FACTORS AFFECTING MEDICAID FUNDING AND IMPLICATIONS FOR HEALTH CARE PROVIDERS

A THESIS

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BY
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FACTORS AFFECTING MEDICAID FUNDING AND IMPLICATIONS FOR HEALTH CARE PROVIDERS

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Introduction

“Not like the brazen giant of Greek fame,
With conquering limbs astride from land to land;
Here at our sea-washed, sunset gates shall stand
A mighty woman with a torch, whose flame
Is the imprisoned lightning, and her name
Mother of Exiles. From her beacon-hand
Gloows world-wide welcome; her mild eyes command
The air-bridged harbor that twin cities frame.
"Keep, ancient lands, your storied pomp!" cries she
With silent lips. "Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!"

- Emma Lazarus, "The New Colossus"

In the Senate of the United States,
December 24, 2009.

Resolved, That the bill from the House of Representatives (H.R. 3590) entitled “An Act to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.”, do pass with the following

AMENDMENTS:

Strike all after the enacting clause and insert the following:
“Strike all after the enacting clause and insert the following…” These words would soon come to mark the beginning of a monumental transformation of health care delivery in the United States. The words were part of three significant events that set the course for the future of American health care provision and production. The first of these was the "Service Members Home Ownership Tax Act of 2009." Also known as H.R. 3590, the bill had already unanimously passed the House of Representatives and was amended in the Senate by striking all language after the enacting clause and inserting the text of the “Patient Protection and Affordable Care Act.” It was then passed in the Senate on December 24, 2009 before a Republican Senator-elect, who had pledged to block the bill’s passage with the 41st vote in opposition, could be officially seated. The amended bill then passed the House on March 21, 2010 and was signed into law March 23rd, 2010. Concurrently, H.R. 4872, the “Health Care and Education Affordability Reconciliation Act of 2010,” was passed as a budget reconciliation bill making adjustments to existing H.R. 3590 law. It passed the House on March 21, 2010 two days before H.R. 3590 was signed into law.

The second significant event came when the Supreme Court upheld the “individual mandate” portion of the Patient Protection and Affordable Care Act (PPACA) that requires citizens to purchase an insurance product or be subject to a tax. This decision came in the majority opinion for “National Federation of Independent Business, et al., v. Sebelius, Secretary of Health and Human Services, et al.” on June 28, 2012. The opinion was written by the Court’s Chief
Justice, John Roberts, and his argument followed that this mandate could be enforced under the federal government’s broad authority to levy taxes. The last, and perhaps most significant of these three events, came when President Barack Obama was reelected to office on November 6, 2012 along with a Republican majority in the House of Representatives. President Obama’s reelection made certain there would be no executive repeal or delays of the law that was considered the signature legislative achievement of his presidency. Each of these events defined the path that America continues to follow towards universal access to health care services for all of its citizens.

**An Inherent Conflict**

The challenges facing health care policymakers are rooted in the inherent conflict and tension between two public goods: the desire to increase access to health care and the desire to share costs in an equitable and responsible way. Opposing sides of this issue not only have a different understanding of rights, but contrasting priorities for the American government. If we ask ourselves the question: Who wants to deny basic life requirements to their fellow citizens? or Who wants to bankrupt the government, physicians or hospitals? The answer is clear: Almost no one. The following research is an exploration of how this tension between two goals, that almost everyone supports, provides a unique backdrop against which the debates over health care reform and Medicaid play out.
The arguments are compelling and the stakes are high. Millions more Americans will soon enroll in the Medicaid program, inundating health care service providers. Medicaid and other entitlements already account for more than 60% of spending by the federal government. Access to health care is clearly the key to more successful health outcomes for patients and it is undeniable that this access can present enormous challenges for individuals who cannot afford insurance. As well as outlining how these debates reflect tensions between the goals that most Americans support, this research seeks to clarify how the country's complicated health care delivery system is both organized and funded. On occasion, the work will draw from professional experience and academic research of health care in Indiana as a case study to illustrate several features of Medicaid policy. Though each state is unique, Indiana's government agencies and health care service organizations face the same challenges as their colleagues across the country.

**Medicaid**

Medicaid is the state and federal partnership program that redistributes tax revenues as health care reimbursement for services provided to qualified, low-income Americans. State governments both contribute tax resources to these expenditures and maintain responsibility for the administration of the program. The Centers for Medicare and Medicaid Services (CMS), a division of the Health and Human Services Department, provides oversight and guidance of the
program by regulating state plans and operations. The Medicaid program began as part of the social welfare changes implemented by President Roosevelt in the 1930’s and has continued to evolve and expand into its present form. More than 62 million Americans are now dependent on Medicaid to pay for their health care, and the program is a central component of the Patient Protection and Affordable Care Act’s expansion of services. Medicaid is different from health insurance as its members do not pay to participate in the program and there are no limitations of its benefits.

**Health Care**

Health care is the collective body of services provided to people in order to maintain or improve health. Those who provide these health care services are both individuals and organizations. Included are a variety of clinical professionals such as primary care and specialty doctors, nurses, technicians, and therapists as well as professionals who are skilled in the operation and administration of health care facilities. Every human being requires health care services at some time in their life. Age and disease positively affect the increased need for health care services, yet precipitous injury also frequently results in necessary and often expensive medical treatments. Paying for these services presents a complex challenge: While the need for health care services by individuals is known, the occurrence and severity of these needs are not. Traditionally, this challenge has been met most effectively by “risk pooling,” or each requiring that participants pay
a small sum into an aggregate and only withdrawing from these funds when necessary. Society has faced the reality that some individuals cannot or will not pay into the system; therefore the payments for these services must be collected directly from the patient, from insurance products or from government entitlement programs. Health care is not the same as health insurance. Health insurance is the shared risk and contribution of a pool of members that exists to support a member during a temporary time of need.

**Structures and Organizations**

Medicaid is governed by the Health and Human Services Department (HHS) of the executive branch of the U.S. federal government. The President of the United States appoints the Secretary of HHS to lead the agency. State governments, led both by elected governors and legislators, submit state Medicaid plans to the federal government for approval and are also responsible for implementing and administering the program. The federal government sets an annual percentage of Medicaid expenditures that states are required to pay toward the program known as the Federal Medical Assistance Percentages (FMAP). Because of the partnership nature of Medicaid, state governments are given broad flexibility to define eligibility requirements, enrollment processes and the services that are reimbursed by the program. As Medicaid spending continues to be an increasing percentage of state budgets, policy makers are debating the return on investment in the program and its long-term sustainability.
Administrative Law and Regulation

Title XIX of the Social Security Act defines the federal authority of the Medicaid program. The implied and enumerated powers provided by the United States Constitution to the executive and legislative branches dictate the manner in which agencies and committees interpret and influence the program. Though Medicaid is regulated at the federal level, it is operated by the states. Health care providers are subject to numerous rules and regulations from state and federal authorities. The intent of these regulations is to improve the quality of health care and many are necessary to ensure patient safety; however, cumbersome compliance requirements have come with a cost. The administrative burdens on organizations result in time and resources dedicated to compliance, rather than patient care. The tendency is for these regulations and other compliance requirements to increase in both number and scope. The Patient Protection and Affordable Care Act, known as health care reform or Obama Care, is the most recent example of the expansion of federal regulation of the health care industry.

Reports and Projections

Medicaid costs for federal and state governments are expected to rise significantly over the next several years. Health care reform mandates that individuals must either purchase insurance or enroll in entitlement programs such as Medicaid. Projecting costs for Medicaid is challenging primarily because
entitlement programs, by definition, have no limits on enrollment and participation is based on eligibility standards rather than availability. Also, economic factors may significantly impact projections. In contrast, health care service provision is more predictable and with known shortages of physicians and other clinical staff, access limitations are expected to increase. Tens of millions of newly eligible Americans are expected to enroll in the Medicaid program in the immediate future, inundating health care service providers with new clients. This will occur concurrently with the reduction of compensation for the services that are provided by health care organizations. These anticipated financial and health outcomes can be discouraging for policy leaders interested in sustaining a program that is an essential safety net for low-income Americans.

Expectations and Challenges

There are many challenges ahead for America’s Medicaid program. One of the greatest is finding a long-term solution to pay acceptable rates to medical service providers. As enrollment in the program expands, either rising costs will force federal and state governments to obtain additional revenue, or payments to medical service providers must be reduced. America’s economy currently remains stagnant with negative growth in the fourth quarter of 2012 and nearly fifteen percent of the country unemployed or underemployed. The number of physicians and other health care service providers who are accepting Medicaid patients has been in decline for years. Medical schools have seen a significant
decrease in applicants and primary care shortages are at an all time high. The PPACA remains politically contentious with some policy leaders at the highest level of state and federal governments dedicated to its repeal. With these numerous and difficult challenges, major policy changes will be required in order to ensure Medicaid’s integrity and viability.
Medicaid

“Good health is important to everyone. If you can't afford to pay for medical care right now, Medicaid can make it possible for you to get the care that you need so that you can get healthy – and stay healthy.”

- Centers for Medicare and Medicaid Website

Introduction

Medicaid is generally perceived to be health care “insurance” for the poor, though the program is not operated as an insurance product. For forty-seven years, the United States Federal government has provided reimbursement to health care providers for products and services delivered to low-income citizens through the federal-state partnership program known as Medicaid. Medicaid programs vary from state to state with respect to eligibility and coverage standards, but each program is approved and overseen by the federal Centers for Medicare and Medicaid Services, a division of the Department of Health and Human Services. The federal government “matches” funding with state expenditures on Medicaid services to providers at varying rates. In 2012, Indiana paid 34 cents of every Medicaid dollar. Mississippi paid 25 cents towards each
Medicaid dollar while Wyoming paid 50 cents.¹ Milliman, an international actuarial and accounting firm, describes this process:

“Medicaid begins with a mix of federal and state funding. The federal government makes annual Medicaid payments to states based on their Federal Medical Assistance Percentages, or FMAPs. Each state’s FMAP—which is determined by a formula that looks at state per capita income relative to the U.S. average—is set somewhere between 50 and 83%. This means the federal government pays between 50 and 83 cents of every Medicaid dollar, leaving the state to pay the difference. While the proportion of federal and state dollars is set each year, the total amount is unlimited, unless the state and federal government have agreed to special financing terms under a waiver of the Medicaid rules. These funds can be further supplemented through a number of different federal grants. A state may use alternative sources of income—such as tobacco or provider taxes—to fund its Medicaid program.”²

This division of state and federal dollars has both an accounting and public administration explanation: U.S. citizen taxpayers pay both federal and state taxes. The division and redistribution of these revenues in this manner ensures that there are “winner” and “loser” states. Some states pay more into the federal system than they receive in return, while others receive more than they have given to the federal government. This method also provides for the flexibility required at the federal level to guarantee services are delivered to American citizens both with an emphasis on fairness and the intent of eliminating disparities whenever possible.

Medicaid in Theory and in Practice

Medicaid is a “safety net” program. This means that the program is intended to temporarily assist individuals with their health care costs in times of financial hardship. The purpose of a safety net program is, by definition, designed to “catch” those who are in immediate need of assistance due to circumstances beyond their control. While that definition has continued to expand over the last several decades, it remains that the citizens who are most vulnerable require government assistance in order to improve their health and financial positions. Because providers are reimbursed for services provided to qualified individuals, Medicaid is often perceived to be medical insurance; however, no premiums are paid by the users of the program. Insurance is defined by risk, and the Medicaid program does not base costs on actuarial calculations of predicted usage. Entitlement programs simply do not function in that manner. Unlike commercial insurance, Medicaid provides retroactive coverage. This comes in the form of reimbursement to providers for services rendered up to several months before the individual applies to the program.

Overview

Federal

The United States federal government is the highest level on the organization chart of the Medicaid program. Specifically, the executive branch is
responsible for its operation. This operation is carried out by the Centers for Medicare and Medicaid Services (CMS) as a division of the Department of Health and Human Services (HHS). CMS oversees the program and reports directly to HHS. The Secretary of HHS is a cabinet appointee of the president and retains authority for the ongoing administration of Medicaid and other social programs. In practice, Medicaid policy is set by the President of the United States. The President, the Secretary of HHS, and the Director of CMS guide the Medicaid program's administration as it partners with state governments. Any significant amendments to state programs must go through a rigorous process of federal review and approval. Standards of care, minimum requirements for eligibility and all reimbursement methodologies are proposed, modified, and adopted under the auspices of CMS leadership.

The U.S. Congress funds the Medicaid program. As an entitlement program, Medicaid falls into the “Non Discretionary” category of the federal budget.\(^3\) An entitlement is any government program to which a person has a right to benefits as defined by law. This means the law requires that Medicaid be paid for and that Congress does not need to pass regular appropriation bills to provide ongoing funding. It is this inherent feature of an entitlement that both stabilizes the access to services and destabilizes the fiscal integrity of the program by omitting requirements for spending restraints. Some entitlements, such as Medicare and Social Security, collect revenues from participants that offset costs

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to the program. Costs are not fully covered by these revenues and the federal
government must therefore borrow cash to pay out to beneficiaries. Medicaid,
other entitlements, and the debt service for these programs now account for
more than 60% of U.S. federal spending.\textsuperscript{4}

\textbf{State Programs}

States both administer the Medicaid program and set guidelines for
eligibility processes and procedures. States are also responsible for overseeing
the complex task of managing provider reimbursement. CMS gives the states
latitude in these administrative categories largely out of necessity. Though the
federal government is able to review and audit the programs administered by the
states, it is not possible for CMS to manage the day-to-day operations required to
screen, underwrite, award and maintain the voluminous Medicaid caseload. This
task falls to state agencies such as Indiana’s Family and Social Service
Administration (FSSA). The state of Indiana web site summarizes the purpose of
the FSSA in the following:

\begin{quote}
“FSSA is a health care and social service funding agency. Ninety-four percent (94\%) of the agency’s total budget is paid to thousands of service providers ranging from major medical centers to a physical therapist working with a child or adult with a developmental disability. The five care divisions in FSSA administer services to over one million Hoosiers.” \textsuperscript{5}
\end{quote}

As with any state government agency, politics are deeply involved in the process. Leadership of the FSSA is appointed by the elected Governor and serves in the Governor's cabinet as a close advisor on health care policy. This vast agency consists of five "care" divisions: The Division of Family Resources, Office of Medicaid Policy and Planning, Division of Disability and Rehabilitative Services, Division of Mental Health and Addiction, and the Division of Aging.

