



2014

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Recommended Citation

Hermer, Laura D. and Lenihan, Merle (2014) "The Future of Medicaid Supplemental Payments: Can They Promote Patient-Centered Care?," *Kentucky Law Journal*: Vol. 102 : Iss. 2 , Article 4.

Available at: <https://uknowledge.uky.edu/klj/vol102/iss2/4>

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The Future of Medicaid Supplemental Payments: Can They Promote Patient–Centered Care?

Laura D. Hermer¹ and Merle Lenihan²

INTRODUCTION

MYRLENE Stimphil is a nurse and the mother of an adult disabled son.³ She and her husband are trying to delay foreclosure on their home after a New York hospital placed a lien on it for over \$40,000. In 2007, Mrs. Stimphil's son, who has been brain damaged since he was born prematurely, had emergency surgery and their health insurance plan unexpectedly dropped his coverage. Mrs. Stimphil asked the hospital for a reduced payment but was told that the hospital would “get back to her.” She told a New York Times reporter, “We don't want to be a burden.”⁴ Meanwhile, her son, who is now twenty-four years old and living with his parents, has been receiving phone calls from a collection agency.

The hospital where Mrs. Stimphil's son received emergency surgery was the recipient of more than \$10 million from New York's Indigent Care Pool in 2010.⁵ The state funds the Indigent Care Pool through several sources, such as a tax on hospital services and federal matching payments from the Medicaid Disproportionate Share Hospital (DSH) program, according to a recent report by the antipoverty group Community Service Society of New York.⁶ The report provides details on the \$1.2 billion in Indigent Care Pool funds that are distributed to New York hospitals each year.⁷ One condition for receiving

1 Associate Professor, Hamline University School of Law. I would like to thank the participants in the 2013 Medicaid Matters workgroup at the University of Kentucky College of Law for stimulating discussion that helped spur some of the ideas in this paper, the University of Kentucky College of Law for sponsoring the workgroup, and the Kentucky Law Journal for helping to make it all happen.

2 M.D., University of Tennessee Health Science Center; Ph.D. (Medical Humanities), University of Texas Medical Branch.

3 Nina Bernstein, *Hospitals Flout Charity Aid Law*, N.Y. TIMES, Feb. 13, 2012, at A1.

4 *Id.*

5 *Id.* (indicating that the hospital where the Stimphil's son had surgery was New York University (NYU) Langone Medical Center). See ELISABETH R. BENJAMIN ET AL., CMTY. SERV. SOC'Y, INCENTIVIZING PATIENT FINANCIAL ASSISTANCE: HOW TO FIX NEW YORK'S HOSPITAL INDIGENT CARE PROGRAM 15 (2012), available at <http://www.cssny.org/userimages/downloads/Incentivizing-PatientFinancialAssistanceFeb2012.pdf> (indicating the amount of Indigent Care Pool funds paid to NYU).

6 BENJAMIN ET AL., *supra* note 5, at 4.

7 *Id.* at 4–5.

Indigent Care Pool funds is that hospitals must offer financial assistance to patients whose income is less than 300% of the federal poverty level.⁸ The authors of the report found that more than half of New York hospitals did not comply with one or more aspects of state law or regulatory guidance regarding obligations to patients to notify and assist them with applying for financial assistance, and that the state poorly enforced these obligations.⁹ As a result, hospitals continued to receive payments on an aggregated basis for the cost of care for patients whose homes are in foreclosure or savings are seized because of hospital collection actions.¹⁰ One of the report's conclusions was that the Indigent Care Pool does not provide an incentive for hospitals to provide financial assistance.¹¹

In 2010, Medicaid financed health and long-term care services to more than 68 million people.¹² Medicaid supplemental payments such as DSH and Upper Payment Limit (UPL),¹³ however, are generally not linked to specific patients or services.¹⁴ Federal DSH payments to states totaled \$11.3 billion in

8 *Id.*

9 *Id.* at 8.

10 See Bernstein, *supra* note 3, at A1.

11 BENJAMIN ET AL., *supra* note 5, at 13.

12 ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 13 (2010), available at <http://www.aging.senate.gov/crs/medicaid1.pdf>. There are some differences in the estimates of the number of people who are Medicaid enrollees. For example, the most recent Kaiser Family Foundation/Urban Institute estimate is 62 million Americans enrolled in Medicaid in 2012. THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID A PRIMER, KEY INFORMATION ON THE NATION'S HEALTH COVERAGE PROGRAM FOR LOW-INCOME PEOPLE 8 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>. The Government Accountability Office (GAO) estimated the number of Medicaid enrollees in 2010 at 53.9 million. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-694, MEDICAID: STATES REPORTED BILLIONS MORE IN SUPPLEMENTAL PAYMENTS IN RECENT YEARS 6 (2012), available at <http://www.gao.gov/assets/600/592785.pdf>.

13 Health policy scholars generally categorize Medicaid supplemental payments as DSH and UPL. See, e.g., DEBORAH BACHRACH & MELINDA DUTTON, CTR. FOR HEALTH CARE STRATEGIES, INC., MEDICAID SUPPLEMENTAL PAYMENTS: WHERE DO THEY FIT IN PAYMENT REFORM? 1, available at http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf. The GAO has categorized Medicaid supplemental payments as DSH and non-DSH. See e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-694, *supra* note 12, at 2.

14 BACHRACH & DUTTON, *supra* note 13, at 1 (“[S]upplemental payments are generally disconnected from the specific services provided to specific patients and delinked from the efficiency or quality of the care provided.”). This point is central to some of the policy debates surrounding, in particular, DSH payments. See *id.* Other commentators also state:

DSH payments, which cannot be directly tied to specific services delivered or to specific Medicaid-eligible recipients, are not appropriate for federal matching unless strictly limited to a predetermined amount based on equitable criteria for distribution among states... Depending on state allocation methods, some hospitals can receive DSH payments that regularly cover virtually all costs of uncompensated care, including any shortfall in Medicaid payments relative to costs. This raises questions about just what charity care and bad debts might be covered by Medicaid DSH payments, and whether this effective cost reimbursement provides any incentive for efficiency.

2011 and \$10.8 billion in 2012.¹⁵ The total expenditure from state and federal sources for DSH was \$17.6 billion in 2010 and when UPL payments are included, the total reaches \$32 billion.¹⁶ In 2011, federal and state Medicaid DSH payments alone (excluding UPL supplemental payments) comprised 4.2% of total national Medicaid expenditures, more than the amount spent on drugs in the program.¹⁷

Under the Patient Protection and Affordable Care Act (ACA), both Medicare and Medicaid DSH payments will be reduced.¹⁸ The Centers for Medicare and Medicaid Services (CMS) finalized the methodology for accomplishing the reduction in Medicaid DSH payments for fiscal years 2014 and 2015.¹⁹ Since

CHOICES FOR EQUITY AND EFFICIENCY 186 (AEI Press 2010).

15 Medicaid Program; Disproportionate Share Hospital Allotments, 77 Fed. Reg. 43,301, 43,312, 43,316 (July 24, 2012).

16 U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-694, *supra* note 12, at 9. The federal government matches state Medicaid spending according to a formula based on state per capita income so that states with a lower per capita income have a higher match. MEDICAID: A PRIMER, KEY INFORMATION ON THE NATION'S HEALTH COVERAGE PROGRAM FOR LOW-INCOME PEOPLE, *supra* note 12, at 31. The federal match rate is the Federal Medical Assistance Percentage (FMAP). *Id.* The FMAP is no less than 50% and ranges up to 73%. *Id.* Nationally, the federal government funds about 57% of Medicaid spending. *Id.*

17 *Id.* at 25 (indicating 3.6% of national Medicaid expenditures was due to the cost of drugs and the same percentage was spent on people who were enrolled in both Medicare and Medicaid).

18 42 U.S.C. § 1396r-4(f)(7)(A)(i)(II) (2011). This article only discusses Medicaid DSH payments and reductions. For further information on the proposed reductions, see *infra* notes 61–65 and associated text.

19 CMS issued proposed rules for the Medicaid DSH Health Reform Methodology (DHRM) in May 2013 and the final rule in September 2013, which is substantively the same as the proposed methodology. The final rules will remain in effect for two years, 2014 and 2015. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 28,551 (May 15, 2013) (to be codified at 42 C.F.R. pt. 447) and Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 57,293 (September 18, 2013) (to be codified at 42 C.F.R. pt. 447). One complication is the role that DSH reductions may play in influencing states to expand their Medicaid programs under the ACA. In the case of states that have not committed to a Medicaid expansion, the methodology for DSH payment reductions could influence the decision because states will be able to somewhat more accurately assess the loss of federal DSH funds along with the loss of funds for the expansion. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566 (2012). See also John A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365, 2366 (2012) (simulating DSH reductions in both the Medicaid and Medicare programs and finding that, even in states that do not expand Medicaid, there will be a nontrivial decrease in DSH funds). On the other hand, some commentators do not expect Medicaid DSH reductions to impact states' decisions on whether to implement the Medicaid expansion. See, e.g., ALISON MITCHELL, CONG. RESEARCH SERV., R42865, MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS 22 (2013), available at http://assets.opencrs.com/rpts/R42865_20131202.pdf ("Potential Medicaid DSH reductions are not a significant factor in states' decisions whether or not to implement the ACA Medicaid expansion because the impact of the Medicaid DSH reductions pales in comparison to other potential impacts. For instance, while the aggregate Medicaid DSH reductions from FY2014 to FY2021 total \$22 billion, if all states implement the ACA Medicaid expansion it is estimated that all the ACA health insurance coverage provisions would reduce uncompensated care by \$183 billion.").

the Medicaid DSH payments will be reduced even in states that choose not to expand Medicaid under the ACA, the significance of these payments has arguably been enhanced.²⁰ Some have viewed the approaching DSH reductions as an opportunity to further ensure that patients benefit from such payments. For example, in a 2012 report commissioned by the Commonwealth Fund, the authors suggest moving away from lump DSH payments that simply sustain safety net hospitals toward payments that stimulate and reward high performance in the care of low-income patients.²¹ The focus of the report is on states' ability to implement DSH payment strategies that are linked to high quality patient-centered care to individuals, especially the uninsured.²²

In this Article, we bring the concept of patient-centered care to the forefront in the discussion concerning Medicaid supplemental payments. For at least the past decade, patient-centered care has been considered an inherent dimension of health care quality as well as a means by which other aims such as improvements in health care outcomes, safety, and efficiency can be achieved.²³

²⁰ See Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. at 28,553.

²¹ DEBORAH BACHRACH, ET AL., THE COMMONWEALTH FUND, TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM FOR VULNERABLE POPULATIONS: FUNDING FOR THE SAFETY-NET HOSPITALS II (Deborah Lorber ed., 2012), available at <http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Vulnerable-Populations.aspx>. Representative John Lewis (D-GA) filed the DSH Reduction Relief Act of 2013, H.R. 1920, 113th Cong. (2013), in May 2013 to delay Medicaid and Medicare DSH reductions for two years. The American Hospital Association supports the legislation. Letter from American Hospital Association Vice-President Rick Pollack to Congressman John Lewis (May 9, 2013), available at <http://www.aha.org/advocacy-issues/letter/2013/130509-let-aha-lewis.pdf>.

²² BACHRACH, ET AL., *supra* note 21, at 12 (“There is evidence that much of the disparity in care experienced by vulnerable populations could be eliminated through the provision of patient- and family-centered primary care that emphasizes team-based care, care coordination, care management, and preventive services (e.g., care delivered through health homes and patient centered medical homes).”) (quoting SCHOR ET AL., THE COMMONWEALTH FUND, ENSURING EQUITY 14 (2011)). Concerning payment strategies to achieve these goals, *see id.* at 20 (“Thus, the first question becomes how best to target the remaining Medicaid DSH dollars to sustain hospitals continuing to serve significant numbers of uninsured patients or more specifically to cover uncompensated care costs of uninsured patients. Again, consistent with the goals of accountability and transparency, the best approach might be to have the hospital “bill” for each uninsured patient and receive in return some percentage of the Medicaid rate it would otherwise receive.”). The state focus in the report is understandable, given that CMS makes it clear that states retain their considerable flexibility in determining the methodology for DSH payments. See Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. at 57,296.

²³ For a brief overview of patient-centered care, emphasizing that patient-centered care is a “quality of personal, professional, and organizational relationships,” see Ronald M. Epstein & Richard L. Street, Jr., *The Values and Value of Patient-Centered Care*, 9 ANNALS OF FAMILY MED. 100, 100 (2011). While patient-centered care has become embedded in several policy initiatives in both the Medicare and Medicaid programs, it does not have a standard definition. The Institute of Medicine (IOM) included patient-centered care as one of the six key elements of health care quality. INSTITUTE OF MEDICINE COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 6 (National Academic Press) (2001). The IOM definition of patient-centered is “providing care that is respectful of and

Patient-centered care is one key metric in the United States' National Quality Strategy, a blueprint for aligning public and private interests to improve health care quality, accessibility, and affordability, and improve the health of communities.²⁴ But the National Quality Strategy has not yet evaluated the use of DSH or other supplemental payment funds in the context of patient-centered care. Mrs. Stimpfil's son may have received care that was patient-centered in some respects, and we do not know the details of his income or qualifications for financial assistance; however, at a minimum, patient-centered care involves informing patients of hospital policies, like the availability of financial assistance, that pertain to them.²⁵

responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." *Id.* Donald Berwick, a former head of CMS for about a year during the Obama administration, has defined patient-centered care as "[t]he experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care." Donald M. Berwick, *What 'Patient-Centered' Should Mean: Confessions Of An Extremist*, 28 HEALTH AFF. w555, w560 (2009), available at <http://content.healthaffairs.org/content/28/4/w555.full.pdf+html>.

