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Medicaid 101

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This article provides an introduction to Medicaid as it relates to individuals who live with chronic illness. It begins with a brief historical synopsis that includes pertinent legislation. Next, the various agencies involved in the Medicaid process are introduced. The challenges with provider participation and access are discussed. Political and ethical implications are explored. It concludes with an evaluation of the effectiveness of Medicaid.

Keywords: *Medicaid; chronic illness; access; ethical implications*

The historical background of Medicaid legislation is both fascinating and complex. Griefinger and Sidel (1984) recall that like the United States itself, concern for the health of the poorest members originates in British history. Subsequently, at the beginning of the 20th century, a concern for the health of children and childbearing women evolved. As a result, the boards of health in some larger American cities made schools responsible for the medical needs of children in families that could not themselves provide such care. During the 1930s, the federal and state governments began to assume the cost of the medical care not only of children but also of elders and the poor. In 1950, amendments to the Social Security Act made federal matching funds available to states with the intent to help provide for the medical care of recipients receiving public assistance. A decade later, through the Kerr-Mills Act, additional federal funds were made available for older citizens who needed help with their medical bills (Pickett & Hanlon, 1990; Provost & Hughes, 2000).

In 1965, as part of the War on Poverty, Kerr-Mills was broadened. Through the Nineteenth Amendment of the Social Security Act, the Medicaid program was created and designed to expand health care coverage for the American poor (Kassler, 1994; O'Connell & Keshavarz, 2008; Provost & Hughes, 2000). The original purpose was to use combined federal and state funds to provide medical care to families with children, blind individuals, disabled persons, and the needy elderly (Provost & Hughes, 2000). Medicaid continues, as it was designed, to be a means-tested program in which participants must prove they are within one of the covered categories, in addition to being below the specified financial threshold (Pickett & Hanlon, 1990).

Since its inception, Medicaid has operated as a cooperative program with matching federal and state funds (Kaiser Commission on Medicaid and the Uninsured, 2004). All participating states and territories must provide coverage to those residents deemed to be categorically and medically needy as well as to other specified groups (Centers for Medicare & Medicaid Services [CMS], 2005). As of 2005, the combined state and federal outlays for the 50 million people covered by Medicaid was more than $300 billion (Health Affairs, 2005), with the federal government spending $181 billion that year (Government Accountability Office [GAO], 2006). Despite specific federally mandated coverage requirements, the individual plans and coverage provided by each state varies widely (Provost & Hughes, 2000).

There have been a number of major and frequent minor revisions to Medicaid since 1965. The Web site for the Department of Health and Human Services lists 2,760 citations when "revisions to Medicaid" is searched, with the first major revision occurring in 1972, when Congress passed Title XVI of the Social Security Act called the Supplemental Security Income (SSI) Program. The purpose of SSI was to replace an assortment of individual state programs and to provide support to the elderly, "deserving poor," and disabled individuals (Rylance, 2000; Sweeney & Fremstad, 2005). This was the origin of Medicaid coverage for persons living with chronic illness and disabilities.

In 1977, the Health Care Financing Administration (HCFA) was created under the Department of Health

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Education and Welfare with the goals to administratively unify Medicaid with Medicare while controlling inflation and health care costs. It was an immense challenge, as Medicare was entrenched in the culture of the Social Security Administration, while Medicaid was closely associated with the Social and Rehabilitative Services Administration (Schaeffer, 2005). Even though the goal of unification was not fully met, Medicaid and Medicare shared many administrative areas as they continued to merge (Derzon, 2005; Schaeffer, 2005). Coverage of hospice care, diagnosis-related groupings, and medical research support were early successful efforts of the HCFA (Derzon, 2005).

Through the Omnibus Reconciliation Act of 1990, Section 1927 was added to the Social Security Act, creating the Medicaid Drug Rebate Program. This law mandates that all pharmaceutical manufacturers that are involved in agreements with any of the 49 participating states and the District of Columbia must provide rebates. Subsequently, the Omnibus Reconciliation Act of 1993 amended Section 1927. Resultant changes included the dates used in calculating prices and coverage of new pharmaceuticals as well as abolishing the open formulary restriction and peer-reviewed literature as a medical indication for the medication (CMS, 2008).

