ONE HEALTH CARE SYSTEM'S EXPERIENCE

Why Medicaid Matters

KEVIN J. SEXTON

We are at a critical time in the evolution of our national health care system, especially with respect to whether it will continue its recent progress toward providing greater health insurance coverage to those in need. The alternative is that we will fall back, increase the ranks of the uninsured and miss an opportunity to help individuals and communities achieve a much higher level of overall health and well-being.

This is why the Catholic Health Association is so committed to preserving and expanding Medicaid, the linchpin of the U.S. health care system's efforts to finance expanded health care opportunities for the most vulnerable in our society.

It will take more than Medicaid to achieve that well-being, which is why CHA is committed to improving our health care delivery system and stretching scarce resources so that funding is available for other critical needs such as child development, violence reduction and environmental protection. But without a strong Medicaid program to ensure access to health care, the nation's health status will not improve, and that matters to all of us.

This article focuses on one institution in one state and its efforts to drive better outcomes through broad advocacy efforts with respect to Medicaid and specific program interventions. It speaks to the goals of all of us in Catholic health care as our institutions work to reflect our commitment to a special option for the poor and to making our communities and our nation healthier.

BACKGROUND

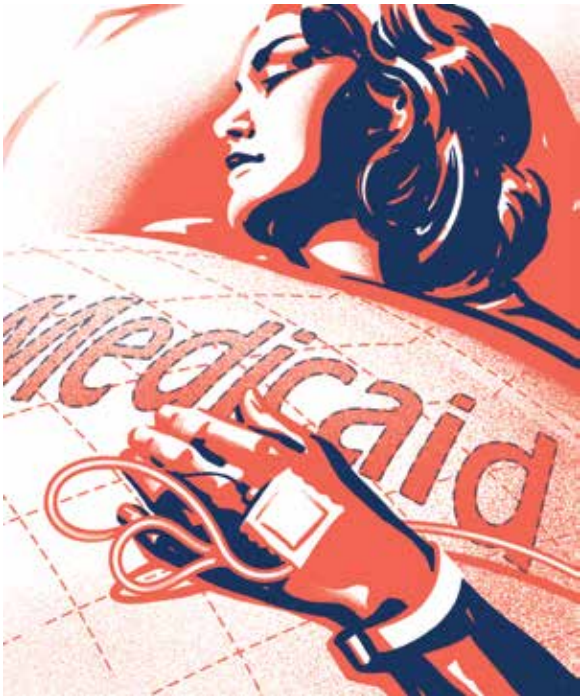
Medicaid, the federal/state partnership that provides financing of health care services for low-income people, has grown and evolved into an essential element of American life. It provides access to care and support to those in need who otherwise would do without it. About 73 million Americans rely on it for that care. Medicaid also provides vital support for individuals and institutions who serve those 73 million people in the communities where they live, often ensuring those institutions are able to stay in operation. Our whole system for providing individual health care as well as public and community health programs depends on Medicaid financing.

Medicaid originated more than 50 years ago as a medical adjunct to federal and state cash assistance programs, and it has possessed features of those programs for much of its life. The most prominent was its requirement that an individual had to be poor, plus fit certain other categories (aged, disabled and in families with dependent children) to be eligible. The other most prominent feature was that states had the authority to set income eligibility standards.

Over time, Medicaid expansions loosened these connections — most notably with the Children's Health Insurance Program, which extended Medicaid to poor children even if their parents or guardians did not meet the cash assistance eligibility criteria. More recently, the Affordable Care Act made income alone the qualifying require-

ment for Medicaid, established a national income standard related to the federal poverty level and offered enhanced federal funding for all states. The U.S. Supreme Court held that states could opt out of this expansion.

The Catholic Health Association is proud of having advocated for these expansions, which have reduced the percentage of uninsured in our country to its lowest level ever. CHA is now urging that the expansions be maintained and that further improvements be made to the ACA to help the needy who still don't qualify for health insurance coverage. Our system will only work if it covers everyone. We all have a stake in that.



Health care systems, especially Catholic health care systems, are highly credible, expert witnesses in the discussion of the future of Medicaid. They are on the front lines, and they know firsthand the connection between ensuring access to health care and good individual and community health. It is critical that Catholic health care systems advocate for Medicaid, which covers more than 20 percent of the U.S. population and includes individuals who are our friends, neighbors and family members. As large institutions, they also are aware of the many other important public needs (education, infrastructure, etc.), and that to meet these needs we must find ways to constrain health care spending. So, it is critical that Catholic health care systems use their skills, their experience and their creativity to get the maximum benefit for those in need from the available Medicaid and ACA funding. This is a major challenge, but it is critical that we contain the rate of growth of these programs while still serving those who rely on them, both for the programs' sustainability and the health of those in need. It will involve inventing more effective outreach programs, taking steps to improve efficiency and stretching available resources to prevent unsustainable spending levels.

