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SPECIAL COMMUNICATION

Past as Prologue: The Effects of the COVID-19 Economic Downturn on Medicaid Coverage for Podiatry Services

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As of 2016, Medicaid accounted for nearly 20% of state general fund budgets. Optional Medicaid services like podiatry are often subject to cost-cutting measures in periods of economic downturn, as was the case in the wake of the 2007 financial crisis. Although the cuts were intended as a cost-saving measure, research indicates they had the opposite effect. The restriction and limitation of these services during the Great Recession resulted in both poorer

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health outcomes for beneficiaries, and poorer financial outcomes for state Medicaid programs.

With states citing record levels of unemployment as of April 2020 and projecting significant declines in annual revenue in 2021, the economic conditions resulting from the COVID-19 pandemic are likely to rival those of the Great Recession. Given the historical precedent for restricting or eliminating optional Medicaid services as a cost-saving measure, it is likely that podiatric services will once again come under scrutiny. Previous efforts by state-level podiatric societies have proven successful in lobbying for the reinstatement of coverage under Medicaid by conveying evidence of the negative outcomes associated with elimination to stakeholders.

The specialty must once again engage policymakers by drawing on evidence gleaned and lessons learned from past cuts of optional Medicaid services to avert counterproductive coverage restrictions intended to mitigate the financial impact of the COVID-19 pandemic.

Coverage for podiatric care under Medicaid generally receives little attention in health-care policy circles; however, it can have a major impact on state budgets, health care, and most importantly, health outcomes. Given the structure of Medicaid across the states, podiatry is a service that is often sacrificed as a covered benefit during times of economic austerity.

However, these cuts have yet to yield anything close to positive results. Often when a state has removed podiatric care from its Medicaid coverage scheme, it has paid for it many times over in increased costs of care further down the road and negative health outcomes. In this article, we review the economic downturn scenarios that lead to these reductions, briefly discuss the

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effects of Medicaid cuts on podiatry, and the response from the profession. Finally, we present concrete steps the podiatric community can take to advocate for podiatric coverage in light of the COVID-19 economic downturn and beyond.

Great Recession

Economic cycles of growth and recession are unavoidable in modern economies. Even allowing for these natural fluctuations, the United States, and the world, have seen two major economic shocks in the past 13 years. The so-called Great Recession, which began in 2007, was the most severe economic downturn since the Great Depression of the 1930s.¹ Unemployment and lack of consumer confidence took a toll on state budgets. Tax receipts and investment income were particularly hard-hit by the lack of consumer confidence and the plunging stock market.² To further strain state coffers, Medicaid spending increased by 7.6% across all states in 2009.²

While the federal government is able to borrow money to cover shortfalls in income relative to spending, virtually every state is required by law to maintain a balanced budget.³ State governments typically balance their books through a variety of measures that break down along three basic approaches: spending cuts, tapping rainy-day funds, and/or raising revenues.⁴ States are understandably reluctant to draw down emergency funds for long-term operating expenses or those funds simply may not be available. Likewise, raising taxes is fraught with fiscal and political problems. Often, the only viable budget solution available to states is cutting program spending.

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The question states must grapple with is what programs to target? Because health care and education make up the majority of most state budgets, they are prime places to direct those spending cuts.² For example, in 2016 Medicaid itself accounted for approximately 19.6% of state general fund budgets.⁵ The Post-9/11 recession of 2001–2003 saw states look at Medicaid cuts as a way to balance budgets. The majority of states in 2003 ultimately focused cost containment by reducing or freezing provider reimbursement rates rather than cutting eligibility or services.⁴ The scope and size of the Great Recession forced states to do more than finding inefficiencies or nibbling around the edges. Program cuts had to be made in order to balance budgets. By 2011 it was estimated that at least 31 states had made cuts to programs affecting eligibility or access to health-care services for low-income children or families.³

