Printed from the News & Observer - www.NewsObserver.com
Published Fri, Feb 18, 2011 02:00 AM
Modified Fri, Feb 18, 2011 04:53 AM

Medicaid costs and cures

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Published in: Other Views

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CHAPEL HILL Gov. Bev Perdue and the General Assembly face the unenviable task of patching up a budget with a $2 billion-plus hole in it. Although all state expenditures are on the block, there has been recent sentiment for targeting the Department of Health and Human Services, which is the second-largest piece of the budget and includes Medicaid, the federal-state health insurance program for children, low-income parents, older adults and people with disabilities. In recent weeks, several approaches have been floated, such as a line-by-line review or standardizing the rates that the state pays to medical providers.

I provide medical services for Medicaid patients in the UNC Health Care System, a core part of the state's health care safety net. Nearly 20 years as a family physician have taught me that this can be a tough group of patients to care for. Many patients have several ongoing conditions, such as heart disease, diabetes and chronic mental illness, and multiple specialists are often involved. Add in the social and economic hurdles that make simple health care tasks - getting transportation to the doctor's office - formidable and you have a recipe for increased emergency room visits, hospital admissions and, concomitantly, higher costs of care.

Just 1 percent of all Medicaid beneficiaries account for 25 percent of all expenditures, according to U.S. Health and Human Services Secretary Kathleen Sebelius. If the intensity of services and associated care costs are concentrated in a small percentage of the total Medicaid population, is there wisdom in targeting the vulnerable and costliest patients - the least among us?

Dr. Atul Gawande recently described (The New Yorker, Jan. 24) several innovative initiatives in New Jersey and Boston that focus on improving the quality of care for the most disadvantaged. Although preliminary, what was striking was that the overall medical costs for these patients actually decreased. Three components contributed to success and cost savings: case management; the use of clinical information that focused on population health and accountability; and access to primary care.

In North Carolina, the infrastructure supporting these elements is already in place through Community Care of North Carolina. CCNC represents a partnership between the state Medicaid office and approximately 1,200 primary care practices. The network is involved in the care of about 1.2 million Medicaid patients, roughly 60 percent of the state Medicaid population, and uses care managers to help primary care physicians manage medically complex patients.

According to an independent evaluation, CCNC expenses were $574 million less than that projected for a traditional case management program between fiscal 2003 and 2007.

North Carolina will still need to address a growing shortage of primary care physicians, especially with Medicaid's expansion under the Affordable Care Act. In 2014, the Medicaid eligibility threshold for non-elderly adults will rise to 133 percent of the federal poverty level (about $30,000 for a family of four). A recent New England Journal of Medicine study reported that North Carolina is among eight states facing the greatest challenge to the extension of Medicaid in light of an expected shortage of primary care physicians. Such a shortfall has the potential to cripple access to primary care, resulting in increased emergency room visits and hospital readmissions and, consequentially, higher costs.

One response to this work force need is increasing medical school enrollments, which the UNC School of Medicine is implementing by sending some third- and fourth-year medical students to Asheville and Charlotte to complete their clinical education.

I am enough of a realist to know that Medicaid will experience substantial cuts, and I worry how this will affect the medical care I can provide. However, when I walk through the N.C. Memorial Hospital, the plaques on its walls remind me of the history of the place, giving me some optimism. During World War II, more young men from North Carolina were found to be medically unfit for military service than any other state. Yet this shameful statistic led to one of the most ambitious and successful programs launched by any state to improve the health of citizens, the Good Health Plan.

Over 60 years later, can we find that same spirit in creating innovative and just ways to continue caring for the least of our neighbors?

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