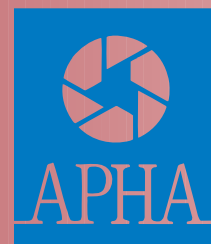


Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow



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Executive Summary

Medicaid provides primary, acute and long-term care to more than 50 million Americans—39 million people in low-income families as well as more than 13 million elderly and persons with disabilities, including more than 6 million Medicare beneficiaries. Although Medicaid has traditionally been viewed solely as an insurer of low-income and vulnerable populations, the program's coverage of essential public health services and financing of public hospitals and clinics improves the health status and outcomes of program beneficiaries and the population as a whole. For example, screening children for blood lead allows for interventions that can prevent delays in a child's intellectual development. The coverage and provision of public health services also affects the population as a whole—if an individual is tested for sexually transmitted infections, she likely will be more aware of her health status and less likely to transmit the infection to others. Public health services, in most instances, have been demonstrated to be cost-effective, most notably in the provision of immunizations and pre- and post-natal care.

Average annual Medicaid spending increased 10.2 percent from 2000 to 2003, due to overall increases in health care costs, an economic downturn and increased program enrollment. This growth has contributed to increasing fiscal pressures at the state and federal level, and for policy-makers to reevaluate the populations served and services covered by the Medicaid program, looking for cost savings. The primary goal of most federal and state Medicaid reform efforts has been budgetary savings. However, good policy, not a dollar figure, should drive Medicaid reform efforts. Medicaid's role as an insurer, provider of essential public health services and financier of public hospitals and clinics should be maintained, if not strengthened, in any Medicaid reform initiative. The Medicaid program does not just affect the health of over 50 million program beneficiaries; it impacts the lives of their families, coworkers, classmates and neighbors. In other words, Medicaid impacts us all.

Medicaid As An Insurer: Improving the Public's Health

Medicaid provides health insurance coverage to 40 percent of all poor individuals, half of all low-income children and one in six Medicare beneficiaries. This provision of coverage has been proven to improve beneficiary health outcomes and health status compared to being uninsured. For example, studies have shown that providing health insurance coverage to children and women with breast or cervical cancer significantly improves their health status and outcomes.

Medicaid Public Health Services

Medicaid support for public health services is essential. State Medicaid programs cover public health serv-

ices ranging from child blood lead screening to school health services to adult immunizations. In many instances, most notably adult immunizations, states are not required to cover these services under their Medicaid programs. Therefore, if any services need to be cut on the state level, such "optional" services will be likely targets. This is an area that has not been adequately explored and needs to be thoroughly evaluated in any Medicaid reform effort. However, any perceived savings resulting from cut-backs are illusory because of the significant impact on the public's health and the cost shift for services that occurs both within and to other health programs.

Medicaid's Financing of Public Health Care Providers: Supporting the Safety Net

In addition to serving as an insurer and increasing program beneficiaries' access to effective public health services, the Medicaid program provides essential financing to public health care providers in the United States. The operation of health centers, public hospitals, community mental health providers, sexually transmitted infection clinics and school health centers are dependent upon sustainable Medicaid payments and financing. If these providers shut their doors, the lives of millions of low-income individuals who are insured by Medicaid, as well as those who may be privately insured or uninsured, will be affected.

Issues in Medicaid Reform

The American Public Health Association recommends that the coverage of current beneficiaries and services be maintained or strengthened in any Medicaid reform effort to protect the public's health. Medicaid is a primary provider of health insurance coverage for individuals living in rural and underserved areas, low-income pregnant women and persons living with HIV/AIDS. Proposed changes in program eligibility need to be closely examined to assess whether they will disproportionately affect minority and rural populations. Also, considering that there are already 45 million Americans who are uninsured and without access to a safety net program, any Medicaid reform effort should not contribute to an increase in that number, or increase the number of underinsured individuals.

The Medicaid program also provides its beneficiaries with access to and coverage of a comprehensive range of services, ranging from primary health services to immunizations to long-term care. However, several proposals, both formal and informal, have the possibility to jeopardize beneficiaries' access to needed health services, which will only adversely affect their health status and outcomes. Medicaid beneficiaries should continue to have access to a comprehensive benefits package and disease prevention and health promotion programs without new or increased financial barriers, as outlined

in APHA's 14 Points.¹ Therefore, the American Public Health Association urges federal and state policy-makers to give due priority to:

Ensuring Access to Preventive Services. Medicaid provides coverage to proven preventive and screening services, which gives beneficiaries incentive to utilize such cost-saving and cost-effective services. Without coverage of immunizations, screening for sexually transmitted infections and chronic diseases and other preventive health services, program beneficiaries will likely not have access to such services,

which not only affects their health status and outcomes, but in the case of immunizations and STI screening, the health status of the population at large.

Protecting the link between "E" and "T" of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Currently, under EPSDT, states are required to treat children for conditions and illnesses detected during screening, which range from mental health disorders to vision and hearing loss. Without the "T," these children from

low-income households and without wrap-around insurance coverage will likely go without necessary treatment. Lack of treatment puts their educational attainment, emotional and cognitive development and lives at risk. However, treating conditions identified by EPSDT screenings early leads to improved emotional and cognitive development, improved educational performance, lower instances of substance abuse and increased economic self-sufficiency.

Prohibiting Cost Sharing for Receipt of Covered Services. Due to the low incomes of Medicaid beneficiaries and their families, instituting or increasing co-payments or premiums is likely to cause beneficiaries to forego needed care, increasingly depend on emergency health services and become uninsured.

Ensuring Access to and Affordability of Prescription Drugs. Although prescription drug expenditures are increasing rapidly under the Medicaid program and nationwide, there are methods through which savings in this area can be achieved without jeopardizing beneficiaries' access to such cost-effective treatment. State and federal policy-makers should: reconsider whether the utilization of Average Wholesale Price (AWP) is the best way to determine the prices of prescription drugs offered under state Medicaid programs; explore the expansion of state purchasing pools to garner larger pharmaceutical drug rebates; and consider requiring larger pharmaceutical industry drug rebates to states across the board.



Introduction

Medicaid is the nation's health insurance program for certain low-income and vulnerable populations that provides primary, acute and long-term care to more than 50 million Americans, with an annual cost topping \$250 billion. Medicaid provides health and long-term care coverage to 39 million people in low-income families as well as more than 13 million elderly and persons with disabilities, including more than 6 million Medicare beneficiaries. The Medicaid program, which began in 1965, is jointly financed by the federal government and the states. The federal government matches state spending for services, with the federal matching rate varying by state from 50 to 77 percent. Overall, the federal government currently finances 57 percent of Medicaid spending.² The federal government establishes broad guidelines for program eligibility, services covered and implementation, but ultimately the states administer the program after determining state-specific eligibility standards—the type, amount, duration and scope of services covered by the program—and payment levels for services provided to program beneficiaries. The Congressional Budget Office projects that increasing medical prices and enrollment for Medicaid will result in an average annual rate of growth for total federal Medicaid expenditures of about 8.4 percent for the FY2008 through FY2015 period.³ On the state side, the program comprised 12.6 percent of state budgets in state fiscal year 2003, which is expected to increase to 12.7 percent in state fiscal year 2004.⁴

Like Medicare, Medicaid operates as an entitlement program, so the federal government is obligated under federal law and the budget process to pay its share of each state's Medicaid costs. There is no cap or ceiling on the amount of federal funding that can be used for coverage provided through Medicaid. As a program that receives mandatory, not discretionary, funding from the federal government, the cost of Medicaid is dependent on the need of eligible individuals for its offered services and on state decisions about program rules, not on a predetermined dollar amount allocated to the program.

The structure of the Medicaid entitlement, coupled with an economic downturn that caused Medicaid enrollment growth as well as economy-wide increases in health care costs, led to an average annual growth in Medicaid spending of 10.2 percent from 2000 to 2003.⁵ This growth has contributed to increasing fiscal pressures on the state level, and for federal and state policy-makers to reevaluate the current nature and funding structure of the Medicaid program.