In contrast to the many legislative addendums, an important development in the unfolding of Medicaid was the recurring veto of the "Contract With America" in 1994. If this proposed legislation had become law, not only would spending be capped and significantly reduced but also Medicaid would have become a block grant (Deparle, 2005). If that had happened, the influence and power of the federal government on Medicaid expenditures would have been markedly reduced (California School of Finance, 2007).

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 altered the eligibility criteria for immigrants (Hunt & Knickman, 2005). Most legal immigrants must meet eligibility conditions and wait 5 years after entering the United States to have been eligible for Medicaid benefits. Under PRWORA, prior to meeting this criterion, they are covered for emergency situations. This emergency coverage extends to illegal immigrants as well (Kaiser Commission, 2008).

In 1997, the State Children's Health Insurance Program (SCHIP) was established to ensure that health coverage was available to children in low-income families who were not otherwise covered by health insurance (Deparle, 2005; Health Affairs, 2005). Senator Edward Kennedy (2005) wrote that the expansion of Medicaid and SCHIP is "the most effective way to benefit minorities."

Through Public Law 106-354, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 was enacted. Since October 1, 2000, full coverage is provided to all uninsured women 65 years old and younger who were diagnosed with these cancers through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program (Westmoreland, 2008). This coverage is comprehensive and not limited to care for the cancer diagnosis.

The Deficit Reduction Act of 2005 did not extend coverage or services. Rather, the primary intent was aimed at reducing federal Medicaid costs through many policy modifications (Rudowitz & Schneider, 2006). The goal of this bill was to reduce spending related to health care by almost $10 billion during a 10-year period. To achieve this, the plan called for an increase in copays and a reduction in some services (Kaiser Commission on Medicaid and the Uninsured, 2004).

Agencies Involved in Medicaid

A number of agencies and organizations are involved in the implementation, regulation, and evaluation of Medicaid. Congress was the creator of Medicaid and continues to wield influence by originating and passing legislation to amend the statute. Since 1965, there have been many changes. In addition to the legislative ability, Congress directly oversees the federal agencies and indirectly the state agencies that implement the programs and various amendments (Rudowitz & Schneider, 2006).

Within the Department of Health and Human Services, CMS is the executive branch agency that is most involved in this implementation (Rudowitz & Schneider, 2006). The purpose of CMS is to guarantee that Medicaid recipients receive state-of-the-art health care and to support the states in efforts to provide it with quality and in a safe manner (CMS, 2006). In addition, CMS aims to do this by "continuing to transform and modernize America's health care system" (CMS, 2008, p. 1). To accomplish this, CMS issues regulations and guidelines to promote compliance with the regulations (Rudowitz & Schneider, 2006). This is no small task, as there are more than 50 unique Medicaid plans (Sparer, 2005). Within the CMS, the Center for Medicaid and State Operations is dedicated to helping the state Medicaid programs deliver "safe, effective, efficient, patient-centered, timely and equitable care" (CMS, 2006, p. 1).

In addition to issuing regulations and guidelines, CMS monitors the states for compliance (Rudowitz &

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Schneider, 2006). Some monitoring activities involve ensuring safe and quality care, such as preventing falls among elderly patients in facilities (CMS, 2007). Others, like the Medicaid Integrity Program, work to eradicate fraud and abuse (CMS, 2006). These are more administrative in nature.

Currently, all 50 states as well as the District of Columbia and Puerto Rico are partnered with the federal government to provide safe and effective health care to individuals identified in their particular plans (CMS, 2005). In addition to the benefits required for participation, each state has the flexibility of designing the program that best serves the needs of their constituents (Hunt & Knickman, 2005). All states and the District of Columbia, but not Puerto Rico, have programs for women with breast and cervical cancer, whereas only nine states and both the District of Columbia and Puerto Rico have programs for individuals with tuberculosis. States can also apply for a State Plan Amendment or waiver to modify their current plans (Rudowitz & Schneider, 2006). In 2005, 30 states and the District of Columbia filed a total of 1,115 Medicaid waivers to expand the categories of individuals they covered (CMS, 2006).