**Implementations**

Each of these agencies is charged with the implementation and operation of hundreds of programs and grants that directly affect the daily lives of millions of people. The state of Indiana administers more than 30 different Medicaid programs including the State Children’s Health Insurance Program, Hoosier Healthwise for pregnant women and children and the Healthy Indiana Plan. There are broad programs, such as the Medicaid for the Aged, Blind and Disabled, and there are very specific programs such as Indiana’s Breast and Cervical Cancer Program that provides payments to providers for treating patients with those unique conditions.

These programs are subject to budget constraints, but because they are entitlement programs, there are few limitations on participation. State budget offices must use estimations based on past usage and projected future enrollment, though specific dollar amounts cannot be capped. These budgets do not significantly impact the operation of these programs because states are
bound by federal oversight. CMS must approve all state plans, though the approvals often give broad discretion and states have flexibility to set criteria for eligibility as well as the authority to administer the application, underwriting and award processes. States have learned to take advantage of this structure by leveraging state revenues to maximize federal contributions.

“One means for states to do this is to make a public health care facility eligible for a higher payment rate, triggering higher matching contributions from the federal treasury, and then require that provider to pay a portion of the surplus back to the state in the form of taxes or voluntary contributions.”

In Indiana, as well as several other states, this is done through “assessment fees” charged to health care facilities in the form of a special tax. The taxes are collected by the state and then paid back, along with the federal matching funds, to health care providers based on their treatment of subsidized patients. In order to meet federal specifications, the program cannot be used solely for the purpose of leveraging federal dollars. The result is a formula that requires some to pay in more to the program than they receive. Another method used by states to leverage federal dollars to pay providers for services to the uninsured population is the disproportionate share hospital payment (DSH).

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8 Indiana Select Joint Commission on Medicaid Oversight. Meeting Minutes. October 18th, 2011.
“The disproportionate share hospital payments program authorizes higher payments to public hospitals and community health centers serving a large number of low-income patients”  

Individuals are not presently required to own a health insurance policy, and that reality combined with millions of undocumented people in the United States results in hospitals providing services to those who have no resources for payment. Some of these services are required by the 1986 Emergency Medical and Labor Act law (EMTALA).  

Federal dollars are allocated to assist the states in reimbursing hospitals who deliver these uncompensated services more often than other hospitals. This funding is drastically reduced by the implementation of the Patient Protection and Affordable Care Act beginning in 2014 and disproportionately impacts urban safety net hospitals. This will result in the loss of jobs. These hospitals account for 13% of America’s hospitals but will suffer 42% of the direct job losses associated with the reduction of DSH.

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10 Emergency Medical Treatment & Labor Act (EMTALA). CMS.gov.


12 Ibid.
Outcomes

In fiscal year 2010, Medicaid paid more than 400 billion dollars towards the reimbursement for services delivered to low-income Americans.\textsuperscript{13} 142 billion dollars of this total went to acute care benefits and another 113 billion dollars was distributed for the reimbursement of long-term care. 104 billion dollars was delivered in the form of capitation payments to Managed Care Organizations (MCOs) that take a fixed amount per enrollee for a contracted time to deliver services that are determined to be necessary. The positive aspect of the MCO delivery system is a known and fixed cost, while the negative is additional complexities for patients with regards to benefits and network options.

| Table 1—Medicaid Outlays for Fiscal Year 2010 by Type of Payment  
| (In billions) |
|----------------|----------------|--------|
| **Title XIX Outlays** \textsuperscript{1} | Federal Share | State Share | Total |
| Medical Assistance Payments: | | | |
| Acute Care Benefits \textsuperscript{2} | $98.5 | $44.2 | $142.7 |
| Long-Term Care Benefits \textsuperscript{2} | 76.3 | 36.7 | 113.0 |
| Capitation Payments and Premiums \textsuperscript{2} | 71.5 | 32.4 | 103.9 |
| Disproportionate Share Hospital (DSH) Payments \textsuperscript{2} | 8.7 | 6.5 | 15.2 |
| Adjustments \textsuperscript{3} | 4.7 | 3.6 | 8.3 |
| Subtotal, Medical Assistance Payments | 259.7 | 123.4 | 383.1 |
| Administration Payments | 10.1 | 8.0 | 18.1 |
| Vaccines for Children Program | 3.8 | — | 3.8 |
| Gross Outlays | 273.5 | 131.4 | 404.9 |
| Collections \textsuperscript{4} | —0.8 | —0.1 | —0.9 |
| Net Outlays | 272.8 | 131.3 | 404.1 |

\textsuperscript{1} Federal outlays are the funds drawn from the U.S. Treasury by the States. The State and total outlays reflect spending as reported by the States for the purposes of drawing Federal funding from the U.S. Treasury. Expenditures represent the spending as it was paid by the State to health care plans or providers. While expenditures and outlays are generally similar, they are not equal mainly due to the timing differences between the States paying for services and the States receiving Federal funds. Neither outlays nor expenditures include Title XIX costs in support of the Children’s Health Insurance Program.

\textsuperscript{2} Benefit expenditures as reported on the CMS-64 (base expenditures).

\textsuperscript{3} Adjustments include net adjustments of benefits from prior periods and the difference between expenditures and outlays.

\textsuperscript{4} Collections from Medicare Part B for the Qualifying Individuals (QI) program and from other miscellaneous sources.


\textsuperscript{13} Office of the Actuary, CMS 2011.
Past, Present, Future

Origins

The origins of the American welfare system are rooted deep within the English Poor Laws. Historically, charity was distributed through religious systems and by religious devotees. England in the 16th Century was fraught with dynamic changes in the traditional structures and roles of the faithful. From 1534, when Henry VIII ascended to the throne and began the conversion of the country to the Church of England, until King George I’s reign in 1714, England struggled to define itself through both the Protestant and Catholic paradigms.14

“The English Poor Law of 1601 was the first systematic codification of English ideas about the responsibility of the state to provide for the welfare of its citizens. It provided for taxation to fund relief activities; it distinguished between the “deserving” and the “undeserving” poor; relief was local and community controlled; and almshouses were eventually established to house those on relief. The law was at once both generous and harsh. Generous in that it acknowledged the government’s duty to provide for the welfare of the poor, but harsh in that it viewed the poor as highly undesirable characters and treated them accordingly.”15

Medicaid has its roots in the first decades of the 20th century. A time of social change, President Franklin Delano Roosevelt had big and bold ideas for how best to use the United States government as a vehicle to support American citizens in need. Not all of his ideas were implemented, but the key goals and

accomplishments contained within his proposals ultimately became the welfare system we have in place today.\textsuperscript{16}

With the foundation laid in early 1935, it was several more decades before the benefits of Roosevelt’s plan began to work their way into the day-to-day lives of the people. There was both a political and moral consensus that the very young and the very old, and later the disabled, require not only community and religious charity, but broad and systemic support that was provided by the federal government. In 1956, amendments were made to the Social Security Act that provided assistance to citizens with disabilities both the young (18 and under) as well as those between the ages of 50 and 64 who had not previously been covered.\textsuperscript{17} It wasn’t until the 1965 amendments that the government formed Medicaid into an individual entitlement with open-ended federal matching funds, as well as created the Medicare program for elderly and disabled.\textsuperscript{18}

<table>
<thead>
<tr>
<th>Disability Time Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954—Social Security Amendments of 1954 establish the disability “freeze.”</td>
</tr>
<tr>
<td>1956—Monthly benefits are provided to disabled workers aged 60–64 and to disabled children (aged 18 or older) of retired or deceased workers.</td>
</tr>
<tr>
<td>1956—Benefits are established for the dependents of disabled workers.</td>
</tr>
<tr>
<td>1960—The requirement that a worker must be at least 50 years of age to be eligible for disability benefits is eliminated.</td>
</tr>
<tr>
<td>1960—Benefits for disabled widow(er)s aged 50 or older are enacted.</td>
</tr>
<tr>
<td>1972—Medicare coverage is extended to Disability Insurance beneficiaries after 24 months of entitlement, and the Supplemental Security Income program is established.</td>
</tr>
<tr>
<td>1977—A new benefit formula is introduced that “decouples” the cost-of-living adjustment from wage increases in an effort to control spiraling Social Security program costs.</td>
</tr>
<tr>
<td>1980—Social Security Amendments of 1980 place a cap on family benefits to disabled workers, require periodic continuing disability reviews, and create work incentives.</td>
</tr>
<tr>
<td>1984—Congress requires the development of new criteria for adjudicating claims involving mental impairments and establishes a “medical review standard” for making determinations on continuing disability reviews.</td>
</tr>
<tr>
<td>1999—The Ticket to Work and Work Incentives Improvement Act of 1999 is enacted, enabling disability beneficiaries to seek employment services and other support services needed to help them reduce their dependence on cash benefits.</td>
</tr>
</tbody>
</table>


In its present form, Medicaid is a federal entitlement program with each state defining its own specific definitions of eligibility criteria. States follow the general outline provided by CMS and make amendments that are submitted for approval. The broad programmatic authority given to the states is due in part to necessity as state employees or contractors are charged with its administration, but also due to budget flexibility. The three primary eligibility criteria are income, category, and special groups and are detailed below.

**Income** - Individual income is determined to be some percentage of the “Federal Poverty Level.” (FPL)\(^\text{19}\) Some programs cover people who have income up to 200% of FPL.

### 2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,170</td>
</tr>
<tr>
<td>2</td>
<td>15,130</td>
</tr>
<tr>
<td>3</td>
<td>19,090</td>
</tr>
<tr>
<td>4</td>
<td>23,050</td>
</tr>
<tr>
<td>5</td>
<td>27,010</td>
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<tr>
<td>6</td>
<td>30,970</td>
</tr>
<tr>
<td>7</td>
<td>34,930</td>
</tr>
<tr>
<td>8</td>
<td>38,890</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $3,960 for each additional person.

**Categorically Eligible** - Pregnant women, children, aged, blind or the disabled meet categorical eligibility.

\(^{19}\) Federal Register Notice, January 26, 2012.
Special Groups -

Medicare Beneficiaries - Medicaid pays Medicare premiums, deductibles and coinsurance for Qualified Medicare Beneficiaries.

Qualified Working Disabled Individuals - Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work.

The Working Disabled - States may also improve access to employment, training, and placement of people with disabilities who want to work through expanded Medicaid eligibility. States may require such individuals to share in the cost of their medical care.

Women with Breast or Cervical Cancer – These women can receive all plan services; TB patients receive only services related to the treatment of TB. The charts below identify the states that include these groups under their Medicaid plans.20

Medicaid is funded using a formula known as the Federal Medical Assistance Percentage (FMAP). This formula has remained basically unchanged throughout the history of the Medicaid program.21 Each state is assigned a required percentage of each dollar, based on need, which the state must “spend” in order for the federal government to deliver the “matching” funds. The percentages for fiscal year 2012 are included in the following chart.

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It is difficult to make accurate projections about future Medicaid spending levels. The Congressional Budget Office (CBO) has provided projections as well as the White House’s Office of Management and Budget. The numerous factors that impact the calculations result in disparities, sometimes significant, in these estimates. Most projections use suppositions of economic growth to approximate...
the Gross Domestic Product (GDP) in order to better reflect growth as a percentage of GDP rather than a dollar amount. This allows for a more relevant picture when adjusting for inflation and other factors. The graph below shows the CBO’s projections for federal health care expenditures as a percentage of GDP.

![Graph showing federal health care expenditures as a percentage of GDP.](CBO.gov)

Source: *The 2012 Long-Term Budget Outlook*

**Policy**

**Original Intent**

Medicaid was created to be a “safety net” program, catching those who lost the ability to fully provide for themselves due to circumstances affecting income or health. In 1960, the Kerr-Mills Act created a new program called
"Medical Assistance for the Aged." It provided federal assistance for elderly citizens whose incomes did not put them in the lowest of indigent categories. Because the vast majority of health care needs come during the latest stages of life, legislators and state executives recognized that as its citizenry aged, there would be proportional growth in the need for assistance.

“One important factor in the passage of both Medicare and Medicaid was that the need and the clamor for health insurance kept increasing. The elderly population was growing, medical costs were rising sharply, and there was a general lack of affordable health insurance and health care options for many. These concerns received increased visibility through national advocacy groups (trade unions, public welfare associations, and advocates for the aged and nursing home reform), and the persistent and effective investigations and studies by the Senate and House Special Committees on the Aging. In addition, local administrators, State welfare commissioners, governors, and congressional delegations concerned about rising costs and increased welfare budgets were eager for relief and complained that Kerr-Mills needed expansion or replacement.”

**Expansion**

"If we think it's important as a society to not leave people out, then we're going to have to figure out how to pay for it"

- President Barack Obama, Blair House Health Care Summit. February 25, 2010

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Since the early 1970’s, Medicaid has functioned with relatively little change. The numbers of enrollees has grown and the types of services that are covered by the program have increased both in number and in scope. Beginning in the 2008 election of President Barack Obama, the country rekindled the debate about the role of government and how much the centralized federal bureaucracy should participate in solving the deficiencies in America’s health system. In essence, the debate was a difference in philosophies, theories and worldviews. In the summer of 2009, citizen groups not typically known for their activism staged marches, public gatherings and town hall meetings to protest what is still referred to by the President’s opponents as a “government takeover of health care.”

In March, 2010, President Obama signed into law H.R. 3590, originally passed as a housing tax break law, as the Patient Protection and Affordable Care Act. In November of 2010, the United States elected a Republican majority in the House of Representatives, effectively dissolving President Obama’s triumvirate of Democratic control of the White House, the House of Representatives and the Senate. To date, the issue remains highly political; however, the Supreme Court ruling National Federation of Independent Business v. Sebelius upheld the keystone of the legislation, the individual mandate, and implementation continues today.

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The new law expands Medicaid in two ways. First, it creates a new category of “no category” in order to make all individuals eligible for the program benefits. Traditional categories of elderly, blind or disabled remain, leaving open questions pertaining to which program applicants should apply. In addition to the creation of a “no category” category, the historical definition of income as determined by the states is repealed and replaced with language used for the purposes of federal tax filing. Under the Modified Adjusted Gross Income (MAGI) standards, income from sources such as Supplemental Security Income and child support may no longer be included by states when setting eligibility criteria for the new program.