Medicaid is a lower-cost insurance provider than pri-

vate insurance for the low-income population, achieving lower annual spending increases than private health insurance providers.⁶ The program, while requiring substantive annual investment at both the federal and state level, does achieve slower increases in per capita costs due to preventive and primary health services being one of its primary foci. State Medicaid programs cover several essential public health services, ranging from immunizations to blood lead screening in children to targeted case management. Without this coverage, beneficiaries would not be able to readily access these preventive services, and therefore would rely on treatment and emergency health services that are not cost-effective to the respective individuals and society.

Ultimately, Medicaid's emphasis on prevention, and the ability of its beneficiaries to access population-based and personal health services, improves the health status and outcomes of its beneficiaries. On the most basic level, the Medicaid program provides a vehicle through which beneficiaries can access needed care and services. Without this program, Medicaid beneficiaries would likely delay seeking care and lose access to preventive services, including but not limited to immunizations, testing for sexually transmitted infections, and lead prevention activities. However, Medicaid also plays a major role in protecting and improving population-based health by being a primary funder of a wide range of public health programs.

The Medicaid program does not only affect the health status and outcomes of its approximately 50 million beneficiaries; it also impacts the health of Medicaid beneficiaries' classmates, coworkers and fellow nursing home residents, individuals with whom they interact every day. Medicaid beneficiaries—both children and adults—being vaccinated against influenza improves the health of the population, as such vaccinations contribute to herd immunity¹ and protect more people against the transmission of influenza. Sexually transmitted infection programs covered by Medicaid ensure that individuals infected with diseases ranging from chlamydia to HIV/AIDS are tested and diagnosed, and begin treatment regimens. These individuals will likely be more aware of their health status and less likely transmit the disease to others.

1 According to the Centers for Disease Control and Prevention, herd immunity is "the resistance of a group to invasion and spread of an infectious agent, based on the resistance to infection of a high proportion of individual members of the group. The resistance is a product of the number susceptible and the probability that those who are susceptible will come into contact with an infected person."

"Between the years 2000 and 2003, five million Americans lost their employer-provided health insurance. During that time, participation in Medicaid rose sharply. That tells me Medicaid is working as it was intended -- covering those who have nowhere else to turn. Medicaid is working - and working well - as our nation's safety net program and it should be protected."

**U.S. Senator
Jeff Bingaman
(D-N.M.)**

Medicaid As An Insurer: Improving the Public's Health

Medicaid covers 40 percent of all poor individuals, half of all low-income children and one in six Medicare beneficiaries². States have to cover populations deemed as “mandatory” under the Medicaid statute, and can receive federal matching funds if they choose to cover “optional” populations. The terms “mandatory” and “optional” are rooted in the historic linkage between Medicaid and the Aid to Families with Dependent Children (AFDC) program, the national welfare program that preceded the Temporary Assistance for Needy Families (TANF) program. The populations that were originally eligible for the program in 1965 are considered to be “mandatory.” Many of the populations that have become eligible for the Medicaid program

since then constitute “optional” populations, although others are mandatory. Mandatory populations include children under age 6 and pregnant women with incomes below 133 percent of the federal poverty level (FPL),³ children ages 6-18 with incomes at or below 100 percent of FPL and families who recently transitioned from welfare to work. Optional populations include children in households with higher incomes, pregnant women with incomes over 133 percent and up to 185 percent of the federal poverty level, and aged, disabled and blind individuals with incomes that exceed Supplemental Security Income (SSI) eligibility levels.

Medicaid, by providing health insurance coverage to persons of color and residents of rural areas, contributes to reducing racial/ethnic and rural/urban health disparities. While one in ten whites are enrolled in the Medicaid pro-

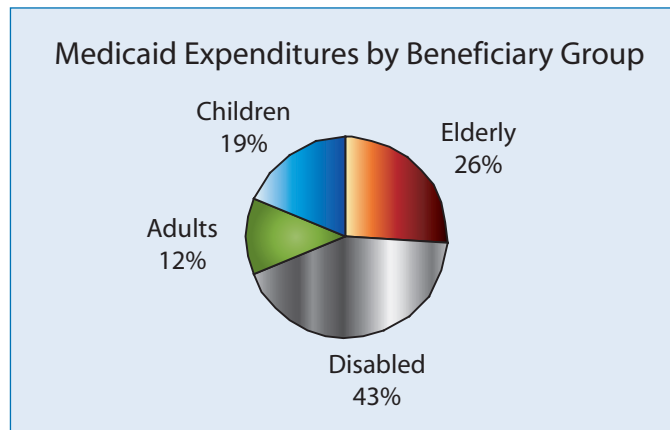
gram, persons of color and other underserved populations make up a disproportionate share of the Medicaid population. Approximately one in five non-elderly African Americans, Latinos and American Indian/Alaska Natives are enrolled in Medicaid, whereas Medicaid covers one in 10 non-elderly Asian Americans.⁷ Roughly one in four low-income Hispanic and Asian/Pacific Islander children, and

one in five low-income African American children, are enrolled in Medicaid.⁸ Medicaid is of growing importance to American Indians/Alaska Natives who utilize the Indian Health Service (IHS) system, as Medicaid is considered the primary payer of IHS health services. Medicaid is an important program in rural areas, as Medicaid, the State Children's Health Insurance Program and other public programs insure 16 percent of residents of remote rural counties, compared to 10-11

percent in other areas. Medicaid provides health coverage to over a quarter of children from remote rural counties.⁹

However, there is a disconnect between the populations that make up a majority of Medicaid beneficiaries and the populations that account for a majority of Medicaid expenditures. Low-income children and adults make up approximately three-quarters of the Medicaid population. However, these populations only account for 31 percent of program expenditures.¹⁰ The nonelderly disabled account for 40-43 percent of all Medicaid spending, even though they only comprise 16 percent of the Medicaid population. 27-30 percent of Medicaid spending is attributable to the elderly beneficiaries of the Medicaid program.¹¹ Therefore, 25 percent of the Medicaid population accounts for 69 percent of program expenditures.¹²

The Medicaid program provides health insurance coverage to its beneficiaries, which has been proven to improve health outcomes and health status compared to being uninsured.¹³ In general, studies have shown that being uninsured or underinsured leads to a decreased utilization of preventive care, as affected individuals only seek necessary health care in urgent situations. Uninsured individuals are less likely to have a usual source of care.¹⁴ For example, the uninsured tend to have diagnoses of malignancies at more advanced stages, and utilize acute care and hospital health services at a higher rate for pre-



Source: Kaiser Commission on Medicaid and the Uninsured. The Medicaid Program at a Glance. January 2005.

2 The Medicaid beneficiaries who are also Medicare beneficiaries are called “dual eligibles.” These individuals are entitled to Medicare Part A (hospitalization costs) and/or Part B (physician services, lab and x-ray services, outpatient and other services) and are eligible for Medicaid benefits. Such benefits include long-term care, and before the creation of the Medicare Part D (prescription drug benefit), prescription drug coverage.