A variety of facilities and agencies coordinate and provide care to many of the individuals covered by Medicaid. Numerous elderly and those with disabilities are cared for in long-term care facilities. In fact, in 2004, 36% of long-term care costs for the elderly were provided by Medicaid (Feldman, Nadah, & Gursen, 2005). Medicaid has made efforts to counter these facility expenditures. Through the state's waiver system, home and community care for people in these groups are encouraged (Provost & Hughes, 2000). In the 1990s, some states began using managed care plans to provide the needed services (Hunt & Knickman, 2005).

Medicaid Considered From an Economic Perspective

A frequent social criticism of Medicaid is the disparity of monies allocated to the elder versus the young Medicaid recipients (Kassler, 1994). Despite the collaborated efforts, in 2002, 17.3% of nonelderly Americans had no health insurance coverage (Hunt & Knickman, 2005). In 1998, whereas 47% of those served by Medicaid were children, only 16% of Medicaid dollars, or an average of $1,203 per child, were spent for their care. At the same time, 26% of those served were elderly or disabled, and 71%, or an average of $10,243 per person, of Medicaid dollars were spent for their care (Provost & Hughes, 2000). One reason for this is the large amount of money spent on long-term care (Feldman et al., 2005).

For decades, the persistent escalation of health care costs has challenged those involved with Medicaid at the federal and state levels (Estes & Lee, 1984). Although some have criticized Medicaid as being responsible for the ever-increasing costs, others have noted that even though physician reimbursement fees for Medicaid patients are their customary fees, those fees had been inflated previously. This inflation resulted in part as an effort to compensate for private pay individuals who did not pay (Pickett & Hanlon, 1990). In fiscal year 2005, Medicaid expenditures exceeded $181 billion (GAO, 2006), and the federal government determined that it needed to curb expenditures (Kaiser Commission on Medicaid and the Uninsured, 2004).

Fiscal errors are a significant issue. The federal government is implementing a plan to estimate the scope of errors among all participating states (GAO, 2006). As Health Maintenance Organizations become involved in the Medicaid arena, private sector approaches to health care finances are becoming apparent. When Health Risk Management became involved in Medicaid in Pennsylvania, it improved the efficiency of the billing system in part by holding providers to billing time frames (Hudson, 1999).

Compounding the cost is the incidence of fraudulent claims and improper payments. To counter fraudulent claims, the government is using technology in The Medicaid Fraud, Abuse and Detection System, which has the capability of collecting, storing, retrieving, and analyzing data in an effort to identify patterns of fraud and abuse. Of all the federal agencies using this technology, Medicaid has the most extensive network. Although there is not currently a system that quantifies and summarizes improper payments, it is known that these are mainly due to errors in medical, data processing, or eligibility reviews. The federal government is using technology to better administer the program. Of the states working to thwart fraud, Texas has been the most aggressive, using fingerprints, smart cards, and other technology in addition to increased staff (GAO, 2006).

Provider Access Issues

Primary as well as specialized ambulatory care is ensured for individuals covered by Medicaid, including those with a chronic illness (Rosenbaum, 2003). Health care provider issues can either be significant facilitators or strong barriers to the successful implementation of

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Medicaid. Concerns about a litigious population along with the complexity of the standards and the system compounded by low payment rates have been identified by providers as barriers to participating in Medicaid (Miller, Margolis, Schwethelm, & Smith, 1999).

A dearth of provider participation is an area of concern. The increase in nonemergency visits to emergency departments (EDs) is a resultant and mounting problem. Between 1985 and 1990, the nonemergent ED visits by persons covered by Medicaid increased by 34% (The Medicaid Access Study Group, 1994). In 2003, the results of the National Hospital Ambulatory Medical Care Survey showed that individuals receiving Medicaid were 4 times more likely to visit an ED for a nonemergent situation (Kaiser Network, 2007). In a telephone survey, the Medicaid Access Study Group (1994) found that the use of EDs is related to the limited access that Medicaid recipients have to outpatient providers. Posing as Medicaid recipients without primary care providers, the study group staff called to schedule physician appointments (The Medicaid Access Study Group, 1994). In many situations, they found this was an impossible task, leaving the ED as the only recourse as suggested by the physician offices.