24 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PRINCIPLES FOR THE NATIONAL QUALITY STRATEGY I, available at <http://www.ahrq.gov/workingforquality/nqs/principles.pdf> (last visited Jan. 4, 2014). The first principle is "Person-Centeredness and Family Engagement":

The most successful health care experiences are often those in which clinicians, patients, and their families work together to make decisions. When patients' needs, experiences, perspectives, and preferences are taken into account—and when they get the clear and understandable information and support they need to actively participate in their own care—outcomes and patient satisfaction can improve. How patients rate their experience is now widely used as a measure of high quality care—but more can be done to empower individuals and make sure their needs and preferences are taken into account.

Id. The complete NQS can be found at <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>.

25 The ACA includes several new requirements that nonprofit hospitals must adhere to. The law creates Section 501(r) of the Internal Revenue Code, which applies to all hospitals that are charitable under Section 501(c)(3). Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 119, 855–57 (Mar. 23, 2010). Nonprofit hospitals are required to have a written financial assistance policy that includes eligibility criteria and whether assistance includes free or discounted care. *Id.* The policy must include: the basis for calculating the amounts charged and the process for applying for financial assistance; the actions taken in the case of nonpayment including collection actions and reporting to credit agencies, if the hospital does not have a separate billing and collection policy; the measures taken to widely publicize the policy within the community to be served by the organization; and must address adherence to the requirements of the Emergency Medical Treatment and Labor Act for individuals regardless of their eligibility under the financial assistance policy. *Id.* The IRS issued proposed regulations in June 2012 regarding the ACA's requirements for charitable hospitals under 501(r). The proposed regulations clarify that hospitals have flexibility in determining eligibility criteria and the amounts and kinds of financial assistance. The policy must contain specific criteria, however, and the regulations make detailed requirements about notifying patients and the public about the financial assistance policy. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148, 38,148–49 (proposed June 26, 2012) (to be codified at 26 C.F.R. pt. 1). The ACA limits the amount that nonprofit hospitals may charge patients who are eligible for financial assistance for emergency and medically necessary care to not more than the amounts generally billed to individuals who have insurance and it prohibits the use of gross charges. Pa-

We propose that the promotion of patient-centered care can be a meaningful context through which to assess Medicaid supplemental payments.²⁶ In this article, we focus specifically on innovative state waiver programs that use DSH funds, not to help hospitals cover the cost of already-delivered uncompensated care, but rather to finance organized systems of coverage or care for the uninsured.²⁷ First, we propose that while patient-centered care is a laudable goal for every patient, Medicaid supplemental payments should be directed toward patient-centered goals of care for low-income patients, whether such patients are enrolled in Medicaid or are uninsured.²⁸ Second, we propose that patient-centered attributes of care, such as treating each patient as a whole person and with respect, dignity, and transparency, can and should be encouraged at all levels of the individual's interaction with the health care and coverage systems.²⁹ Third, we propose that Medicaid supplemental payments should encourage the active engagement of patients in care processes through shared power to influence such processes.³⁰

tient Protection and Affordable Care Act § 9007. The hospital may not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy. *Id.* In the IRS proposed regulations, the meaning of "extraordinary collection actions" includes any legal or judicial process such as placing a lien on property, foreclosure on a property, garnishing wages, or body attachments. *Additional Requirements for Charitable Hospitals*, 77 Fed. Reg. at 38,149, 38,155.

²⁶ We are proposing that the concept of patient-centered care can be meaningful even when it is not associated specifically with the patient-centered medical home model. Thirty-two states currently report that their Medicaid programs incorporate a patient-centered medical home model. VERNON K. SMITH, ET AL., *THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID TODAY; PREPARING FOR TOMORROW: A LOOK AT STATE MEDICAID PROGRAM SPENDING, ENROLLMENT AND POLICY TRENDS 9* (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8380.pdf>.

²⁷ See *infra* Part II.

²⁸ See *infra* notes 35, 39-41, and accompanying text. This assertion is based on the intent of the legislators who created Medicaid DSH payments and the current definition of uncompensated care costs as arising from unreimbursed Medicaid costs and costs attributable to uninsured people. In addition, this assertion moves the discussion toward the potential population of people who could benefit from patient-centered care rather than focusing solely on patients who have received care in part as a result of DSH payments. See *infra* notes 226-229 (detailing the percentage of the uninsured population in each state covered by expansions).

²⁹ Berwick, *supra* note 225, at w563 (arguing that transparency should extend to all aspects of care, including science, costs, outcomes, processes, and errors).

³⁰ Patient-centered care is usually conceived of as encouraging patients to become actively engaged in their care, though not forcing them to do so. Some scholars view the sharing of power as a corrective to the doctor-centered paternalism of earlier decades or the tendency to view patients in technical terms related to their disease. See, e.g., Patrick S. Duggan, et al., *The Moral Nature of Patient-Centeredness: Is It 'Just the Right Thing to Do'?*, 62 *PATIENT EDUC. & COUNSELING* 271, 272 (2006). Patient-centeredness is also an integral part of the Medicare Shared Savings Program through which Accountable Care Organizations (ACOs) are authorized. See *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, 76 Fed. Reg. 67,802, 67,806, 67,826 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425). In order to demonstrate patient-centeredness, ACOs must include Medicare beneficiaries in their governance structure and incorporate

Part I briefly reviews some of the legislative and policy history of Medicaid supplemental payments, including the recently issued final methodology for DSH payment reductions. Part II provides an examination of different programs initiated in four states that use a portion of their respective Medicaid DSH funds to finance expanded coverage or care for residents who otherwise would be uninsured, including its proposed role in expanding Medicaid in the state. In the analysis of each program, we pay particular attention to the program's function from the perspective of the individual using it. Part III assesses patient-centered attributes of care in the four programs.

I. THE ACA'S MEDICAID EXPANSION AND A BRIEF HISTORY OF MEDICAID DSH

The ACA authorized the largest national expansion of Medicaid to date. It directs all states, as of 2014, to open Medicaid enrollment to all non-elderly individuals earning less than 133% of the federal poverty level, and offers a substantially increased matching rate for the new population.³¹ The Congressional Budget Office (CBO) estimated shortly before the ACA's enactment that 16 million uninsured people would obtain coverage under the Medicaid expansion.³² In conjunction with the additional 16 million uninsured people the CBO estimated would obtain potentially subsidized private coverage through health insurance exchanges or marketplaces, the ACA promised to slash America's uninsured population by half, from approximately 16% to 8%.³³

Congress sought to defray the expense of the coverage expansions and other new outlays authorized by the ACA.³⁴ As one means of doing so, it imposed a

results of beneficiary experiences of care into improvement plans. *Id.* Another groundbreaking way that patients' voices and preferences are being brought to health care systems as partners is through the Patient-Centered Outcomes Research Institute. See Rachael Fleurence, et al., *How the Patient-Centered Outcomes Research Institute Is Engaging Patients and Others in Shaping Its Research Agenda*, 32 HEALTH AFF. 393, 393 (2013).

³¹ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012); 42 U.S.C. § 1396d(y)(1) (2012). While the language of the statute does not exclude minors from the expansion, the statute elsewhere assumes that children will participate not in the expansion but in the Children's Health Insurance Program, given that funding for the expansion is authorized only for individuals between age 19 and 64. See 42 U.S.C. § 1396d(y)(2)(A) (2012).

³² Letter from Douglas W. Elmendorf, Dir. of the Cong. Budget Office, to House Speaker Nancy Pelosi (March 20, 2010), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.

³³ *Id.* at tbl.4.

³⁴ The CBO estimated the Medicaid expansion would add \$434 billion to federal expenditures between 2010 and 2019, and subsidies and other expenses for expanding private coverage an additional \$464 billion. *Id.* More recent estimates that include a full ten year period in which both expansions will be in effect estimate \$710 billion in additional Medicaid costs and \$1,075 billion in additional costs for private coverage subsidies and related expenses. JESSICA BANTHIN & SARAH MASI, CONG. BUDGET OFFICE, CBO'S ESTIMATE OF THE NET BUDGETARY IMPACT OF THE AFFORDABLE CARE ACT'S HEALTH INSURANCE COVERAGE PROVISIONS HAS NOT CHANGED MUCH

cut of approximately 20% to Medicaid DSH funds over a seven-year period.³⁵ The DSH program was intended to provide additional support to hospitals that cared for a greater proportion of Medicaid and/or uninsured patients than the mean, in light of expected hospital payment reductions authorized by the Omnibus Budget Reconciliation Act of 1981.³⁶ President Obama and others justified the ACA's DSH reduction based on the improved access to health coverage that the ACA would afford.³⁷

The DSH program has been characterized as being "essential to the financial stability of safety net hospitals."³⁸ Indeed, DSH funds support not just care for Medicaid patients, but uncompensated care more broadly. Yet it is addressed specifically to hospitals, rather than to the individuals they serve.³⁹ States must designate a hospital as a disproportionate share hospital if it has a Medicaid inpatient utilization rate greater than one standard deviation above the mean rate for that state, or if its "low-income utilization rate" exceeds 25%.⁴⁰ Uncompensated care provided to the uninsured is expressly included as

OVER TIME (2013), available at <http://www.cbo.gov/publication/44176>.

35 Michael K. Gusmano & Frank J. Thompson, *Safety-Net Hospitals at a Crossroads: Whither Medicaid DSH?*, in THE HEALTH CARE "SAFETY NET" IN A POST-REFORM WORLD 172 (Mark A. Hall & Sara Rosenbaum eds., 2012) (indicating Medicaid DSH funding will be reduced by \$18 billion between 2014 and 2020). See also 42 U.S.C. § 1396r-4(f)(7)(A) (2012).

36 See RANDALL R. BOVBERG & JOHN HOLAHAN, MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES 63 (1982); *Medicaid Disproportionate Share Hospital (DSH) Payments*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html> (last visited Jan. 4, 2014).

37 See, e.g., Foon Rhee, *Obama Outlines Healthcare Savings*, BOSTON.COM (June 13, 2009, 06:00 AM), http://www.boston.com/news/politics/politicalintelligence/2009/06/obama_outlines_1.html ("As health reform phases in, the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered."). See also, e.g., *Saving Money with Reduced Disproportionate Share Hospital Allotments*, WHITEHOUSE.GOV, <http://www.whitehouse.gov/health-care-meeting/proposal/titleii/hospital-allotments> (last visited Jan. 4, 2014).

38 Richard Haugh, 'Massive Devastation' Feared from DSH, UPL, IME Cuts, 76 HOSP. & HEALTH NETWORKS, no. 6, 2002 at 39.

39 Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964 pmb1. (Sept. 30, 1981) (to be codified at 42 C.F.R. pt. 447). The House Report noted,

[There is] concern about the impact of State payment practices on hospitals that treat a large volume of Medicaid patients and patients without health insurance. The report notes that these hospitals, especially those in urban areas provide many public health and social services to residents of their areas, as well as serving as hospitals of last resort for the poor. As a result, these hospitals experience special costs. Meeting these costs is often difficult, since these hospitals also frequently receive only a small proportion of their overall revenues from non-public sources. The report states that, for these reasons, many of these hospitals are now and will continue to be financially distressed, and will experience special costs that States should take into consideration.

46 Fed. Reg. at 46,969-70.

40 42 U.S.C. §§ 1396r-4(b)(1), (4), (d) (2011) (indicating that such hospitals must additionally have at least two attending obstetricians who agree to provide obstetric services to Medicaid patients and also have a Medicaid inpatient utilization rate of at least 1%, unless they are children's

part of the low-income utilization rate.⁴¹ Hence, Medicaid DSH funds—funds that are counted as part of the program’s overall budget—help finance care for some populations who do not have Medicaid coverage, and who in fact might not qualify for Medicaid at all. Researchers at the Urban Institute estimate that more than 30% of hospital uncompensated care for uninsured patients nationwide is paid for by Medicaid supplemental payments.⁴²

Although DSH funds are important for many safety net hospitals, the program has suffered from poor oversight and accountability over the years. DSH funds do not compensate hospitals for the specific costs of care provided to an identifiable patient. Rather, a state, at its discretion, provides qualifying hospitals with one or more lump sums that need not total, but must not exceed, costs that qualify as “uncompensated care” costs under the statute.⁴³ No direct connection exists between the funds a hospital receives and the provision of care to an identifiable patient. Without such a connection, some hospitals have treated the funds as a windfall with which to make expenditures they might not have financed otherwise, such as new construction or the purchase of capital-intensive equipment.⁴⁴ While such spending might benefit the hospital, and by extension, perhaps, its low-income patients, it has little, if anything, to do with facilitating direct care for the underserved.

Spending DSH funds on matters unrelated to uncompensated health care has not been limited to hospitals. Oversight and accountability problems have also affected state-level use of DSH funds. In the earlier years of the program, many states reputedly used portions of the funds for purposes that had nothing to do with supporting health care services for the poor.⁴⁵

hospitals or do not offer nonemergency obstetric services).

41 42 U.S.C. § 1396r-4(b)(3)(B) (2011).