Podiatric Care in the Crosshairs

States have the authority to add or remove optional services from their Medicaid plans. Podiatry, as an optional Medicaid service, was a particularly appealing place to find additional revenue.⁶ Prior to 2008, six states did not include access to podiatrists for the adult Medicaid population: Alabama, Alaska, Connecticut, Nevada, New York, and Wyoming. Following the Great Recession, between 2009 and 2012, five more states eliminated access to podiatrists in their states' Adult Medicaid program: Arizona, California, Kansas, Michigan, and South Carolina.⁷

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These cuts had disastrous effects on podiatric patients. Patients, especially those with chronic conditions such as diabetes, develop a trusting relationship with their podiatrists, and by eliminating access to services, states forced patients to find another health-care provider or forgo care. The complete lack of access or delay in care led to increased hospitalizations and amputations. A landmark study by Skrepnek et al⁶ demonstrated the effect of these cuts in one southwestern state. The Arizona legislature eliminated Medicaid reimbursement for podiatrists in 2010 with an estimated annual savings of \$351,000.⁶ While appearing to save money on the front end, the elimination of podiatric care ultimately had the opposite effect. Subsequent expenditures for conditions such as treatment of the diabetic foot increased dramatically. Following the repeal of podiatric care from Arizona Medicaid (also known as Arizona Health Care Cost Containment System, or AHCCCS), hospitalizations increased by 36.7%, length of stay by 22.5%, per patient hospital charges by 37.5%, and severe aggregate outcomes (sepsis, amputation, death) by 49%.⁶ Estimates place this increased cost at approximately \$16.7 million dollars.⁶ Ultimately for every dollar saved by cutting podiatry coverage, the state spent approximately \$48 to treat preventable, follow-on complications. Podiatric services were ultimately restored in Arizona effective October 1, 2016 (House Bill 2704).⁸ Similar effects have been noted with cutting other optional services such as adult dental care.^{9,10}

Comparable results have been found in the Medicare population. It should be noted that Medicare is a completely separate and distinct program from Medicaid with important coverage and administrative differences. For example, Medicare is a completely federal

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program and therefore not subject to state policy variations. As such, because Medicare covers the services of podiatric physicians, the coverage is not state specific. Medicare also serves a population that is overwhelmingly older (65 years of age and older). Although these differences limit our ability to make an apples-to-apples comparison with Medicaid populations, the clinical outcomes of access are consistent and therefore instructive to the underlying value of podiatric care.

Carls et al¹¹ established a relationship between access to podiatric care and cost of treatment in a sample of Medicare patients. Researchers employed a sophisticated case-matching study design to estimate treatment cost and amputation rates for patients receiving podiatric care versus those who did not. Costs for Medicare patients receiving podiatric care for diabetic foot ulcers were \$3,624 lower for the 2-year period following the initial diagnosis. Cost for commercially insured patients who saw a podiatrist were \$13,474 less than the matched sample not receiving podiatric care.¹¹ Amputation rates also varied in relation to access to podiatric care. The amputation rate for patients in the commercial insurance sample were 2.67% lower for those receiving care from a podiatric physician and 1.35% lower for those in the Medicare panel.¹¹

Current Economic Conditions

The economic downturn brought about by the COVID-19 pandemic is likely to rival or surpass the Great Recession. The unemployment rate in April 2020 reached a high of 14.7%, according to the Bureau of Labor Statistics.¹² Nearly every single state cited record-level unemployment

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rates. Although the economic picture stabilized somewhat during summer of 2020,¹³ fears of a fall/winter surge in the virus has the markets on edge.¹⁴ If the previous economic downturn teaches us anything, it is that the current scenario may be dire for many state social services as investment in health and education will likely shift to unemployment and housing.

The National Conference of State Legislatures is projecting revenue declines of 20% or greater in four states (CA, CO, NM, and WY) and declines of 11% to 20% in another 16 states.¹⁵ The Center on Budget and Policy Priorities estimates the cumulative budget shortfall nationally at \$555 billion for fiscal years 2020 to 2022.¹⁶ There are compounding factors contributing to these predictions. States are increasing spending on programs like Medicaid and unemployment due to job losses and health-care costs, while at the same time consumers are spending substantially less due to both job loss and social distancing.¹⁷ These twin pressures reduce state and local sales tax revenue, so state incomes are decreasing while outlays are increasing.¹⁸ Many businesses, especially small businesses, may not survive the shutdown; simply returning to 'business as usual' post-COVID is not a likely scenario.