Inadequate Information About Medicaid

Kenney and Haley (2001) purported that the major reason for eligible children not being cared for through Medicaid and SCHIP services was parents not understanding that the children were eligible for services. In addition to a general lack of information, language can be a significant barrier to obtaining Medicaid support. At one New York City hospital, when the in-patient Medicaid eligibility unit was replicated in the out-patient obstetric clinic and supported with a bilingual staff, 75% of the women who were not previously covered were determined to be Medicaid eligible. They subsequently received care (Jones, 1986). Even when eligible individuals are aware of and understand their eligibility, some are reluctant to access Medicaid services because of a perceived stigma (Miller et al., 1999). It is reasonable to consider these same issues for elderly individuals.

Physical Access Limitations

In some instances, physical access to Medicaid services is limited by geography and safety concerns. Kelton, Levitt, and Pasquale (2006) specifically identified transportation issues and the physical site where care was provided as barriers. Conversely, when Medicaid offices are centrally located and associated with local health or social service departments, the location may facilitate the use of services (Miller et al., 1999). Because the particular aspects of any Medicaid plan are implemented at the state and local level, the location and delivery of services is diverse.

Political Implications

With federal and more than 50 state and territory visions, missions, priorities, agendas, and billions of dollars involved, Medicaid is intrinsically political. During the 1990s, amid clashes with the Republican Congress about Medicaid importance and expenditures, Democratic President Clinton focused not on the relatively small number of dollars spent on poor and minority women and children but rather on the large sums spent on the elderly in nursing homes. By accenting the previous middle-class status of these patients, along with the current middle-class status of their families, he shifted the focus of Medicaid recipients and expenditures to a middle-class population (Grogan & Patashnik, 2003).

During the second Bush administration, an important area of political dispute was whether to transform Medicaid from an entitlement to a block grant (Deparle, 2005; Grogan & Patashnik, 2003). Thompson and Burke (2007) wrote that although President Bush would have liked for the copious number of waivers within the system to erode the current Medicaid structure, thus facilitating conversion to block grant, it did not occur. They noted that in actuality, the large number of waivers did the opposite and eroded the political support for change to a block grant.

Grogan and Patashnik (2003) described Medicaid as being at a political crossroads of possibilities. One future road leads to Medicaid, evolving into universal health care for all citizens. The other leads to coverage for a distilled population of only the most indigent citizens. Key stakeholders on these paths include the Health Insurance Association of America, Families USA, the National Governor's Association, and the American citizens who vote.

Ethical Considerations

Daniel Callahan would likely highlight the aging members of our society among the voters. With the majority of Medicaid dollars being spent on the elderly, issues related to aging are critical when considering the future of Medicaid (Callahan, 2006). At what price should society support the interdependence of aging spouses? If it is cost effective for family members to care

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for the elderly at home, is it not reasonable that they be financially supported to do so? Yet should the government decide that an elderly woman must care for her aging husband at home with minimal support? Is it reasonable that all long-term care for the elderly should be provided through a government agency? These are among the important questions requiring thoughtful and considerate answers.

Some individuals do not support the philosophy of Medicaid on the premise of "God helps those who help themselves." From a market justice perspective, individuals who cannot pay for their health care or insurance are not entitled to receive the care (Beauchamp, 1984). From a social justice view, Beauchamp (1986) would counter that the recipients of Medicaid have also been inundated by the influences of our society as well as their particular biological and familial factors. The question of how free and capable any citizen is to control his or her own health care and social fate remains open for debate. From a social justice perspective, it does not matter, as all individuals are entitled to good health care (Beauchamp, 1984).