42 Jack Hadley, et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFF. W399, W402–05 (2008), available at <http://content.healthaffairs.org/content/27/5/w399.full.pdf+html> (discussing that of the medical care that uninsured people receive, more than one third of such care is paid for out of pocket. The definition of uncompensated care by these researchers is “care received but not paid for by either the uninsured themselves or by a health insurer.” The researchers adjust their estimates to account only for “new funding,” based on other research that shows a significant portion of DSH funds are not used to support patient care. They also do not count DSH payments received by mental hospitals, nursing homes, and some other providers and then they “adjust for the share of the state contribution that represents intergovernmental transfers and other financial transactions whose purpose is to increase federal matching dollars.”).

43 See Reporting Requirements, 42 C.F.R. §§ 447.299(c)(11), (15) (2012). See also Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904–01, 77904 (Dec. 19, 2008) (to be codified at 42 C.F.R. pt. 447) (“Under those hospital specific limits, a hospital’s DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients (‘uncompensated care costs’).”).

44 Leighton Ku & Teresa A. Coughlin, *Medicaid Disproportionate Share and Other Special Financing Programs*, 16 HEALTH CARE FIN. REV., Spring 1995, at 27, 39.

45 *Id.* at 41.

This is perhaps unsurprising, given some of the schemes that various states devised to maximize federal reimbursement using DSH funds. Senator David Durenberger described one program:

[T]he State adopted a tax—and I use that word with caution—on noninstitutional providers participating in Medicaid. The revenue from the tax precisely equals the State's share of costs for Medicaid. The State then will raise payments to the providers in an amount that again precisely equals the revenue derived from the tax. When the cost of the tax is subtracted from the increased Medicaid payment to the provider, the provider continues to receive the same payment that they had received prior to the imposition of the tax. The effect for the U.S. taxpayer is that the Federal Government pays 100 percent of the costs of this State's Medicaid budget.⁴⁶

In a 1995 study, Ku and Coughlin found that 17 of the 39 states in their study kept at least 50% of the funds they received through their DSH program, rather than passing them on to disproportionate share hospitals.⁴⁷ It was assumed that many of these funds were used for general revenue purposes rather than for the state's Medicaid program or subsidizing uncompensated care, but because of state variation and lack of oversight, no definitive determination could be made.⁴⁸ Thomas A. Scully, Associate Director of the Office of Management and Budget during the George H. W. Bush administration, observed that “[n]obody knew what happened to the money It wasn't good government. It was a disaster. It was money going out the back door when nobody was watching.”⁴⁹

Congress tightened controls on the program over the years through a series of legislation enacted in the 1990s and 2000s. In addition to capping total DSH allotments and restricting the forms and amounts of provider taxes and other contributions that states use to fund their DSH programs, Congress also instituted state reporting and audit requirements in 2003 that were intended to provide the information necessary to verify two issues: first, that states were properly determining the amount of uncompensated care each hospital was providing; and second, that the DSH payments states made to hospitals did not exceed each individual hospital's total uncompensated care costs.⁵⁰ Federal skepticism regarding the program nevertheless remained. In that regard, both George W. Bush administrations sought, notably, to obtain agreements from states seeking Section 1115 waivers to cap or otherwise limit their Medicaid

⁴⁶ 137 CONG. REC. 34,653–54 (1991) (statement of Sen. David Durenberger).

⁴⁷ Ku & Coughlin, *supra* note 44, at 42.

⁴⁸ See *id.* at 47; U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-94-133, MEDICAID: STATES USE ILLUSORY APPROACHES TO SHIFT PROGRAM COSTS TO FEDERAL GOVERNMENT 1-3 (1994), available at <http://archive.gao.gov/t2pbat2/152543.pdf>.

⁴⁹ Dan Morgan, *Small Provision Turns into a Golden Goose; States Used Subsidy to Balance Budgets*, WASHINGTON POST, Jan. 31, 1994, at A1.

⁵⁰ 42 U.S.C. §§ 1396r-4(j)(1), (2) (2012). The final rule on the DSH audit requirements was issued in 2008 and included a transition period through 2010. See *e.g.*, Merle Lenihan & Laura D. Hermer, *On the Uneasy Relationship between Medicaid and Charity Care*, 28 NOTRE DAME J.L. POL'Y & ETHICS (forthcoming 2014) (manuscript at 43).

supplemental payments.⁵¹ Some of these states separated the funds from general revenues by allocating them to “uncompensated care pools” (known in some states as “low income pools,” or “safety net care pools”), while others used alternative arrangements, often allocating the funds toward partial coverage expansion.⁵²

In their original form, uncompensated care pools allowed states to amass contributions broadly from hospitals to draw down federal DSH matching funds, and then redistribute the funds back to hospitals on the basis of uncompensated care costs.⁵³ As modified in several states under waivers from the Bush administration, they accomplished several additional purposes. First, uncompensated care pools allowed states to use DSH funds not merely to support hospitals’ uncompensated care costs, but also those of other providers, such as physicians, who normally would not be eligible to receive such payments.⁵⁴ In some cases, they offered a means for states transitioning to managed care to continue to receive what they would have received in UPL payments.⁵⁵ Also, in

51 This occurred in the broader context of a crackdown on “inappropriate” intergovernmental transfers, by which some states funded their share of Medicaid supplemental payments. *See, e.g.*, Kishan Kumar Putta, *States, Providers: No IGT Legislation This Year; CMS Must Issue Rule*, *INSIDE CMS*, June 17, 2004, at 1–2, available at 2004 WLNR 81125.

52 *See, e.g.*, Laura D. Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 *GEO. J. ON POVERTY L. & POL’Y* 405, 413 (2010) (noting that uncompensated care pools predate the George W. Bush administrations, but the number of states employing them expanded during Bush’s presidency). *See also, e.g.*, RANDALL R. BOVBERG, ET AL., *MARKET COMPETITION AND UNCOMPENSATED CARE POOLS I* (2000).

53 BOVBERG, *supra* note 52, at 3.

54 *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., No. II–W–00206/4, *MEDICAID REFORM SECTION III5 DEMONSTRATION 25* (2005), available at http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf (providing in relevant part that “Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.”).

55 Inpatient services: Application of Upper Payment Limits, 42 C.F.R. § 447.272(b)(2) (2012) (stating UPL payments are payments that a state receives from the federal government by paying a provider—often a public hospital—substantially more for Medicaid services than it otherwise would, potentially up to the “upper payment limit” set by federal rules). *See* Robert Mechanic, *Medicaid’s Disproportionate Share Hospital Program: Complex Structure, Critical Payments*, *NAT’L HEALTH POL’Y F.*, Sept. 14, 2004, at 9, available at http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf (noting, at that time, the state seeks federal matching funds for the payment. The provider, meanwhile, transfers back funds totaling much if not all of the “overpayment” to the state, often through an intergovernmental transfer.). *See, e.g.*, Teresa A. Coughlin, et al., *Restoring Fiscal Integrity to Medicaid Financing?*, 26 *HEALTH AFF.* 1469, 1470 (2007); Letter from Cindy Mann, Dir., Ctr. for Medicaid and CHIP Servs., to State Medicaid Dir. (March 18, 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf> (stating CMS recently started requiring states to disclose, among other matters, the source of

some cases, they permitted hospitals to use a small percentage of the funds for purposes other than uncompensated care.⁵⁶ In exchange for these concessions, the federal government received a new cap on the total amount of supplemental payments a state would claim.⁵⁷ In addition, the government, in certain cases, limited or ended some of the more controversial means by which some states raised funds for use in drawing down federal Medicaid supplemental payments.⁵⁸

While deeply problematic in other respects, the Bush administration's Section 1115 waiver policies included at least one theoretically laudable goal: to impel states to come up with a more transparent and organized plan for providing care to the uninsured using Medicaid DSH and other funds. Under its "Health Insurance Flexibility and Accountability" (HIFA) demonstration initiative, the administration "encourage[d] States to develop comprehensive insurance coverage for individuals with incomes up to twice the federal poverty level using Medicaid and SCHIP funds," and gave "States the flexibility to increase health insurance coverage through support of private group health coverage and simplifies the waiver application process."⁵⁹ Some states opted to use a portion of their DSH funds as part of a HIFA demonstration or other coverage expansion.⁶⁰

Congress acknowledged the latter strategy in the requirements it enacted to effectuate Medicaid DSH reductions under the ACA. Under the ACA, CMS must impose the largest percentage reductions on either (1) states with the lowest percentage of uninsured residents, or (2) those which fail to target their DSH payments to hospitals with high Medicaid inpatient and uncompensated care volumes.⁶¹ "Low DSH" states get a smaller reduction.⁶² Finally, CMS must "take[] into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under Section 1115 as of July 31, 2009."⁶³ In its discussion of the proposed

non-federal funding for their UPL payments.).

⁵⁶ See, e.g., Teresa A. Coughlin & Stephen Zuckerman, *State Responses to New Flexibility in Medicaid*, 86 MILBANK Q. 209, 213 (2008).

⁵⁷ *Id.*

⁵⁸ In the case of Iowa, for example, the state agreed to end its use of certain intergovernmental transfers and provider taxes as a condition of the IowaCare § 1115 waiver it received in 2007. See Letter from Leslie V. Norwalk, Acting Admin., Ctrs. for Medicare & Medicaid Servs., to Kevin Concannon, Dir., Iowa Dep't of Human Servs. (Apr. 26, 2007) available at <http://www.ime.state.ia.us/docs/IowaCareFinalPackage04262007.pdf>.

⁵⁹ *Innovative Health Care Options in Medicaid and the State Children's Health Insurance Program*, GEORGEWBUSH-WHITEHOUSE.ARCHIVES.GOV, <http://georgewbush-whitehouse.archives.gov/infocus/medicare/health-care/health-medicaid.html> (last visited Jan. 6, 2014).

⁶⁰ See, e.g., Hermer, *supra* note 52, at 413.

⁶¹ 42 U.S.C. § 1396r-4(f)(7)(B)(i) (2012).

⁶² 42 U.S.C. § 1396r-4(f)(5)(B) (2012) (discussing that Low DSH states are states whose DSH payments total only between 0 and 3% of their total Medicaid budget).

⁶³ 42 U.S.C. § 1396r-4(f)(7)(B)(iii) (2012).

regulations, CMS writes that,

[c]onsistent with the statute, for states that include DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration as of July 31, 2009, we propose to exclude from DSH allotment reduction, for the HMF [high volume of Medicaid inpatients factor] and the HUF [high volume of uncompensated care factor] ..., the amount of DSH allotment that each state currently continues to divert specifically for coverage expansion in the budget neutrality calculation. Amounts of DSH allotment included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction. Uncompensated care pools [UCPs] and safety net care pools [SNCPs] are considered noncoverage expansion purposes. For section 1115 demonstrations not approved as of July 31, 2009, any DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, under a later approval would also be subject to reduction.⁶⁴

In other words, the final rules will not protect *all* DSH funds that were included in a budget neutrality calculation under a Section 1115 waiver approved prior to August 1, 2009. Rather, a state must have expressly designated those funds for use in expanding coverage for them to be protected from reduction.⁶⁵

One might think such programs will no longer be relevant following the expansion of coverage under the ACA through the extension of Medicaid to all of the lowest-income Americans and the commencement of the coverage mandate in January 2014. But this is not the case. It is not merely that the Supreme Court ruling in *NFIB v. Sebelius* made the Medicaid expansion optional for states.⁶⁶ Rather, the ACA has never promised universal coverage. Even the Congressional Budget Office's most optimistic estimates never exceeded 92% coverage.⁶⁷ Approximately 30 million U.S. residents will remain uninsured after the ACA is fully implemented.⁶⁸ A majority of them will not

64 Medicaid Program; Disproportionate Share Hospital Payments, 78 Fed. Reg. 28551, 28558 (May 15, 2013) (to be codified at 42 C.F.R. pt. 447).

65 Funds in a safety net care pool or uncompensated care pool that are specifically designated toward coverage expansion rather than toward support of uncompensated care, capacity expansion, or other purposes, may be treated as protected. Such decisions will likely be made on a case-by-case basis. Telephone interview by Laura Hermer, Associate Professor, Hamline Univ. School of Law with Richard Strauss, Senior Financial Advisor, Financial Management Group, Center for Medicaid and CHIP Services (July 12, 2013) (more information on file with the author). According to an interpretation from the Congressional Research Service, Maine, Massachusetts, Wisconsin, and the District of Columbia would have a portion of their DSH funding protected from reduction. See MITCHELL, *supra* note 19, at 18. CMS plans to publish a technical guide that further elucidates the calculation of DSH funds used for a coverage expansion under a § 1115 waiver demonstration. See Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. at 57,293.

66 *Nat'l Fed'n of Ind. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012).

67 Letter from Douglas W. Elmendorf to Nancy Pelosi, *supra* note 32 (regarding the spending and the revenue effects of an amendment to H.R. 4872, the Reconciliation Act of 2010 tbl.4).

