to see positive incremental change, it will be important to strengthen the foundation of Medicaid, to build the infrastructure as well as to maintain the positive new directions of recent years. First, we need to take steps to bring primary care physicians and other health professionals into the Medicaid program and to hold on to the ones we have. To do this, fees must be increased, a measure that will certainly cost more. There is, however, one way to begin to address this problem without substantial new expenditures: get serious about expanding managed care.

Managed-care plans reallocate resources from emergency rooms and other services to primary and preventive care. In a good Medicaid managed-care plan, it is possible to increase reimbursement to primary care physicians at no additional overall cost to the Medicaid program. But Medicaid managed care has been stalled for years, mired in red tape and waiver processes, provider ambivalence, analytic uncertainty, and questionable State commitment. These obstacles can be overcome, but it will require a renewed effort by government, and openness by providers, to take the plans for managed-care programs off the drawing board and beyond the demonstration stage.

Second, we should continue to look for opportunities to expand Medicaid coverage to the uninsured. For example, buy-in plans—an idea discussed in the Bush-Dukakis presidential debate and alluded to in the Omnibus Reconciliation Act of 1989—can be developed. Through a buy-in to Medicaid, it is possible to offer a significant percentage of the working uninsured an option for health coverage at rates substantially below those otherwise available in the marketplace. Yet Medicaid buy-in plans have not been developed to any substantial extent. Where they exist, Medicaid managed-care plans represent an opportunity for buy-in strategies; buying in to managed care is obviously preferable to buying in to care in emergency rooms or Medicaid mills. Broader use of buy-in also offers the potential to reduce the stigma of Medicaid by making it a more inclusive program with a more diverse clientele.

It will also be important to maintain recent efforts to make Medicaid a more active force for better health care, rather than just a passive payer of bills. For example, many States have taken the lead in building comprehensive prenatal care programs into their Medicaid plans. Such programs offer a comprehensive package of services and typically also reform payment to make it possible to provide comprehensive care on a single-point-of-entry basis. The usual approach is to provide a global fee for a comprehensive package of services including outreach, the identification of high-risk cases, home visiting, case management, nutrition and substance abuse counseling, and other critical services necessary to make a difference through prenatal care. This is important because providers are unlikely to offer comprehensive, single-point-of-entry services if they have to submit separate bills to Medicaid agencies for each individual service. Also, clients will not get comprehensive quality services if they have to go shopping for services at 5 or 10 different locations. Comprehensive prenatal care programs could be mandated by the Federal Government as a necessary part of every State Medicaid program, or alternatively, States could be given incentives to offer such plans through enhanced Federal matching rates. There is ample precedent for enhanced matching rates where the Federal Government wants to encourage State action.

Similarly, if the recent eligibility expansions are to achieve their full potential, it will also be important for Medicaid agencies to continue to expand efforts to reach newly eligible populations. As State administrators well know, offering a service does not guarantee its use. As the link was broken between Medicaid and welfare eligibility, Medicaid agencies lost their natural connection to women and children in the welfare office. As a result,

Medicaid agencies will need to become more active in outreach activities, a role they have not historically played. The Federal Government could encourage such activities at very limited cost by mandating outreach or enhancing matching rates for outreach activities.

Although there are cost implications to encouraging comprehensive care and outreach in Medicaid, it would be a modest investment compared with the benefits. These steps and others like them are important if we are to consolidate the gains made in recent years in enhancing coverage in Medicaid.

Conclusion

Medicaid has had an important impact on health care services for the poor in America. In the absence of a national health insurance program, Medicaid is the closest we come as a Nation to providing publicly financed access to care for those who lack it. In prenatal care for low-income women, services to the elderly and disabled, and coverage for poor children, Medicaid is the difference between receiving services or doing without. Medicaid is also crucial to maintaining even a minimum capacity at inner city hospitals to deal with problems like cocaine abuse, crack-addicted infants, and AIDS.

But it will be difficult to maintain the momentum of the recent past. State deficits, resistance to new mandates, and Federal aversion to increased spending will all work to slow or even reverse expansion and experimentation in Medicaid.

It is encouraging that the Health Care Financing Administration (HCFA) is reorganizing to focus more effectively on Medicaid issues—Medicaid has been a poor relation for too long in HCFA. This change will also facilitate a sharper focus on important State-Federal Medicaid issues such as the certification of State psychiatric hospitals and developmental centers and standards for nursing home care. The opportunity exists for the States and HCFA to work together constructively to achieve common goals, and this opportunity must be seized.

However, the role of the States as innovators is wearing thin. Funds are needed to build the base of Medicaid—to attract and keep providers, to offer comprehensive services, to emphasize outreach—and to enhance the program through efforts such as buy-in initiatives or managed care.

Medicaid is only one of the many areas in social welfare and health policy where limitless demand collides with limited resources. Given this reality, the tension between the needs of people and the capacity of Medicaid to address those needs will continue to grow. As a result, States will focus even more intensely on Medicaid as budgets become tighter, Medicaid spending continues to grow, and demands for service increase. It will require attention, commitment, and money to maintain enhancements already achieved and to continue in a positive direction.

In the final analysis, how one views the Medicaid program, its recent changes, and its prospects for the future depends on one's perspective. To human services commissioners and Medicaid directors, the kinds of changes discussed here are truly important. Some of them, such as breaking the link between Medicaid and welfare or offering a guarantee of Medicaid coverage after employment, may even seem revolutionary in nature. But to the taxpayer or budget officer seeking quick fiscal relief or to the child advocate who still sees children suffering and mishandled by the system, modest incremental improvements in Medicaid offer little comfort.

Both the need for continued incremental change and for longer term reform warrant our attention. It would be a mistake to pursue either one at the expense of the other.

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Medicaid: Challenges and opportunities

by James R. Tallon, Jr.

Introduction

If you read the newspapers or professional journals, listen to political speeches or the "man on the street," a consensus with seeming contradictions becomes apparent: Very few people think Medicaid works well—it costs too much, it does not buy good care, it is out of control. Yet there is a strong base of support among the public and within government and academic sectors to maintain and enhance access to health care, particularly for the poor.

The essential design of Medicaid has remained largely unchanged through its 25-year history despite criticism from all quarters. Medicaid is an important feature of the American social welfare system—a system that has survived numerous economic and political cycles. In part, this survival reflects the preference of our political culture for incremental change, a preference that has rescued Medicaid and other safety net programs from dismantling. We are regularly confronted with urgent crises that forestall consideration of long-range problems and solutions. However, the failure to take on broad, systemic issues has also stymied legitimate efforts to reform or create anew the program.

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