Although much has been written about the importance of public health from the view of the "common good," what that means has never been definitively elucidated (Parmet, 2006). Is the common good ensuring that all citizens receive adequate health care because the good of one is reflected in the entire population? Is the common good ensuring that no one contracts a communicable disease that could be transmitted to the rest of society? Is the common good protecting the children because they will be the leaders and caregivers of the future? Any one of these could support an argument for providing health care to all citizens, yet the underlying intentions vary markedly.

Telfer (1986) wrote about health care ethics from a utilitarian perspective. In describing her position, she stated simply, "The state is responsible for the health of the citizens" (p. 580). She further noted that during the 1980s, except for those holding extremist values, this was an accepted position.

Evaluation of the Effectiveness of Medicaid

Evaluating how effective Medicaid is in meeting national health objectives is challenging and complex. Clearly, Medicaid is not a perfect system and is not the answer to providing even adequate health care coverage for all Americans. At the same time, it is providing essential medical services for many.

Medicaid has affected society in general. Referring to Medicaid and Medicare as the primary causes of change in American health care, Freidson (1987) claimed that as a result of these programs, the visibility, discussion, and political action of health care costs increased. A consideration in assessing effectiveness of any program is to analyze how financially viable it is. In 2005, the Medicaid federal expenditures exceeded $181 billion (Williams, 2006). When discussing the financial challenges of Medicaid, McIlroy reassured that health management groups tend in subsequent years to recoup dollars lost (Hudson, 1999).

From a managed care perspective, Roohan, Anarella, and Gesten (2004) reported that in the quality assurance program they conducted on New York State Medicaid Managed Care, performance increased over time and was generally higher than national benchmarks. They also found that the difference between Medicaid and commercial plan rates was shrinking, with less variability when compared.

Kassler (1994) described Medicaid as deficient because "although low-income households make up 75 percent of Medicaid beneficiaries, they get only 30 percent of the funds" (p. 135). On the surface, this criticism seems valid, but upon further consideration, the validity is not so clear. Many of the low-income families Kassler cited were young and had small children who are generally healthy. It is feasible that the cost of well-baby clinics, immunizations, minor trauma, and acute infections are far less costly than managing chronic illnesses and long-term care.

The number of uninsured Americans continues to increase. In 1993, there were 37 million uninsured Americans, compared with 45 million in 2005 (Delaune, 2005). Although Medicaid is less than a perfect system, it is insuring at least minimal health care to many young and older individuals with chronic illness who otherwise would receive none.

Although the original concept of Medicaid was relatively simple, it has evolved into a complex coordination of health coverage for increasing groups of Americans. Medicaid affects and is affected by interrelating factors that include political, social, ethical, financial, legal, and health care decisions. In addition, professionals providing care are affected by financial challenges as well as political changes.

A Glance at the Future of Medicaid

Barack Obama made a commitment to improve the health care of American citizens as an economic imperative (Sack, 2008). He noted past successes of Medicaid, while stressing the importance of the future expansion of Medicaid and SCHIP programs (Obama, 2008). Consistent with his experience as a member of the Senate's Medicaid

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Table 1
Highlights of Medicaid Legislation