Podiatry has already started to feel the effects. California, which reintroduced Medicaid coverage for podiatry on January 1, 2020,¹⁹ considered elimination in response to economic conditions as early as May 2020.²⁰ Georgia, Colorado, and Ohio are also looking at Medicaid program cuts to a variety of programs.²¹ Without additional federal financial assistance, the specialty could be facing another round of cuts.

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Response from the Specialty

With Medicaid cuts a clear possibility in the coming months, it can be constructive to look at how podiatrists and their patients responded to the Great Recession coverage reductions. The specialty responded to the elimination and the threat of elimination of services on several fronts. At the state level, podiatric societies, with assistance from the American Podiatric Medical Association (APMA), challenged cuts to services by podiatrists. For example, when then-Governor Tim Kaine threatened to eliminate services by podiatrists, the Virginia Podiatric Medical Association, with assistance from APMA, mobilized. Podiatrists met with legislators in their districts and held lobby days at the state capitol in Richmond to help legislators understand the value that podiatrists provide to Medicaid patients. As a result, the state conducted a study on care by podiatrists in the state program and found that cuts would have an adverse impact on patients and the health-care system in Virginia.²² Similar scenarios played out in other states. For example, Michigan eliminated services by podiatrists only to reinstate coverage a year later because legislators recognized the negative effects on Medicaid beneficiaries.

Other state chapters, like the Illinois Podiatric Medical Association (IPMA), reached out to their state legislators early on and built relationships with lawmakers. According to IPMA Insurance Chair Jondelle Jenkins, DPM, who also chairs APMA's Center for Professional Advocacy Advisory Group, when the Illinois state legislature threatened to eliminate services by podiatrists in the Medicaid program due to budgetary cuts, she reached out directly to the

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legislative committee that oversees the Medicaid budget. IPMA representatives educated committee members on issues such as: diabetic foot care, problems with diabetic wounds, and the connection between diabetes and peripheral vascular disease. The impact that lack of care by a podiatrist would have on Medicaid-enrolled patients with diabetes resonated with lawmakers. IPMA also used several research studies to demonstrate the value of care, including the Virginia-produced study.²³ Services by podiatrists were ultimately maintained in the Medicaid program in Illinois for adults with diabetes and was fully reinstated in 2014.²⁴ APMA also participated in several National Conference of State Legislatures' Legislative Summits and spoke with legislators from across the country about podiatric medicine and the value of care podiatrists provide to their patients.

At the national level APMA doubled its already robust advocacy efforts, and APMA-supported legislation to include podiatrists as physicians under Medicaid was included in the House-passed version of the Patient Protection & Affordable Care Act in 2009. Unfortunately, this provision was stripped out of the final bill. Since then, APMA has worked with congressional sponsors to reintroduce the language as the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act.²⁵ The story behind the introduction of the HELLPP Act provides a fantastic example of the potential value in building individual relationships. In this case, one Ohio podiatrist invited his member of Congress, Rep. Bill Johnson (R-OH), to his office to learn about podiatry. Because of that outreach effort, Rep. Johnson became the chief Republican sponsor of the HELLPP Act in the US House of Representatives. Likewise an Iowa

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podiatrist, who regularly meets with Sen. Charles Grassley (R-IA), invited him to run with him at a local community race. Because of this relationship, Sen. Grassley became a champion for podiatry and the HELLPP Act.

Building upon these examples for state level and individual advocacy, podiatric associations and podiatrists should build relationships and maintain ongoing conversations with policymakers about the benefits of podiatry in the state Medicaid program. Waiting until the next economic downturn may be too late. These conversations should occur with all relevant actors, including governors as they propose budgets for the legislature to consider; the state Medicaid agency, as that office typically proposes spending levels to the governor; and with state legislators as they vote on the final package. Advocates for podiatric care should meet at least annually with these policymakers in order to continually reinforce the value of care.