Solvency

The ‘fiscal soundness’ or solvency of Medicaid is called into question by both political parties and is less of a disagreement of facts than it is a difference in priorities. In 2010, more than 400 billion dollars were spent on Medicaid with federal taxes paying nearly seventy percent of the outlays and state tax dollars covering the balance. In 2011, the CMS Chief Actuary submitted his report to Health and Human Services Secretary Kathleen Sebelius detailing Medicaid’s anticipated growth and expenditure rates. According to the report, the total costs associated with the Medicaid program will more than double in the next decade.

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28 CMS, 2011.
The costs of the program paid for by state tax revenues will nearly triple.\textsuperscript{29} The following graph was included in the report in order to show both the historic trend and the projected growth of the program.

\begin{center}
\textit{-Office of the Actuary, CMS - 2011}
\end{center}

\textsuperscript{29} CMS, 2011.
Health Care

“But all these requisites belong of old to Medicine, and an origin and way have been found out, by which many and elegant discoveries have been made, during a length of time, and others will yet be found out, if a person possessed of the proper ability, and knowing those discoveries which have been made, should proceed from them to prosecute his investigations.”

- Hippocrates, De Prisca Medicina

Health Care Production and Provision

Health care services in the United States are provided by a multitude of diverse organizations. These providers range from the sole proprietor delivering primary care, to the nursing home care corporation that is large enough to have its shares traded publicly on the New York Stock Exchange. Health care services may also be administered by public organizations, such as county or Veteran's hospitals. City and county health departments often provide a variety of resources to people who meet appropriate residency requirements. Hospitals, specialty care clinics and diagnostic service providers often organize in business formats that favor the reimbursement sources of their clients.
Each of these organizations relies on revenue from multiple sources. For some, clients use commercial insurance that is either purchased through their employer or independently to pay the majority of their health care expenses. Other organizations have a “payor mix” that is heavily weighted in favor of government reimbursement programs such as Medicare and Medicaid. Because there are numerous commercial and government programs available to persons within the geographic delivery area of the provider, most health care service organizations are required to invest in extensive administrative revenue cycle operations in order to accurately and efficiently coordinate reimbursement for services. These operations consist of skilled personnel as well as a host of technology systems that have been designed to manage the complex revenue processes of health care delivery systems.

**Primary Care**

Primary care is an important part of the health care system. It is the access point into the disparate systems where illnesses and diseases are diagnosed and where preventative care is delivered. Primary care physicians meet regularly with patients to discuss their general health, their medication needs and other subjects that may help doctors to identify issues that may need further assessment. For most people, the primary care staff is the frontline of health care. The primary care physician's responsibility is to provide the initial assessment of the patient’s needs and refer that patient to specialty care or
prescribe treatment options. Patients without access to primary care often seek their health care at hospital emergency rooms.

Patients often receive preventative care for related issues in the primary care setting and avoid more costly access points, such as the emergency room, for services that require a referral from a primary care physician. Primary care physicians, and more specifically the access to them, are often viewed as the keystone of preventative care and the reduction of emergency room utilization. Use of the emergency room may also lead to a specialty care follow-up appointment as well as additional appointments with the primary care physicians.

**Acute Care**

Acute care is health care that focuses on specific treatment and services. Acute care is often associated with hospitals. Major areas of acute care include emergency rooms, “specialty care” clinics that provide services such as orthopedics, oncology and obstetrics, and surgical departments. In the field of acute care, surgery may be performed either in the “inpatient” or “outpatient” setting, depending on whether or not patients need to be admitted. Typically, when a patient is admitted to the hospital for an “inpatient” service, this indicates that the treatment will require a significant level of clinical observation and recovery time. Diagnostic services such as Magnetic Resonance Imaging (MRIs), X-Rays, and Computed Tomography (CT-Scans) are regularly utilized throughout the acute care delivery system. Acute care can be very expensive and often
presents significant financial challenges for individuals who do not have a source of reimbursement.

**Long-Term Care**

Long-term care is health care that is delivered to patients over an extended period of time. The settings for this type of care vary widely. Most often, the term long-term care is associated with skilled nursing home care and though much of long-term care is provided through these institutional facilities, advances in medicine and social philosophy have resulted in several emerging care options. In addition to the traditional 24-hour skilled nursing care, providers offer services such as assisted living, where medical staff is available nearby, as well as adult day-services that deliver part time and respite care for individuals. These services are intended to allow the patient to live a more independent life as well as reduce the caretaking burden on the family. One of the most challenging issues for long-term care is financing. There are multiple reasons that many individuals ultimately rely on Medicaid to pay for these long-term health care services.

“First, most persons lack the resources to pay out of pocket for more than a few months of care, which typically costs more than $6,000 a month. Second, private long-term care insurance continues to be more expensive than many persons can afford and often carries restrictions on the type and extent of help provided. Third, although Medicare pays substantial portions of acute medical care expenses for older citizens, it covers “long-term care” costs
only for short periods of specialized recuperative or rehabilitative care following hospitalization.”\textsuperscript{30}

Providers

Physicians

Physicians are the center of every health care organization. In 2010, there were roughly 209,000 physicians practicing primary care in the United States.\textsuperscript{31} Along with Nurse Practitioners and Physician Assistants, these medical staff serve as the gateway into nearly every aspect of the modern health care system. Primary care physicians, who may be Medical Doctors (MD) or Doctors of Osteopathy (DO), provide the initial assessments that determine a patient’s navigation through the care delivery process. Many of these physicians operate out of “Community Health Centers” which exist “to address the widespread lack of access to basic health care,” according the National Association of Community Health Centers.\textsuperscript{32} As the entry point into the health care system, primary care physicians make preliminary diagnoses, administer prescription drugs, and make referrals into specialty care.

The National Association of Community Health Centers (NACHC) also works closely with state primary care associations. These associations provide both advocacy and regulatory support for numerous frontline medical

\textsuperscript{31} Agency for Healthcare Research & Quality. 2012.
\textsuperscript{32} NACHC.org. 2012.
professionals. As one example of these organizations, the Indiana Primary Health Care Association (IPHCA) defines the comprehensive primary care services as including “medical, dental, and behavioral health services.” The IPHCA “has a diverse membership that includes CHCs, interested individuals, and organizations that support IPHCA's important mission.” 33 Primary care physicians are particularly sensitive to vacillations in reimbursement rate policies and are experiencing an industry shortage just as tens of millions of Americans are receiving Medicaid coverage for the first time.

Hospitals and Safety Nets

There are nearly 6,000 hospitals in the United States. Twenty percent of these hospitals maintain a “for-profit” tax classification while another twenty percent are organized as state or local government hospitals. The rest are considered nongovernment “not-for-profit” hospitals. The tax classification exists primarily to regulate subsidies and provide guidance for best practices. The organizations are held to the same clinical standards, with most using the Joint Commission for its accreditations. 34 These hospital systems are responsible for delivering acute care services for inpatient admissions as well as other specialty care clinics and outpatient surgeries. Perhaps best known for emergency services, hospitals function as centralized delivery systems for highly skilled

33 IPHCA.org. 2012.
areas of medicine. The following table details the most recent count of hospitals, by classification, in the United States.

| Total Number of All U.S. Registered * Hospitals | 5,724 |
| Number of U.S. Community ** Hospitals | 4,973 |
| Number of Nongovernment Not-for-Profit Community Hospitals | 2,903 |
| Number of Investor-Owned (For-Profit) Community Hospitals | 1,025 |
| Number of State and Local Government Community Hospitals | 1,045 |
| Number of Federal Government Hospitals | 208 |
| Number of Nonfederal Psychiatric Hospitals | 421 |
| Number of Nonfederal Long Term Care Hospitals | 112 |
| Number of Hospital Units of Institutions (Prison Hospitals, College Infirmaries, Etc.) | 10 |
| Total Staffed Beds in All U.S. Registered * Hospitals | 924,333 |
| Staffed Beds in Community** Hospitals | 797,403 |
| Total Admissions in All U.S. Registered * Hospitals | 36,564,886 |
| Admissions in Community** Hospitals | 34,843,085 |
| Total Expenses for All U.S. Registered * Hospitals | $773,546,800,000 |
| Expenses for Community** Hospitals | $702,091,034,815 |
| Number of Rural Community** Hospitals | 1,984 |
| Number of Urban Community** Hospitals | 2,955 |
| Number of Community Hospitals in a System *** | 3,007 |
| Number of Community Hospitals in a Network **** | 1,535 |


Hospitals that service large populations of uninsured or underinsured patients are known as “safety net” hospitals. Many public hospitals are defined in this manner as those people who have no other sources of payment often utilize these systems. Funding mechanisms are put in place in order to subsidize care that is otherwise unreimbursed. Some local governments use property taxes or other collected revenues to provide subsidies to these providers, and most also
rely heavily on additional state and federal programs such as the Disproportionate Share Hospital (DSH) payments.

“The National Association of Public Hospitals and Health Systems represents America’s safety net hospitals and health systems. These facilities provide high-quality health services for all patients, including the uninsured and underinsured, regardless of ability to pay. They provide many essential community-wide services, such as primary care, trauma care, and neonatal intensive care, and train many of America’s doctors, nurses, and other health care providers.”  

An example of one of these safety net hospitals is Wishard Health Services, located in Indianapolis, Indiana. It has much in common with other safety net hospitals: an urban location, an underserved population, and a clearly stated mission that is dedicated to serving the community. Indianapolis is the twelfth largest city in the United States with a metropolitan population of more than 1.7 million people and Wishard is one of America’s five largest safety net health systems. According to the health system’s website, they provide care in nearly one million outpatient visits each year. The organization maintains a 316 bed hospital along with a dozen community health centers. It operates one of the two “level 1” trauma units in Indiana as well as the premier burn treatment and recovery facility in the state.

35 NAPH.org. 2012.
38 Ibid.
Skilled Nursing Homes

Skilled nursing homes are an integral part of the health care system as the principal delivery setting for rehabilitative and end-of-life care. Institutional based, these providers specialize in providing “around the clock” health care services to those individuals who are unable to perform the basic “activities of daily living” on their own. These “ADLs” consist of basic life requirements such as bathing, eating, dressing and toileting. The inability to perform these tasks may be due to advanced age, but may also be the result of an injury that may be rehabilitated. When a person needs assistance with these tasks, it is necessary to have clinical staff close by. The most affordable way to provide this care is to centralize residential and health care resources and this often results in the model used by nursing homes today. Paying for this care presents a significant challenge for most people. The following chart demonstrates the percentages of reimbursement sources that pay for long-term care.

![Chart showing reimbursement sources for long-term care]

Source: Henry J. Kaiser Family Foundation, Medicaid and Long-Term Care Services and Supports (Washington: Kaiser Family Foundation, February 2009). Estimates are for 2006 and do not include the value of informal care provided by friends and family.
Medicare and Medicaid pay for the majority of Long-term care services and therefore some unique challenges exist for Long-term care facilities. Advanced aged, disability and diminished income are required for individuals to participate in the government programs and reimbursements rates vary from state to state and from service type to service type. State and federal legislation and administration are often changing and require consistent engagement to remain both compliant and equitable. In order to advocate for providers of Long-term health care, businesses have organized into entities such as the American Health Care Association, which is a federation of state health organizations representing more than 11,000 non-profit and for-profit nursing facilities, assisted living, and other providers. 39

Home Health Care

Home health care consists of a variety of services including skilled nursing, therapy and home care services.40 The home based setting for the delivery of care is often preferred due to its ease of use by patients as well as its focus on independent living. Providing these services to the patient in their residence not only accommodates the wishes of the individual and their family, but also reduces the possibility of new injury or exacerbation of present injury during travel to and from institutional providers. In order to advocate for home

care services, many of these providers are represented nationally by the National Association of Home Care and Hospice.

“NAHC is the nation’s largest trade association representing the interests and concerns of home care agencies, hospices, home care aide organizations, and medical equipment suppliers.”

Patients and Clients

Users of Primary Care

Nearly every citizen of the United States who uses any part of the health care system has experienced primary care. As the entry point into the health system, individuals schedule appointments with their doctor, visit an urgent care facility or go to “after-hours” locations such as a hospital emergency room. At each facility, a physician (or nurse practitioner) is present to make preliminary assessments and facilitate the next actions in the patient’s health care pathway. In many areas, community health centers (CHCs) provide these services to people irrespective of their ability to pay. From 2006 to 2008, these CHCs averaged more than 31 million visits each year. The vast majority of these were for patients who participate in public health care assistance programs. The following chart, including data from the Centers for Disease Control (CDC),

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41 NAHC.org. 2012.
demonstrates payment sources and demographics of patients visiting community health centers where primary care is provided.

Access to Primary Care through Medicaid

Health insurance is not the same as health care. There are many individuals who have health insurance through public welfare systems who are unable to coordinate timely appointments. One reason for this is the reality that nearly one third of doctors in the United States will not accept new Medicaid patients. Disparities in reimbursements along with additional regulatory and compliance requirements have forced many practices to simply turn new patients

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away. The Patient Protection and Affordable Care Act has attempted to address the reimbursement gap that exists in patient access by allocating additional Medicaid funding to primary care services in 2013 and 2014. This may or may not solve the problem as doctors may choose to only accept new patients when they learn that the 2014 increases will last. If they take on new patients before confirming increases, they will lose money when the rates return to present levels. The graph below reveals a substantial level of physicians who refuse to accept new patients with government funded sources.

46 H.R. 3590, Patient Protection and Affordable Care Act. Cost estimate for the proposal to amend the bill to provide all states the same level of federal assistance for Medicaid that Nebraska would receive under the Senate-passed version Congressional Budget Office January 21, 2010.
**Safety Net Population**

Many who are uninsured or enrolled in public assistance programs obtain their services through safety net health care delivery systems. Because these systems maintain designated funding streams for servicing underserved populations, they must develop revenue cycle models and processes that are able to sustain high levels of uncompensated care. Wishard Health Services in Indianapolis, Indiana is an example of this type of safety net health system. The “payor mix” of the organization is 45.2% uninsured, 25.6% Medicaid, 18.1% Medicare and only 8.3% commercial. With Medicaid paying below cost for many services and uninsured patients making up nearly one half of all accounts, local, state and federal subsidies become critical to keep Wishard and organizations like it financially viable.