Date	Development	Significance
July 1965	Medicaid signed into law and became Title XIX of the Social Security Act	Granted health care coverage of welfare recipients through a volunteer relationship of states and federal governments. Lyndon Johnson signed House (307-116) & Senate (70-24).
1972	Social Security Amendments of Supplemental Security Income With 209 (b) option	Repealed the maintenance of effort condition for states. Signed into law by Richard Nixon. All states except Arizona participated in Medicaid.
1977	Health Care Financing Administration created	Created by Joseph Califano, Secretary of Health, Education and Welfare to administer Medicaid & Medicare programs.
1981	Omnibus Reconciliation Act of 1981 (OBRA 81)	Reduced federal matching funds FY 82-84 and repealed hospital payment rate requirement
	– OBRA 81- 1915 b	– states can pursue mandatory managed care enrollment
	– OBRA 81 - 1915 c	– coverage of community and home long-term care for elderly
1985	Consolidated Omnibus Reconciliation Act	Mandated coverage for all Aid to Families With Dependent Children (AFDC) women who are pregnant
1986	OBRA 86	States to cover emergency medical care for illegal immigrants
1987	OBRA 87	Nursing home reforms: quality, monitoring, and enforcement
1988	Medicare Catastrophic Coverage Act (MCCA)	States must pay Medicare payments and cost sharing to Medicaid recipients 100% below federal poverty level.
1989	MCCA repealed	Medicaid proviso continued
1990	OBRA 90	– Coverage to all low-income children 6 through 18 years – Began Medicaid Prescription Drug Rebate Program
1991	Medicaid Voluntary Contribution & Provider-Specific Tax Amendments	Restricted monies from provider taxes & payments as state contribution of Medicaid expenses. National ceiling established on special payments to disproportionate share hospitals.
1993	Approval of Section 1115 waivers	Oregon Health Plan extended coverage. Tennessee began TennCare.
1996	Personal Responsibility and Work Opportunity Act of 1996	Through repeal of the AFDC, linkage between welfare and Medicaid replacing it with Temporary Assistance for Needy Families block grant.
1997	Balanced Budget Act (BBA) of 1997	Established State Children's Health Insurance Program; states can use funds for uninsured children. Expanded coverage for elderly and disabled.
1999	Olmstead vs. L.C. Ticket to Work & Work Incentives Act	States to provide community care when institutional care is not appropriate. States can cover working disabled with incomes 250% of federal poverty level.
2000	Breast & Cervical Cancer Treatment & Prevention Act	States can provide medical care to uninsured women with breast and cervical cancer regardless of income.
2005	Medicaid Advisory Commission	To identify methods to save $10 billion and guarantee long-term sustainability.

Source: Adapted and compiled from Kaiser Commission on Medicaid and the Uninsured (2004).

Working Group (U.S. Senate, 2008), as president he assured support through an economic stimulus package of state Medicaid programs (McKnights, 2008). This support may be tested by increases in the number of people who do not have health insurance as well as by health care providers that do not accept Medicaid reimbursement. It is certain that the complex mosaic of interrelating factors will continue to shape Medicaid as it approaches 50 years of providing health care to those in need.

References

Beauchamp, D. E. (1984). Public health as social justice. In P. R. Lee, C. L. Estes, & N. B. Ramsay (Eds.), *The nation's health* (2nd ed., pp. 306-313). Boston: Jones and Bartlett.

Beauchamp, D. E. (1986). Public health as social justice. In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (2nd ed., pp. 585-593). New York: McGraw-Hill.

California School of Finance. (2007). *School of finance glossary*. Retrieved March 16, 2008, from California School of Finance

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database: www.californiaschoolfinance.org/MoreInformation/SchoolFinanceGlossary/tabid/73/Default

Callahan, D. (2006). Curing, caring, and coping. *America*, *3*(194), 12-16.

Centers for Medicare & Medicaid Services (CMS). (2005). *Medicaid at-a-glance 2005: A Medicaid information source*. Retrieved February 4, 2008, from Department of Health and Human Services Web site: http://www.cms.hhs.gov/MedicaidGenInfo/downloads/MedicaidAtAGlance2005.pdf

Centers for Medicare & Medicaid Services. (2006, July). *Value-based . . . results-driven . . . healthcare: the Medicaid/SCHIP Quality Initiative*. Retrieved February 20, 2008, from Department of Health and Human Services Web site: http://www.cms.hhs.gov/medicaidSCHIP

Centers for Medicare & Medicaid Services. (2008). *History of the Medicaid Drug Rebate Program*. Retrieved February 6, 2008, from Centers for Medicare & Medicaid Web site: www.cms.hhs.gov/MedicaidDrugRebateDispR/downloads/mdrphistory.pdf

Deficit Reduction Act of 2005: Implication for Medicaid. (2006). Retrieved March 21, 2008, from the Henry J. Kaiser Family Foundation Web site: http://www.kff.org/medicaid/upload/7465 .pdf

Delaune, J. M. (2005). Health care in this decade: An interview with Senator Hillary Rodham Clinton (D-NY). *Kennedy School Review*, *6*, 3-6.