3 2005 Federal poverty guidelines are \$9,570 for an individual living alone, \$12,830 for a family of two, \$16,090 for a family of three and \$19,350 for a family of four.

ventable illnesses and complications.¹⁵ The uninsured also have higher mortality rates resulting from hospitalizations when compared to insured individuals.¹⁶

One in four children in the United States are covered by Medicaid and would be uninsured without it. Medicaid's comprehensive benefits for children address the unique needs of low-income children for early intervention and health services, which ultimately contributes to the health status of this population. Children who are uninsured have a higher incidence of preventable disease than those who are insured.¹⁷ Due to inability to access needed services, uninsured children are more likely to have common speech, hearing and behavioral problems that are common but treated within the privately insured population.¹⁸ On the other hand, Medicaid-insured chil-



dren experience better health outcomes. For example, children in Medicaid who are asthmatic experience lower rates of hospitalization and use of emergency health services, and have improved health status in general.¹⁹ Also, children enrolled in Medicaid are able to access specialty care at the same levels as those covered by private insurance, which is vitally important for children with chronic conditions or disabilities.²⁰

The health benefits of the Medicaid program can also be seen in the health status of beneficiaries with breast and cervical cancer. Women in Medicaid are more likely to be screened for cancers that can be detected early, such as breast and cervical cancer, and therefore are able to access needed care before they become symptomatic. Medicaid beneficiaries who enroll in the program at least three months before breast or cervical cancer diagnosis are significantly less likely to be diagnosed with distant metastases than those enrolling in the program shortly before, on or after cancer diagnosis.²¹

"We know that racial and ethnic differences in access to health care significantly contribute to the racial and ethnic health disparities that we see today. In fact, their persistence escalates national health care spending and adversely impacts the system for everyone -- including the insured. Medicaid, however, extends access to care for millions of racial and ethnic minorities who otherwise would be uninsured. Cuts to the Medicaid program, therefore, will reduce access to health care and only exacerbate racial and ethnic disparities in health and in health care.

From our work as Chair of the Congressional Black Caucus Health Braintrust, I know that cutting Medicaid would catapult an already dysfunctional healthcare system from its current crisis into catastrophe. Preserving and expanding this critical program must be a core component in efforts to ensure that all Americans have equitable access to equitable health care in this country."

**The Honorable Donna M. Christensen, Member of Congress,
Chair of the Congressional Black Caucus Health Braintrust**

"Medicaid is an essential component of public health. There is growing evidence that chronic diseases such as obesity, diabetes and hypertension are greatly affected by childhood behaviors. Medicaid ensures children and their mothers have access to comprehensive health care services, which reduces their risk of chronic illness in adulthood."

**U.S. Senator
Dick Durbin
(D-III.)**

Medicaid Public Health Services

All states are required to provide a number of “mandatory” services in their state Medicaid programs. The amount, duration and scope of the coverage of these services must be sufficient to meet programmatic requirements as stated by federal law. The coverage of these services, in general, must be uniform statewide. “Mandatory” services covered under the Medicaid program include:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children younger than 21, which include necessary dental, vision and hearing care as well as any treatment potentially reimbursable under federal Medicaid law that is found to be medically necessary for a particular child;
- Family planning services and supplies;
- Health care provided at Federally Qualified Health Centers, and rural health clinics, if allowed under state law;
- Inpatient and outpatient hospital services and care;
- Laboratory and x-ray services;
- Nursing facility and home health services for individuals older than 21;
- Pregnancy-related health care and 60 days of post-natal care; and
- Primary health care provided by physicians.²²

Optional services include such basic benefits as prescription drugs, as well as services like dental care for adults, which only some states cover.

Medicare provides coverage for care provided in home, such as that provided by nurses, and very limited amounts of institutional long-term care. At the same time, private insurance has not yet devised an effective approach to covering long-term care. Therefore, there is a void in coverage for institutional and other types of long-term care services, such as nursing home care and community care, which Medicaid fills. As Medicaid’s beneficiaries are low-

income, private long-term care insurance is out of their reach. Medicaid beneficiaries receiving long-term care often have disabilities that cannot be handled by family members, and are severe and costly in nature, and comprise roughly one-third of Medicaid spending.²³ Acute care, including hospitalizations, accounts for 57 percent of program spending. Five percent of program spending is attributable to disproportionate shares hospital (DSH) payments, which states are able to provide to hospitals that serve a large number of Medicaid-insured and uninsured patients, to partly make up for low Medicaid reimbursement rates.

States cover essential public health services under their Medicaid programs, ranging from targeted case management to certain school health services. Many of these services fall under the auspices of “optional” services, and therefore states are not required to offer these services to their Medicaid populations. “Optional” services are likely to be targeted for cuts on the state and federal level to achieve desired budgetary goals. Therefore, in the process of reforming the Medicaid program, the clear health and financial benefits of these essential public health services, despite some being “optional” in nature, need to be taken into account.

Child Blood Lead Screening

Lead poisoning remains a public health issue of concern in the United States, as it adversely affects child development and is associated with a loss of cognitive abilities in children, as measured by intelligence quotient (IQ) points.²⁴ Children can be exposed to lead from many sources, ranging from lead-contaminated paint to the resulting dust, soil and chips. Due to the housing structures in which low-income families are more likely to reside, Medicaid-eligible children are at a higher risk for lead poisoning. Therefore, children enrolled in the

SPOTLIGHT: Rhode Island

In 1998, the Centers for Medicare & Medicaid Services approved a section 1115 demonstration project⁴ that allowed Rhode Island to use Medicaid funds for replacing windows in the homes of lead-poisoned children, in addition to providing case management services. Its program is limited to replacing windows in the homes of children who are covered by Rlte Care, the state’s Medicaid program. Under the waiver, window replacement is provided on an out-of-plan basis if a housing inspection determines that it would effectively reduce the child’s future exposure to lead. This demonstration project enables case managers to assist homeowners in the identification of alternative housing, application for lead hazard reduction funds and receipt of funding for replacement of lead contaminated windows in the homes of lead poisoned children enrolled in Rlte Care.²⁶

4 Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot or demonstration projects that are likely to assist in promoting the objectives of the Medicaid statute. Flexibility under section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Section 1115 demonstration projects must be budget-neutral over the life of the project.

Medicaid program are required to be screened for blood lead under the EPSDT program at 12 and 24 months of age, or between 36 and 72 months if they are enrolled later in life. State Medicaid programs provide coverage and reimbursement for blood lead screening and diagnosis, lead poisoning treatment and follow-up services.²⁵

Coverage of Sexual and Reproductive Health Services

States are required to cover family planning services under their Medicaid programs, which are targeted towards individuals of childbearing age and minors who are sexually active. Medicaid also is the single largest source of public funding for family planning services and supplies.²⁷ Medicaid-covered sexually transmitted infection screening includes screening for gonorrhea, chlamydia, syphilis, human papillomavirus, genital herpes and HIV. In fact, being insured by Medicaid has been shown to increase an individual's chances of being screened for STIs.²⁸ As approximately 14 percent of patients in public sexually transmitted infection clinics have Medicaid coverage, Medicaid revenues directly support the operations of such clinics, which rely on direct reimbursement for Medicaid claims, the Federally Qualified Health Center Reimbursement Program and the Medicaid Administrative Match program.²⁹

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Since its inception, EPSDT has changed Medicaid's role in providing health care to children. Under EPSDT, children enrolled in the Medicaid program have access to comprehensive health care, including preventive health care services and follow-up services after treating a health problem. EPSDT provides Medicaid-enrolled children under age 21 access to comprehensive preventive care, including but not limited to immunizations, physical exams, dental and vision care, and mental health and hearing screenings.³⁰ Medicaid's coverage of immunizations, like other forms of health insurance, increases rates of child immunization.³¹ Therefore, maintaining coverage of immunizations through EPSDT is vital to ensure that children have access to the 2005 Childhood Immunization Schedule of the National Immunization Program recommended immunizations, which protect against several preventable illnesses and diseases including measles, mumps, rubella,

hepatitis B, influenza and polio.³²

The provision of dental and vision care under EPSDT is vital to child health and development. If vision care is not provided under EPSDT, child Medicaid beneficiaries will likely not access such services, which may adversely affect