**Skilled Nursing Population**

One out of every ten nursing home admissions is less than 65 years of age. While nearly half of admissions are over the age of 85, the trend toward providing services that are focused on rehabilitation and return to independent living is changing the business model of traditional nursing homes. Providing health care along with residential living accommodations is a unique combination

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http://www.wishard.edu/~/media/4783DE9AC84C4231BCB94E76FD37D03E.ashx.
of services that requires a special collection of professionals. While skilled clinical care may be required at any time, it is not required at all times. Many services provided by these facilities such as food service, activity direction and transportation are not clinical in nature. Nursing home residents often live very fulfilling lives as part of the community and only require skilled medical care as part of their daily regimen as age or their illness progresses. The following chart details the illnesses that result in the majority of nursing home admissions.

![Chart detailing illnesses resulting in nursing home admissions](image)

**Home Health Care Population**

For those who do not require full time skilled nursing care, home health care is becoming an increasingly popular delivery setting for long-term care.
The charts above show a wide variety of services and patients who already use these services. Those who need basic assistance with services like wound care;
home care or physical therapy can receive care in their own personal residential setting. Expansion of these services is likely as national policy makers continue support proponents of shifting long-term care delivery from institutional based to home and community based care settings.

“A major public policy goal in the United States is "rebalancing" the long-term care system – reducing what was formerly, for many people, a near-total reliance on nursing facilities and increasing the use of home and community-based alternatives. Between 1995 and 2008, the percentage of Medicaid long-term care dollars spent on home and community-based services increased from 19% to 42%”

Policy and Payor Sources

Commercial

The two sources of health care insurance in the United States are operated in the form of either risk pools or entitlements. In the simplest terms, or most convenient definitions, risk pools collect from the pool the amount required to offset the risk. Entitlements create a legal obligation from the government to the resident. Private (non-government) insurance risk pool options use actuarial science to forecast approximations of outlays and allow people or employers to

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pay premiums based on the anticipated costs. By doing so, most people and their employers are able to afford the nominal costs of premiums and deductible payments. This type of risk mitigation has been around for thousands of years. Sustainability is not predicated on use or participation, but on the calculations that drive collections of funds into the pool. For these programs to benefit their participants, or profit in order to benefit shareholders, they must remain both competitive and relevant; they must pay reimbursement rates that are acceptable to health care providers. Moreover, there is a direct correlation between the type of insurance a patient uses and that patient’s health outcomes.

“The relationship between health status and private insurance coverage was negative, shown by the greater percentage of individuals with excellent health who had private insurance (86.2 percent) compared with those with poor health (63.0 percent). Public insurance, conversely, was more common among those with worse health: 28.0 percent of those with poor health had only public insurance, compared with only 4.6 percent of those with excellent health.”

Medicare

Medicare is the first of the two primary entitlement programs providing health care reimbursement in the United States and was enacted in 1965 as part

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of President Lyndon Johnson’s Great Society Programs.\textsuperscript{53} Primarily, Medicare provides medical payments for individuals over the age of 65, though the program does provide benefits to others who are disabled or suffering some terminal illnesses. The largest expansion of the program came during the administration of President George W. Bush when prescription drug benefits were added in 2003.\textsuperscript{54} The federally funded entitlement is unique among most government programs in that it is not limited in scope by the income levels of its recipients.\textsuperscript{55} Perhaps due to a philosophical disposition towards equitability, the program was designed to collect from all (who earn income) and pay to all, unlike other progressive taxing systems. Medicare is popular among health care providers because it pays significantly higher rates than Medicaid for services.

\textit{Medicaid}

Medicaid is the other major entitlement program in America and it serves as the majority payor to health care providers for services delivered to low-income citizens. Perhaps the most serious deficiency, from a provider's perspective, is the low reimbursement: it pays approximately one half the rates of commercial insurance. This reality results in numerous challenges for organizations such as preferential priority to commercial and Medicare patients in

\begin{footnotesize}
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\item \textsuperscript{54} CMS.gov http://www.cms.gov/About-CMS/Agency-Information/History/index.html.
\end{itemize}
\end{footnotesize}
order to reduce cost shifting. The actuarial firm, Milliman describes this cost shift in the following:

![2007 Physician Payment Levels](image)

"In many areas, public programs pay providers significantly lower rates than do commercial health plans... The payment differential can be thought of as a cost shift from the public programs to commercial payers. That is, if Medicare and Medicaid paid higher rates, commercial payers could pay lower rates with healthcare providers still achieving the same overall reimbursement. As it is, commercial payers subsidize the cost of Medicare and Medicaid, essentially through a hidden tax." 

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Policy makers who favor redistribution and progressive taxing methods favor this cost shifting as a means to collect from sources with the highest propensity and ability to pay.

**Dual Eligibility**

When individuals meet eligibility criteria for both Medicare and Medicaid, they are considered to be a “dual eligible” beneficiary. 57 Once they are enrolled in both programs (enrollment is neither automatic nor mandatory) a complex

coordination of benefits follows. Because Medicare and Medicaid pay different rates for the same services to the same patient, various dynamic guidelines govern when providers may receive favorable reimbursement. These rules and regulations are different for service types as well as products such as medical devices and pharmaceuticals. The result is a disparity in payments for both systems and a disproportionate share between the Medicare and Medicaid programs. The following graph shows how these beneficiaries account for an imbalance in Medicare and Medicaid reimbursements.
Charity Care

The final method for reimbursing health care providers for services provided to the uninsured or underinsured is through a charity care program. There are various ways these programs are designed and administered and most receiving funding from foundations, endowments or intergovernmental transfers of property tax revenues. Some health care networks receive philanthropic donations that are pooled, invested and used to subsidize some or all of that network’s unreimbursed services. Along with disproportionate share hospital payments, charity care can provide enough supplemental revenue to maintain a sound business structure. Community hospitals that are operated by state or local governments rely on taxes to be collected and redistributed to the facility to sustain operations.

In 2012, the Internal Revenue Service issued notice of a proposed rule that will add several new requirements to hospitals that are organized as a 501(c)(3) non-profit who continue to provide charity welfare programs. The rule requires these non-profit hospitals develop and maintain an official Financial Assistance Policy (FAP) that conforms to federal guidelines. Failure to comply with this rule may result in the loss of tax exempt status or monetary penalties. The core FAP requirements consist of maintaining written policies for financial assistance and emergency medicine, limits on amounts that may be charged for
medically necessary services, restricting collection activities and conducting regular “community health needs assessments.”

The Health Advantage program that is administered by the Health and Hospital Corporation of Marion County, Indiana functions as another financial safety net program for county residents. The program is designed to provide reimbursement to Wishard Health Services for those individuals who have neither employer-sponsored health insurance nor government-assisted coverage. This charity care is available to low-income residents of Marion County who do not have access to other forms of assistance. While it is not insurance and no premiums are collected, patients are awarded participation in the program with the understanding that balances for non-elective health care services will not be charged to the individual, but rather waived on an account-by-account basis.

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58 IRS.gov. 2013.
59 Wishard Health Advantage Website, 2012.
Structures and Organizations

“Why man, he doth bestride the narrow world
   Like a Colossus, and we petty men
   Walk under his huge legs and peep about
   To find ourselves dishonorable graves”

- William Shakespeare’s Julius Caesar

Federal

Federal Overview

The United States regulates every part of the health care industry at the federal level. State health departments traditionally provide oversight to providers of health care. These health departments, however, are ultimately responsible to the many federal authorities that make up the Department of Health and Human Services. These include the Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Health Resources and Service Administration (HRSA) and many more. These divisions issue rules, regulations and direct the implementation of all relative programs.

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60 HHS.gov. 2012.
**HHS and CMS**

The Department of Health and Human Services serves as the agency for the administration and delivery of all health and welfare related programs. HHS also includes 11 regional operation divisions located strategically throughout the country. The Secretary of HHS is part of the President’s cabinet and is responsible for processes that impact more American lives than any other division of the executive branch. The reporting structure for the department is detailed in the organization chart below. The Centers for Medicare and Medicaid Services provide “health insurance” coverage for more than 100 million people through the Medicare, Medicaid and SCHIP programs.61

61 CMS.gov. 2012.
**Congressional Oversight**

Congress’s oversight of the Health and Human Services Department is granted largely through the “implied powers” in Article I, Section VIII of the U.S. Constitution as well as the “advice and consent” powers as referred to in Article II, Section II. From the Constitution, Congress derives its authority to reject or confirm executive branch appointments to agencies such as the Health and Human Service Department as well as ensure that these agencies are performing to the expectations of the public. It exercises these powers often through the legislative committee hearings and through the use of special investigations.\(^62\)

Specifically, Congress uses the Committee on Oversight and Government Reform to review and investigate these federal agencies. At present, the Committee is engaged with the investigation of issues such as illegal gun programs overseen by the Justice Department, “waste” in federal information technology spending, and actions taken by the State Department during the attack on an American embassy in Benghazi, Libya.\(^63\) The broad authority to initiate and carry out these investigations is detailed in the committee’s charter.\(^64\)

\(^{62}\) Article I, Sec. 8 & Article II, Sec.2, U.S. Constitution.  
\(^{64}\) Ibid.
The Supreme Court of the United also derives its authority from the United States Constitution. Article III, Sections I and II provide for one Supreme Court with broad judicial powers over all law, as well as any additional inferior courts that may be determined necessary by Congress. Both the scope and the finality of this power may be limited as decisions handed down by the Supreme Court must ultimately be administered by the executive branch.\(^{65}\)

Upon the passing of the Patient Protection and Affordable Care Act into law, many state agencies hesitated to begin the planning and implementation of the massive new program until it had been vetted through the trial process. Several independent businesses brought a lawsuit against the Department of Health and Human Services and Secretary Kathleen Sebelius that challenged the constitutionality of several key components of the PPACA. The government’s authority to require state governments to expand their Medicaid programs as well as mandate that all citizens purchase a health insurance product was of particular interest to those seeking guidance on how and when to implement the law. The Court ultimately upheld most parts of the law, including the mandate to purchase health care insurance or pay a fine. Chief Justice John Roberts, in his majority opinion, detailed his position regarding the line between the Court’s authority and the President’s policies.

\(^{65}\) Article III, Sec.1 & Article III, Sec.2, U.S. Constitution.
“Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our Nation’s elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices.”

State

Indiana FSSA

State governments base their organizational structures on that of the federal government. Each has an executive, legislative and judicial branch, though their relative relationships and authorities differ from state to state. The Governor of Indiana is elected every four years in a general election. The Secretary of the Family and Social Services Administration is appointed by the Governor and functions as a member of the Governor’s Cabinet. As detailed in the chart titled “Our Functional FSSA,” the Secretary appoints the Directors of each of the agency’s divisions. The Director maintains ultimate authority and is the public representation of the division, while his or her appointed Deputy Director operates as Chief of Staff. The Family and Social Services Administration has an annual budget of approximately 6.5 billion dollars that consists of both state and federal funds. Of the FSSA’s total budget, 94% is paid to the service providers of medical and developmental care. The Office of Medicaid Policy and Planning and FSSA maintain a relationship similar to the

67 FSSA.In.gov. 2012.
Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS).

“The Office of Medicaid Policy and Planning (OMPP) administers Medicaid programs and performs medical review of Medicaid disability claims. Medicaid is more than just health coverage. It provides vital health care to about one in seven Hoosiers. Nearly 800,000 people stay healthy, or start on the road to better health, thanks to Medicaid.”

Our Functional FSSA

- FSSA Website. FSSA.IN.gov. 2010

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68 Indiana FSSA Website, 2013.
Legislature

Indiana’s legislative branch functions much like the U.S. Congress, with two separate houses made up of representative and senators. A key difference from the federal model is that the Indiana General Assembly serves only as a part time legislative body. Sessions are held each year and only last for a few months. The Indiana General Assembly website details their basic structure and history:

“The two houses of the General Assembly (House and Senate) were created at the time Indiana became a state in 1816. The current makeup of the General Assembly, consisting of 100 Representatives serving 2-year terms and 50 senators serving 4-year terms, was established in the Constitution of 1851. The General Assembly met every other year until 1972, when it began meeting annually.”

These elected officials represent their constituencies and are intended to provide both voice and influence to the political process. Though most lawmaking must defer to federal statutes that may overlap in jurisdiction, the state level legislative body has a great deal of influence over the general operation and administration of most programs and policies.

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69 State of Indiana. 2013. Indiana http://www.in.gov/legislative/
Primary Care Organization

Primary care organizations, and the access to them, are clearly the key to more successful health outcomes for patients. States that maintain the highest ratios of primary care doctors to patients have significantly better health outcomes. This includes several areas of illness from cancer to infant mortality. It is true even when controlling for many of the socio-demographic factors that
traditionally impact these outcomes.\textsuperscript{70} Physicians who serve in primary care roles have increasingly moved from traditional family practice models to partnerships with larger health care providers as part of the ongoing consolidation of the American health care system.

“Led by advances in surgery, hospitals underwent a major transformation in the early twentieth century. To attract surgeons, hospitals supplied needed facilities and nursing personnel free of charge and allowed surgeons to collect fees for their own services. When the Great Depression made hospitalization unaffordable for many people, the rise of Blue Cross (closely tied to the American Hospital Association) and Blue Shield insurance plans (sponsored by organized medicine) ensured that hospitals and surgeons would be paid by insurance for inpatient care.” \textsuperscript{71}

\textit{Acute Care Organization}

The majority of hospitals in the United States are community hospitals, hospitals that are geographically located to provide acute care services to a geographic region or specific population. Of these community hospitals, nearly half are non-profit, nongovernment hospitals. Most originated as the result of the collective need for services by the surrounding public. The remaining community hospitals are a combination of state and local government hospitals and investor-owned, for profit organizations. Each of these institutions exists to provide


\textsuperscript{71} Sandy, Lewis G., Thomas Bodenheimer, L. Gregory Pawlson and Barbara Starfield. The Political Economy of U.S. Primary Care. Health Affairs July/August 2009 vol. 28 no. 4 1136-1145.
services such as emergency care, diagnostic, surgery and other medical procedures to clients who require admission to the facility. Health care services organizations are often partners with physician groups who work with hospitals to provide these types of care. The result can be a complex billing structure for patients as they concurrently receive services from the organization as well as the physician group.

