

## **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 such as 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 that they had the opposite effect. The restriction and limitation of these services during the Great Recession resulted in both poorer health outcomes for beneficiaries, and poorer financial outcomes for state Medicaid programs. With states citing record levels of unemployment as of April of 2020 and projecting significant declines in annual revenue in 2021, the economic conditions resulting from the coronavirus disease of 2019 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 coronavirus disease of 2019 pandemic. (*J Am Podiatr Med Assoc* 113(2), 2023)

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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 and briefly discuss the 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 coronavirus disease of 2019 (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.<sup>1(p1)</sup> 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.<sup>2</sup>

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To further strain state coffers, Medicaid spending increased by 7.6% across all states in 2009.<sup>2</sup>

Although 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.<sup>3</sup> 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.<sup>4(p385)</sup> 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.

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.<sup>2</sup> For example, in 2016, Medicaid itself accounted for approximately 19.6% of state general fund budgets.<sup>5</sup> The post-9/11 recession of 2001 to 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.<sup>4(p390)</sup> 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 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.<sup>3(p4)</sup>

## 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.<sup>6</sup> Before 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.<sup>7</sup>

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 to or delay in care led to increased hospitalizations and amputations. A landmark study by Skrepnek et al<sup>6</sup> 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. Although 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 the Arizona Health Care Cost Containment System), 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%.<sup>6</sup> Estimates place this increased cost at approximately \$16.7 million.<sup>6</sup> 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).<sup>8</sup> Similar effects have been noted with cutting other optional services such as adult dental care.<sup>9,10</sup>

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 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 (aged 65 years 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 al<sup>11</sup> established a relationship between access to podiatric care and cost of treatment in a sample of Medicare patients. Researchers used 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.<sup>11(p111)</sup> Amputation rates

also varied in relation to access to podiatric care. The amputation rate for patients in the commercial insurance sample were 2.67% less for those receiving care from a podiatric physician and 1.35% less for those in the Medicare panel.<sup>11(p111)</sup>

## Current Economic Conditions

The economic downturn brought about by the COVID-19 pandemic is likely to rival or surpass that during the Great Recession. The unemployment rate in April of 2020 reached a high of 14.7%, according to the Bureau of Labor Statistics.<sup>12</sup> Nearly every single state cited record-level unemployment rates. Although the economic picture stabilized somewhat during the summer of 2020,<sup>13</sup> fears of a fall/winter surge in the virus has the markets on edge.<sup>14</sup> 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 (California, Colorado, New Mexico, and Wyoming) and between 11% and 20% in another 16.<sup>15</sup> The Center on Budget and Policy Priorities estimates the cumulative budget shortfall nationally at \$555 billion for fiscal years 2020 to 2022.<sup>16(p4)</sup> There are compounding factors contributing to these predictions. States are increasing spending on programs such as Medicaid and unemployment because of job losses and health-care costs, and consumers are spending substantially less because of both job loss and social distancing.<sup>17</sup> These twin pressures reduce state and local sales tax revenue, so state incomes are decreasing and outlays are increasing.<sup>18</sup> Many businesses, especially small businesses, may not survive the shutdown; simply returning to “business as usual” after COVID-19 is not a likely scenario.

Podiatry has already started to feel the effects. California, which reintroduced Medicaid coverage for podiatry on January 1, 2020,<sup>19</sup> considered elimination in response to economic conditions as early as May of 2020.<sup>20</sup> Georgia, Colorado, and Ohio are also looking at Medicaid program cuts to a variety of programs.<sup>21</sup> Without additional federal financial assistance, the specialty could be facing another round of cuts.

## 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 the 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.<sup>22</sup> Similar scenarios played out in other states. For example, Michigan eliminated services by podiatrists only to reinstate coverage 1 year later because legislators recognized the negative effects on Medicaid beneficiaries.

Other state chapters, such as 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 the APMA’s Center for Professional Advocacy Advisory Group, when the Illinois state legislature threatened to eliminate services by podiatrists in the Medicaid program because of budgetary cuts, she reached out directly to the 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. The IPMA also used several research studies to demonstrate the value of care, including the Virginia-produced study.<sup>23</sup> Services by podiatrists were ultimately maintained in the Medicaid program in Illinois for adults with diabetes and fully reinstated in 2014.<sup>24</sup> The 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, the 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, the APMA has worked with congressional sponsors to reintroduce the language as the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act.<sup>25</sup> 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, Representative Bill Johnson (R-OH), to his office to learn about podiatry. Because of that outreach effort, Representative Johnson became the chief republican sponsor of the HELLPP Act in the US House of Representatives. Likewise an Iowa podiatrist, who regularly meets with Senator Charles Grassley (R-IA), invited him to run with him at a local community race. Because of this relationship, Senator Grassley became a champion for podiatry and the HELLPP Act.

Building on 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 the governor's office as he or she proposes a budget 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 to continually reinforce the value of care. Concrete steps podiatrists can take to cultivate relationships are:

1. Invite their member of Congress and state legislators to their office and other events.
2. Schedule a meeting with legislators and travel to their office.
3. 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 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,<sup>31</sup> 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, but 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 stays engaged. Podiatrists should start talking with their legislators today and building relationships. According to Dr. Jenkins, policymakers cut all "non-essential 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 states 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 can learn more about contacting their elected leaders at [www.apma.org/eAdvocacy](http://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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