

The Impact of Medicare and Medicaid on Delivery of Healthcare

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MEDICARE AND MEDICAID

The development of countries depends on different factors. Improving the healthcare of a country is one of the factors. Healthcare is an important aspect of society as well as a country since it helps people in the timely diagnosis, treatment, and management of different types of diseases (Kathe & Painter, 2019). The United States is termed as a well-developed country with established programs for health care that benefit people from different age groups. Medicare and Medicaid are two important healthcare programs for aging and low-income people in the United States (Kathe & Painter, 2019). For people aged 65 or older along with younger having disability problems, Medicare insurance provides paid medical assistance as well as trust funds for the betterment of their health (Landers & Zhou, 2014). To help people from different sectors of society, the Medicaid assistance program helps certain individuals as well as families with low incomes and resources. Both Medicare and Medicaid programs have different benefits and eligibility criteria that vary from state to state (Richardson, 2010). In this essay, an overview of the eligibility criteria of the Medicare and Medicaid programs, the possible improvement in these healthcare programs for vulnerable populations along a possible effect on medical billing will be mentioned.

Medicare is a health insurance program whereas Medicaid is an assistance program. Both these programs have different eligibility criteria that differ on the basis of services offered by a state. The United States Health Department and Human Services offer Medicare health insurance program is a federal program for people above the age of 65, younger people with disabilities, and patients with end-stage fatal diseases, no matter what their income is (Segal et al., 2014). Even though patients pay small amounts for their hospital and other costs, however, small premiums are essential for non-hospital coverage. The United States health department and Human Services mentioned that the Medicare program is essentially the same everywhere in the United States and is organized by the Centers for Medicare & Medicaid Services, an agency of the federal government. Medicare has two parts. Eligibility for part A requires the patient to be 65 or older along with their role as a responsible citizen if they have medical taxes for at least 10 years (Segal et al., 2014). Patients at the age of 65 can gain insurance aspects of part A without paying any premiums if they are potentially receiving benefits from social security or they are eligible to receive Social Security (Landers & Zhou, 2014). Moreover, patients can receive insurance if their individual or their spouse has worked as a government medical officer. Contrary to this, every patient has to pay to receive the benefits of part B of Medicare. Services offered in part B are deducted from Social Security, Railroad Retirement, or Civil Service Retirement check. However, if an individual does not receive any of these payments,

Medicare charges for part B after every three months.

For patients with low income, Medicaid is an assistance program that helps these patients with their medical expenses (Richardson, 2010). Medicaid eligibility guidelines vary for every state. Medicaid services are offered to individuals who fall under the category of need. People in the category of need usually include children under the age of 18 whose household income is not enough to manage their basic necessities. Children who are below 138 percent of the federal poverty level are also eligible for Medicaid programs. Other than this, pregnant women along with the people who receive supplemental security income also fall under the category of need for Medicaid programs. The Medicaid program doesn't pay directly to the individuals, however, this assistance program is paid to the healthcare providers who work to reach out to the potential candidates eligible for the program.

Even though Medicare and Medicaid health assurance programs have benefited different people in the United States population, however, there is some room for improvement in both programs, especially for the benefit of the vulnerable population. Roughly 11 million people in America are over the age of 65 with severe health needs. Some of the patients are eligible for Medicare as well as Medicaid health assurance programs hence are termed 'dual eligibles' (Moskowitz et al., 2012). However, one of the basic issues is that Medicare and Medicaid programs don't interact with one another which leads to potential issues for the 'dual eligibles' who are caught between the two programs and in turn receive less optimal healthcare facilities. People qualifying as 'dual eligibles' are the same people who pay 40% of Medicaid as well as 27% of Medicare (Moskowitz et al., 2012). Research suggests that such patients possibly have multiple chronic conditions with a functional impairment such as having issues in day-to-day activities of bathing or walking around. Since this combination is becoming expensive for the taxpayers, hence the need to improve Medicare and Medicaid programs for vulnerable people is turning out as an important issue.

Research suggests that the key goal of health insurance is to protect individuals facing unexpected medical expenditures. Based on the Bipartisan Policy Center report, in the year 2015, Medicare beneficiary expenditures per person for individuals having multiple chronic conditions were roughly seven times higher than the ones with no chronic diseases (Landers & Zhou, 2014). One of the major concerns in Medicare and Medicaid programs is the lack of standardized assessments to address the needs of a beneficiary. The researcher mentioned that the Medicare world looks at diseases with a set of codes however, the program has no measurement for the function. Keeping in view these major drawbacks, standardized assessment should be introduced as a part of Medicare and Medicaid programs along with a revised costing plan for vulnerable populations so that the maximum number of people can gain benefits from the health care programs. Moreover, these programs can be improved with the help of better opportunities, incentives and improvised parameters for healthcare assessments as these improvements will help patients fighting financial issues.

Similar to the third-party payer, billers send claims for the medical billing of Medicare and Medicaid. When a claim is made to Medicare, the administrative process is involved which is processed by the Medicare Administrative Contractor (MAC) (Moskowitz et al., 2012). Medicare Administrative

Contractor (MAC) evaluates each potential claim made to Medicare and processes the claims. Claims are processed in a time period of 30 days. For processing traditional Medicare billing, important information such as procedure codes, Prices, NPI numbers, diagnosis codes, Place of Service codes, and input patient information. Medical-related financial strain faced by individuals such as difficulty in paying bills has reduced over the passage of time. Contrary to Medicare billing, Medicaid claims are more difficult as they differ from state to state. Hence, the claim forms and formats used by the biller change on the basis of the state the person is in. In general, medical biller creates claims with proper information and a list of prices. However, while billing for Medicaid, the programs should be noted clearly as they cover a large number of services with fewer exceptions. Medicare and Medicaid affect billing in a different way however, when the payer has an insurance plan, the plan is billed even before the Medicaid (Kathe & Painter, 2019). Based on the long procedure of claims. Medicare programs affect medical billing in terms of time and tediousness (Richardson, 2010). More time is required for all the claims made in the Medicare program, hence the process turns tedious at times. However, Medicare and Medicaid programs have helped different people around the country.

In the U.S., the “Affordable Care Act (ACA)” gained recognition among different people after its introduction (Landers & Zhou, 2014). After the implementation of the Affordable Care Act (ACA), its potential effects were observed on Medicare and Medicaid recipients. Affordable Care Act has helped Medicare and Medicaid recipients by reducing overall spending and improving service delivery as well. The ACA has gradually reduced the costs by reconstructing the payments for the overall advantage of Medicare programs. These reductions were based on the fact that Medicare Advantage was spending more money than the original Medicare. When the ACA was introduced, some exceptions were made in the enrollment of Medicare Advantage as the payments were cut down which triggered the benefit of reductions and the overall enrollees in the Medicare Advantage plans. Hence, ACA affected Medicare and Medicaid recipients with reduced costs and focused prescriptions (Billieux et al., 2017).

To conclude, Medicare and Medicaid health insurance programs work for the benefit of the people. People aged 65 or older, young people with disabilities, and those with lower incomes are considered eligible for these programs (Kathe & Painter, 2019). Eligibility for Medicare remains the same however, in the case of Medicaid the eligibility differs from state to state. Medicare and Medicaid health insurance programs can be improved for the vulnerable population by offering better screening programs and funding plans. Medicare and Medicaid receivers were affected positively after the ACA Act was introduced as the costs were potentially reduced along with an improved pricing plan.

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