68 The CBO's estimate of the number of uninsured residents after the ACA's implementation totaled twenty-three million immediately before the ACA became law. Following the Supreme Court's decision, the CBO revised its estimate upward by seven million. CONGRESSIONAL BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT

be undocumented immigrants, but rather citizens or legal residents.⁶⁹ Most will lack independent means to pay for any more than the most basic health care.⁷⁰ Safety net providers, with their already-thin margins, will continue to need public support to provide health care to many of these individuals.⁷¹

Allocating hospitals and other institutional providers a lump sum to help make them whole for uncompensated costs, however, is an inadequate solution to the problem of uncompensated care for a number of reasons. From a policy standpoint, if DSH's goal is truly to fill the financial gap created by providing care to uninsured and/or Medicaid patients, the solution is to provide adequate coverage or compensation that follows the individual patient, rather than rely on a program focused on shoring up hospital finances. It is extraordinary that any other solution would be contemplated. The genesis of the problem is the health care needs of people. These needs, if left unmet, result in significant ills, not just to the individual in question,⁷² but to the individual's family,⁷³ employment and earnings,⁷⁴ and society in general.⁷⁵ These are the needs that our health care system is supposed to meet. Given the costs of the system, most people cannot afford to pay for much more than basic health care out of pocket.⁷⁶ Yet, rather than find a way to ensure that all residents of this nation

UPDATED FOR THE RECENT SUPREME COURT DECISION 13 (July 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>; Letter from Douglas W. Elmendorf to Nancy Pelosi, *supra* note 32, at 9.

69 See Letter from Douglas W. Elmendorf to Nancy Pelosi, *supra* note 32, at 9.

70 According to research by Buettgens and Hall, the median modified adjusted gross income (MAGI) of those who will remain uninsured after the major health insurance expansion provisions of the ACA go into effect in 2014 is only 130% of the federal poverty level. Matthew Buettgens & Mark A. Hall, *Who Will Be Uninsured After Health Insurance Reform?* 6 (Mar. 2011), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69624.

71 See, e.g., BRUCE SIEGEL, NAT'L ASS'N OF PUB. HOSP. AND HEALTH SYS., STATEMENT ON CMS PROPOSED RULE ON MEDICAID DSH REDUCTIONS (May 13, 2013), available at <http://www.naph.org/Main-Menu-Category/Newsroom/2013-Press-Releases/20130513-Medicaid-DSH.aspx?FT=.pdf>.

72 Jack Hadley, *Sicker and Poorer — the Consequences of Being Uninsured*, 60 MED. CARE RES. REV. 3S, 14S (2003) (finding forty-three out of fifty-one studies identified as examining the existence of a relationship between insurance or medical care use and improved health status reported a "significant and positive relationship").

73 *Id.* at 59S-60S (reporting on studies finding that where a family has a sick member, the caregiver's work and income are negatively affected). See also, e.g., INST. OF MED., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 69-76 (2003) (finding that health insurance coverage improves peace of mind and financial security for families and improves health outcomes for children).

74 Hadley, *supra* note 72, at 57S-60S (finding that poor health, in a variety of contexts, reduces annual income).

75 INSTITUTE OF MED., *supra* note 73, at 122 (finding, inter alia, that "[h]ealth insurance contributes essentially to obtaining the kind and quality of health care that can express the equality and dignity of every person").

76 Milliman estimated that, in 2012, health care costs for a family of four averaged over \$20,000. Christopher S. Girod, et al., 2013 *Milliman Medical Index*, MILLIMAN I (MAY 22, 2013),

can obtain necessary health care, this patchwork system of coverage will leave multiple gaps, even post-ACA. Medicaid is a crucial public coverage program, which, because of its costs and because it has a shifting, impoverished, and hence politically-weak constituency, provides reimbursement that falls far too short in most states as compared to all other major forms of coverage.⁷⁷ There remain tens of millions of residents who lack coverage altogether.⁷⁸ And yet the response is not to make these people whole, but rather to offer, through back-door means, billions in federal funds to states which, until quite recently, have been poorly traceable once they arrive in state coffers and have at times been divvied out to health care providers—when divvied out at all⁷⁹—on other bases than need or dessert.⁸⁰

In this system, states and institutional health care providers are at the center—not people. By emphasizing the needs of states and hospitals, rather than those of people who are uninsured or the recipients of cash-strapped public programs, the ostensible purpose of DSH is turned on its head. In the process, we fail to respect, and often also fail to assist, the very people whom DSH is supposed to help. If a state plays fair with its DSH funds, and hospitals in that state use the funds to support the provision of charitable care, then uninsured and Medicaid patients benefit.⁸¹ However, in those states that play “shenanigans” with funding, or give DSH funds to institutions with a weak or dubious charitable care mission, then the needs of lower income patients become an afterthought at best.⁸² It is true that federal law has gradually been

available at <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/mmi-2013.pdf>. The median household income in 2011, the most recent year available, was \$50,054.00. Carmen DeNavas-Walt et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, U.S. CENSUS BUREAU 5 (Sept. 2012), available at <http://www.census.gov/prod/2012pubs/p60-243.pdf>.

77 See, e.g., THE HENRY J. KAISER FAMILY FOUND., STATE HEALTH FACTS, MEDICAID-TO-MEDICARE FEE INDEX, <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/> (last visited Jan. 4, 2014).

78 DeNavas-Walt et al., *supra* note 76, at 21 (finding that, in 2011, 48.6 million Americans lacked health insurance).

79 Ku & Coughlin, *supra* note 44, at 27; GEN. ACCOUNTING OFFICE, GAO/HEHS-94-133, MEDICAID: STATES USE ILLUSORY APPROACHES TO SHIFT PROGRAM COSTS TO FEDERAL GOVERNMENT 14 (1994) (noting that the states they studied obtained “hundreds of millions” in federal Medicaid matching funds without putting up their own share, and that the federal government is not “required to verify that monies are used for the purpose for which they were obtained.”).

80 Lenihan & Hermer, *supra* note 50 (manuscript at 40).

81 See, e.g., Obaid S. Zaman et al., *America’s Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey 14* (May 2012), available at <http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx> (finding that nearly one quarter of the costs of the unreimbursed care of NAPH-member public hospitals were financed by Medicaid DSH funds).

82 See, e.g., Morgan, *supra* note 49 (“Some state officials conceded privately that their use of loopholes in the [DSH] program was a money-raising ‘scam.’ Truthfully, it was just raping the federal budget,” said Tennessee Gov. Ned Ray McWherter (D), whose own administration was particularly effective in maximizing federal Medicaid payments. . . . States could decide largely on their own which institutions qualified for the funds. The formulas used by some states allowed al-

playing catch-up with these excesses.⁸³ But even if the federal government ultimately managed to eradicate all the inappropriate uses that both states and institutions have made of DSH over the years, the program would still provide only an indirect solution to the problem it was created to address. A different strategy, one prioritizing individual coverage or care, should be implemented instead.

II. STATE PROGRAMS EXPANDING COVERAGE USING DSH FUNDS

A number of states have already sought and received federal waivers that allow them to use DSH funds to implement precisely such a strategy: instituting programs of individual coverage or care, rather than simply reimbursing hospitals for uncompensated care after the fact. Not all of these states, however, have been equally successful in ensuring that the targeted population receives comprehensive health care that is delivered as efficiently and seamlessly as possible. Some of the programs provide much more complete data than others regarding the program's enrollment, costs, health care quality, and outcomes. However, enough data exists regarding each to make a number of comparisons and draw some preliminary conclusions regarding the patient-centeredness of each.

A. Iowa

In 2005, Iowa sought and received a Section 1115 waiver to use Medicaid dollars to provide limited coverage to certain members of its population who were not otherwise eligible for Medicaid.⁸⁴ The waiver was not initially something the state sought independently.⁸⁵ Rather, it had its genesis through negotiations between the state and CMS as part of CMS's "crackdown" in 2004 on intergovernmental transfers (IGTs) between the state and public health care facilities. Iowa and a number of other states used IGTs to draw federal funding in excess of what they would receive if they were funded solely based on proper expenditures in their respective Medicaid programs.⁸⁶ Iowa, facing the likely

most every hospital to get some of the disproportionate share money, even those treating only small numbers of the poor. Moreover, the states could do what they wanted with the federal reimbursements that came in, because on paper the hospitals had already been paid.").

⁸³ See, e.g., Teresa A. Coughlin et al., *Restoring Fiscal Integrity to Medicaid Financing?*, 26 HEALTH AFF. 1469, 1478–79 (2007) (attributing "many of the changes we observed to recent federal efforts to step up oversight of [supplemental payment] programs").

⁸⁴ H. File 84I, 81st Gen. Assemb., Reg. Sess. (Iowa 2005).

⁸⁵ *Federal Official Hears Complaints About Medicaid Changes*, LIFE SCIENCE WEEKLY, Mar. 1, 2005.

⁸⁶ Iowa described the role of University of Iowa Hospitals and Clinics (UIHC) in drawing down additional federal funding as follows:

Since FY 93, the Iowa General Assembly has provided for supplemental disproportionate share and indirect medical education adjustments, comprised of

loss of over 16% of its total annual federal Medicaid funds, agreed to halt its use of specific IGTs⁸⁷ and expand its Medicaid program to adults between the age of 19 and 64 earning not more than 200% of the federal poverty level who are otherwise ineligible for Medicaid, in exchange for retaining most of the threatened loss of federal funding.⁸⁸ The repurposed funding was only partially

state and federal matching Medicaid dollars, payable only to the UI Hospitals and Clinics. This adjustment was created to generate payments back to the state equal to its appropriation for indigent patient care at the UI Hospitals and Clinics. UI Hospitals and Clinics payments back to the state are comprised of approximately 2/3rds federal dollars and 1/3rd state dollars. This leveraging mechanism would be lost if the indigent patient care appropriation was distributed to other non-state-owned hospitals.

UNIV. OF IOWA HOSP. & CLINICS, *Overview of the Indigent Patient Care Program* UNIV. OF IOWA HEALTH CARE 24 (Dec. 16, 2004), <http://www.regents.iowa.gov/Meetings/DocketMemos/04Memos/deco4/IndigentPatientCare.pdf>. Between 1992 and 2004, UIHC returned over four hundred and two million dollars in IGTs to the state of Iowa. *Id.* at 25.

In their unregulated form, IGTs permit a state to transfer funds to a public health care facility as payment for “Medicaid” services, whether in the form of disproportionate share payments or payments at a rate in excess of regular Medicaid rates under the upper payment limit. U.S. GEN. ACCOUNTING OFFICE, GAO-04-574T, *MEDICAID: INTERGOVERNMENTAL TRANSFERS HAVE FACILITATED STATE FINANCING SCHEMES 2* (2004), available at <http://www.gao.gov/new.items/do4574t.pdf>. The public health care facility then transfers most, if not all, of the funds back to the state. *Id.* At the same time, the state uses its Medicaid payment to the health care entity to draw down federal matching funds. *Id.* While many of these excesses were curbed by legislation in the 1990s and early 2000s, some states continued these practices in ways CMS found to be improper. *See id.* at 3. For example, local contributions to a state’s share of Medicaid funding in excess of 60% are not permitted. 42 C.F.R. § 433.53(b) (1993). With respect to DSH payments, states may not make DSH payments to qualifying health care entities in excess of the entity’s rate of uncompensated care. 42 U.S.C. § 1396r-4(g)(1)(A) (2012). Rather than go through the regular rulemaking process, CMS exerted pressure in 2004 and 2005 on states viewed as particular offenders, including Iowa, to stop using IGTs. *See, e.g.*, Kishan Kumar Putta, *Baucus Says Rulemaking or Legislation Needed for CMS IGT Crackdown*, INSIDE CMS, July 15, 2004, at 1, available at 2004 WLNR 81695.

87 *See, e.g.*, IOWA CODE ANN. § 249J.20 (West 2008), amended by 2010 Iowa Acts 512–13 (current version at IOWA CODE ANN. § 249J.21 (West Supp. 2013)) (“Payments, including graduate medical education payments, under the medical assistance program and the expansion population to each public hospital and each public nursing facility shall not exceed the actual medical assistance costs of each such facility reported on the Medicare hospital and hospital health care complex cost report submitted to the centers for Medicare and Medicaid services of the United States department of health and human services. Each public hospital and each public nursing facility shall retain one hundred percent of the medical assistance payments earned under state reimbursement rules.”); IOWA CODE ANN. § 249J.23 (West 2008), amended by 2010 Iowa Acts 513–15 (current version at IOWA CODE ANN. § 249J.24 (West Supp. 2013)) (“[M]oneys received as federal financial participation funds under the expansion population provisions of this chapter and credited to the account, moneys received for disproportionate share hospitals and credited to the account . . . shall be deposited in the [IowaCare] account,” and that “[t]he account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state.”).

88 IOWA CODE ANN. § 249J.5(1) (West 2008), amended by 2010 Iowa Acts 506–07 (current version at IOWA CODE ANN. § 249J.5 (West Supp. 2013)). The expansion also added, among a few other populations, women earning less than 300% of the federal poverty level and their newborns who are otherwise ineligible for Medicaid, provided their medical expenses, if subtracted from their income, would result in an income totaling not more than 200% of the federal poverty level. While they qualify only for obstetrical and newborn care, most may receive it from any Medicaid provider in the state. *Id.* § 249J.5(3).

co-extensive with DSH funding; the eliminated IGTs included not only some DSH—in this case, from the University of Iowa Hospitals and Clinics—but also some UPL and indirect medical education (IME) transfers. At the same time it left the majority of Iowa’s DSH funds intact and in traditional form.⁸⁹ In 2011, however, IowaCare was amended to include an uncompensated care pool as a repository for DSH funds used to defray specific forms of uncompensated care.⁹⁰

The IowaCare program replaced the state’s former indigent care or “State Papers” program, which afforded limited care to certain uninsured Iowans through the University of Iowa Hospitals and Clinics, and the Community Care Program through Broadlawns Medical Center.⁹¹ Previously, these programs together served approximately 14,000 people.⁹² Under IowaCare, the covered population increased. The program covered 25,204 people in its first year (2006), and by 2012 that number had increased to 61,918.⁹³ Program enrollment was kept in check both through inconvenience—during the first five years of the program, most care was offered only through UIHC in Iowa City and Broadlawns in Des Moines—and through permitting the state to

89 The four IGTs that were eliminated in the agreement were the Upper Payment Limit Transfer from Franklin Memorial Hospital, the Supplemental Disproportionate Share (DSH) Intergovernmental Transfer from the University of Iowa Hospitals and Clinics, the Supplemental Indirect Medical Education Transfer from the University of Iowa Hospitals and Clinics, and the Nursing Facility Upper Payment Limit Transfer from County Operated Nursing Facilities. See PROPOSED AGREEMENT BETWEEN IOWA AND CMS REGARDING INTERGOVERNMENTAL TRANSFERS AND RELATED ITEMS (DRAFT), IOWA GENERAL ASSEMBLY (Mar. 12, 2004), available at <http://staffweb.legis.state.ia.us/lfb/medicaid/Potential%20Basis%20IGT%20Discussions%20with%20CMS.pdf>.