Concrete steps podiatrists can take to cultivate relationships are:

- Invite their member of Congress and state legislators to their office and other events
- Schedule a meeting with legislators and travel to their office
- Engage in political advocacy and attend or host campaign fundraisers

Demonstrating the value of podiatric care through empirical research is another important approach to advocacy. Scientific studies, including those discussed above, help legislators, governors, and other policymakers understand what podiatrists do to preserve limbs and

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prolong lives. However, many of these studies are nearly a decade old. With the expansion of Medicaid in many states as a result of the Affordable Care Act and the increased prevalence of diabetes in the past 10 years, especially in minority populations,³¹ the health-care landscape has changed. As a result, more peer-reviewed studies are needed to understand the impact of podiatry on Medicaid beneficiaries. Most studies, as expected, focus on podiatrists' role in preventing nontraumatic lower-limb amputations. However, podiatrists offer many other benefits to Medicaid beneficiaries and additional research is needed to demonstrate the efficacy of the full range of services podiatrists provide. Having these studies available to demonstrate the value of care by podiatrists will help to educate policymakers and counter efforts to cut benefits.

Conclusions

As Medicaid coverage for podiatry once again comes under scrutiny, it is vital that the specialty stay engaged. Podiatrists should start talking with their legislators today and building relationships. According to Dr. Jenkins, policymakers cut all "nonessential services" without thinking about the impact. By building relationships now, podiatrists can educate policymakers and potentially thwart cuts. Dr. Jenkins also recommends that state podiatry societies hire a professional lobbyist and seek to ensure that the state mandate services by podiatrists in the state Medicaid program. Podiatry should increase its grassroots advocacy including support for the HELLPP Act. Podiatrists, staff, patients, colleagues, and friends learn more about contacting

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their elected leaders at www.apma.org/eAdvocacy. Finally, the profession needs diverse, timely, and rigorous scientific research to better demonstrate the value and benefits podiatrists offer to the Medicaid program.

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References

1. Modrek S, Stuckler D, McKee M, et al: A review of health consequences of recessions internationally and a synthesis of the US response during the Great Recession. *Public Health Rev* **35**: 10, 2013; doi:10.1007/BF03391695.
2. Gordon T: State budgets in recession and recovery. Available at: <https://www.brookings.edu/research/state-budgets-in-recession-and-recovery/>. Accessed June 16, 2020.
3. Johnson N, Oliff P, Williams E: An update on state budget cuts. Available at: <https://www.cbpp.org/research/an-update-on-state-budget-cuts>. Accessed June 16, 2020.
4. Coughlin TA, Zuckerman S: Three years of state fiscal struggles: how did Medicaid and SCHIP fare? *Health Aff (Millwood)* **24 (Suppl 1)**: W5-385-W5-398, 2005; doi: 10.1377/hlthaff.W5.385.
5. Medicaid and CHIP Payment and Access Commission: Medicaid's share of state budgets. Available at: <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>. Accessed June 15, 2020.
6. Skrepnek GH, Mills JL, Armstrong DG: Foot-in-wallet disease: tripped up by "cost-saving" reductions? *Diabetes Care* **37**: e196, 2014; doi: 10.2337/dc14-0079.
7. Kaiser Family Foundation: Medicaid Benefits: Podiatrist Services. Available at: <https://www.kff.org/medicaid/state-indicator/podiatrist-services/>. Accessed July 23, 2020.

This Special Communication has been reviewed, accepted for publication, and approved by the author. It has not been copyedited, proofread, or typeset and is not a final version.