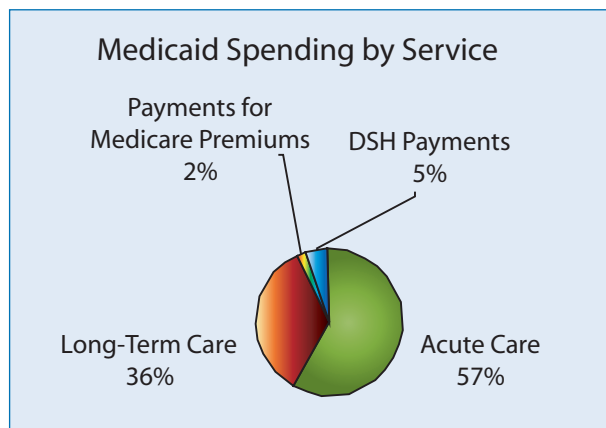


the development of these children and affect their quality of life. Dental care is the largest unmet health care need of poor children in the United States.³³ Studies have shown that preschool aged, Medicaid-enrolled children who have an early preventive dental visit are more likely to use subsequent preventive services and experience lower dentally related costs.³⁴ Conversely, children with tooth decay are more likely to be underweight, and are likely to have poorer school attendance rates, which ultimately impact their parents' ability to go to work.^{35,36}

The mental health screening provided under EPSDT is essential to effectively detect and treat child mental illness. States are required to screen children for mental health and substance abuse disorders under the program.³⁷ This is important because one in 10 children suffers from a serious mental health problem that causes impairment, and low-income children have more mental health problems than other children.^{38,39} Children enrolled in Medicaid and SCHIP experience the highest prevalence of mental health problems among all children ages 6-17.⁴⁰ Continuing mental health screening and treatment under EPSDT will contribute to reducing the disparities in the use of mental health services among children.

School Health Services

State Medicaid programs have supported school-based health services as an important point of service for eligible children to access needed medical care.



Source: Kaiser Commission on Medicaid and the Uninsured. The Medicaid Program at a Glance. January 2005.

SPOTLIGHT: Michigan

In 1993, the Michigan Department of Education and Michigan Department of Community Health partnered to enroll intermediate school districts in the Medicaid program. This school health program is unique because all intermediate school districts (ISDs) in the state are Medicaid providers. Therefore, Medicaid reimburses providers for services provided to Medicaid beneficiaries who also are eligible for special education and other programs. As the ISDs are the listed Medicaid providers, there is a need for local school districts and public school academies to work with their ISD to participate in the program. ISDs in Michigan receive the federal share of Medicaid reimbursement, as the state share is considered to be previously allocated. For each \$100 claimed by ISDs in 2004, for services that had already been delivered, ISDs received approximately \$33. ISDs can be reimbursed in two ways. First, there is a fee-for-service component of the program, which reimburses ISDs for direct health services ranging from speech therapy to physician services to medical transportation. The second method for ISDs to receive reimbursement is to participate in Medicaid outreach and enrollment strategies. Ultimately, this program has had a substantial positive fiscal impact on school districts in the state. Since 1993, Michigan's Medicaid program has reimbursed ISDs more than \$300 million.⁴⁵

According to CMS, to be covered by Medicaid, school health services must be "included among those listed in the Medicaid statute (section 1905(a) of the Act) and included in the state's Medicaid plan or be available under the Early and Periodic Screening, Diagnostic and Treatment benefit."⁴¹ School health services, often administered by a school nurse or health aide, range from vision and hearing screenings to assistance with chronic health conditions such as asthma to providing immunizations. Many school districts enter into agreements with state Medicaid offices in order to receive reimbursement for school-based counseling and other mental and physical health services, as well as support services for Medicaid-eligible students with disabilities. Studies suggest that disparities between schools in the availability of health services may be partly explained by differences in access to Medicaid for financing of health services provided at the school.⁴²

School health services positively affect children's use of services and health care expenses, as their location helps overcome such barriers to care as transportation and inconvenient appointment times. Also, school health services have been shown to improve students' academic levels, as healthy students achieve a higher academic level than unhealthy students.⁴³ In many cases, school-based health clinics serve as comprehensive centers for medical and mental health screening and treatment of children on or near the school grounds.⁴⁴ Nationally, there are approximately 1,300 school-based health clinics that serve 1.1 million children.^{45,46}

Adult Immunizations

Medicaid coverage of adult immunizations improves the public's health, as more people are protected against transmission of disease, and such immunizations contribute to herd immunity. However, adult immunizations are not considered to be a mandatory service covered by state Medicaid programs; adult immunizations fall under "preventive services," which are "optional" and need not be covered by states. Therefore, states vary in the extent to which they cover adult immunizations. However, most states have chosen to cover adult immunizations in their Medicaid programs due to impacts on the health status and outcomes of adult Medicaid beneficiaries, primarily the elderly and disabled.⁴⁷

Forty-eight state Medicaid programs furnish some

immunization coverage and payment for adult immunizations for non-institutionalized adult beneficiaries. Of these, 32 states offer coverage that follows ACIP recommendations. The most commonly covered vaccines for adults in state Medicaid programs are the pneumococcal

SPOTLIGHT: New York

New York's coverage of adult immunizations under its Medicaid program is one of the most comprehensive in the country. The state's program provides coverage for all eight ACIP-recommended adult immunizations: hepatitis A; influenza; measles, mumps and rubella (MMR); varicella; tetanus and diphtheria; pneumococcal; meningococcal; and hepatitis B. New York's Medicaid program reimburses for the cost of vaccine and providers for vaccine administration. Also, it provides full vaccine replacement to providers who furnish immunizations to adults. It does, however, charge a nominal co-pay to adult recipients of immunizations. There is, therefore, room for improvement in the program, as eliminating co-payments would entirely remove the financial barrier adults face in getting immunized.⁵¹

and influenza vaccines, whereas Hepatitis A and meningococcal vaccines are covered least frequently. Cost sharing for adult immunizations is very common, with 27 states requiring a co-payment for adult immunizations.⁴⁸

Without adult immunization coverage under Medicaid, low-income adults will likely not get vaccinated, due to financial barriers. These adults would ultimately be reliant on receiving needed vaccines from the 317 grant program, which is authorized by section 317 of the Public Health Service Act. However, as only 5-8 percent of 317 program funding is allocated towards adult immunizations due to the demands and prioritization of the childhood vaccination program, there is a lack of resources necessary to carry out comprehensive adult immunization campaigns. Also, this program is discretionary in terms of its funding, and therefore is reliant on Congress every fiscal year to sustain and increase its funding levels.⁴⁹

Ensuring access to immunizations has been proven time and time again to achieve cost savings. Most recently, in 2003, the Centers for Disease Control and Prevention

estimated \$6.30 in direct savings for every dollar spent on vaccinations, which amounts to roughly \$10.5 billion in annual savings. If societal costs such as disability, death and loss in work productivity are factored into the figure, the cost savings achieved by immunizations increases to \$18.40 for every dollar spent, which amounts to \$42 billion in savings per year.⁵⁰

Maternal and Child Health Services

Medicaid currently requires coverage of pregnant women with incomes below 133 percent of FPL; most states go beyond this requirement to cover such women up to 185 percent of the FPL or even higher levels.⁵² Pregnant women in the Medicaid program have increased access to prenatal care and needed maternal health services.⁵³ Medicaid's coverage of prenatal care achieves cost savings, as such care improves birth outcomes and helps to prevent low birthweight births. Such coverage also has an impact on infant mortality. For each normal birth that occurs instead of a very low birthweight birth, roughly \$59,700 in cost savings is achieved in the first year of care alone. Long-term cost savings resulting from not having to care for a low birthweight infant is approximately \$400,000. By improving birth outcomes, Medicaid-covered prenatal care can also help prevent respiratory and digestive problems in infants, which can result in cost savings of approximately \$61,000 per child, from not having to pay for one month of intensive care costs. Overall, considering that first year health costs for one unhealthy baby can reach \$1 million, investing in Medicaid prenatal care is a very cost-effective activity.⁵⁴