90 The funds may be used to pay for certain uncovered services at Broadlawns; care coordination with respect to durable medical equipment, in-home health care, and rehabilitative services; and limited laboratory and radiological services are offered through federally qualified health centers. See, e.g., News Release, David A. Vaught, Auditor of State of Iowa, A Review of the IowaCare Program Administered by the Iowa Medicaid Enterprise Within the Department of Human Services 6 (Oct. 29, 2012), available at <http://auditor.iowa.gov/reports/1260-4010-BoPI.pdf>.

91 See, e.g., PATTY FUNARO, IOWA LEGIS. SERVS. AGENCY, LEGAL BACKGROUND BRIEFING ON IOWACARE PROGRAM 4 (Dec. 2006), available at <https://www.legis.iowa.gov/DOCS/Central/Guides/LBB/iowacare.pdf>.

92 *Id.*

93 Peter C. Damiano et al., *Evaluation of the Iowa Care Program: Baseline Information for the Medical Home Expansion*, IOWA RESEARCH ONLINE II (Oct. 1, 2011), [hereinafter Damiano, *Iowa Care Program: Baseline Information*] http://i.u.iowa.edu/ppc_health/75; *IowaCare Narrative*, IOWA DEP’T OF HUMAN SERVS. 3–39, [hereinafter *IowaCare Narrative*] http://www.dhs.state.ia.us/uploads/IowaCare_Narrative.pdf (last visited Jan. 4, 2014). According to Urban Institute researchers, the number of uninsured Iowans is 299,000, so about 17% of the uninsured are covered by IowaCare (taking into account that people covered by IowaCare would have been uninsured without the program and assuming that IowaCare enrollees are included in national data as among the insured.). JOHN HOLAHAN ET AL., THE KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS IO (Nov. 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>.

limit, close, or reduce enrollment if either state or federal funds fell short of demand.⁹⁴ Benefits include limited inpatient, outpatient, and physician and nurse practitioner services, as well as very limited dental services and pharmaceuticals.⁹⁵

Despite the limited benefits available through IowaCare, costs per enrollee are similar to those for non-aged, non-disabled Medicaid adults.⁹⁶ At the same time, at least some enrollees in IowaCare had to pay more money out-of-pocket for care than Medicaid recipients. Originally, enrollees were required to pay a monthly premium not to exceed one-twelfth of 5% of the enrollee's annual income, if the enrollee's income equaled or exceeded 100% of the federal poverty level, or one-twelfth of 2% if the enrollee's annual income did not exceed the federal poverty level.⁹⁷ In 2007, that requirement was removed for individuals earning less than the federal poverty level, and following renewal of the waiver in 2010, those earning 150% of the federal poverty level or less are no longer expected to pay a monthly premium, and those exceeding that income pay only up to one-twelfth of 5% of their annual income.⁹⁸

Peter Damiano and colleagues published reports evaluating IowaCare on behalf of the state in 2008 and 2011.⁹⁹ While they only occasionally included comparisons of their IowaCare survey outcomes to outcomes for Medicaid

94 IOWA CODE ANN. § 249J.7(1) (West 2008), amended by 2010 Iowa Acts 507 (current version at IOWA CODE ANN. § 249J.7 (West Supp. 2013)); IOWA CODE ANN. 249J.5(4) (West Supp. 2013). Six federally qualified health centers were added as medical home providers in the 2010 waiver renewal. CTBS FOR MEDICARE AND MEDICAID SERVS., No. II-W-00189/7, EXPENDITURE AUTHORITY 9-10 (2011), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/downloads/IowaCareCurrentApprovalDocuments.pdf>.

95 IOWA CODE ANN. § 249J.6(1) (West 2008), amended by 2010 Iowa Acts 506-07 (current version at IOWA CODE ANN. § 249J.6 (West Supp. 2013)).

96 IowaCare benefits are projected to cost \$2,640 per enrollee in 2013, whereas Medicaid benefits for adults in Iowa in 2010 averaged \$2,204. *IowaCare Narrative*, supra note 93, at 3-39; THE HENRY J. KAISER FAMILY FOUND., STATE HEALTH FACTS: MEDICAID PAYMENTS PER ENROLLEE, FY 2010, <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee-fy2009/?state=IA> (last visited Jan. 5, 2014). In this regard, the Iowa Department of Human Services observes that IowaCare enrollees tend to be less healthy than comparable Medicaid recipients. *IowaCare Narrative*, supra note 93, at 3-39. Additionally, while services provided by other facilities and outside providers are reimbursed pursuant to Medicaid rates, services provided through UIHC, through which approximately one-third of IowaCare enrollees receive services, are reimbursed at "100 percent of reasonable and allowable costs"—a rate which likely far exceeds the applicable Medicaid rates. IOWA ADMIN. CODE 1.441-92.9(2)-(3) (2013).

97 IOWA CODE ANN. § 249J.8(1) (West 2008), amended by 2007 Iowa Acts 914 (current version at IOWA CODE ANN. § 249J.8 (West Supp. 2013)).

98 IOWA CODE ANN. § 249J.8(1)-(2) (West Supp. 2013); see also IOWA DEP'T OF HUMAN SERVS., No. II-W-00189/7, IIS DEMONSTRATION WAIVER RENEWAL APPLICATION II (2010), available at <http://www.ime.state.ia.us/docs/IowaCareRenewalFinal100809.pdf>.

99 Damiano, *Iowa Care Program: Baseline Information*, supra note 93, at 11; Peter C. Damiano et al., *First Evaluation of the IowaCare Program*, IOWA RESEARCH ONLINE 9-10 (Dec. 3, 2008) [hereinafter Damiano, *First Evaluation of IowaCare*], <http://www.ime.state.ia.us/docs/FirstEvaluationoftheIowaCareProgramReportFINAL2008.pdf>.

recipients in the final report, they completed a survey using many of the same or similar measures on behalf of the state with respect to Iowa's Medicaid managed care program in 2009.¹⁰⁰ The results with respect to key comparable measures in the two studies show that both Medicaid fee-for-service and Medicaid managed care recipients reported being in somewhat better health, more satisfied with their care, and having greater ease of obtaining care than IowaCare enrollees. Although more Medicaid recipients reported having one or more chronic conditions (56%) than IowaCare enrollees (42%), more IowaCare enrollees reported that they were in "fair/poor" health (38%) than Medicaid recipients (20%).¹⁰¹ IowaCare enrollees reported less ability to get necessary care in a timely manner in comparison with both fee-for-service and Medicaid managed care recipients.¹⁰² Transportation problems were common in the IowaCare program, given the limited physical locations in which enrollees could obtain care.¹⁰³ Between 34% and 42% of enrollees who were unable to obtain care also reported that the plan's limited benefit package prevented them from obtaining needed tests or treatments.¹⁰⁴ Even more—up to 57%,¹⁰⁵ depending on location—could not obtain necessary care because they could not afford it, as compared to 32% of Medicaid recipients.¹⁰⁶ More than half of the 17% of enrollees who had to pay a premium after the 2010 amendments worried "somewhat" or "a great deal" about their ability to pay it.¹⁰⁷ Ninety-six percent of Medicaid recipients would "probably" or "definitely" recommend their plan to family or friends who needed coverage, as compared to 79% of IowaCare enrollees.¹⁰⁸ IowaCare enrollees frequently reported being grateful for their coverage in narrative comments on the survey, but the limited coverage and limited treatment locations were reportedly problematic for many

100 Peter C. Damiano et al., *Evaluation of Iowa's Medicaid Managed Care Program: The Consumer Perspective*, IOWA RESEARCH ONLINE 7 (Nov. 1, 2009) [hereinafter Damiano, *The Consumer Perspective*], http://ir.uiowa.edu/cgi/viewcontent.cgi?article=1046&context=ppc_health.

101 Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at 15; Damiano, *The Consumer Perspective*, *supra* note 100, at 30.

102 Only 53% of UIHC and 63% of "other" IowaCare enrollees could "always" or "usually" get care when they thought they needed it in 2010, as compared to 85% of Medicaid fee-for-service patients and 87% of Medicaid managed care recipients. Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at app. A; Damiano, *The Consumer Perspective*, *supra* note 100, at app. B, B-2. The IowaCare numbers were lower in 2010 than they were in 2007, when 67% of respondents could "always" or "usually" get such care. Damiano, *First Evaluation of IowaCare*, *supra* note 99, at app. A.

103 Between 21% and 59% of enrollees, depending on location of service, reported being unable to obtain care at least once in the preceding 6 months because of lack of transportation. Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at app. A, 9.

104 Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at app. A, 9.

105 *Id.*

106 Damiano, *The Consumer Perspective*, *supra* note 100, at app. B, B-4.

107 Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at 14.

108 *Id.* at 21.

of survey respondents.¹⁰⁹

Despite IowaCare's inferior results on certain key measures in comparison with Iowa's Medicaid program, and despite its scant benefits package and access issues, Iowa characterized IowaCare in its renewal application as "a bridge to the more comprehensive coverage that will be available through the Medicaid expansion beginning in 2014."¹¹⁰ The Supreme Court decision in *NFIB v. Sebelius* opened other options for Iowa, however. For some time, Republican Governor Terry Branstad sought to expand Medicaid to a limited number of Iowans through the creation of a new and even more expensive program based loosely on the Healthy Indiana Plan.¹¹¹ Fierce opposition in the Democrat-led Senate, however, led to the creation of a compromise plan that would use Federal Medicaid expansion funds to finance a plan, the "Health and Wellness Plan," which replaces IowaCare.¹¹² The plan will cover non-Medicaid eligible Iowans earning 100% of the federal poverty level or less, and leave those earning more than that eligible for coverage and subsidies through the health insurance exchange.¹¹³ Benefits will be similar to those offered to Iowa state employees through the employees' health plan, adjusted to additionally cover non-included essential health benefits under the ACA and wrap-around coverage for Medicaid prescription drug, dental, and habilitation services not

109 In one comment typical of its kind, a respondent wrote, "I have nothing to say but thank you for this great insurance that you offer to people like me that had never had a chance to a great ins. I'm grateful that IowaCare is in my life and I thank the very nice, polite and professional staff that make people feel welcomed. Thank you!" Damiano, *Iowa Care Program: Baseline Information*, *supra* note 93, at app. B, 33. Another respondent wrote, in a typical comment regarding treatment locations, that "Iowa City was just too far away (3 hrs) for regular checkups to control my diabetes, Waterloo about 1 hour away (much better). I am on Rx Outreach program but can't get my insulin and supplies through them. Have type 2 diabetes and gets very expensive. Local doctor has tried to get help for me for checkups (about 15 minutes away) but can't get this covered." *Id.* at 34. Yet another observed that "To qualify, debt should be considered, not just income. Our business failed, we went bankrupt, but none of that mattered. I had a heart attack, because I did not qualify for health insurance and did not get treatment for blood pressure and heart problems until after the heart attack. I am really upset with IowaCare requirements." *Id.* at 54.

110 IIIJ DEMONSTRATION WAIVER RENEWAL APPLICATION, *supra* note 98, at 22.

111 See, e.g., Press Release, Office of the Governor, The Healthy Iowa Plan (Mar. 4, 2013), available at <https://governor.iowa.gov/wp-content/uploads/2013/03/The-Healthy-Iowa-Plan.pdf>; Craig Robinson, *Branstad Health Care Proposal Is Modeled After Welfare Reform of 1990's*, THE IOWA REPUBLICAN (Mar. 4, 2013), <http://theiowarepublican.com/2013/branstad-health-care-proposal-is-modeled-after-welfare-reform-of-1990s/>. For information about the Healthy Indiana Plan, see *infra* Part II.2.

112 S.File. 446, Sec. 170, 85th Leg. (Iowa 2013) (to be codified at IOWA CODE § 249N.5); S.File. 446, Sec. 179, 85th Leg. (Iowa 2013) (to be codified at IOWA CODE § 249J.26).