HOLY CROSS HEALTH

Holy Cross Health, in Silver Spring, Maryland and a part of the Trinity Health system, has worked for more than 20 years to drive good policy in the state's Medicaid program and in Maryland's hospital rate-setting program while, at the same time, initiating and managing programs to focus on those most in need in the community. With respect to Medicaid, Holy Cross advocated successfully for broad eligibility and adequate physician reimbursement, especially in primary care, to ensure that people in need were eligible and then could access care when they needed it.

In the case of Maryland's hospital rate-setting program, which operates under state law and a federal waiver and sets almost all hospital reimbursement levels, Holy Cross advocated for the program to recognize the cost of care for the uninsured poor. Holy Cross' ultimate goal was to leverage these public programs and attract other public and philanthropic support to build comprehensive programs that would provide better access and better care.

Holy Cross was fortunate that the Medicaid program in Maryland traditionally was among the more expansive in the United States, and that the rate-setting program, although it mandated lower payments overall compared with most states, did

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not discriminate in its hospital payment levels for Medicaid and did provide an allowance for the care of the uninsured.

The most significant gaps in the Maryland Medicaid program were in the areas of prenatal care of immigrant women ineligible for Medicaid and ambulatory care for poor adults.

In 1999, the medical care of pregnant women, usually immigrants who could not qualify for Medicaid, was a large, urgent and growing need. The rapid increase in immigration around the turn of this century challenged Holy Cross much as it did Catholic hospitals 100 years before. Surprisingly, Montgomery County, the state's largest (more than 1 million residents) and wealthiest county, also had by far the largest number of women in this category in the entire state.

Holy Cross put together a "Maternity Partnership" program in cooperation with local government and took responsibility for the prenatal care, deliveries and follow-up care for uninsured pregnant women throughout Montgomery County. The county government provided a per-patient stipend, and the state provided emergency Medicaid payments for the inpatient obstetrics care. Holy Cross committed to cover the shortfall and finance a major capital investment to create an outpatient obstetrics center and improve and expand obstetrics facilities and operations for all patients.

During the 15 years or so that followed, more than 22,000 uninsured women received prenatal care and had their babies delivered at Holy Cross, with outstanding clinical results that lowered the cost of follow-up hospital and ambulatory care. Holy Cross also provided related gynecology care and gynecologic oncology services. It was the only health care facility in the county where such services were available to women who were uninsured. The overall obstetrics program grew to become by far the state's biggest, and that helped support the large Holy Cross contributions to the care of those in need, including financing the critical physician care element of the program.

At the same time as the obstetrics expansion, Holy Cross faced a community need to expand its emergency room capacity. Population growth drove that need, but it also was obvious that an alternative to emergency room care was required for county residents who lacked access to primary care because they had no health insurance.

Holy Cross set out to build outpatient capacity for uninsured adults who made up the bulk of that population, once the OB/GYN needs had been met. It started with one center in 2004, eventually expanding to four. Once again, Holy Cross made the financial commitment of both capital and operating funds, the county provided assistance and a number of foundations contributed additional help. Over time, the program grew to 50,000 visits a year that provided an alternative to emergency room care. The health centers also became a vehicle for working with each of their local neighborhoods on improving health care broadly. The Holy Cross funding came from its success in attracting more patients overall, from operating successfully under the rate-setting program by lowering its costs, and then with the passage of the ACA and its Medicaid expansion, qualifying some of its previously uninsured patients for Medicaid.

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The overall takeaways from these two initiatives are the following: Success starts with knowing the core purpose of your institution — what you believe is most important. There is no better guide to determine what to do or measure how

you are doing than a good mission statement and a plan for how you are going to accomplish it. For Holy Cross, it meant attracting more people from all walks of life, which significantly improved the financial capacity to serve those in need; paying very close attention to containing costs; learning to excel in the Maryland system with creative, high-quality programs that generated net income while gaining credibility with the regulators, government officials and the public; and most importantly, leveraging the skill and commitment of an outstanding workforce and medical staff who were inspired to do even more because they believed in the institution's intention to serve everyone — they knew the difference between a slogan and a real commitment backed by action.

There is wide variation in Medicaid programs and health care delivery practices across the United States. There also are wide differences in the challenges faced by individual hospitals and health systems as they confront their futures. However, we all believe that a special option for the poor must be in the DNA of Catholic health care.

This issue of *Health Progress* is a challenge to put that commitment into action, and this article highlights one successful effort to do that. The environment within which Catholic health care faces this challenge is very stressful. Hopefully this brief case study and the outstanding work being done every day in institutions across the country offer encouragement and perhaps a place to start.

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