8. Arizona Health Care Cost Containment System: Program Changes and Fee Schedule Changes. Available at: <https://azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/SectionA/ProgramChangesFeescheduleChanges.pdf>. Accessed September 29, 2020.
9. Singhal A, Caplan DJ, Jones MP, et al: Eliminating Medicaid adult dental coverage in California led to increased dental emergency visits and associated costs. *Health Aff (Millwood)* **34**: 749, 2015; doi: 10.1377/hlthaff.2014.1358.
10. Wallace NT, Carlson MJ, Mosen DM, et al: The Individual and program impacts of eliminating Medicaid dental benefits in the Oregon Health Plan. *Am J Public Health* **101**: 2144, 2011; doi:10.2105/AJPH.2010.300031.
11. Carls GS, Gibson TB, Driver VR, et al: The economic value of specialized lower-extremity medical care by podiatric physicians in the treatment of diabetic foot ulcers. *JAPMA* **101**: 93, 2011; doi:10.7547/1010093.
12. US Bureau of Labor Statistics: Labor force statistics from the current population survey. Available at: <https://data.bls.gov/timeseries/LNS14000000>. Accessed August 17, 2020.
13. Rosenberg E: U.S. economy added 1.8 million jobs in July as it worked to recover from the coronavirus pandemic. *Washington Post*, October 28, 2020. Available at: <https://www.washingtonpost.com/business/2020/08/07/july-2020-jobs-report/>. Accessed October 28, 2020.
14. Nelson E, Phillips M: Stocks Slide as Virus Cases Surge. *The New York Times*, October 26, 2020. Available at: <https://www.nytimes.com/live/2020/10/26/business/economy-us-coronavirus>. Accessed October 28, 2020.
15. National Conference of State Legislatures: Coronavirus (COVID-19): Revised state revenue projections. Available at: <https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx>. Accessed August 17, 2020.
16. Aron-Dine A, Hayes K, Broaddus M: With need rising, Medicaid is at risk for cuts. Available at: <https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts>. Accessed October 28, 2020.
17. Rudowitz R, Hinton E: Early look at Medicaid spending and enrollment trends amid COVID-19. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/>. Accessed June 22, 2020.

This Special Communication has been reviewed, accepted for publication, and approved by the author. It has not been copyedited, proofread, or typeset and is not a final version.

18. McNichol E, Leachman M, Marshall J: States need significantly more fiscal relief to slow the emerging deep recession. Available at: <https://www.cbpp.org/research/state-budget-and-tax/states-need-significantly-more-fiscal-relief-to-slow-the-emerging-deep>. Accessed June 18, 2020.
19. Glionna JM: Medi-Cal benefits eliminated a decade ago, such as foot care and eyeglasses, are back. Available at: <https://californiahealthline.org/news/medi-cal-benefits-eliminated-a-decade-ago-such-as-foot-care-and-eyeglasses-are-back/>. Accessed June 13, 2020.
20. Ibarra A: Medi-Cal budget cuts loom in California. Available at: <https://calmatters.org/health/coronavirus/2020/05/california-medi-cal-budget-cuts-benefits/>. Accessed October 28, 2020.
21. Zeballos-Roig J: 3 cash-strapped states are making deep cuts to Medicaid as coronavirus devastates their budgets — and millions of jobless people lack health insurance. Business Insider, May 6, 2020. Available at: <https://www.businessinsider.com/states-medicare-cuts-coronavirus-devastates-economy-budgets-ohio-dewine-2020-5>. Accessed May 13, 2020.
22. Commonwealth of Virginia, Department of Medical Assistance Services: Report on Medicaid coverage of podiatry services. Available at: <https://rga.lis.virginia.gov/Published/2010/RD328/PDF>. Accessed April 27, 2020.
23. Commonwealth of Virginia, Department of Medical Assistance Services Pane G: Report on Medicaid coverage of podiatry services. Available at: <https://rga.lis.virginia.gov/Published/2010/RD328/PDF>. Accessed April 27, 2020.
24. West's Smith-Hurd Illinois Compiled Statutes Annotated. Elimination and Limitations of Medical Assistance Services. Vol Chapter 305: Public Aid; 2009 [effective July 1, 2012]. Available at: <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1413&ChapterID=28>. Accessed November 4, 2020.
25. DeGette D: Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians Act. Available at: <https://www.congress.gov/bill/116th-congress/house-bill/2235/text>. Accessed June 16, 2020.