113 *Id.* While all providers in the medical assistance (Medicaid) program are included in the health and wellness plan network, the plan requires plan members to choose a primary care provider and, if available, a medical home. *Id.* The authorizing legislation also incorporates Gov. Branstad's concept of using accountable care organizations for providing care. It does not, however, require their creation and use, but only permits them if such develop. *Id.*

otherwise included.¹¹⁴ Under the original legislation, plan members earning at least 50% of the federal poverty level would have been required to make monthly payments for their “membership” in the plan, as well as cost-sharing amounts not to exceed the limits set for exchange participation under the ACA.¹¹⁵ CMS, however, put further restrictions on Iowa’s imposition of premiums.¹¹⁶

B. Indiana

In contradistinction to Iowa’s creation of a new state plan using public hospitals and other public providers to extend limited care to certain uninsured Iowans, Indiana opted to use a substantial portion of its DSH funds, in addition to other funding, to offer private, high-deductible coverage to certain low-income, uninsured Indianans who did not otherwise qualify for Medicaid.¹¹⁷ The Healthy Indiana Plan (HIP) started in 2008, and is currently approved through December 31, 2014.¹¹⁸ It is available to no more than 36,500 childless Indianans and a presently uncapped number of “caretakers,” or parents with dependent children.¹¹⁹ Enrollees must be between the ages of 18 and 64, have

¹¹⁴ See 42 U.S.C. § 1396u-7(b)(1)(B) (2013); IOWA CODE ANN. § 249A.3(1)(v) (West 2013); S.File. 446, Sec. 171, 85th Leg. (Iowa 2013) (to be codified at IOWA CODE § 249N.6). The plan notably fails to cover non-emergency transportation coverage, by omission. See, e.g., Clay Masters, *Iowa Opens the Door to Medicaid Coverage, on Its Own Terms*, NPR (Dec. 26, 2013), available at <http://www.npr.org/blogs/health/2013/12/26/257374213/iowa-opens-the-doors-to-medicaid-coverage-on-its-own-terms>.

¹¹⁵ S.File. 446, Sec. 172, 85th Leg. (Iowa 2013) (to be codified at IOWA CODE § 249N.7). Contributions are waived, however, for members who “complete all required preventive care services and wellness activities,” to be specified in subsequent regulations. *Id.* Given Gov. Branstad’s interest in the Healthy Indiana Plan (HIP), it may be that Iowa’s requirements will resemble those of HIP. For more information on those requirements, see *infra* notes 118–27 and accompanying text.

¹¹⁶ For participants earning between 50% and 100% FPL, CMS will permit Iowa to impose premiums on nonexempt households, and only up to a maximum of \$5/month. CTRS. FOR MEDICARE & MEDICAID SERVS., II-W-00289/5, IOWA WELLNESS PLAN: SPECIAL TERMS AND CONDITIONS 7–8 (2013), available at http://www.dhs.state.ia.us/uploads/Iowa_Wellness_STCs_I2_30_I3%20Final.pdf.

¹¹⁷ CTRS. FOR MEDICARE & MEDICAID SERVS., No. II-W-00237/5, HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS 2 (2007) [hereinafter HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS], available at [http://www.in.gov/fssa/files/IN_-_Healthy_Indiana_Plan_\(HIP\).pdf](http://www.in.gov/fssa/files/IN_-_Healthy_Indiana_Plan_(HIP).pdf). The state allocated 40% of its disproportionate share hospital (DSH) funds to the program. See INDIANA FAMILY & SOC. SERVS. ADMIN., THE HEALTHY INDIANA PLAN: SECTION III5 AFFORDABLE CHOICES DEMONSTRATION PROPOSAL 41–42 (2007) [hereinafter HIP DEMONSTRATION PROPOSAL], available at <http://svcinc.org/PDF/Waiver22807.pdf>; THE HENRY J. KAISER FAMILY FOUND., FEDERAL MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS, <http://kff.org/medicaid/state-indicator/federal-dsh-allotments/> (last visited Jan. 5, 2014).

¹¹⁸ Letter from Cindy Mann, Dir., Ctrs. for Medicaid and CHIP Servs., to Debra Minott, Sec’y, Ind. Family and Soc. Servs. Admin. (Sept. 3, 2013), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-ca.pdf>.

¹¹⁹ CTRS. FOR MEDICARE & MEDICAID SERVS., No. II-W-00237/5, HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS 9–10 (2010), available at <http://www.medicaid.gov/Medicaid->

no access to employer-sponsored coverage, and earn less than 200% of the federal poverty level.¹²⁰ HIP's benefits package is much richer than IowaCare's; benefits include mental health care services, inpatient hospital services, prescription drug coverage, emergency room services, physician office services, diagnostic services, and outpatient services, including therapy services and comprehensive disease management, among others.¹²¹ However, benefits per enrollee are capped at \$300,000 annually, and \$1 million over an individual's life.¹²² Additionally, enrollees must have a health savings account in connection with HIP, which they must use to cover HIP's \$1,100 deductible.¹²³ The law currently requires enrollees to pay at least \$160 per year into the account, called a "personal wellness and responsibility" ("POWER") account, and must additionally pay between 2% and 5% of their income, up to a maximum of \$1,100.¹²⁴ The state makes up any shortfall.¹²⁵ If an enrollee fails to make his required POWER account contribution, he is dropped from the program and cannot reapply for a minimum of 12 months.¹²⁶ If an enrollee has a physical exam in the first year, and receives age- and gender-specific preventive care from a list of required services in subsequent years, then any balance remaining in the POWER account at the end of the year rolls over to the next.¹²⁷

The limited data regarding HIP that Indiana has allowed to be publicly released suggest that it may work reasonably well for the small number of Indianans who manage to obtain coverage under it. However, the state's reluctance to publicly disclose programmatic data known to exist is troubling,

CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-ar.pdf. The original cap was 34,000. *Id.* at 10. The number of childless adults covered under HIP as of May 31, 2013, is 12,137, with 52,931 on the waiting list. Debra Minott, Sec'y FSSA, Presentation to the Health Finance Commission: Update on Healthy Indiana Plan 2 (June 25, 2013), *available at* http://www.in.gov/legislative/senate_democrats/files/blog/HIP%20Update%20Helath%20Finance%206-25-2013.pdf.

120 IND. CODE ANN. § 12-15-44.2-9 (LexisNexis 2006). HIP is not an entitlement, and enrollment can be limited at the state's discretion. *Id.* § 44.2-8.

121 Additional benefits include home health services, including case management, urgent care center services, preventative care services, family planning services (excluding abortion services and related pharmaceuticals), hospice services, substance abuse services, and, following recent amendments, "a service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act." *Id.* § 44.2-4.

122 *Id.* § 44.2-6.

123 *Id.* §§ 44.2-10(a)-(c), 44.2-11(b)(2)(A).

124 *Id.* § 44.2-11(b)(2). CMS denied approval of the \$160 minimum payment provision, however, so that portion of the law remains currently ineffective. Letter from Cindy Mann, Dir., Ctrs. for Medicaid and CHIP Servs., to Michael Gargano, Sec'y, Ind. Family and Soc. Servs. Admin. (July 31, 2012), *available at* http://www.in.gov/aca/files/CMS_IN_Letter_7_31_12.pdf.

125 IND. CODE ANN. § 12-15-44.2-11(c) (LexisNexis 2006). Employers and non-profit organizations can also make contributions. *Id.* §§ 44.2-10(a)(2), (4).

126 *Id.* §§ 12-15-44.2-11(d), (e).

127 *See, e.g.,* SEEMA VERMA, HOW HIP WORKS II (2012), *available at* <http://gov.idaho.gov/priorities/pdf/Healthy%20Indiana%20Plan.pdf>.

and suggests that the positive results cited by the state may be the *only* positive results, and that the program may be performing disappointingly in other respects. In May 2013, only 37,316 out of an estimated 400,000 uninsured Indianans earning less than 138% of the federal poverty level were enrolled in HIP, which is far less than the 127,000 Indianans that the original waiver application contemplated covering, and far fewer even than expected given CMS's ultimate decision to cap covered childless adults (caretakers were left uncapped).¹²⁸ Indiana commissioned Mathematica to produce, among other services, a health outcome analysis based on a survey of HIP enrollees concerning recent history of health insurance coverage, overall health status, access to care, utilization of care, unmet health care needs and barriers to utilization of health care, satisfaction with HIP, knowledge about and use of POWER accounts, and demographic characteristics.¹²⁹ The report was submitted in 2011, but Indiana did not make it publicly available.¹³⁰ Instead, the state released data from both Mathematica and Milliman (a consulting firm the state hired to perform actuarial work related to the ACA) on the first two years of the program, and a state summarization of an unknown amount of the 2011 Mathematica report is also available.¹³¹

A 2010 Mathematica study evaluating the first two years of the program found that the majority of HIP enrollees are age 50 or older, and earn less than

128 HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS, *supra* note 117, at 10; HIP DEMONSTRATION PROPOSAL, *supra* note 117, att. 6 at 8; Debra Minott, *supra* note 119, at 2. There were 867,000 uninsured people in Indiana, so only about 4% of uninsured residents overall were covered by Healthy Indiana, assuming that people covered by Healthy Indiana would have been uninsured without the program and assuming that HIP enrollees are included in national data as among the insured. HOLAHAN ET AL., *supra* note 93, at 10.

129 IND. LEGISLATIVE SERVS. AGENCY, THE HEALTHY INDIANA PLAN AND COVERAGE OF CHILDLESS ADULTS ACROSS THE STATES 3-4 (2011), available at http://www.in.gov/legislative/publications/Healthy_Indiana_Plan.pdf.

130 E-mail from Carol Irvin, Senior Researcher, Mathematica Policy Research, to Laura Hermer, Assoc. Professor, Hamline Univ. Sch. of Law (July 16, 2013, 10:32 CST) (on file with the authors). One of us (Hermer) attempted to obtain a copy of the report from Indiana's Family and Social Services Administration. The state declined to provide it, and instead offered a draft of its 2010 Annual Report to CMS on the HIP waiver, in which some of the Mathematica report data is summarized. INDIANA FAMILY AND SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN DEMONSTRATION § III5 ANNUAL REPORT (Draft, 2011) [hereinafter HEALTHY INDIANA ANNUAL REPORT] (on file with the authors). The draft of the 2010 Annual Report indicates that additional data from Mathematica should be available for the final version of the 2010 Annual Report. *Id.* at 25, n.18. However, the final version of the report was not provided to us.

131 See ROB DAMLER, MILLIMAN, EXPERIENCE UNDER THE HEALTHY INDIANA PLAN: THE SHORT-TERM COST CHALLENGES OF EXPANDING COVERAGE TO THE UNINSURED I (2009); IND. FAMILY & SOC. SERVS. ADMIN., THE HEALTHY INDIANA PLAN: SECTION III5 WAIVER EXTENSION APPLICATION 6 (2013) [hereinafter HIP SECTION III5 WAIVER EXTENSION APPLICATION], available at <http://www.in.gov/fssa/hip/files/April22013HIPWaiverExtensionApp.pdf>; CAROL IRVIN, HEALTH FINANCE COMM'N, HEALTHY INDIANA PLAN: THE FIRST TWO YEARS 4, II (2010), available at http://www.mathematica-rnr.com/publications/redirect_PubsDB.asp?strSite=PDFs/health/healthyIndiana_Irvin.pdf.

the federal poverty level.¹³² The number of enrollees with one or more chronic diseases is high, but less than the results found in the IowaCare program: between 28% and 38%, depending on the condition.¹³³ Ten percent of HIP enrollees lost coverage due to failure to make their required contribution to their POWER account.¹³⁴ Indiana reports, in its 2013 waiver renewal application, that “[o]ver 12 months of enrollment, on average HIP enrollees show a 14.8% decline in non-emergent [emergency department] use and a 25% increase in physician office visits.”¹³⁵ Again according to Indiana’s summarization of data from the 2011 Mathematica report (that the state has not publicly released), 70% of enrollees “indicated that the monthly contribution was just the right amount and something they could afford.”¹³⁶ Additionally, a smaller percentage of HIP enrollees who were required to pay into their POWER account reportedly used the emergency department for non-emergent care (25%), as compared with HIP enrollees whose earnings were too low at the time of the study to be required to make any payment (34%).¹³⁷ The reason for this finding is unknown, but the state suggests it is because enrollees who pay into their POWER accounts have more “skin in the game,” and thus make thriftier decisions in their consumption of health care.¹³⁸ This makes only questionable sense, however, given that HIP enrollees who make non-emergent use of the emergency department must pay a co-payment ranging from \$3 to \$25 for non-emergent use of the emergency department, yet cannot use any funds from their POWER account for this purpose.¹³⁹

HIP has proved to be far more expensive than the state contemplated, much more so than it would have been to have simply provided Medicaid coverage for the same population. Between January and August 2009, an average HIP non-caretaker enrollee who did not have a specified, high-cost health condition cost the state \$412.54/month, and one that did—and hence was put into the Enhanced Services Plan (ESP)—cost \$1007.02/month.¹⁴⁰ Yet, comparable

132 IRVIN, *supra* note 131, at 16–17.

133 *Id.* at 19.

134 *Id.* at 25.

135 HIP SECTION III5 WAIVER EXTENSION APPLICATION, *supra* note 131, at 19.

136 *Id.*

137 *Id.* at 19–20. Prior to the 2010 amendments, the most impoverished HIP enrollees were not required to make any payment to their POWER accounts. *See, e.g., id.* at 19 (observing that, during a period when there was no minimum contribution requirement, approximately 20% of HIP enrollees were not required to pay any POWER account contribution).

138 *Hearing on the Need for Medicaid Reform: A State Perspective Before the H. Comm. on Energy and Commerce & the S. Comm. on Health*, 113th Cong. 4 (2013) (statement of Seema Verma, President, SVC, Inc.); HIP SECTION III5 WAIVER EXTENSION APPLICATION, *supra* note 131, at 6, 22.

139 *Id.* at 8.