**Long-term Care Organization**

Long-term care services providers in America are both far more numerous and diverse in their organization structures, patient populations and service provision. Primarily, long-term care is equated with skilled nursing home care, though in reality there are several other service types that require treatment for long periods of time without full time residential care. There are more than 16,000 nursing homes in the United States and the majority of them are proprietary in tax classification. Geographically, nearly two thirds of these facilities are located in the south and Midwest of the country. Half of these facilities are independently owned while the others operate as part of a multi-facility organization. The following table details the tax classification and composition of various nursing home facilities throughout the United States.
Policy

Health Systems and Medicaid

In many ways, Medicaid is deeply embedded into both American culture and American society. The tax dollars allocated to Medicaid pay for the health care for one third of American children, and for the care of a quarter of non-
elderly adults. Hospitals depend on this welfare system to pay for services such as labor and delivery as well as emergent services to low-income citizens. As detailed in the chart below, Medicaid pays only a fraction of private insurance; however, there are some benefits for health care providers who accept Medicaid. First and foremost, the payments received are preferable to receiving nothing at all. Because laws require some health care providers to provide emergency services, much of this care would be delivered simply to comply with federal regulation or to “do the right thing” when a fellow human is in a dire state of health and needs clinical assistance. Medicaid also tends to reimburse providers faster than some commercial insurance plans and Medicare. Medicaid improves cash flow and can help “keep the lights on” for organizations carrying significant amounts of receivables on their balance sheets.

Primary Care and Medicaid

Access to primary care for Medicaid participants remains an unsolved problem. Because, on average, Medicaid only pays clinicians 66% of Medicare fees, doctors and other medical providers remain reluctant to treat patients with Medicaid as their only source of reimbursement. 73 Rural areas are disproportionately impacted by this practice and services such as dental care and internal medicine can be extremely difficult for residents to find and access. The Patient Protection and Affordable Care Act attempts to address this disparity by adding or increasing the Geographic Practice Cost Indices (GPCIs) to benefit rural practitioners. 74 With millions of more citizens becoming eligible for Medicaid, this disparity is likely to continue. The data in the following chart includes statistics from the Health Resources and Services Administration (HRSA) that reveals alarming levels of primary care physician access in the United States.

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Acute Care and Medicaid

Most hospitals and acute care providers accept Medicaid patients, but they are challenged by the low reimbursement rates. Hospitals rely on both state and federal governments to set the compensation levels in a manner consistent with both the provider’s need to receive revenue and the government’s need to balance budgets. An entitlement based program makes this increasingly difficult,
because the uncompensated care is not limited by dedicated funds. Neither hospitals nor state governments are able to limit the costs of most services that do not fall under a managed care contract with a third party.

“From the federal-state Medicaid program for the poor, blind and disabled, hospitals receive either (1) case-based payments (D.R.G.’s) or (2) a set amount of dollars per day of inpatient stay (per-diem payments) or (3) fees for individual services and supplies (fee-for-service or F.F.S. payments). The levels of these payments are set unilaterally by the state governments. In many states these payments are much lower than the full cost of providing the services.”

Long-term Care and Medicaid

Medicaid pays for the majority of long-term health care services in the United States. Because many of these services are not covered by the standard Medicaid program, Medicaid has created the option of provider Home and Community Based Service “waivers” to individuals who qualify.76 These services include assisted living, home health care and other non-traditional care. Medicaid requires the recipient to have minimal or no monthly income as well as no more than a nominal amount of assets in order to qualify for the program. The result is that those people who need long-term care and do not have significant wealth, necessarily become impoverished in order to receive Medicaid payment for services.

Administrative Law and Regulation

“Athenian: Of this process of change let us discover, if we can, the cause; for this, perhaps, would show us what is the primary origin of constitutions, as well as their transformation.

Clinias: You are right; and we must all exert ourselves,—you to expound your view about them, and we to keep pace with you.”

- Plato, Laws

Federal

Constitution

The Congressional powers to provide for the general welfare of the country are included in Article I, Section 8 of the U.S. Constitution and it is the “commerce clause” that grants authority for Congress to regulate commerce with foreign nations, among the states, and with the Indian tribes. It is upon these few words that legal precedent has founded the federal oversight and regulation of any and all health care delivery conducted in the United States. At this time, there are 65,000 employees of the Department of Health and Human Services
who are paid to administer this oversight, averaging more than 1,200 employees for each of the 50 states.\textsuperscript{77}

\begin{quote}
\textit{“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people”}

- Tenth Amendment, U.S. Constitution.
\end{quote}

The Tenth Amendment to the U.S. Constitution, which defines federalism as it is presently recognized, affords powers not granted to the federal government by the Constitution to the states. The last of the Amendments included in the Bill of Rights is often referenced in support of states’ rights advocates who are concerned with the “overreach” of federal authorities in their attempts to “preserve and protect the principles of a strictly limited government.” \textsuperscript{78}

\textit{Title XIX}

Title XIX is the legislation that governs the Medicaid program along with Title XXI that details the Children’s Health Insurance Program. The major reforms and modifications included in the Patient Protection and Affordable Care Act are implemented as amendments to Title XIX statute and its respective subsections.

\textsuperscript{78} Tenth Amendment Center. 2012. http://tenthamendmentcenter.com/about/.
“Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the territories) to assist states in furnishing medical assistance to eligible needy persons.”

This section of the Social Security Act also gives the “power of the purse” to executive branch administrators. States are required to submit all program modification requests to federal regulators for approval, if HHS or CMS determine that there is evidence of non-compliance with overarching guidelines, funding may be withheld as a result.


80 Social Security Act. Title XIX, Sec. 1904. [42 U.S.C. 1396c].
The Patient Protection and Affordable Care Act (PPACA) is the most significant health care related legislation passed in the United States since the original 1965 Social Security Amendments. The controversial law mandates that most U.S. citizens purchase health insurance, significantly expands the Medicaid program and creates a new subsidy program for those individuals and families who are living at or below 400% of the Federal Poverty Level. The outcomes of this law, which has come to be referred to as “ObamaCare” by both advocates and critics, have resulted in polarizing and divisive opinions between those who
support and those who oppose the law’s actions. Prior to 2008, a majority of Americans believed that it was the responsibility of the federal government to make certain that all Americans had health care coverage. At the end of 2012, and shortly after President Obama was reelected, that majority was reversed as most Americans declared that it was not the responsibility of the federal government to ensure health care coverage. As recently as 2011, only 4 in 10 Americans were in favor of Congress allowing the law to stand.

Do you think it is the responsibility of the federal government to make sure all Americans have healthcare coverage, or is that not the responsibility of the federal government?

![Graph showing poll results on government responsibility for healthcare coverage.](chart)

The passage of the new law through the budget reconciliation process in 2010, the Supreme Court decision upholding the law and the reelection of President Obama ensured that the implementation of most of the PPACA requirements would continue. Even as 3 out of 4 Americans believe that the mandate to buy health insurance is

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unconstitutional, there are some parts of the law that remain popular. Most favored are the various health insurance reforms, such as requiring insurance companies to accept applicants irrespective of health status or previous health conditions as well as removing the lifetime caps on coverage. The law also creates “Health Benefit Exchanges” in order to provide subsidies to those who are not included in the expanded Medicaid program. States are required to either set up their own “exchange” or defer to the federal government. The following flowchart, prepared by the Kaiser Family Foundation, demonstrates the path for all citizens of the United States to determine their personal obligation to purchase health insurance as mandated by the PPACA.

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The Requirement to Buy Coverage Under the Affordable Care Act

Do any of the following apply?
- You are part of a religion opposed to acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are incarcerated.
- You are a member of an Indian tribe.
- Your family income is below the threshold requiring you to file a tax return ($9,350 for an individual, $18,700 for a family in 2010).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

Yes → There is no penalty for being without health insurance.

No →

Were you insured for the whole year through a combination of any of the following sources?
- Medicare
- Medicaid or the Children’s Health Insurance Program (CHIP).
- TRICARE (for service members, retirees, and their families).
- The veteran’s health program.
- A plan offered by an employer.
- Insurance bought on your own that is at least at the Bronze level.
- A grandfathered health plan in existence before the health reform law was enacted.

Yes → The requirement to have health insurance is satisfied and no penalty is assessed.

No →

There is a penalty for being without health insurance.

2014
Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.

2015
Penalty is $325 per adult and $162.50 per child (up to $697.50 for a family) or 2.0% of family income, whichever is greater.

2016 and Beyond
Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

The penalty is pro-rated by the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for Bronze level coverage in an Exchange. After 2016, penalty amounts are increased annually by the cost of living.

Key Facts:
- Premiums for health insurance bought through Exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an Exchange in 2016 would be $4,500-5,000 for an individual and $12,000-12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).
- In 2010 employees paid $999 on average towards the cost of individual coverage in an employer plan and $3,997 for a family of four.
State

**FSSA Partnership with CMS**

The Centers for Medicare & Medicaid Services (CMS) maintains governance of the Medicaid program for the Department of Health and Human Services (HHS) at the federal level. In a similar model, the Office of Medicaid Policy and Planning (OMPP) administers Medicaid on behalf of the Family and Social Services Administration (FSSA) at the state level in Indiana. Because Medicaid is a partnership program, mutually operated and funded by states and the federal government, it is imperative that both entities maintain open communication in order for policies and procedures to be appropriately administered. One example is within long-term care, as the Indiana Division of Aging works closely with the CMS waiver program to fund and operate non-traditional services. This program requires that states prepare and submit any requests to CMS for review and approval.\(^8^5\) This has allowed states to make changes to their Medicaid programs to better serve their residents.

> "Many of these recent changes were brought about not through legislation but through waivers of federal requirements. Medicaid waivers allow the federal government, as a long-standing statutory authority, to permit states to alter their programs in ways not otherwise allowed under federal Medicaid law. These recent state Medicaid waivers cover a wide variety of initiatives, ranging from shifting beneficiaries to managed care, to expanding

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\(^8^5\) Indiana FSSA Website, 2013. FSSA.IN.gov.
Indiana Medicaid

The Indiana Medicaid program currently consists of five major programs as well as some expansion services for prescription drugs, newly pregnant women and the partially disabled. These programs are traditional Medicaid, Hoosier Healthwise, Care Select, Healthy Indiana Plan (HIP) and Medicaid waiver plans. Each program has been through the submission and approval process with CMS in order to meet federal guidelines and regulations. Traditional Medicaid provides reimbursement for most primary care, acute care, pharmacy and nursing home services to the aged, blind and disabled. The Hoosier Healthwise program is utilized to provide coverage for pregnant women, children, and low-income families. Care Select is the state’s venture into capitated managed care, where private companies contract with Indiana to take a per enrollee fee in order to oversee the coordination of benefits for individuals with chronic illnesses. The Healthy Indiana Plan is Indiana’s program to “fill the gap” that has been preset until recently in the current Medicaid program. It requires participants to pay a “small monthly fee” and currently does not reimburse

providers for services such as vision, dental or maternity services. CMS has approved HIP through the end of 2013, and Indiana Governor Mike Pence has stated that he would like to use the program to expand the state’s Medicaid program as directed by the Patient Protection and Affordable Care Act.

Health Care Committees

Indiana state regulatory authorities have included the requirement of multiple boards, commissions and task forces to govern its health programs. The Indiana Family and Social Services Administration (FSSA) is currently held accountable to twelve. The Indiana State Department of Health is assigned another half dozen health related boards. These boards include several related to services provided to elderly or otherwise vulnerable populations. Each committee was created to provide additional oversight and community input for state policies and procedures. The composition of these groups includes a variety of gubernatorial appointments as well as designated representatives of the community.

Indiana and the Patient Protection and Affordable Care Act

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Like other states, Indiana is preparing for the implementation of major portions of the PPACA that begin in January, 2014. The strategic planning is focused on three main tasks: the establishment of the Health Benefits Exchange, preparation for additional Medicaid enrollees and the administration of the new roles and processes created by the PPACA. Some of this responsibility falls to the Indiana Department of Insurance (IDOI). Along with the FSSA, the IDOI is following the direction of Governor Pence to comply with the new federal rules and regulations regarding access to the Health Benefits Exchange and Medicaid. Indiana has opted to allow the federal government to run the exchange on its behalf with the option of taking it over if it is both successful and costs are not prohibitive. The table that follows details the timeline for selected PPACA provisions.
Providers

*Indiana State Department of Health*

Article XIX of the Indiana Code provides for the establishment of the Indiana State Department of Health (ISDH) and defines it as “the superior health department of the state” to which all other health boards are subordinate. The language also states that the ISDH “shall supervise the health and life of the citizens of Indiana and shall possess all powers necessary to fulfill the duties prescribed in the statutes and to bring action in the courts for the enforcement of health laws and health rules.”\(^{91}\) This law broadly defines the many ways the ISDH agency is able to generate rules and regulations as well as enforce those rules through licensure restrictions and fines.

*Primary Care Regulations*

Primary care and other physicians are regulated by their respective state boards of health. In Indiana, it is the Medical Licensing Board of Indiana that is responsible for this administration as instructed by Title 844 of the Indiana Administrative Code.\(^{92}\) The Federation of State Medical Boards is the national organization of these state boards and functions as a support system to coordinate best practices and disseminate information throughout the federation.

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\(^{91}\) Indiana Code.IC 16-19-3-1.

\(^{92}\) Indiana Administrative Code. 844 IAC 1-14. & IC § 25-22.5.
membership. The FSMB defines the regulatory authorities of these boards as follows:

“The 10th Amendment of the United States Constitution authorizes states to establish laws and regulations protecting the health, safety and general welfare of their citizens. Medicine is a regulated profession because of the potential harm to the public if an incompetent or impaired physician is licensed to practice. To protect the public from the unprofessional, improper, unlawful, fraudulent and/or incompetent practice of medicine, each of the 50 states, the District of Columbia, and the U.S. territories has a medical practice act that defines the practice of medicine and delegates the authority to enforce the law to a state medical board. State medical boards license physicians, investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians where appropriate. By following up on complaints, medical boards give the public a way to enforce basic standards of competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession. There are currently 70 state medical boards authorized to regulate allopathic and osteopathic physicians.”