Deparle, N. A. (2005, July 26). *What does it take to run Medicare and Medicaid?* Retrieved March 16, 2008, from http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.326/DC2

Derzon, R. A. (2005, July 26). *The genesis of HCFA*. Retrieved March 15, 2008, from http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.326/DC2

Estes, C. L., & Lee, P. R. (1984). Policy shifts and their impact on home health care. In P. R. Lee, C. L. Estes, & N. B. Ramsay (Eds.), *The nation's health* (2nd ed., pp. 373-380). Boston: Jones and Bartlett.

Feldman, P. H., Nadah, P., & Gursen, M. D. (2005). Long-term care. In A. R. Kovner & J. R. Knickman (Eds.), *Jonas & Kovner's health care delivery in the United States* (8th ed., rev., pp. 275-325). New York: Springer.

Freidson, E. (1987). The medical profession in transition. In L. A. Aiken & E. Mechanic (Eds.), *Application of social science to clinical medicine and health policy* (pp. 63-79). New Brunswick, NJ: Rutgers University Press.

Government Accountability Office. (2006, April). *Improper payments: Federal and state coordination needed to report national improper payment estimates on federal programs* (GAO 06 347). Washington, DC: Author.

Griefinger, R. B., & Sidel, V. W. (1984). American medicine: Charity begins at home. In P. R. Lee, E. L. Estes, & N. B. Ramsay (Eds.), *The nation's health* (2nd ed., pp. 176-186). Boston: Jones and Bartlett.

Grogan, C., & Patashnik, E. (2003). Between welfare medicine and mainstream entitlement: Medicaid at the political crossroads. *Journal of Health Politics, Policy and Law*, *28*, 821-858.

Health Affairs. (2005). *CMS reflections: A milestone for Medicare and Medicaid*. Retrieved March 15, 2008, from http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.326/DC2

Hudson, T. (1999). Should you toss Medicaid when it's losing money? *Hospitals & Health Networks*, *73*, 28.

Hunt, K. A., & Knickman, J. R. (2005). Financing for health care. In A. R. Kovner & J. R. Knickman (Eds.), *Jonas & Kovner's health care delivery in the United States* (8th ed., rev., pp. 47-89). New York: Springer.

Jones, J. E. (1986). Overcoming barriers to Medicaid eligibility. *American Journal of Public Health*, *76*, 1247.

Kaiser Commission. (2008, March). *Medicaid and the uninsured*. Retrieved March 14, 2008, from the Henry J. Kaiser Family Foundation Web site: http://www.kff.org/medicaid/upload/7761.pdf

Kaiser Commission on Medicaid and the Uninsured. (2004). Medicaid: A timeline of key developments. *The Henry J. Kaiser Family Foundation*. Retrieved March 13, 2008, from http://www.kff.org/medicaid/medicaid_timeline.cfm database

Kaiser Network. (2007). *Coverage and access: Emergency department visits reach record number in 2003*. Retrieved March 14, 2008, from the Henry J. Kaiser Family Network Web site: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=30382

Kassler, J. (1994). *Bitter medicine: Greed and chaos in American health care*. New York: Carol Publishing Group.

Kelton, C. M., Levitt, M., & Pasquale, M. K. (2006). Barriers to SCHIP enrollment: A cross-county study of the State Children's Health Insurance Program in Pennsylvania. *Politics and the Life Sciences*, *24*(1-2), 22-31.

Kennedy, E. M. (2005). The role of the federal government in eliminating health disparities. *Health Affairs*, *24*, 452-458.

Kenney, G., & Haley, J. (2001). *Why aren't more uninsured children enrolled in Medicaid or SCHIP?* (Urban Institute working paper). Washington, DC: U.S. Government Printing Office.

The Medicaid Access Study Group. (1994). Access of Medicaid recipients to outpatient care. *The New England Journal of Medicine*, *330*, 1426-1430.