140 IND. OFFICE OF MEDICAID POLICY & PLANNING, IND. FAMILY & SOC. SERVS. ADMIN., QUARTERLY FINANCIAL REVIEW 7 (Aug. 2009) [hereinafter AUG. 2009 QUARTERLY FINANCIAL REVIEW] (unpublished report) (on file with author). *See also* Hermer, *supra* note 52, at 420 (“It is difficult to justify spending so much more for HIP coverage than it would cost to provide comparably

Medicaid recipients cost only an average of \$350.31/month.¹⁴¹ Since then, the disparities in cost have grown. For example, between January and December of 2011, the most recent year in which the state publicly released data breaking down Medicaid and HIP per capita expenditures separately for the entire year, HIP caretakers cost \$415.79/month and ESP enrollees cost \$2,436.81/month, whereas a comparable Medicaid recipient cost only \$293.48/month.¹⁴² HIP's more generous physician reimbursement almost certainly accounts for some of the discrepancy between the costs of HIP and Medicaid, especially given that average physician reimbursement rates for Indiana's Medicaid program are only about 62% those of HIP.¹⁴³ However, this does not account for the full disparity, particularly considering that the pool of comparable Medicaid recipients also includes those with the same high-cost health conditions who are segregated into the separate and much more costly ESP group in HIP.

Indiana safety net hospitals may also fare worse under HIP. On the one hand, a legislative report found that, in aggregate, Indiana hospitals received about \$7 million more in HIP funds than they would have in DSH funds, had HIP not gone into effect.¹⁴⁴ However, the report also found that the hospitals receiving business from HIP were not identical to the ones that would have received DSH funds.¹⁴⁵ Over half of the hospitals receiving reimbursement from HIP received no DSH payment in 2009.¹⁴⁶ Some of the hospitals were even located outside of the state.¹⁴⁷ Yet about \$151 million of Indiana's approximately \$215 million annual DSH allotment has gone to fund HIP—moneys that otherwise are intended to help support care for uninsured and low income populations at Indiana's safety net hospitals.¹⁴⁸ It would be one thing if a substantial portion

more generous benefits under Medicaid...”).

141 AUG. 2009 QUARTERLY FINANCIAL REVIEW, *supra* note 140, at 7 (referring to risk-based managed care).

142 IND. OFFICE OF MEDICAID POLICY & PLANNING, IND. FAMILY & SOC. SERVS. ADMIN., QUARTERLY FINANCIAL REVIEW 13 (Dec. 2011), available at http://www.in.gov/fssa/files/December_2011_OMPP_QFR_FINAL.pdf.

143 Indiana's physician fees for all services represents 62%, with primary care fees at 55%, obstetric care at 78%, and other services listed at 69%. THE HENRY J. KAISER FAMILY FOUND., MEDICAID-TO-MEDICARE FEE INDEX, <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?state=IN> (last visited Jan. 5, 2014).

144 HEALTH FIN. COMM'N, IND. LEGISLATIVE SERVS. AGENCY, ISSUES CONCERNING HOSPITAL SUPPLEMENTAL PAYMENT PROGRAMS UNDER THE OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES 22 (July 2010), available at <http://www.in.gov/legislative/publications/2010%20Issues%20Concerning%20Hospital%20Supplemental%20Payments%20Programs.pdf>.

145 *Id.* at 31.

146 *Id.* at 23.

147 *Id.* at 22.

148 HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS, *supra* note 117, at 31; E-mail from Brian Tabor, Vice President of Gov't Relations, Ind. Hosp. Ass'n, to Laura Hermer, Assoc. Professor of Law, Hamline Univ. Sch. of Law (July 8, 2013) (on file with author). See also Thomas B. Langhorne, *With Loss of Funds Projected, Indiana Hospitals Pray for Medicaid Expansion*, EVANSVILLE COURIER & PRESS, June 22, 2013, available at <http://www.courierpress.com/>

of Indiana's uninsured population could obtain coverage through HIP, but this is not the case. HIP covers only approximately 5% of Indiana's total uninsured population.¹⁴⁹ The remaining uninsured population still needs medical care, yet some hospitals receive fewer DSH funds to support unreimbursed services.

Indiana has requested permission from CMS to use HIP as its vehicle for expanding Medicaid. Without that permission, Governor Mike Pence has vowed not to expand Medicaid at all.¹⁵⁰ If CMS approves HIP as Indiana's vehicle for expanding Medicaid, Indiana has proposed to no longer count DSH funds toward HIP funding.¹⁵¹ The state observed, by way of explanation, that because those eligible for enrollment in HIP will be eligible for Medicaid starting in 2014, they should no longer be needed to be counted as a "waiver" population for the purpose of calculating budget neutrality. In other words, the state wants to be released from having to make up funds elsewhere in its Medicaid program to pay for the population it wants to cover via HIP.¹⁵² If the waiver is approved, and if Indiana additionally obtains permission to not use any of its DSH funds towards HIP, then the full sum of Indiana's DSH funds will be subject to reduction under the ACA. Milliman, the actuarial firm, projects that it will be slightly *less* expensive to expand Medicaid using HIP than Indiana's Medicaid program.¹⁵³ Milliman explains that, although HIP's provider reimbursement rates are greater, HIP's benefit package is less rich than Medicaid, and that HIP—unlike Medicaid—has both annual and

news/2013/jun/22/no-headline—hospitals2/?print=1 (discussing the expected loss of Medicaid DSH payments under the Affordable Care Act); HIP DEMONSTRATION PROPOSAL, *supra* note 117, at 9 (explaining that Indiana requested Medicaid § 1115 authority to redirect DSH payments from inpatient hospital care for the uninsured to instead pay for health coverage); FEDERAL MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS, *supra* note 117.

149 HIP presently covers fewer than 40,000 Indianans, yet Indiana's uninsured population in 2011, the most recent year for which figures are readily available, was 809,900. See THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, <http://kff.org/other/state-indicator/total-population/?state=IN> (last visited Jan. 6, 2014).

150 See, e.g., Langhorne, *supra* note 148, at 3; Rick Seltzer, *Hoosiers & Health Care: Consumers Facing Changes, Choices Starting This Fall*, HERALD-TIMES (Bloomington, Ind.), June 28, 2013, available at <http://insuranceneedsnet.com/oarticle/2013/06/28/hoosiers-health-care-consumers-facing-changes-choices-starting-this-fall-%5bhc-a-385786.html#U1VbhRbpzll>.

151 The original HIP demonstration project included a budget neutrality agreement that diverted DSH funding. See HIP SECTION 1115 WAIVER EXTENSION APPLICATION, *supra* note 131, at 30.

152 *Id.*

153 They claim this, despite programmatic experience consistently showing that per member per month (PMPM) rates for HIP are higher than PMPM for comparable Medicaid groups. See *supra* notes 140–42 and accompanying text. See also Letter from Robert M. Damler, Principal and Consulting Actuary, Milliman, to Michael Gargano, Sec'y, Ind. Family and Soc. Servs. Admin. (Sept. 18, 2012), available at http://www.in.gov/aca/files/ACA_Fiscal_Impact_Update_9.2012.pdf (providing an executive summary of the enrollment and fiscal impact associated with the ACA). Interestingly, CMS accepted similar claims in its renewal of HIP in 2011. See HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS, *supra* note 117, at 35–38.

lifetime limits.¹⁵⁴ Additionally, and while cautioning that the difference may be “nominal,” Milliman goes on to state:

[T]he Healthy Indiana Plan was developed based upon the concept of personal responsibility. The personal responsibility is associated with two key concepts: (1) self-pay contributions to the POWER account and (2) incentives / rewards related to the POWER account and use of preventive care services. These concepts of personal responsibility are not found in the Medicaid state plan program for the parent population, which requires few copayments for use of services. As identified in independent analyses from Mathematica, individuals that have a required POWER account contribution utilized services in a more efficient manner than those without a POWER account contribution

Due to the presence of the POWER account, we would expect that the overall health care costs to be lower under the Healthy Indiana Plan benefit design as compared to the current Medicaid state plan benefit package.¹⁵⁵

If CMS grants Indiana’s request, it will remain to be seen whether these assumptions prove to be correct, or if expenses for HIP will be far greater than originally anticipated, as they have been to date.

C. Massachusetts

The MassHealth Section 1115 demonstration has evolved over its 16 years into a fundamental cornerstone of Massachusetts’ near-universal coverage of its residents. From its inception in 1997, a key focus of MassHealth—Massachusetts’ Medicaid program—has been the expansion of eligibility.¹⁵⁶ Today, MassHealth provides coverage to one-fifth of the state’s population.¹⁵⁷ Initially, the waiver’s funding supported not only MassHealth, but also Commonwealth Care, a program that subsidized private coverage for certain lower-income adults. These programs, in conjunction with other forms of coverage and the state’s other health reform efforts, resulted in the coverage of 97% of Massachusetts’ residents in 2011.¹⁵⁸

¹⁵⁴ Letter from Robert M. Damler, Principal and Consulting Actuary, Milliman, to Patricia Casanova, Dir., Office of Medicaid Policy & Planning, Family & Soc. Servs. Admin. (Feb. 25, 2013), available at http://www.in.gov/aca/files/Healthy_Indiana_Plan_Benefit_Relativities.pdf (noting that the Healthy Indiana Plan does not include, *inter alia*, coverage for maternity services, or vision and dental services).

¹⁵⁵ *Id.*

¹⁵⁶ See, e.g., THE BLUE RIBBON COMM’N ON HEALTH CARE: MEDICAID EXPANSION WORKING GRP., SUMMARY OF FINDINGS AND RECOMMENDATIONS ON THE MASSHEALTH MEDICAID EXPANSION 3 (1995) [hereinafter BLUE RIBBON COMM’N], available at <http://archives.lib.state.ma.us/bitstream/handle/2452/49338/ocm33130222.pdf>.

¹⁵⁷ A study published by the Kaiser Foundation shows that Medicaid covered 20% of Massachusetts’ population in 2011. HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, *supra* note 149.

¹⁵⁸ DIVISION OF HEALTH CARE FIN. AND POLICY, MASSACHUSETTS HOUSEHOLD AND EMPLOYER INSURANCE SURVEYS: RESULTS FROM 2011 2 (Ctr. for Health Info. and Analysis 2013), available at <http://www.mass.gov/chia/docs/r/pubs/13/mhisreport-1-29-13.pdf> (“The state continues to have the highest health insurance coverage rates in the nation.”).

Massachusetts accomplished this significant achievement in part by seeking to streamline access, making it easier for residents to obtain coverage. Thus, for example, one of the state's preliminary goals in instituting MassHealth was to smooth eligibility levels across different categories of Medicaid recipients.¹⁵⁹ A Blue Ribbon Commission charged with making recommendations on expanding Medicaid in 1995 suggested raising the income limits for certain categories of Medicaid recipients “to make it easier for all members of a family to become eligible for Medicaid,” as well as “to reduce the likelihood that modest changes in income or administrative paperwork would result in periods of uninsurance.”¹⁶⁰ That goal remains one that the state has continued to stress throughout the duration of the waiver.¹⁶¹

In 2006, Massachusetts enacted legislation intended to expand coverage to nearly all its residents. DSH played an integral role in this effort: according to John McDonough, the Bush administration threatened to pull the state's \$350 million in annual DSH funds when it considered the state's waiver renewal request for MassHealth.¹⁶² In order to keep the DSH funds, Massachusetts had to reallocate some of those funds toward subsidies for certain lower-income, uninsured Massachusetts residents to purchase coverage through Commonwealth Care.¹⁶³ While MassHealth covers traditional categories of Medicaid beneficiaries up to 133% of the federal poverty level (or greater, in the case of disabled individuals, pregnant women, and children), most non-elderly, non-disabled, non-pregnant adults did not qualify prior to the 2006 reforms.¹⁶⁴ Commonwealth Care was developed for these individuals.¹⁶⁵ Adults

159 BLUE RIBBON COMM'N, *supra* note 156, at 3.

160 *Id.*

161 *See, e.g.*, OFFICE OF MEDICAID, EXEC. OFFICE OF HEALTH AND HUMAN SERVS., SECTION III5 DEMONSTRATION AMENDMENT 4 (2013), *available at* <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/iii5-demonstration-amendment-request-6-4-13.pdf> (outlining proposals “intended both to conform to the changes under the ACA and to support the Commonwealth's ability to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration.”).

162 JOHN E. McDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 39 (2011).

163 *Id.* (describing then-Governor Romney's and Senator Kennedy's key roles in developing a plan to keep federal dollars coming in).