Acute Care Regulations

In 2001, ten years prior to the passage of the PPACA, the American Hospital Association commissioned the PricewaterhouseCoopers firm to provide an objective analysis of the state of hospital regulation in America. The chart below presents a summary of the federal, state and local governing agencies with which hospitals are required to interact in order to maintain compliance.

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93 Federation of State Medical Boards, 2006.
The study also took into account how these agencies interact with each other and what steps were taken on behalf of the organizations to ensure that the health care providers being regulated were not unnecessarily overburdened. Little evidence of efficiencies was discovered and the lack of coordination between government agencies indicated nothing short of a systemic failure.

“Almost no coordination exists among various federal agencies or between similar agencies at local and state levels, and private-sector accreditation. Even within the Department of Health and Human Services (HHS)—the major federal regulator of hospitals—there is little coordination among its different divisions. HCFA, for example, has trouble coordinating its Medicare and Medicaid rules and instructions—more than 130,000 pages. (That’s three times the size of the Internal Revenue Service Code and its federal tax regulations.)”

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**Long-term Care Regulations**

Nursing Homes, also known as Skilled Nursing Facilities or SNFs, are also regulated both by state and federal agencies. Nurse auditors employed by the Indiana State Department of Health conduct surprise surveys, known as “no notification” surveys, of these long-term care providers and assess penalties for deficiencies. Fines may be issued and operations may be shut down as a result of these surveys, so providers dedicate a significant amount of human and financial resources to ensure that auditors find their facilities to be in compliance. The Indiana State Department of Health also responds to complaints that are received through published website forms and hotlines. Patients, family members or an anonymous party may submit a complaint which results in an investigation. Along with this state regulator, The Department of Health and Human Services issues regulations for nursing homes that cover topics from clinical compliance to upgrades to sprinkler systems.95

Title VI of the PPACA includes multiple sections of new and modified rules and regulations for nursing homes including expanded accountability standards, new quality assurance programs and additional ways for complaints to be received and processed.96 Regulations for long-term care services that are not “institutional” in nature vary widely from state to state. Due to the relatively recent

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95 Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicare and Medicaid Programs; Fire Safety Requirements for Long Term Care Facilities Automatic Sprinkler Systems GAO 08-1106R. August 6, 2008.
96 Affordable Care Act: Opportunities for the Aging Network. Administration on Aging. & Patient Protection and Affordable Care Act. Final as Passed Both House and Senate.
advent of services such as home health care, adult day care centers and adult foster care, state health departments have only begun to develop regulations that will accompany licensure, certifications or accreditations.

Policy

*Indiana State Department of Health Organization*

In addition to its many divisions and departments, the Indiana State Department of Health has several boards and committees that provide oversight and set policy for the organization as required by the Indiana Code. The following chart illustrates the organizational structure of the Indiana State Department of Health Organization.
Regulatory Impact on Primary Care

Due in part to the reality that one third of doctors say they are no longer willing to accept new Medicaid patients, new regulations and reimbursement methodologies contained in the PPACA are intended to increase the participation of these primary care providers in the program.\textsuperscript{97} Of major concern to many primary care providers is that the planned increases are scheduled to sunset at the end of 2014.\textsuperscript{98} The American Association of Family Physicians, an organization representing more than one hundred thousand doctors, advocates reducing regulatory burdens on physicians who serve Medicare and Medicaid beneficiaries. They have reported that an assessment of new regulations intended to enhance efficiency and transparency in the CMS agency itself is anticipated to remove duplicative and outdated requirements.\textsuperscript{99} As the shortage of primary care physicians becomes more pronounced, it will be imperative that obstacles to accepting government payor sources are minimized.

Regulatory Impact on Acute Care

Hospitals are extremely complex, multifaceted organizations made up of clinical staff and health care administration professionals. To maintain both a

\textsuperscript{97} Lubell, Jennifer. Small practices may be least able to take new Medicaid patients. American Medical Association News. Aug. 20, 2012.
\textsuperscript{98} Herman, Bob. 8 Points From the Medicaid Primary Care Physician Proposed Rule. Beckers Hospital Review. May 09, 2012.
solvent business model and a successful and compliant medical services operation, it is of the utmost importance that regulations do not cause an unnecessary burden. Research in this area reveals that some of these regulations remain an obstacle to the efficient delivery of health care.

"With already overwhelmed waiting areas, hospitals with emergency departments have started implementing new approaches to handle overcrowding in anticipation of the nearly 34 million uninsured that will enter the market in 2014 under the ACA insurance mandate. Their organizational changes range from differing intake procedures based on severity of care needed; more efficient use of bed space; and, lowering readmission rates."  

The AHA/PricewaterhouseCoopers reports details the ratio of paperwork to patient care in the following graphic.

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Regulatory Impact on Long-term Care

In April of 2010, the President of the American Health Care Association issued a memorandum to member organizations. AHCA is the largest advocacy trade association representing nursing homes and assisted living facilities in the United States. In short, the memo stated that the PPACA will add or modify multiple regulations for member organizations. The memo highlighted several key regulatory areas that would dramatically impact providers of long-term care services: 101

- Civil Monetary Penalties (CMPs): Within the next year, CMPs may be significantly reduced for facilities that self-report and promptly correct deficiencies. Additionally, CMPs may be placed in an escrow account following completion of the informal dispute resolution process, or 90 days after the date of the imposition of the CMP.

- Quality Assurance and Improvement Program (QAPI): Prior to December 31, 2011, HHS will establish and implement a QAPI program for nursing homes.

- Nursing Home Compare: Within one year, HHS will expand the data on Nursing Home Compare to include more detailed staffing; links to state 2567s; summary information on the number, type, severity, and outcome of substantiated complaints; instances of criminal violations by employees; and more.

- GAO Report on Five Star: Under the law, GAO will evaluate how the Five Star Nursing Home Rating System is being implemented, problems associated with the system, and how it may be improved.

- National Independent Monitor Demonstration Project: HHS will establish a demonstration project to develop, test, and implement use of independent monitoring program to oversee interstate and large intrastate nursing facility chains.


Reports and Projections

“There are two sentences inscribed upon the Delphic oracle, hugely accommodated to the usages of man’s life, KNOW THYSELF, and NOTHING TOO MUCH; and upon these all other precepts depend. And they themselves accord and harmonize with each other, and each seems to illustrate the energy of the other; for in Know thyself is included Nothing too much; and so again in the latter is comprised Know thyself.”

- Plutarch, Consolatio ad Apollonium

Federal

Congressional Budget Office

In April of 2010, Richard Foster of the Congressional Budget Office (CBO) released a report that detailed significant increases in overall health care expenditures as the direct result of provisions of the Patient Protection and Affordable Care Act. Also contained in the report was more than 500 million dollars of spending cuts to the Medicare program.102

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<td>18.2%</td>
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<td>19.3%</td>
<td>19.8%</td>
<td>20.2%</td>
<td>20.5%</td>
<td>21.0%</td>
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102 Congressional Budget Office. April, 2010.
The concerns with this report, for those focused on the fiscal implications of the PPACA, were the stated net cost increase of health care spending by 250 billion dollars over 10 years, the increase in National Health Expenditures (NHE) as a % of GDP from 17.8% in 2010 to 21.0% in 2019 and Medicare reductions of more than 575 billion dollars. For advocates of expanded health care coverage, there was another area of disappointment as indicated in the graph below.

Under the PPACA, 23.1 million Americans are expected to be uninsured in the year 2019. This stands contrary to the general perception that the law equates to universal coverage for citizens. The law was promoted as a plan to provide coverage to all Americans and even years after this report was released, this
Another major problem with the PPACA was recognized in October, 2011 when HHS Secretary Kathleen Sebelius announced that the CLASS Act portion of the law would be abandoned. The program was declared to be actuarially unsustainable and would be discarded, along with the original proposed savings of nearly 40 billion dollars. This brings the estimated costs of the PPACA closer to 300 billion over 10 years. Those opposing the law demanded accountability as cost estimates continued to rise. Supporters of the law pointed out that the cost was still less than the Medicare Part D prescription drug benefit expansion that was passed by Republicans in 2003 estimated to be 727 billion dollars over 10 years.104

“Medicare Chief Actuary Richard Foster calculated the [CLASS] program needed to enroll more than 230 million—more than the entire nation’s workforce— to be financially feasible.”105

The Supreme Court decision of National Federation of Independent Business v. Sebelius in June of 2012 also affected these projections. Because states would not be forced to expand their Medicaid programs, projected costs would most certainly decline. Soon after the opinion was issued, the Congressional Budget Office along with the Joint Committee on Taxation released a revised estimate.

103 Levey, Noam N. Obama’s win means his healthcare law will insure all Americans. November 08, 2012.
104 2009 Annual Report of the Board of Trustees Federal Hospital Insurance and Medical Insurance trust funds.
“CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of $1,168 billion over the 2012–2022 periods—compared with $1,252 billion projected in March 2012 for that 11-year period—for a net reduction of $84 billion. The projected net savings to the federal government resulting from the Supreme Court’s decision arise because the reductions in spending from lower Medicaid enrollment are expected to more than offset the increase in costs from greater participation in the exchanges. That outcome is projected to occur despite the fact that the government’s average additional costs per person in the exchanges will be greater than its average savings per person for those who, as a result of the Court’s ruling, will not enroll in Medicaid. Why? Because the number of additional people entering the exchanges as a result of the ruling is projected to be only about half the number who will not be obtaining Medicaid coverage many of whom will be ineligible to participate in the exchanges.”

For those searching for clear and honest answers to questions of cost, the ambiguity can be frustrating. Perhaps the root of most long-term budget disparities is the historic pattern of both Presidents and Congresses passing temporary legislation that bypasses or delays planned reductions. This important detail has not gone unnoticed by the Congressional Budget Office, which is often tasked with “scoring” legislation as it is written, not as it will likely be implemented. This results in a propensity to provide misleading information to the public. To deal with this complexity, the CBO has begun to issue two distinct and qualified projections: the “extended baseline scenario,” and the “extended alternative fiscal scenario.” The difference between these two is essentially the

difference between the written law and the law enacted. Baseline is the law as written, and Alternative is the law as likely enacted. This can be clearly demonstrated in the two, very different, 2012 CBO budget projection scenarios:

The CBO defines the two scenarios in the following:

“The extended baseline scenario, which reflects the assumption that current laws generally remain unchanged; that assumption implies that lawmakers will allow changes that are scheduled under current law to occur, foregoing adjustments routinely made in the past that have boosted deficits. The extended alternative fiscal scenario, which incorporates the assumptions that certain policies that have been in place for a number of years will be continued and that some provisions of law that might be difficult to sustain for a long period will be modified, thus maintaining what some analysts might consider “current policies,” as opposed to current laws.”

The Extended Alternative Fiscal Scenario includes these assumptions that have been in practice long enough to be known as the rule and not the exception:

- Expiring tax provisions (other than the current reduction in the payroll tax rate for Social Security) are extended;
- The AMT is indexed for inflation after 2011;
- Medicare’s payment rates for physicians’ services are held constant at their current level (rather than dropping by an estimated 27 percent in January 2013 and more thereafter, as scheduled under current law); and
- The automatic spending reductions required by the Budget Control Act, which are set to take effect in January 2013, do not occur (although the original caps on discretionary appropriations in that law are assumed to remain in place).  

**Government Accountability Office**

The U.S. Government Accountability Office, which functions as an independent and nonpartisan agency, surveyed state budget directors regarding their opinions on the PPACA Medicaid expansion and requested to report back with concerns.

“In terms of states’ views on the fiscal implications of the Medicaid expansion on states’ budget planning, our survey found that across fiscal years 2012 to 2020, the majority of state budget directors believe that three aspects of Medicaid expansion will contribute to costs: (1) the administration for managing Medicaid enrollment, (2) the acquisition or modification of information technology systems to support Medicaid, and (3) enrolling previously eligible but not enrolled individuals in Medicaid. At the same time, state budget directors expressed uncertainty about how other aspects of expansion will affect their budgets,

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such as the impact of shifting existing Medicaid enrollees into health benefit exchanges.”

**State**

**FSSA**

“Under the ACA, the federal government will fully cover the cost of the newly eligible individuals in 2014, 2015, and 2016. After that, states will be required to contribute toward the costs for those individuals. States’ shares of the costs rise over several years so that, for 2020 and subsequent years, states will be required to pay 10 percent of the costs for such individuals.”

The question is this: Is this a good deal for states? There are various opinions, but the present consensus among states is, yes. The Indiana Family and Social Services Administration hired the global actuarial and consulting firm Milliman to provide an analysis of Indiana’s costs of implementing the PPACA. Milliman reported back multiple scenarios. Each of the options presented Indiana with some tough choices: Take the money now and figure out how to pay for the gap when the subsidies reduces in four years, or forego the money and risk the consequences of increasing costs in other areas of uncompensated care. The following table, included in the Milliman report, details the cost to Indiana taxpayers under several scenarios.

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109 Medicaid Expansion: States’ Implementation of the Patient Protection and Affordable Care Act GAO-12-821, Aug 1, 2012.

The firm that estimated these costs to Indiana taxpayers for the Family and Social Services Administration also keeps track of health care costs for all Americans. In May 2012, Milliman announced that for the first time annual health care costs for American families were greater than 20,000 dollars in 2012, yet it also noted that “the rate of increase is not as high as in the past, but the total dollar increase was still a record.”


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Milliman

Industry

*Health Care General*

National Health Expenditures for the United States are expected to grow significantly over the next decade. Medicaid enrollment is anticipated to increase at a record pace as major portions of the PPACA are implemented.

“*The government-sponsored share of health spending is projected to increase from 45 percent in 2010 to about 50 percent by 2020, driven by expected robust Medicare enrollment growth, Medicaid coverage expansions, and Exchange plan premium and cost-sharing subsidies.*”[^112]

[^112]: National Health Expenditure Projections. 2010-2021. CMS.
In compliance with federal statutory requirements, the Centers for Medicare and Medicaid are required to submit projections to the public each year that predict spending growth in federal health care expenditures. The graph below provides the anticipated increases in National Health Expenditures each year.