McKnights. (2008). Obama calls for Medicaid increase in stimulus package. *McKnights Long-Term Care News & Assisted Living*. Retrieved December 13, 2008, from www.mcknights.com/Obama-calls-for-Medicaid-increase-in-stimulus-package/article/120762

Miller, C. L., Margolis, L. H., Schwethelm, B., & Smith, S. (1999). Barriers to implementation of a prenatal care program for low income women. *American Journal of Public Health*, *79*, 62-64.

Obama, B. (2008). *Obama '08: Background questions and answers on health care plan*. Retrieved December 13, 2008, from http://www.barackobama.com/pdf/Obama08_HealthcareFAQ.pdf

O'Connell, M., & Keshavarz, A. (2008). *Introduction to Medicaid Title XIX of the Social Security Act*. Retrieved March 9, 2008, from Advocacy, Incorporated Web site: http://www.macmhb.org/TSG/Access%20Eligibility/medaid99.pdf

Parmet, W. E. (2006). Health care and the constitution. In P. Illingworth & W. E. Parmet (Eds.), *Ethical health care* (pp. 400-409). Upper Saddle River, NJ: Pearson Prentice Hall.

Pickett, G., & Hanlon, J. J. (1990). *Public health: Administration and practice* (9th ed., rev.). St. Louis, MO: Times Mirror/Mosby College Publishing.

Provost, C., & Hughes, P. (2000). Medicaid: 35 years of service. *Health Care Financing Review*, *22*(1), 141-153.

Roohan, P. J., Anarella, J. P., & Gesten, F. C. (2004). Quality oversight and improvement in Medicaid managed care. *Journal of Public Health Management Practice*, *10*, 321-329.

Rosenbaum, S. (2003). Medicaid's role in ambulatory health. *Journal of Ambulatory Care Management*, *26*, 296-306.

Rudowitz, R., & Schneider, A. (2006, August). *The nuts and bolts of making Medicaid policy changes: An overview and a look at the Deficit Reduction Act*. Retrieved February 3, 2008, from the Henry Kaiser Family Foundation Web site: http://www.kff.org.kmu

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Rylance, B. J. (2000). Reform or retrenchment: Changes in SSI. *Journal of Disability Policy Studies*, *11*, 143.

Sack, K. (2008, December 14). Necessary medicine: Health care and the economy share a sickbed. Maybe they can recover together. *The New York Times*, p. WK1.

Schaeffer, L. D. (2005). *Turning Medicare and Medicaid into health programs: The role of organizational culture*. Retrieved March 15, 2008, from http://content.healthaffairs.org/cgi/content/full/htlfaff.w5.326/DC2

Sparer, M. S. (2005). The role of government in U.S. health care. In A. R. Kovner & J. R. Knickman (Eds.), *Jonas & Kovner's health care delivery in the United States* (8th ed., rev., pp. 132-161). New York: Springer.

Sweeney, E., & Fremstad, S. (2005). *Supplemental security income: Supporting people with disabilities and the elderly poor*. Retrieved March 14, 2008, from Center for Budget and Policy Priorities Web site: http://www.cbpp.org/7-19-05imm.htm

Telfer, E. (1986). Justice, welfare and health care. In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (2nd ed., pp. 579-585). New York: McGraw-Hill.

Thompson, F. J., & Burke, C. (2007). Executive federalism and Medicaid demonstration waivers: Implications for policy and democratic process. *Journal of Health Politics, Policy and Law*, *32*, 967-1006.

U.S. Senate. (2008). *Barack Obama: U.S. Senator for Illinois: Health care*. Retrieved December 13, 2008, from http://www.senate.gov/

Westmoreland, T. M. (2008). CMS letter to state officials. *Centers for Medicare and Medicaid Services: Breast and cervical cancer: Prevention and treatment*. Retrieved March 19, 2008, from Centers for Medicare & Medicaid Services Web site: http://www.cms.hhs.gov/MedicaidSpecialCovCond/downloads

Williams, M. (2006, April 14). Improper payments: Federal and state coordination needed to report national improper payment estimates on federal programs. *GAO Reports*, 1-77.

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