Forty percent of births in the United States are covered by Medicaid; infants born to these women are automatically eligible for the first year of life, and subsequent eligibility is dependent on family income.⁵⁵ Infants who have continuity of care are less likely to utilize emergency health services than uninsured children.⁵⁶ For this population enrolled in Medicaid, the coverage of a series of early well-child visits prevents avoidable hospitalizations.⁵⁷ Overall, children without health insurance have higher emergency room utilization rates than those who are publicly or privately insured.⁵⁸

Coverage of Tuberculosis-Related Care

States can offer Medicaid coverage to TB-infected individuals who would be financially eligible for Medicaid at the Supplemental Security Income (SSI) level. State Medicaid coverage of TB-related services includes: physician services, laboratory services, chest x-rays, TB case-management and therapeutic drugs. This coverage ultimately improves the health status and outcomes of affected individuals, as directly observed therapy has been successful in ensuring patients complete multi-course TB treatment, thus reducing the chances of development of drug-resistant strains. This is a benefit for both the individual patient and for the public's health. The eight states and District of Columbia that currently provide Medicaid benefits to TB-infected individuals, who comprise an optional population under Medicaid, help facilitate early TB diagnosis and treatment and ensure completion of TB treatment.⁵⁹ Inasmuch as many second- and third-line therapies for drug-resistant TB are quite expensive, the availability of Medicaid reimbursement is vitally

important and allows state and local health departments to reserve their limited discretionary resources for public health screening, epidemiology and infrastructure.

Reimbursement of Public Health Laboratory Screening Activities

Medicaid contributes to newborn screening by providing some reimbursement for public health laboratory expenditures, which account for approximately 74 percent of states' expenses in newborn screening.⁶⁰ Currently, 45 states charge fees to cover the laboratory costs associated with newborn screening. Public health laboratories have been responsible for newborn screening since the mid-1960s and currently conduct approximately 97 percent of all newborn screening tests in the United States.⁶¹ These tests help detect some health problems and conditions that may not be detected by a physician during a routine exam. The filter paper blood spot sample that is drawn during every infant's first two to three days of life is tested for several conditions and disorders that have the ability to cause mental retardation or death if left untreated.

Targeted Case Management

States may provide targeted case management services to Medicaid beneficiaries. The Centers for Medicare and Medicaid Services define targeted case management services as "services which assist an individual eligible under the plan in gaining access to needed medical, social, educational and other services."⁶² Targeted case management is considered an optional service under the Medicaid program. In most states, targeted case management services are directed at high-risk, high-cost beneficiaries, including individuals living with chronic diseases, AIDS patients, and high-risk pregnant women. Such services have been shown to contribute to improving the health status of high-risk Medicaid beneficiaries. For individuals with diabetes, case management, when added to primary care, substantially improves glycemic control. Ultimately, such case management can contribute to reducing disparities in health status among low-income ethnic populations with diabetes.⁶³ For individuals living with AIDS, Medicaid targeted case management leads to a more speedy initiation of antiretroviral treatment.⁶⁴ Also, such case management for individuals with HIV/AIDS has been shown to reduce costs, as their adherence to treatment regimens reduces the need and demand for inpatient care.⁶⁵ Case manage-

SPOTLIGHT: Baltimore HealthCare Access, Inc.

Baltimore HealthCare Access, Inc. (BHCA) is a quasi-public agency of the Baltimore City Health Department established in 1997 as the state of Maryland was transitioning from a Medicaid fee-for-service program to managed care. BHCA conducts care coordination, Medicaid/SCHIP program outreach and eligibility determination activities, and ombudsmen services to enrollees of *HealthChoice*, the Maryland Medical Assistance Managed Care Program. For eight years, it has been assisting enrollees of *HealthChoice* in accessing needed, comprehensive health care services.⁶⁷

"Covering children is not only the right thing to do, but by ensuring that children have access to preventive care, it is also one of the best ways of reducing long-term strain on America's health care system."

**U.S. Senate
Majority Leader
Bill Frist, MD
(R-Tenn.)**

ment offered to pregnant women has been shown to positively impact their emotional well-being, lifestyle behaviors, financial situation, service utilization and, in general, maternal and infant physical health.⁶⁶

Medicaid and State Children's Health Insurance Program (SCHIP) Outreach Efforts

States are able to utilize Medicaid/SCHIP funds to conduct outreach campaigns targeted at enrolling eligible children in Medicaid and SCHIP. These efforts assist parents of Medicaid- and SCHIP-eligible children in overcoming com-

mon barriers to enrollment, including lack of knowledge about the programs, administrative hassles, face-to-face interview requirements and English-only applications. Beginning in the late 1990s, states were very successful in raising public awareness of the Medicaid and SCHIP programs by streamlining the programs' respective application processes, launching statewide media campaigns and implementing community-based outreach strategies. Ultimately, these efforts resulted in a decrease in uninsurance rates of children in families with incomes between 100 to 200 percent of the federal poverty level. While 22.8 percent of those families lacked health insurance in 1997, the number dropped to 14.7 percent in 2003.⁶⁸

SPOTLIGHT: California's Express Lane Eligibility Program

During its process of implementing new and innovative measures to increase enrollment in Medi-Cal (California's Medicaid Program) and Healthy Families (the state's SCHIP program), California targeted the 800,000 uninsured children in the state that were already participating in public programs, ranging from the school lunch program to those in families eligible to receive food stamps. By streamlining the enrollment processes for Medicaid and SCHIP, using information that parents of eligible children already provided for enrollment in related public programs, the Express Lane Eligibility Program had two positive outcomes. Parents of eligible children found it much easier to apply for Medicaid and SCHIP, and it reduced the workload of state agencies by eliminating duplication of efforts. The program, implemented in the 2003-2004 school year, now allows children in families who qualify for the free school lunch program and the food stamp program to be rapidly enrolled in the state's Medicaid or SCHIP program.⁶⁹ However, federal law has created obstacles to the most effective possible use of these strategies. Because non-health programs use slightly different technical rules for measuring income (such as the definition of household), Medicaid must evaluate each individual's income, even though another public agency has already determined the individual's income level. In addition, limited information technology resources in California and resulting incompatible computer systems made it more costly and cumbersome to transfer information between means-tested programs.

Medicaid's Financing of Public Health Care Providers: Supporting the Safety Net

In addition to serving as an insurer and increasing program beneficiaries' access to effective public health services, the Medicaid program provides essential financing to public health providers in the United States, without which their grant and other funding sources would be inadequate to sustain their viability. In 2001, Medicaid paid for 17 percent of hospital care and prescription drugs in the United States, and almost half of nursing home care.⁷⁰ Medicaid's financing of providers does not only contribute to the health of Medicaid beneficiaries; it impacts the health of other patients—uninsured or insured by other public or private providers—and the individuals with whom they interact at home, work, school and in the community.

Medicaid contributes to approximately one-third of health center operating revenue.⁷¹ 39 percent of health center patients are uninsured; 34 percent are covered by Medicaid. That leaves 27 percent of the roughly 11.3 million patients of health centers being insured by another provider, but receiving care at the health center, which depends on Medicaid funds to survive.⁷² Such providers, without Medicaid-dependent operating funds, will have decreased capacity to detect a bioterrorist attack or an emerging disease spread promptly.

Medicaid is also a primary financier of public hospitals and health systems, from which approximately 10 million individuals receive care. One-fifth of patients of public hospitals are covered by commercial insurance. Without Medicaid funding, public hospitals, which are already operating on narrow margins, would likely close their doors and not be able to serve all patients in need—privately and publicly insured individuals, and the uninsured. This is rooted in the fact that public hospitals, outside of receiving reimbursements for their care of Medicaid beneficiaries, receive Medicaid disproportionate share hospital payments, which finance 23 percent of uncompensated care. Without this funding, such hospitals would have lost approximately \$1.8 billion in 2002.⁷³ Between 1996 and 2002, more public hospitals were lost than for-profit and

non-profit hospitals—16 percent of public hospitals in cities were lost, and 27 percent of those located in the suburbs closed.⁷⁴ If additional public hospitals close, anyone who lives or works in the vicinity of such hospitals could be placed at risk if they experience an emergency.

