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Ethical Case Analysis

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Abstract

 The following is a description of the present day Medicaid system and how the Affordable Care Act will change what is known of today’s Medicaid program. The Community Care of North Carolina will provide a blueprint for the literature and future of healthcare reform. Leadership and economic analysis will be presented and compared from what currently is beginning used today to what will be in place in the year 2014. Application for healthcare providers on both micro and macro system levels will also be discussed.

Ethical Case Analysis

 Medicaid is the largest public health insurance program in the United States and covers over sixty million low-income individuals. The program is administered by states within broad federal rules and financed jointly by states and the federal government. Those benefitting from the Medicaid program include children, some parents, people with disabilities and seniors. Without this program most of these beneficiaries would be uninsured. Coverage for these individuals improves their access to care by lowering the financial barriers they face and connecting them with health plans as well as with healthcare providers. Medicaid is a major service payer that provides essential funding for to providers including hospitals and health centers that provides care to underserved communities and many of the nations uninsured. The Medicaid program is also the single largest source of coverage for nursing home and community-based long-term care. Altogether, Medicaid finances seventeen percent of all personal health spending (Kaiser Family Foundation, 2012).

 Milstead presents the impact of the Affordable Care Act on North Carolina’s Uninsured Population through a case study format. Charts from the text descript what different groups of peoples Medicaid coverage looked like in the year 2009 and then compared that data to what is to come in the year 2014. In the year 2011, childless, nondisabled, nonelderly adults could not qualify for Medicaid (Milstead, 2013). However, changes are being made and in the year 2014 we will all begin to see the results of these changes for the Medicaid Program like shown in the case study charts.

**Medicaid now**

Medicaid currently provides health coverage for over sixty million individuals, including one in four children, but low parent eligibility levels and restrictions in eligibility for other adults mean that many low-income individuals remain uninsured (Kaiser Family Foundation).To qualify for Medicaid prior to health reform, individuals had to meet financial eligibility criteria and belong to one of the following specific groups: children, parents, pregnant women, people with severe disability, and seniors. Non-disabled adults without children were generally excluded. Minimum eligibility levels are set by the federal government for each category of people, which are up to one hundred thirty three percent of federal poverty level for pregnant women and children but are much lower for parents. States do have the option to expand coverage to higher incomes but Medicaid eligibility levels for adults remains very limited. Seventeen states limit Medicaid coverage to parents earning less than fifty percent of poverty and only eight states provide full Medicaid coverage to other low-income adults (Kaiser Family Foundation, 2012).

**Affordable Care Act**

The Patient Protection and Affordable Care Act will ensure that all American’s have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. The Congressional Budget Office has determined that the Patient Protection and Affordable Care Act is fully paid for and will provide coverage to more that ninety-four percent of Americans while staying under the nine hundred billion dollar limit that President Obama established, bending the health care cost curve, and reducing the deficit over the next ten years and beyond (Responsible Reform for the Middle Class, 2004).

 The Affordable Care Act is a key element in the expansion of Medicaid to all individuals with incomes up to one hundred thirty eight percent of the federal poverty level (Kaiser Family Foundation). Beginning in the year 2014, adults can qualify for Medicaid if their income is below the precious percentage and enrollment will be simplified. States will not only be required to simplify enrollment but must also conduct outreach initiatives to vulnerable populations. However, the planned Medicaid program expansion will not cover undocumented immigrants or most legal immigrants who have been in the United States for fewer than five years.

**Expansion**

In 2014, many uninsured people will gain coverage through the states Medicaid program. Beginning that year, the Affordable Care Act requires that states expand Medicaid coverage to most uninsured adults with modified adjusted gross income no greater than one hundred thirty eight percent of the federal poverty limit. Children in families with incomes no greater than two hundred percent of federal poverty level will continue to be eligible for Medicaid or North Carolina Health Choice. The new expansion will focus on eligibility and enrollment, new benefit mandates or options and options for home and community-based services (Sommers & Rosenbaum, 2011).

**Community care**

 Community Care of North Carolina (CCNC), North Carolina’s Medicaid care management program, is considered to be a national model of patient-centered medical home. Community Care of North Carolina is a leader in testing new delivery and payment models (Holmes, 2010).

The changes coming in eligibility requirements will be a major expansion to the North Carolina Medicaid Program, especially for low-income adults. Currently to qualify for Medicaid, a person must be a citizen or lawful permanent immigrant in the United States for at least five years and generally limited to children of low-income families, or adults who are either pregnant, have dependent children under the age of nineteen living with them, disabled or elderly. Even if a person meets these categorical eligibility rules, the individual must also have an income below a certain income threshold and have limited resources or assets to quality. However in 2014, Medicaid will begin to cover most adults with incomes up to one hundred thirty eight percent of federal poverty level. The affordable Care Act removes the categorical restrictions and resource limits for most adults (Holmes, 2010).