- CMS, NHE Projections 2011-2021 & Dan Munro, Forbes.com

Primary Care

Because primary care doctors are the gateway to the health care system in the United States, it is important to understand the obstacles to access that will
exist for the 50 million currently uninsured Americans who may acquire health insurance coverage in the coming years. Primary care doctors, and the administrators of the practices that they operate, have found themselves at the critical juncture of supply and demand within the health care delivery system. For years, medical students have been choosing career paths that have trended away from internal medicine practices and towards specialty care. This reality has already created a shortage in primary care that will increase as the PPACA is “expected to flood the system with new patients in the coming years.” According to Association of American Medical Colleges, the United States faces a shortage of more than 90,000 physicians by 2020.


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113 Massachusetts General Hospital. News Release: Newly insured patients may have trouble finding primary care physicians: Current safety-net providers are attentive to issues of quality but may be unable to care for more patients 26/Nov/2012.


In particular, the access to primary care is shrinking disproportionately to the population reimbursed through the Medicaid program. Rates have been consistently reduced either at the federal or state level for providers of clinical services, or they have been subject to vicissitudes of policy debates and budget constraints. The pending increase in the volume of patients accompanied by the decreases and instability in reimbursement rates has forced many in private practice to make tough decisions about the patients they serve. In an article that appeared on the cover of Modern Physician Magazine, Dr. Lisa Swanson, a pediatrician working near Dallas, Texas tells a typical story:

“If I accepted even 10% Medicaid, I would have to close my office... Pediatricians make very low margins. I am barely in business. …It breaks my heart I can't treat Medicaid patients because I took care of them when I was a resident.”

The Obama administration, in its implementation of the Affordable Care Act, attempted to address this issue by temporarily increasing some Medicaid reimbursement rates for primary care services. The American Academy of Family Physicians supported this increase as a way to keep new doctors from adding to the 20% who have ceased taking on new Medicaid patients. They also issued a warning that unless the government permanently funds this increase for services

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provided to Medicaid clients, in a few years the necessity to restrict access would return.³¹¹⁷

“The problem will grow worse as the U.S. population increases and ages. As people age, they are more likely to develop multiple and complex chronic conditions—and the number of people over age 65 is expected to double between 2000 and 2030… At the same time, almost one in three physicians is over age 55 and likely to retire within the next two decades. A large percentage of them are primary care doctors.”³¹¹⁸

The Annals of Family Medicine graph below charts the compounding effects of population growth, aging and the PPACA on primary care access.

![Graph](image)


**Acute Care**

Hospitals are in the crosshairs of several provisions to be enacted by the PPACA. Numerous health care regulations, which have been proposed by interest groups for years, saturated the law as it was crafted in the House of Representatives. In many ways, the PPACA became the vehicle to enact regulation that would not otherwise be included due to the lack of public support. The House Ways and Means, Education and Workforce and Energy and Commerce Committees, have increase the time that health care providers will have to spend to remain in compliance with the PPACA.

At present, the total number of this additional time stands at 127,602,371 hours per year. Estimates were derived from the respective agencies’ own estimates.\(^{119}\) Along with additional compliance paperwork, the PPACA adds new financial penalties to hospitals based on their readmission rates in order to reduce Medicare spending. One problem with the formula used to penalize health care providers is that it disproportionately impacts safety net and urban hospital systems as it uses 2008-2011 data for penalties in 2013.\(^ {120}\)

\[\text{\small \textit{Using data from various nationally recognized sources, the National Association of Public Hospitals and Health Systems (NAPH) projects hospitals will see $53.3 billion more uncompensated care costs by 2019 than originally estimated when lawmakers approved the Affordable Care Act (ACA).}}\]

\(^{119}\) ObamaCare Burden Tracker. House Ways and Means Committee et al. 2013.

The additional $53.3 billion in uncompensated care costs, calculated using CBO, U.S. Bureau of Labor Statistics, U.S. Census Bureau, and American Hospital Association annual survey data, would coincide with a total $14.1 billion in Medicaid disproportionate share hospital (DSH) reductions.”

It is the intention of the PPACA that the reduction in the disproportionate share hospital is offset by the expanded Medicaid coverage; however, this simply returns health care systems to their initial problem with the low-income government program: the reimbursement is below the cost of doing business. The graph below details the historic trend of payment-to-cost ratios for hospitals and demonstrates how private pay sources consistently subsidize both the Medicare and Medicaid programs.

Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid

- Austin Frakt, 2011. Figure sources: AHA 2003, 2010.

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Long-term Care

Long-term care accounts for almost one third of total Medicaid expenditures. The PPACA primarily focuses on two areas of reform in the field of long-term care. The first is “rebalancing” long-term care reimbursement from institutional based health care providers to “home and community” based service providers. The other is the addition or modification of compliance rules and quality assurance regulations. Consistent with estimates from other medical services providers, these new requirements will both increase the cost of doing business by necessitating providers to assign new resources as well as reduce the amount of revenues received by institutional based health care service systems. In 2011, the PPACA creates the “State Balancing Incentive Program” aimed at providing enhanced FMAP (federal matching assistance percentage) payment for non-institutional based care.

“The 10 states GAO contacted reported considering several factors in deciding whether to pursue the PPACA options, including potential effects on state budgets, staff availability, and interaction with existing state Medicaid efforts. States were attracted by the increased federal funding available under some of the options, but were concerned about their ability to contribute their share of funding. Limited staff resources and competing priorities were also concerns.”

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Perhaps the larger concern is not how the money is spent, but how much of the money is spent. This would require the federal government to extend credence to state executives allowing them to work with citizens to determine how best to utilized their tax dollars. The state executives and legislators are ultimately responsible for managing the state budget. According to the National Governors Association, Medicaid is already the largest single line items in state budgets averaging nearly 25 percent and continues to rise.\(^{125}\) With the populations aging in larger numbers, the problem appears to only get worse. The following graph projects the growth of the aging population as a percentage of total population.

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Expectations and Challenges

“It is really true what philosophy tells us, that life must be understood backwards. But with this, one forgets the second proposition, that it must be lived forwards. A proposition which, the more it is subjected to careful thought, the more it ends up concluding precisely that life at any given moment cannot really ever be fully understood.”

- Søren Kierkegaard

Medicaid

“It should not be surprising that a disability system developed in the 1930's and created during the political conflicts of the 1950's and 1970's should experience strains after nearly half a century of operation. Still, the warnings of the system's founders remain relevant. Simply put, things do not always work out as planned in disability policy. Correcting the system's flaws by restricting benefits can, for example, lead to a reaction of the sort that occurred between 1981 and 1984. By the time that Congress acted in 1980 in response to rising disability rolls, the disability incidence rate was already heading down. After the administration moved to implement the new law in an aggressive manner beginning in 1981, the system nearly fell apart, as governors ordered their state disability determination offices not to cut people from the rolls and administrative law judges and the courts reversed many of the policies of the Social Security Administration. The ultimate result was that more people, rather than less, entered the rolls.”

**Political Challenges**

Medicaid and the government provision of health care in general, have always been controversial. The role of government, the responsibility of society to provide for those who cannot, and strategies to pay for these services are all continuously debated. These subjects have not been so vigorously argued in the court of public opinion since the 1960’s. The issue of government health care has become polarizing for Americans and is poised to remain a divisive political issue for some time. The instability that this has created for health care providers is counterproductive to producing a better and more efficient health care system. Like other businesses, health care systems require the ability to forecast key components of their revenue models such as labor and compliance costs, demand for product or services and workforce supplies.

Though the PPACA was passed, upheld by the Supreme Court, and Barack Obama was reelected to a second term as President, the issue remains far from settled in Washington, DC. The political sides are as far from agreement as they have ever been. The Patient Protection and Affordable Care Act has become the signature legislation of President Obama’s first term. The Republican Speaker of the House of Representatives’ opposition to the law has led to the passage of H.R. 6079, a bill that repeals the entire PPACA.\(^{127}\) Though it remains largely symbolic as it will not be recognized by the Democrat led Senate, its passage sends a clear message that the battle continues. As the American

economy continues to struggle to recover from a recession that ended in June of 2009, health care issues have been consistently linked to job issues. Republican House Speaker John Boehner has stated unequivocally that the PPACA is “making our economy worse.”

His position is in part due to the additional regulations required of businesses by the law as well as the 500 billion dollars in additional taxes that are required over the next ten years. Because of these political challenges, health care reform moves forward under a constant threat of repeal.

**Fiscal Challenges**

Possibly the greatest challenge to the PPACA, including the Medicaid expansion, is the country’s ability to pay for it. While the general consensus remains that when government provides more services the costs increase, proponents of the law claim that it will in fact reduce the costs to individuals. Because Medicaid is funded by both state and federal taxes and the Supreme Court has provided states with the option whether or not to participate in the expansion, it remains up to the individual state governments to determine how they will move forward. As of March 27th, 25 states have confirmed participating

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in the Medicaid expansion, 15 are not participating, 5 states are undecided, 3 are leaning towards not participating and 2 are leaning toward participating.\(^{131}\)

One of the most significant issues with projecting the actual cost of the new provisions is the consistently growing estimate. When the PPACA was proposed, it was stated by President Obama and others that the costs would be approximately 900 billion over 10 years.\(^{132}\) This was a significant spending increase but was comparable to the Medicare Part D prescription drug expansion passed by a Republican-led House of Representatives and signed into law by Republican President George W. Bush in 2003.\(^{133}\) Each year since that proposal, the Congressional Budget Office has increased the estimate. The ten year cost estimate has now tripled to 2.6 trillion dollars.\(^{134}\)

One of the reasons for such a significant disparity is the disingenuous scoring of the proposal that counted revenues for the first three years, prior to any of the costs that begin in 2014, and omitting the respective implementation costs. This makes the proposal technically accurate, though misleading. The political website, FactCheck.org, a division of the Annenberg Public Policy Center of the University of Pennsylvania agreed:

"The 11-year figure is much higher than CBO’s original 10-year estimate because it includes three additional years of full implementation of the coverage provisions."

\(^{132}\) President Barack Obama before a joint session of Congress, 2009.
\(^{133}\) 2009 Annual Report of the Board of Trustees Federal Hospital Insurance and Medical Insurance trust funds.
of the law. The federal subsidies and expansion of Medicaid, which are by far the most costly elements of the coverage provisions, don't go into effect until 2014. So, that 2010-2019 estimate includes four years of very low coverage costs (relatively speaking), and the 11-year estimate only includes two years of very low costs, plus three extra years of full implementation costs.”

Ranking Republican Jeff Sessions of the United States Senate Budget Committee was less gracious. His white paper on the ever growing estimates included numerous deficiencies in the report demonstrating that, as long as the projections are in a constant state of debate, it will be increasingly difficult to collectively solve the problem of funding the program for the long term.

Societal Expectations

It is accepted as fact that vast numbers of Americans will now be insured by the federal government through the Medicaid program or will be required by law to purchase a commercial health insurance product. In 2010, the Rand Corporation provided an analysis of the changes in coverage as a result of the Medicaid and State Children’s Health Insurance Program expansions. The model showed an estimated 6 to 26 percentage increase in coverage based on two key data points:

“About 6 to 35 million people will newly enroll in Medicaid, but just 3 to 12 million of them were previously uninsured.

Crowd out of private insurance, whereby individuals switch from group or other coverage to Medicaid/SCHIP, may account for 30 to 60 percent of new Medicaid/SCHIP enrollees under this proposal.”

The Rand projections pre-date the Supreme Court decision of National Federation of Independent Business v. Sebelius which extends states greater flexibility in the implementation or expansion of their respective Medicaid/SCHIP programs. This makes the compilation of accurate projections difficult.

What is known is that additional enrollment will necessarily result from the new guidelines that are included with the PPACA with respect to the method by which income is determined for Medicaid applicants. This means that items that are presently counted as income, such as Social Security benefits and child

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support payment, will no longer be acknowledged for the purposes of eligibility determination under the Modified Adjusted Gross Income (MAGI) formula.

"The new rules also are very different from the way Medicaid calculates gross income today. In particular, many items now included in income for the purposes of determining Medicaid eligibility are excluded from taxable income for purposes of the federal income tax and hence will not count when using MAGI." 138

Providers

Providers Manage Projections

The expectation is that providers will have a very difficult time managing the current projections. An oversaturation of Medicaid patients, from a market perspective, combined with unstable reimbursement methodologies and poorer health outcomes promises great obstacles for health care providers to both appropriately and efficiently offer clinical services. Medicaid recipients are significantly more likely to be in worse health or be physically or mentally disabled than those who are privately insured. The following graph from the Kaiser Family Foundations details the health disparities between Medicaid enrollees and the privately-insured.

Access is almost certainly one of the contributing factors to this disparity and the expectation is that this will not improve if current trends continue.

“Although 96 percent of physicians accepted new patients in 2011, rates varied by payment source: 31 percent of physicians were unwilling to accept any new Medicaid patients; 17 percent would not accept new Medicare patients; and 18 percent of physicians would not accept new privately insured patients. Physicians in smaller practices and those in metropolitan areas were less likely than others to accept new Medicaid patients.”

The shortage of doctors is already a significant obstacle to health care with more than half of the United States below the national average of physicians per 1,000 people.

**Sustainability**

In order for the Medicaid program, either in its present form or post expansion state, to be sustainable it will require state and federal governments to both balance budgets and reimburse health care providers at rates that are more in line with private health insurance companies. The newly eligible for health coverage under the PPACA will find the benefit of little use if they are unable to locate a provider willing to accept them as a new patient or schedule a timely
appointment for them to receive services. The organizations charged with delivering care to these vulnerable populations are finding it increasingly difficult to sustain their operations.

"In 2008, neither Medicare nor Medicaid paid all of hospitals' costs for treating their patients, though Medicare's payment-to-cost ratio was higher than Medicaid's. More profitable to hospitals than Medicaid or Medicare, private payers ratios have improved since the late 1990s." \(^{140}\)

**Primary Care**

The challenges for consumers and providers of primary care are clear: The United States will need thousands of additional physicians and other clinical professionals working in the field of primary care in order to adequately serve the population. This has been true for some time, but the implementation of the PPACA has increased the gap between existing primary doctors and the number required by more than 10%. American is now expected to require 52,000 more primary care doctors in 2025 than it presently has. \(^{141}\) Of concern, is the reduction in medical school applications. The following chart from the American Association of Medical Colleges reveals an unstable trend of applicants to medical schools.