Public hospitals would not be the only health providers closing their doors without Medicaid financing. Medicaid is also the largest source of revenue for community mental health providers,⁷⁵ and a primary source of funding of public sexually transmitted infection clinics⁷⁶ and school health centers. In the case of school health centers, Medicaid financing positively correlates with the availability of health services available to students.⁷⁷



Medicaid financing also impacts macro-level care delivered by obstetricians and gynecologists. Forty percent of births in the United States are covered by Medicaid; newborns are automatically eligible and remain eligible for the first year of life.⁷⁸ Medicaid also is the single largest source of public funding for family planning services and supplies.⁷⁹ Without such funding, OB/GYN care for middle-class and other insured women could be in jeopardy, as revenue streams for hospitals and other providers who oversee deliveries would not be as substantial.

"There is no greater test of our values than the way we treat the most vulnerable members of our national community. For forty years, Medicaid has allowed millions of Americans to meet the challenge of serious illness or living with a disability. We should be doing all we can to strengthen, not weaken, this valuable safety net."

**U.S. Senator
Edward
Kennedy
(D-Mass.)**

Issues in Medicaid Reform

"Our goal here should be to improve the health of children, pregnant women, elderly, and disabled Americans on Medicaid, not to find savings in the program."

U.S. Representative Heather Wilson (R-N.M.)

The common primary goal of any Medicaid reform measure proposed by federal policy-makers has been cost savings. However, such reform measures should not undercut the public's health in the process. Investing in the public's health today will ultimately save in national health expenditures and improve national well-being tomorrow. In order to protect the public's health, the American Public Health Association recommends that the coverage of current beneficiaries and services be maintained or strengthened in any Medicaid reform effort.

Outside of providing health insurance coverage to vulnerable populations and covering the provision of effective and quality health services, the population-level impacts of any Medicaid reform initiative need to be evaluated. The American Public Health Association stresses that Medicaid reform should not disproportionately affect persons of color and other medically disadvantaged populations, including individuals residing in rural areas. Also, considering that there are already 45 million Americans who are uninsured, without access to a safety net program, any Medicaid reform effort should not contribute to an increase in that number, or increase the number of underinsured individuals.

Medicaid Coverage of Eligible Individuals Ensure Coverage of Individuals Residing in Rural and Underserved Areas

Any cuts in benefits or populations will disproportionately affect minority and rural Medicaid beneficiaries, and will exacerbate health disparities, as having health insurance and being able to access health care are inextricably linked. Medicaid reform initiatives need to ensure that these populations are protected. Medicaid currently contributes to approximately one-third of health center operating revenue; therefore, sustained Medicaid funding is integral to the ability of health centers to penetrate communities that are rural or have high percentages of minority residents.⁸⁰ Health center penetration in states' medically underserved communities has been associated with state level reductions in racial and ethnic health disparities.⁸¹

Medicaid reform initiatives, in order to be effective in reducing health disparities, need to include and fund extensive outreach and education efforts. Administrative barriers for Medicaid-eligible underserved populations need to be limited to ensure those in need are able to enroll in the program and access care. Permitting mail-in applications, simplifying program enrollment forms, offering program forms and information in languages other than English and utilizing workers stationed in nontraditional areas, such as schools and places of worship, facilitates increased program enrollment and retention rates.

SPOTLIGHT: Mississippi

As of June 2003, approximately 584,800 individuals were enrolled in Mississippi's Medicaid program,⁸² more than 20 percent of the state's population. Considering that approximately 56.5 percent of the state's nonelderly Medicaid enrollees are African American,⁸³ who only comprise 36.3 percent of Mississippi's population,⁸⁴ and that roughly 17 percent of residents of rural areas are enrolled in the Medicaid program,⁸⁵ any changes to the Medicaid program will likely disproportionately affect African Americans and residents in rural areas, further exacerbating racial/ethnic and rural/urban health disparities.

Insure Coverage of Pregnant Women

Medicaid currently requires coverage of pregnant women with incomes below 133 percent of FPL, and states are able to cover pregnant women with incomes above this threshold as part of an optional population. Pregnant women in the Medicaid program have increased access to prenatal care and needed maternal health services.⁸⁶ Forty percent of births in the United States are covered by Medicaid; newborns are automatically eligible and remain eligible for the first year of life.⁸⁷ If this population is not covered by Medicaid, there likely will be: higher maternal and infant mortality rates, due to the difficulties in accessing vital prenatal care; higher long-term care needs for children born to mothers who have not had good prenatal care; and an increased number of deliveries that are not covered by Medicaid or another form of insurance, reducing the revenues received by public hospitals.

Guarantee Coverage of Persons Living with HIV/AIDS

Medicaid is the largest single payer of medical services for persons living with AIDS (PLWA) in the United States. The program serves more than 230,000 PLWA, approximately 55 percent of all PLWA and up to 90 percent of all children with AIDS.⁸⁸ As such, Medicaid beneficiaries are more likely to receive highly effective antiretroviral therapy than members of the uninsured population.⁸⁹ Mothers with HIV/AIDS who are enrolled in their state Medicaid program and receive prenatal care are less at risk for adverse birth outcomes.⁹⁰ It is imperative that this population remains eligible for and enrolled in the Medicaid program, as becoming uninsured is associated with significantly lower rates of antiretroviral, antipneumocystic and antidepressant use.⁹¹ Ultimately, PLWA losing Medicaid coverage would result in restricted access to care and abil-

ity to adhere to the necessary treatment regimens, which will increase the likelihood of this population experiencing higher rates of HIV/AIDS morbidity and mortality.

Provide Coverage to Women with Breast and Cervical Cancer

Breast cancer, the most frequently diagnosed cancer in women, ranks second among cancer deaths in women.⁹² Low-income women can currently access free or low-cost screening for breast and cervical cancer from the Centers for Disease Control and Prevention. The Breast Cancer and Cervical Cancer Prevention and Treatment Act (BCCTPA) of 2000 provides states with the option of offering Medicaid coverage to women who are diagnosed with breast or cervical cancer through the CDC screening process.⁹³ If this coverage option is limited or eliminated, affected women would likely have no outlet to access affordable cancer treatment regimens, which will likely result in poor health status and outcomes due to delaying care, which lessens the effectiveness of treatment regimens.

SPOTLIGHT: Maryland Cutting Optional Populations

Beginning July 1, 2005, the state of Maryland no longer covers pregnant women and children who have been legal residents for fewer than five years and were not enrolled in the program prior to that date. Ultimately, affected populations will turn to costly, uncoordinated care, which is of concern considering its possible effects on the health status of newborns, the likelihood of lack of quality of prenatal care, and potential pregnancy-related complications.

Continue Coverage of “Optional” Populations

Despite the adjective normally affixed to these populations, “optional” populations are not optional. For “optional” populations and services, the designation of “optional” is a historical artifact, not a rational division between needy people and not-needy people, or between essential services and inessential ones. “Optional” populations have just as significant a need for Medicaid and the services covered by the program, and are not able to afford health insurance coverage on the private market like the rest of the Medicaid population. “Optional” populations, which currently comprise 29 percent of all Medicaid beneficiaries and half of elderly Medicaid beneficiaries,^{94, 95} are among the neediest of program beneficiaries despite their designation, and are likely to lack access to another form of health coverage should their Medicaid coverage be terminated, as they will not be able to afford the high costs of purchasing health insurance on the private market. “Optional” Medicaid beneficiaries include pregnant women and infants less than one year of age whose family income is over 133 percent and up to 185 percent of the federal poverty level (FPL), uninsured individuals with tuberculosis, women with breast or cervical cancer and legal immigrants who are long-term U.S. residents.