**Economy**

To put these changes into perspective, a person working at minimum wage ($7.25 per hour) at forty hours a week and fifty weeks per year would earn $14,500 per year. Generally this income is too high to qualify for Medicaid under North Carolina’s current Medicaid eligibility rules. As stated previously, a single nonelderly adult who is not disabled cannot currently qualify for Medicaid in North Carolina regardless of income. Parents can qualify but it is difficult. A parent in a family of four would only qualify in North Carolina if his or her income was less than $7,128 per year, which is less that half of what a person earns on minimum wage. However, beginning January 1, 2014, this adult would be able to qualify regardless of whether he or she had children (Holmes, 2010). The Medicaid expansion will increase enrollment rates for children ages six to eighteen, working parents, nonworking parents and childless adults (Milstead, 2013). A pregnant woman is always counted as two people for Medicaid eligibility purposes. A pregnant woman in 2014 will be able to qualify for Medicaid if she makes under about $27,000 per year. In 2014, North Carolina has the option of reducing the income eligibility guidelines of pregnant women to one hundred thirty eight percent of federal poverty level and moving those pregnant women with higher incomes into private subsidized coverage (Holmes, 2010). The income guidelines for a single adult without dependent children would be $15,028 per year or $30,843 per year for a family of four based on 2011 federal poverty levels. This change is a major expansion and will provide coverage to many low- income adults. If an individual is not eligible for Medicaid under the new coverage groups, then the person can apply for Medicaid under another category (Holmes, 2010).

**Financing**

 The federal government and the states share the cost of Medicaid through a system of federal matching payments. The Federal Medical Assistance Percentage is based on a formula in the law and is at least fifty percent in every states but higher in poorer states, reaching seventy four percent in the poorest state in 2012. Currently, the federal government funds about fifty seven percent of Medicaid costs overall (Kaiser Family Foundation, 2012).

 During the period 2014-2016, under the Affordable Care Act, the federal government will finance one hundred percent of the costs for individuals newly eligible for Medicaid due to expansion. The federal share will phase down gradually, to ninety percent in 2020 and thereafter. The Congressional Budget Office estimates the total federal cost of the Medicaid expansion to be nine hundred thirty one billion dollars and state costs to be seventy three billion dollars from 2014-2022. This increase in state spending represents a very small increase over what states would otherwise have spent on Medicaid. In return, states will increase coverage for their low-income uninsured residents and reduce the uncompensated care burden on safety-net providers. In addition, the infusion of significant federal funds will bolster their economies (Kaiser Family Foundation, 2012).

**System change**

Healthcare changes daily and during the past ten years improvement work has flourished over macro and micro systems. Most work begins in the small, micro institution as a hospital safety project or a primary care diabetes program and is small. The Community of North Carolina innovation encompasses many institutions and is very large. The innovation includes over one thousand primary care practices and over seven hundred fifty thousand patients. Change and improvements on the macro scale that much time but large projects such as the Community Care of North Carolina should grad leaders’ attention for its size alone (Bodenheimer, 2008).

 Small, micro improvement work is sometimes short-lived, due to collaboration and financial barriers. Such work is of little value and can create discouragement among reformers. The Community Care of North Carolina began as a small project in 1988 and was launched in a large capacity in 1998. Had it not been for the leadership, the small pilot of 1988 could have died. Project leaders must recognize and expect large pilots of improvement take time. Over just a couple a years, leaders may not see a huge cost improvement (Bodenheimer, 2008).

**Collaboration**

 Collaboration may be the central lesson taught by Community Care of North Carolina between the payer and practices. Payers and clinicians have a long tradition of hostility. Payers blame clinicians for uneven quality and lack of prompt patient access to appointments. Healthcare providers complain about low pay, mindless paperwork and ruthless denials of care (Bodenheimer, 2008). What impactful improvements could healthcare make if the payers and practitioners worked together? Leaders must focus on professional qualities that build the moral of their facilities constituents.

One huge concern that is always brought up by both the practitioners and payers is that of financial payments versus quality care. Many payers feel that primary care practices need to show improvement to deserve new revenues. Community Care of North Carolina follows more of an investment model, but the is not open-ended. This model is compact and stresses hat “we will pay you extra and you are expected to improve”. Regional networks and other structures will be developed to guarantee ongoing conversation between payer and clinicians and to monitor and further develop the entire process (Bodenheimer, 2008).

**Medical home**

A key feature of the new healthcare changes is a push for all patients to have a medical home. This move will force healthcare leaders to engage in research for the best evidence based quality care practices to implement in their facilities. The four pillars of primary care are first-contact care, longitudinal care, comprehensive care and coordination of care. All of these areas should be the sole responsibility of practitioners to lead their patients into trusting relationships so that they will choose to return and be confident in the care they receive (Bodenheimer, 2008).

Acute care generally involves a healthcare provider providing a limited number of distinct services to a patient. However, chronic care for those patients with long-term continuous management and treatment need extensive collaboration of care. Community Care of North Carolina has chosen a blended payment model consisting of a primary care fee on top of fee-for-service payments, plus chronic care team support provided by Medicaid-paid case managers who assist clinicians. Within our micro facilities we must form and establish some kind of financial funding to meet economic budgetary needs (Bodenheimer, 2008).

 Small practices have failed to match quality metrics of larger integrated systems much like micro system webs have failed to positively impact macro worldwide systems. Regional networks must take on the role of an aggregating organization for smaller networks. Just as the Community Care of North Carolina has become a macro blueprint for healthcare, facilities worldwide, regardless of rank or size, should research and apply small tests of change to improve their care and practice. Sharing evidence through publishing can provide improvements from micro to macro systems widespread (Bodenheimer, 2008).

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