This challenge may both begin and end with America’s Medical Colleges and other teaching institutions. A steady decline in medical school applicants since 1998 is a growing cause for concern. Those who do attend are choosing surgery or other specialty areas and will require incentives to select a primary care career path. Student loan debt, lower compensation and higher liability insurance costs are all prohibitive to the next generation of doctors. States will also require more educational opportunities for Doctors of Osteopathy who are significantly more likely to select a career in family medicine.\textsuperscript{142} This chart, from the American Medical Association, demonstrates how nearly half of Osteopathic physicians are dedicated to the practice of primary care.

The greatest challenge for individual hospitals and acute care providers is adapting to increasing regulatory requirements while managing decreasing levels of compensation. For years, hospitals have been restructuring revenue models to adjust to these trends and the result is an unprecedented consolidation of health systems in America:

“Irving Levin Associates, a research firm that tracks healthcare mergers and acquisitions, reports that M&A hit $61.2 billion in the second quarter and the highest annual levels since the 1990s. Three of five hospitals now belong to a parent company’s network, while more than half of physicians are
This does not have a positive financial effect on patients or taxpayers as the market consolidation will continue to increase prices. The PPACA is partially financed by reducing the rate increases for Medicare. This will exacerbate the cost shift problem by charging more to private plans as the law encourages providers to merge into “Accountable Care Organizations” (ACOs).

The safety net hospitals that serve populations of patients on public assistance, or have exceptionally lower percentages of commercial payor sources, have even more cause for concern about the funding mechanisms being implemented by the PPACA. These systems are particularly sensitive to amendments that result in negative reimbursement methodologies. In recent months, the National Association of Public Hospitals has advocated for numerous issues that include asking Congress to reconsider the reduction of Disproportionate Share Hospital payments, maintaining flexibility in state Medicaid funding mechanisms and retaining payments for evaluation and management services.

“The Affordable Care Act (ACA) offers expanded health coverage for low-income Americans, in part by increasing Medicaid eligibility to people with incomes below 133 percent of the federal poverty level. To offset part of the cost of expanded coverage, the ACA made significant cuts to DSH payments on the assumption that all coverage provisions

would be implemented, lessening the burden on hospitals of providing uncompensated care. However, while the ACA-mandated DSH cuts remain at their original levels, the Supreme Court ruling effectively made the coverage expansion voluntary for states, which means high levels of uninsured may remain. DSH cuts begin in FY 2014, and by FY 2019, would reduce federal DSH support by approximately 50 percent.”

Long-term Care

“Under the ACA, the regulatory environment for Skilled Nursing Facilities and Nursing Facilities has drastically changed. These changes will likely impact facilities’ policies, operations and management practices. Therefore, it is important that facilities take the appropriate steps to be ready for upcoming changes in the law under the ACA. In addition, facilities should currently have procedures in place consistent with the Office of Inspector General’s (OIG) guidance on compliance programs.”

The Community Living Assistance Services and Supports program (CLASS Act) was included in the original PPACA law though its implementation has since been cancelled. The intention of CLASS was to encourage citizens to begin to invest early in their long-term care services. Though the program was eventually determined to be unsustainable, it was a clear indication that there is consensus about the need to address the escalating costs of long-term care. The costs have been growing and they are anticipated to accelerate over time. Older

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nursing home residents are expected to double from 1.2 million in 2000 to 2.7 million in 2040 and home health care patients from 2.2 million to 5.3 million in that same time frame.\textsuperscript{148} Val J. Halamandaris, President of the National Association for Home Care & Hospice sums up this alarming reality by stating that “I only need to give you one statistic: 5 percent of the public is responsible for 50 percent of health care bills in the United States.”\textsuperscript{149}

\textbf{Structures and Organizations}

\textit{Federal Government}

At this time, the federal government is moving forward with the implementation of the Patient Protection and Affordable Care Act. The task at hand is finding a way to sustain a plan that puts 50 percent of Americans on Medicare or Medicaid by 2020. Under the direction of President Barack Obama, Health and Human Services Secretary Kathleen Sebelius has instructed states to meet imposed deadlines for coordinating the Health Benefits Exchanges, now referred to as “health insurance marketplaces.” She has also instructed that states take action toward expanding their Medicaid programs. The expectation is that if all states expand Medicaid under the PPACA, more than one quarter of all


\textsuperscript{149} Cashin-Garbutt, April. Affordable Care Act: an interview with Val J. Halamandaris, President of the National Association for Home Care & Hospice (NAHC) August 17, 2012.
Americans will be enrolled in the federal low-income program by 2020. Including the 64 million Americans anticipated to be enrolled in Medicare by that time puts more than half of the U.S. population on federal government managed health insurance.

State Government

State governments have similar challenges as most have made the decision to move forward with the federal government’s proposed Medicaid expansion. Many states have also begun the transition to enacting major policy provisions of the PPACA. States who have executive or legislative leadership who are aligned either politically with the current federal administration have been the earliest to adopt certain measures, such as the Health Insurance Exchanges. The PPACA gives states the option to establish a state exchange that meets federal standards or with the federal government to operate an exchange, but must have one in place by January, 2014.

Title XIX of the Social Security act has been amended by the PPACA in order to remove the considerable discretion that states have with respect to

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eligibility and covered services. The greatest obstacle for states will be restructuring both revenue models and personnel organizations to administer the expanded program beginning in 2014. States will also need to find a way to pay for the gap in federal reimbursement when the enhanced federal match (FMAP) begins to decrease in 2017. The requirements and responsibilities placed on states by the PPACA to participate in the new health care exchanges also present challenges. As seen in the chart below, the majority of states are allowing the federal government to establish and operate the initial exchanges.


Policy and Regulation

Federal Challenges

Two opposing ideologies have made the PPACA health care reform law politically polarizing. One side views access to health care as a fundamental right that the government has a duty to provide - as it provides other rights. The other side does not understand that access to be a right, and hence argues both that the PPACA is an unconstitutional expansion of governmental power, and an unwise increase in federal spending. The law, as written, did not pass the House of Representatives and passed the Senate without a single Republican vote.\textsuperscript{154}

This major conflict does not appear to be ending in the near future and health care providers across the nation are caught in the middle. As long as the “repeal of Obama Care” remains high on the list of some federal and state policy makers, the reality is a climate of unstable reimbursement and regulation. In order to guarantee Americans health insurance and also deliver on the responsibility to pay for that guarantee, the opposing sides will ultimately need to reconcile. The following passages suggest that this will not be an easy task.

\textit{“The commitments we make to each other – through Medicare, and Medicaid, and Social Security – these things do not sap our initiative; they strengthen us. They do not make us a nation of takers; they free us to take the risks that make this country great.”}

- Barack Obama, Inaugural Address, 2013.

\textsuperscript{154} U.S. Senate Roll Call. H.R. 3590. PPACA.
“President Obama has won re-election, but his health care law is still driving up costs and making it harder for small businesses to hire workers. As was the case before the election, ObamaCare has to go.”


**State Challenges**

The amount of federal dollars being offered to states for Medicaid expansion is simply too appealing for most states to turn down. For three years, the federal government has pledged to pay 100% of all expanded Medicaid reimbursement. Indiana is still debating whether or not to expand Medicaid and accept the funds. It is undeniable that the expansion brings in billions of additional federal dollars; however, Indiana and other states will be required to start contributing to their own tax revenues as early as 2017.\(^{155}\) Seen in the graph below, those new tax revenues must grow considerably to keep up with the pending reduction in federal support.

HHS Secretary Sebelius has stated that the administration is committed to being flexible with states as they plan their expansions, but to date there has been no resolution with Indiana’s proposals to expand under managed-care or other cost sharing models. Health care providers in Indiana and other states anxiously await resolution so that they may continue to deliver medical services.

“The state's costs to implement the federal Affordable Care Act (ACA) would be about $2.6 billion over seven years if Medicaid is expanded and will increase nearly $612 million even without expansion. Milliman Inc, the state's actuary, has provided new estimates to the Indiana Family and Social Services Administration (FSSA) about ACA's enrollment and financial impact to the state's Medicaid program based on the recent U.S. Supreme Court decision, which makes a Medicaid expansion optional for states.”

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156 HHS Secretary Kathleen Sebelius in letter to National Governors Association. 2013.
157 Indiana Family and Social Services Administration. FSSA.IN.gov. 2012.
### Medicaid

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### CHIP

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### Healthy Indiana Plan

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### Administration

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### All Programs

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Conclusions

“Lastly, and above all, each man thinks those things good which are the object of his special desire, as victory of the man who desires victory, honor of the ambitious man, money of the avaricious, and so in other instances. These then are the materials from which we must draw our arguments in reference to good and the expedient.”

- Aristotle, Rhetoric

Medicaid

The state and federal partnership Medicaid program provides a critical financial safety net for low-income Americans. In order to maintain this program, state and federal governments must work together to ensure that the program meets the health care needs of the people that it serves, and also retains its financial integrity. Each state has unique resources and priorities and the result is a variety of state programs. The Centers for Medicare and Medicaid Services (CMS) will continue to provide oversight and guidance to these states in its role as the federal authority for this partnership. Taking its place among the social welfare changes enacted by President Roosevelt in the early 20th century, Medicaid has a history that is rich in the traditions of Americans taking responsibility to assist the needs of its citizens. This history also includes significant political contention as the income disparity between the rich and the
poor continues to grow and redistributive policies become ever more strained. Proponents of these important and necessary programs face a harsh reality: After nearly fifty years of expanding Medicaid and other entitlement programs, the number of Americans in poverty has reached record levels.¹⁵⁸

Health Care

Health care in America is changing. The services that maintain and improve health that are being delivered by providers include medicines and technologies that did not exist at the time when most of the architecture of government payment methods were first designed and enacted. Doctors and other health care professionals now have access to more treatment options with better health outcomes than ever before. These outcomes have been achieved though great expense. Many of these new treatments and diagnostic procedures are costly due to the significant investment that is required for research and development in the field of medicine. This is true for prescription drugs, medical devices, imaging equipment, and the education of health care professionals. To date, the result of this investment is America’s status as the global leader in health care delivery. This is an important success, though it is an undeniable failure that all of America’s citizens do not have access to this delivery system. Eliminating this disparity is the intent of health care reform, even as it is evident

that negative consequences will most certainly result when adding new patients to a system already experiencing a shortage of providers.

**Structures and Organizations**

As the nation’s highest ranking executive official, the President of the United States is ultimately responsible for setting the course of health care policy for the country. Through the Health and Human Services Department and the Centers for Medicare and Medicaid, the executive branch exercises its authority by determining the operation and implementation of the Medicaid program. States partner with the federal government as partners in both the funding and administration of Medicaid. As the nation moves forward with the implementation of the Patient Protection and Affordable Care Act, states have responded in a variety of ways.

Some states have aligned with the federal government to coordinate Health Insurance Exchanges. Many have not. As of March, 2013, more than half of states have chosen not to operate a state exchange and have opted out of the partnership with the federal government. Most of these states have cited the unknown future costs associated with the program as the reason they have declined. The PPACA requires the administration to establish and operate these Federally Facilitated Exchanges if the states decline participation. The result will be the centralization of the enrollment procedures as citizens will most likely be required to be “screened” by the federal exchange prior to becoming eligible for
state-based Medicaid programs. This creates a need for an enhanced level of federal and state coordination that has not previously existed within the enrollment process.

**Administrative Law and Regulation**

In 2012, the United States Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act, effectively ending all legal challenges that sought to prohibit the law’s implementation. America has historically yielded to these decisions in part because the U.S. Constitution clearly states the powers that are given to the executive and legislative branches and how disputes between them are to be resolved. Even as the House of Representatives are led by a Republican majority who are dedicated to the repeal and replacement of the PPACA, the Democrat led executive branch continues to facilitate the actions required by the law.

Health care providers remain caught in the middle of this political quarrel in the environment of uncertain reimbursement rates and increasing regulatory compliance requirements. Complex and cumbersome administrative burdens, increased by the PPACA, will continue to force organizations to choose between dedicating vital resources to either patient care or to maintaining compliance with state and federal regulations. Government agencies must work with health care providers to reduce these burdens in order to more effectively serve the millions of people who will be coming into the delivery system with the expansion of
There is great opportunity for this to occur as practical solutions to health care access remains a common goal that most Americans support.

**Reports and Projections**

The long term forecasts for Medicaid and other federal health care programs are sobering. Already a substantial portion of the federal budget, national health expenditures are expected to outpace the growth of the economy over the next decade. In the 1960s, these national health expenditures were less than 6% of the U.S. economy. By 2020 these costs will exceed 20% of the Gross Domestic Product. This is the result of the combination of expanded Medicaid, increased enrollment in the Medicare program and the tax subsidies of private health care insurance as mandated by the PPACA. Without meaningful reform, these projections will soon become a reality for policy makers and tax payers throughout America. Perhaps more distressing is the fact that these expenditures must be reconciled concurrently with the necessary reduction of a U.S. national debt that has increased to nearly 17 trillion dollars. It is true that it costs more to provide more health care services. Innovation and new technology in medicine will continue to create opportunities for efficiencies within the delivery system, but they are not panaceas for rising health care costs.
 Expectations and Challenges

America’s Medicaid program faces many challenges. First and foremost, policy makers must deal with the imbalance between revenues and health care expenditures while acknowledging that the problem of access is exacerbated by increasing demand on a system that is already limited in its supply of providers. Current policy falls far short of achieving this goal. Without question, the PPACA creates parity between those currently receiving Medicaid benefits and those who will be newly eligible due to expanded income guidelines in 2014. The unfortunate reality for both patients and providers is that the funding increases are not in proportion to the expanded population. Cuts in the Medicare program along with payment reductions to providers in the form of penalties and rate reductions become necessary in order to expand this entitlement to all American citizens. Decreased access to providers will result as fewer doctors accept Medicaid patients and even greater cost shifting occurs to non-government payment plans. Wait times to access primary care will increase and delays into the system are well known to produce negative health outcomes. To avoid these consequences, it will require providers, policy makers and advocates from across the political spectrum to work together to create real solutions to these long term and systemic problems.
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