Medicaid Coverage of Services Ensure Coverage of Preventive Services

Medicaid provides coverage to proven preventive and screening services, which gives beneficiaries’ incentive to utilize such cost-saving and cost-effective services. Any changes to the program need to maintain the vital emphasis on prevention, as catching disease and chronic conditions early ultimately improves health outcomes, and saves money.

For adults, immunizations and other preventive services fall under the “optional” service categorization, which means that states have the option to cover such services, and flexibility in the extent to which such services are covered. Forty-eight states have chosen to cover adult immunizations in their Medicaid programs, enabling low-income adults to have access to such vaccines as pneumococcal and influenza vaccines. Any change to the program should improve this coverage, not limit it.

Sexually transmitted infection screening and testing is another important preventive service covered by the Medicaid program. This includes screening for gonorrhea, Chlamydia, syphilis, human papillomavirus, genital herpes and HIV. Many STIs, if caught early, have very cost-effective treatment regimens. Identifying these diseases early also helps to prevent the infected individuals from transmitting the respective disease to others, which saves on additional treatment costs. Again, any change to the program should improve this coverage, not limit it.

Providing insurance to low-income families increases the utilization of pediatric preventive services.⁹⁶ Women in the Medicaid program are more likely to be screened for preventable disease than low-income, uninsured women.^{97, 98, 99} This increased utilization of screening and other preventive services allows for chronic and other disabling conditions to be detected sooner, which increases positive health outcomes and decreases the likelihood of needing the most expensive treatment options and continuous long term treatment.

Protect the Link Between the “E” and “T” of EPSDT

Although the EPSDT program emphasizes children’s access to preventive health services, there is a need to maintain the program’s other focus on early intervention and treatment of conditions and illnesses detected during screening, due to the effect on the quality of life of and long-term expenditures associated with affected children. Under EPSDT, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by screening services must be provided. Without the “T,” these children, due to family income and inability to be insured otherwise, would likely go without necessary treatment. Such treatments include all “mandatory” and “optional” services covered under state Medicaid programs that meet state medically necessary standards. There are no limits as to the amount, duration and scope of medically necessary intervention and treatment services provided to children under EPSDT. Without the “T,” chronically and congenitally ill children enrolled in Medicaid will not have access to the services they need to improve or maintain their health status, as

the costs of these treatments will likely cause them to forego treatment if they are not covered. Treating conditions identified early by EPSDT screenings leads to improved emotional and cognitive development, improved educational performance, lower instances of substance abuse and increased economic self-sufficiency.

Mental Health Intervention and Treatment Services

One of every five children and adolescents has a mental disorder, with one in 10 having a serious emotional disturbance that affects daily functioning. Early intervention and treatment in this arena can minimize negative consequences for children and their families, as well as costs to society.¹⁰⁰ Early intervention and treatment for mental disorders and illnesses has been shown to be cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention.¹⁰¹ Also, early intervention and treatment in this area have the potential to improve school readiness, health status and academic achievement, and reduce the need for grade retention and special education services and welfare dependency.^{102, 103} If mental disorders are left untreated, the consequences are severe, ranging from an increased likelihood of alcohol and drug use to suicide.¹⁰⁴ Social and economic consequences of no treatment also include higher school dropout rates and increased probability of landing in the juvenile justice system or jail.

Treatment of Hearing Defects

Under EPSDT, child Medicaid beneficiaries have access to treatment methods for defects in hearing, including hearing aids. Also, corrective services provided by a speech pathologist are covered. Otitis media with effusion, the most common cause of acquired hearing loss in children, has been associated with delayed language development and behavioral problems. However, effective treatment for clearing effusions exists. Most common medical treatment methods include the use of decongestants, antihistamines, mucolytics, steroids and auto inflation. Surgical treatment options include grommet insertion, myringotomy and adenoidectomy. Studies have shown that earlier treatment for otitis media is positively correlated with a reduction in behavioral problems.¹⁰⁶

In general, if congenital or acquired hearing loss remains untreated, lifelong deficits in speech and language acquisition, poor academic performance, personal-

social maladjustment and emotional difficulties can result.¹⁰⁷ On the flipside, early language therapy and intervention leads to better speech and language development.^{108, 109, 110} Earlier surgical intervention of hearing problems offers a more expeditious improvement of performance without increasing the risks for complications.¹¹¹ In fact, in the case of cochlear implants, pediatric surgery has been demonstrated to be cost-effective. Studies have shown that there is a net cost savings ranging from \$30,000 to \$100,000 per child, even when the full cost of the cochlear implant is included. Savings resulting from education costs alone range from \$30,000 to \$40,000. Such surgery also improves overall quality of life—the quality-adjusted life year (QALY) gain associated with the surgery has been calculated to be 16.33; the cost per undiscounted QALY gain has been estimated to be \$2,153.12 and the cost per discounted QALY gain has been estimated to be \$16,525.60.¹¹²

Treatment of Loss of Vision and Other Vision Problems

Under EPSDT, eligible children receive treatment for defects in vision, including eyeglasses. Visual impairment, including refractive error, affects approximately 20 percent of children in the United States.¹¹³ Amblyopia, more commonly known as lazy eye, is the most common cause of visual impairment in childhood. Studies have shown that treatment for the condition is most effective in younger children.¹¹⁴ In fact, the United States Preventive Services Task Force found that early treatment of amblyopia and amblyogenic risk factors can improve visual acuity. Such early treatment includes surgery for strabismus and cataracts; use of glasses, contact lenses or refractive surgery treatments to correct refractive error; and visual training patching or atropine therapy of the nonamblyopic eye to treat amblyopia.¹¹⁵

Dental Treatment Services

Tooth decay is the most common chronic disease in childhood. The “T” of EPSDT ensures that eligible children have access to services to restore their teeth and medically necessary interventions to relieve children of pain and infections. Due to the infectious nature and early onset of dental caries, and the success of early interventions, there is a need for children under EPSDT to maintain access to such services. If dental caries are left untreated, abscesses, cellulites and systemic spread of disease can result. Also, lack of treatment increases the probability of premature loss of primary molars. Untreated dental caries can also contribute to a decrease in affected children’s quality of life. Children with dental problems lose an estimated 52 million school hours annually, with poor children, including Medicaid beneficiaries, experiencing nearly 12 times as many restricted activity days from dental disease as children from higher-income families. In the long haul, lack of treatment has the potential to affect speech, nutrition, economic productivity and quality of life.¹¹⁶

Ending coverage of dental treatment methods under EPSDT is likely to have an adverse effect on children with untreated caries seeking necessary care in emergency departments. In 1997 to 2000, with dental treatment services for children being



covered under EPSDT, there were an estimated 2.95 million emergency department visits in the United States for complaints of tooth pain or tooth injury, for an average of 738,000 visits annually.¹¹⁷ It must be assessed what effect eliminating coverage of treatment services under EPSDT or lowering federal matching rates for such services would have on emergency department visits for dental-related problems.

SPOTLIGHT: Oregon Lessons Learned

In 2002, under Section 1115 waiver authority, Oregon made a number of program changes, including increasing premiums for low-income adults to \$6-\$20, depending on income, and tightening policies concerning nonpayment. Following the premium increases, enrollment dropped by nearly half or roughly 50,000 people. Enrollment losses occurred among all those subject to the increased premiums, but were largest among those with the lowest incomes. Nearly one-third of surveyed disenrollees pointed to premium costs as the main reason they lost coverage.¹¹⁹ Further, other analyses found an increase in emergency room visits by uninsured patients in the first few months following the program changes and increased pressures on clinics.^{120, 121}

prescription drug pricing practices under the Medicaid program versus further restricting their coverage under the program and utilization by program beneficiaries.

Although Medicaid programs have used formularies to balance health care needs and cost containment, prescription drugs included in states' formularies should be comprehensive in nature and not restrictive for individuals living with chronic diseases or HIV/AIDS. Instead, to achieve desired savings in this line, state and federal policy-makers should reconsider whether the utilization of Average Wholesale Price (AWP) is the best mechanism for determining how much states pay for prescription drugs in their Medicaid program. As utilization of AWP usually leads to overpayment for prescription drugs, reform in this area could achieve substantial savings. The inspector general found that, in 1999, \$1.5 billion could have been saved in the Medicaid program had there not been overpayment for prescription drugs to the pharmaceutical companies and pharmacies using AWP.¹²⁴

Supporting increased utilization of state pooling to achieve larger rebates from pharmaceutical companies is another strategy that can be expanded upon to achieve more affordable drug pricing under Medicaid. Seven states as of September 2004—Michigan, Vermont, Alaska, Nevada, New Hampshire, Minnesota and Hawaii—are participating in a multi-state pooling supplemental rebate agreement to utilize leverage in numbers to achieve

"If you impose a co-pay, they may choose not to go get the medication, and we think there is a far greater cost to the system if they do not get that medication,"

Idaho Gov. Dirk Kempthorne (R)

Prohibit Cost Sharing for Receipt of Covered Services

Considering that Medicaid beneficiaries have generally poorer health status and less income—most with incomes less than \$1,200 a month—than privately insured individuals, the institution of premiums and co-payments in state Medicaid programs will likely not succeed in achieving desired and sustained cost savings at the federal and state levels. Implementing new or increasing existing co-payments and premiums in state Medicaid programs, as most recently experienced in Oregon, has been shown to cause individuals to lose Medicaid coverage and not utilize affected services. Low-income individuals will likely forego receiving early care and therefore depend on more costly hospitalization if co-payments or premiums are established or increased.¹¹⁸



Ensure Access to and Affordability of Prescription Drugs

Prescription drug costs under Medicaid are escalating rapidly; Medicaid expenses for prescription drugs doubled between 1998 and 2002, and they have quadrupled since 1992.¹²² In 2003, the Medicaid program spent more than \$31 billion on prescription drugs alone.¹²³ This is at a time when prescription drugs are an "optional" Medicaid benefit. However, maintaining and treating conditions using prescription drugs is cost-effective when compared to the alternative, which oftentimes is expensive medical treatment. State and federal policy-makers should review

lower prices for prescription drugs for their Medicaid programs. Participating states expected to save up to \$8 million each in 2004, resulting in approximately \$19.5 million in federal savings. This program is expected to cover approximately 1.1 million Medicaid beneficiaries.¹²⁵ CMS recently approved the second multi-state purchasing pool—comprised of Maryland, West Virginia and Louisiana—which is expected to cover approximately 1.3 million Medicaid beneficiaries and provide participating states with up to \$30 million in cost savings each in 2006. These pools should be used as best practices, and CMS should examine the utilization of additional pools to achieve lower prescription drug prices under the

Medicaid program. Also, larger pool sizes should be evaluated to the extent they would be successful in generating larger rebates. The implementation of larger pharmaceutical industry drug rebates across the board, so states would not have to pool together, would also be effective.

Provide An Appropriate Coverage Benefits Package

In any Medicaid reform effort, individual health consumer protections are required. Medicaid beneficiaries need access to an appropriate coverage benefits package that provides linkage and continuity of care between preventive health services and primary, acute and specialty care. Also, beneficiaries need to have the choice of primary and specialist physicians and access to preventive services. This appropriate coverage benefits package needs to be comprehensive in nature, so that Medicaid beneficiaries are fully insured, not underinsured. This requires Congress in any Medicaid reform proposal to establish reasonable standards for states regarding the scope of covered services to provide a national “floor” of ensured access to care and access to preventive services.

Ensure Coverage of Mental Health Services

Medicaid has become the largest payer of mental health care.¹²⁶ Up to 13 percent of Medicaid expenditures is spent on behavioral health services.¹²⁷ In 2001, Medicaid paid approximately \$2.6 billion to public psychiatric hospitals, which amounted to a third of their total operating costs.¹²⁸ Medicaid also currently funds more than half of public mental health services administered by states. Medicaid is expected to fund two-thirds of such services by 2017.¹²⁹ As of 2002, Medicaid is the largest source of revenue for community mental health providers, the program’s payments comprising 38 percent of their total funding.¹³⁰ Therefore, not providing coverage for mental health services under the Medicaid program would not only worsen access to needed care and health outcomes of individuals with mental illness or substance abuse problems, but would also adversely affect the ability of institutional and community-based mental health providers to operate.

Continue Coverage of “Optional” Services

“Optional” services currently make up 60 percent of all expenditures for “mandatory” and “optional” populations.¹³¹ Eliminating coverage of such services would likely serve as an obstacle to Medicaid beneficiaries receiving

these needed services, which is especially troublesome when considering the “optional” benefit of outpatient prescription drugs, upon which much of modern health care is predicated. The elderly and individuals with disabilities will be disproportionately affected by changes in coverage of “optional” services, as 84 percent of spending on the elderly and 62 percent of spending on the disabled qualifies as being “optional” in nature.¹³² “Optional” services, which include targeted case management, long-term care services and prescription drug coverage, provide Medicaid beneficiaries with the comprehensive coverage of services necessary to maintain and improve their health status and outcomes. Like “optional” populations, “optional” services are not optional; these services contribute to improving the health outcomes and status of Medicaid beneficiaries. Many optional services also achieve cost savings and are cost-effective alternatives to medical care, as in the case of prescription drugs and chiropractic care.

Ensure Coverage of Long-Term Care Services

Medicaid is a primary source of long-term care of the elderly in the United States. Any Medicaid reform initiative must include expanded coverage and improved availability and coordination of in-home and community-based health and supportive services for persons of all ages requiring long-term care. Equitable reimbursement of long-term care providers is essential. The funding of institutional long-term care in Medicaid should be in the context of a planned long-term care strategy aimed at effective and appropriate use of community-based services and alternatives. Limiting individuals’ ability to access long-term care will likely increase burdens on family and community members, and lead to worse health outcomes due to not receiving needed health care services on a regular basis.



Conclusion

The recent activities of federal and state policy-makers directed at the Medicaid program signify that there is a need to examine the populations served and services covered under the Medicaid program, and how Medicaid reform has the ability to affect them. Although the stated goal of policy-makers concerning Medicaid reform has been budgetary savings, the effects of Medicaid reform on the public's health needs to be examined. Outside of proving to be a cost-effective health insurance provider, the Medicaid program has provided its beneficiaries access to essential preventive and primary health services, ranging from immunizations to school health services to sexually transmitted infection testing services. These services not only affect the health and well-being of the individuals receiving them; they impact the health of the population on the whole, by less-

ening disease transmission rates and improving community, school and occupational health. Medicaid also supports the nation's health safety net, especially through its financial support of health centers, public hospitals and other public health care providers.

The purpose of the Medicaid program is to provide health coverage to eligible populations. Medicaid reform should strive to promote and protect the health of current Medicaid beneficiaries and medically disadvantaged populations by maintaining the program's focus on and coverage of preventive and primary health services.

Ultimately, a goal of reform should not be short-term budgetary savings but rather to limit the increase in the number of uninsured and underinsured individuals in the United States and maintain the program's role in narrowing the nation's health disparity gap.

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“Medicaid is the largest and most varied insurer in America, fulfilling many of the basic public health functions of the Federal government. Given the many tasks that have been assigned to it, Medicaid works well. But the changes proposed in the current discussion will undo its basic guarantees and structures, leaving some of our most vulnerable people with no place to turn and leaving the public health of the nation to uncertain financing and a flawed marketplace. If these beneficiaries and these services fall through the safety net, the nation will pay the price.”

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