164 MASS. MEDICAID POL'Y INST, CTR. FOR HEALTH LAW AND ECON. & UNIV. OF MASS. MED. SCH., *MASSHEALTH: THE BASICS* 5 (2012), *available at* <http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf>. In addition to traditional Medicaid categories, MassHealth also covers individuals who have been unemployed long-term. *Id.*

165 MassHealth covered 895,000 residents in 2011, as compared with Commonwealth Care, which covered 175,000. BLUE CROSS BLUE SHIELD OF MASS. FOUND., *HEALTH REFORM IN MASSACHUSETTS EXPANDING ACCESS TO HEALTH INSURANCE COVERAGE: ASSESSING THE RESULTS* 8 (2013), *available at* http://bluecrossmafoundation.org/sites/default/files/download/publication/Monitoring%20MA%20Reform%20March%202013_o.pdf. The total number of uninsured people in Massachusetts in 2012 was 224,000 so Commonwealth Care covered 44% of the would-be uninsured in the state (taking into account that people covered by Commonwealth Care would have

who did not have access to employer-sponsored coverage,¹⁶⁶ did not qualify for MassHealth or other government-sponsored coverage programs, and earned less than 300% of the federal poverty level were able to choose¹⁶⁷ a health plan from among a variety of Medicaid managed care plans available in the Commonwealth Care program.¹⁶⁸ The state subsidized premiums and copayments, and offered hardship waivers for enrollees facing difficult financial circumstances.¹⁶⁹ While state regulations provided that plans should encourage appropriate utilization through affordable copayments, the state prohibited plans from requiring recipients to meet a deductible.¹⁷⁰ The state's Medicaid program performed eligibility determinations for Commonwealth Care.¹⁷¹

The state subsidy amount for Commonwealth Care was paid for in part through the state Safety Net Care Pool (SNCP), into which the state's DSH dollars are put as a condition of the MassHealth waiver.¹⁷² The SNCP was capped at \$4.4 billion over the life of the current waiver, from December 2011 through June 2014.¹⁷³ Just over \$1 billion of those funds were designated to fund Commonwealth Care subsidies during the current waiver period.¹⁷⁴ The remainder of the funds needed to finance the program, which Governor Deval Patrick estimated to cost \$737.1 million in 2013, were obtained through an

been uninsured without the program). See *HOLAHAN ET. AL.*, *supra* note 93, at 10.

166 Employer-sponsored coverage can be defined, more specifically, to include employer-sponsored coverage in which the employer pays for at least 20% of the annual premium for family coverage or 33% of the premium for individual coverage. 956 MASS. CODE REGS. 3.09(1)(c) (LexisNexis 2013).

167 Individuals earning less than 100% of the federal poverty level, and hence who owe neither premiums nor copayments under Commonwealth Care, will be automatically assigned a plan if they fail to choose one within a specified period of time of not less than 90 days. 956 MASS. CODE REGS. 3.11(1), (2) (LexisNexis 2013).

168 956 MASS. CODE REGS. 3.09(1) (LexisNexis 2013). Only Medicaid managed care organizations (MMCOs) may offer a plan through Commonwealth Care. 956 Mass. Code Regs. 2.06(1) (LexisNexis 2013).

169 956 MASS. CODE REGS. 3.12(4), (7), (8) (LexisNexis 2013)

170 956 MASS. CODE REGS. 2.06(1)(a)(2) (LexisNexis 2013). Premiums and copayments were waived for individuals who earn less than 100% of the federal poverty level. For those earning between 100 and 150% of the federal poverty level, one of the five plans offered required no premium from enrollees; the others cost between \$3 to \$28 per month. Monthly premiums increased for those earning more. See *Commonwealth Care Monthly Premiums*, MASS. HEALTH CONNECTOR (on file with author).

171 STEPHANIE CHROBAK, *MEDICAID MANAGED CARE CONG., HEALTH CONNECTOR, OVERVIEW OF THE MASSACHUSETTS HEALTH CONNECTOR AND HEALTH REFORM 8* (2011), available at http://www.iirusa.com/upload/wysiwyg/New%20Media/MMCCPres_o60911.pdf.

172 CTRS. FOR MEDICARE & MEDICAID SERVS., *NO. II-W-00030/1, SPECIAL TERMS AND CONDITIONS, MASSHEALTH MEDICAID SECTION III5 DEMONSTRATION 48* (2011), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/III5/downloads/ma/ma-masshealth-ca.pdf>.

173 *Id.* at 58.

174 *Id.* at 102.

increased cigarette tax and other fees.¹⁷⁵ Commonwealth Care coverage cost an average of \$374.80 per member per month (PMPM) in 2013, of which enrollees paid between \$0 and \$116, depending on their income.¹⁷⁶ Costs were initially much higher, and declined since 2010.¹⁷⁷ Nevertheless, they were still much greater than those for non-elderly, non-disabled adults in MassHealth. That group cost only about \$263 PMPM in 2010, despite the fact that the plans participating in Commonwealth Care were identical to those participating in MassHealth.¹⁷⁸ While medical inflation undoubtedly accounts for some of the discrepancy, the difference is otherwise unexplained.¹⁷⁹

Most enrollees reported high satisfaction with Commonwealth Care generally, as well as with individual features of their respective plans. General enrollee satisfaction appeared to be higher in Commonwealth Care than it is for enrollees in IowaCare or the Healthy Indiana Plan. While satisfaction was lower in 2012 (77% either “satisfied” or “extremely satisfied”), over 30% of enrollees were “satisfied” with Commonwealth Care in 2011 and 2013, and more than half were “extremely satisfied.”¹⁸⁰ Over 80% rated their plan and provider choice as “good,” “very good,” or “excellent” in the three surveyed years, and over 85% rated their quality of care accordingly.¹⁸¹ The available statistics for Commonwealth Care generally show that enrollees were more comfortable with the amount they need to pay for the program than enrollees in both Iowa’s and Indiana’s expansion programs. Eighty-three percent of enrollees found the amount they were charged for premiums to be reasonable, a nearly 20%

175 JOHN KASPRAK, OLR RESEARCH REPORT MASSACHUSETTS HEALTH CARE LEGISLATION (2010), available at <http://www.cga.ct.gov/2010/rpt/2010-R-0277.htm>; *Summary of Fiscal Year 2013 Budget*, OFFICE OF THE GOVERNOR, http://www.mass.gov/bb/hi/fy13hi/exec_13/hdefault.htm (last visited Jan. 6, 2014).

176 DANIEL APICELLA, MASS. HEALTH CONNECTOR, COMMONWEALTH CARE FY 2014 RENEWAL 3 (2013), available at <https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2013/2013-02-14/CommCareFY2014Renewal.pdf>.

177 MASS. DIV. OF HEALTH CARE FIN. AND POLICY, HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS, FEBRUARY 2011 EDITION 21 (2011), available at <http://www.mass.gov/chia/docs/r/pubs/11/2011-key-indicators-february.pdf>. See also APICELLA, *supra* note 176, at 3.

178 See STATE HEALTH FACTS: MEDICAID PAYMENTS PER ENROLLEE, FY2010, *supra* note 96.

179 See, e.g., ROBERT SEIFERT & STEPHANIE ANTHONY, MASS. MEDICAID POLICY INSTITUTE, THE BASICS OF MASSHEALTH 3 (2011), available at https://www.umassmed.edu/uploadedFiles/CWM_CHLE/Included_Content/Right_Column_Content/MassHealth%20Basics%202011-FINAL.pdf (noting that per-member spending in MassHealth has increased annually at a rate of 1.1% from 2005 to 2010). It is possible that pent-up health care need could account for some of the difference, particularly given that the PMPM costs for Commonwealth Care were initially much higher and have declined over time. See APICELLA, *supra*, note 176, at 3.

180 JEN BULLOCK ET AL., MASS. HEALTH CONNECTOR, COMMONWEALTH CARE MEMBER SURVEY AND CONTRACT RENEWALS 6 (2013), available at <https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2013/2013-04-11/CommCareMemberSurveyContractRenewals.pdf>.

181 *Id.* at 7.

increase from 2011.¹⁸² However, the survey found increased problems with both coverage retention and ease of application between 2011 and 2013.¹⁸³ As a result of problems the survey identified, Commonwealth Care proposed improving communication with enrollees concerning renewal, creating an online application, and enhancing consumer support.¹⁸⁴

The Urban Institute surveyed Massachusetts residents generally concerning their health care experiences. While the results are not broken down by coverage form, they are distinguished by income level, which can act as a rudimentary proxy for type of coverage in this context. Lower-income adults, or adults earning less than the Commonwealth Care cutoff of 300% of the federal poverty level, were more likely than higher-income adults to report having problems paying medical bills (26% versus 11%).¹⁸⁵ Twenty-three percent of lower-income adults reported having medical debt, in comparison with 18% of higher-income adults.¹⁸⁶ Nearly one in five lower-income adults reported foregoing necessary health care because of costs, as compared with nearly one in ten higher-income adults.¹⁸⁷ Nevertheless, lower-income adults generally were 3.2% less likely to forego necessary care in 2010 than they were in 2006, prior to the implementation of Massachusetts' health reform.¹⁸⁸

Compared with Healthy Indiana Plan enrollees, the reduction in non-emergent use of the emergency room in Massachusetts was not as great as that reported for certain HIP enrollees.¹⁸⁹ Comparable data for usual source of care is not available; however, while Commonwealth Care enrollees were 5.7% more likely to have a usual source of care than they were before Commonwealth Care started, HIP enrollees reported both improved access to care and a decline

182 *Id.* at 8.

183 Twenty-nine percent of enrollees lost coverage at some point after obtaining Commonwealth Care in 2013, up from 20% in 2011. Of that group, 14% lost coverage due to failure to pay their premiums. *Id.* at 12.

184 *Id.* at 14-15.

185 SHARON K. LONG ET AL., HEALTH REFORM IN MASSACHUSETTS AS OF FALL 2010: GETTING READY FOR THE AFFORDABLE CARE ACT AND ADDRESSING AFFORDABILITY 47 (2012), available at <http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf>. This compares favorably to one national study by the Centers for Disease Control and Prevention, which found that, in the first six months of 2012, 30% of the poor (less than 100% of the federal poverty level), 34 percent of the near-poor (100% - 199% of the federal poverty level), and 14% of the non-poor (200% or more of the federal poverty level) reported trouble paying medical bills. ROBIN A. COHEN ET AL., PROBLEMS PAYING MEDICAL BILLS: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY 2011-JUNE 2012 4 (2013), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/problems_paying_medical_bills_january_2011-june_2012.pdf.

186 LONG ET AL., *supra* note 185, at 48.

187 *Id.*

188 *Id.* at 27.

189 See Peter B. Smulowitz et al., *Emergency Department Utilization After the Implementation of Massachusetts Health Reform*, 58 ANN. EMERGENCY MED. 225, 229 (2011). *C.f.* AUG. 2009 QUARTERLY FINANCIAL REVIEW, *supra* note 140, at 19 (indicating data for the HIP enrollees in Indiana).

in respondents answering that their usual source of care is the emergency department after obtaining HIP.¹⁹⁰ Lower-income adults in Massachusetts were over 14% less likely to be uninsured in 2010 than in 2006, while Indiana's overall rate of uninsurance rose from 13.1% to 16.3% from 2006 to 2009.¹⁹¹

Massachusetts discontinued Commonwealth Care as of January 1, 2014, now that the ACA's coverage expansion has taken effect. Rather, former Commonwealth Care enrollees earning 133% of the federal poverty level or less will enroll in one of two primary MassHealth plans: MassHealth Standard for current MassHealth enrollees, with benefits identical to those currently available through MassHealth, and MassHealth CarePlus for newly-eligible enrollees, with benefits identical to those available through Commonwealth Care plus any essential health benefits not currently offered through Commonwealth Care.¹⁹² Those earning more now obtain private coverage through the Connector, Massachusetts' health insurance exchange.¹⁹³ Individuals earning between 133% and 300% of the federal poverty level will receive additional subsidies for health insurance from the state, using funds previously allocated from the SNCP for Commonwealth Care subsidies.¹⁹⁴

D. California (*Healthy San Francisco*)

The City of San Francisco created the Healthy San Francisco program as an organized, low cost, yet comprehensive solution to the problem of uninsurance among San Francisco residents. Before the program began, the uninsured could seek care from traditional safety net providers: public hospitals funded in part by county general funds, community health centers supported in part by federal funding, and private hospitals and physicians offering emergency services or charity care.¹⁹⁵ In 2006, then-Mayor Gavin Newsom created the Universal Healthcare Council to propose to the city how best to provide health

190 HIP SECTION 1115 WAIVER EXTENSION APPLICATION, *supra* note 131, at 18; LONG ET AL., *supra* note 185, at 26.

191 LONG ET AL., *supra* note 185, at 25; ERIC R. WRIGHT & MICHAEL COOK, IND. UNIV. CTR. FOR HEALTH POLICY, THE STATE OF HEALTH INSURANCE COVERAGE IN INDIANA 2009 27 (2010), available at <http://www.healthpolicy.iupui.edu/PubsPDFs/State%20of%20Health%20Issue%20Brief.pdf>.

192 EXEC. OFFICE FOR HEALTH AND HUMAN SERVS., MASSHEALTH: ROADMAP TO 2014 II-12 (2013), available at <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/aca-transition-plan-draft.pdf>.

193 *Id.* at 3.

194 *Id.* at 14. CMS approved this waiver provision. See CTRS. FOR MEDICARE & MEDICAID SERVS., II-W-00030/1, MASSHEALTH MEDICAID SECTION 1115 WAIVER: SPECIAL TERMS AND CONDITIONS 56 (2013), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>.

195 Mitchell H. Katz & Tangerine M. Brigham, *Transforming a Traditional Safety Net into a Coordinated Care System: Lessons from Healthy San Francisco*, 30 HEALTH AFF. 237, 239 (2011).

care access to the 82,000 city residents who were uninsured.¹⁹⁶ Its goal was for all San Franciscans to “have access to comprehensive health services and a ‘medical home.’ Such a program should ‘enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.’”¹⁹⁷ It additionally should facilitate the creation and reinforcement of a “consistent, sustainable provider/patient relationship.”¹⁹⁸

The council sought to create a system that would not undermine or supplant employer-sponsored coverage, and ultimately arrived at a plan that it, the city, and ultimately the courts, deemed not to be health insurance, but rather a system of access to care.¹⁹⁹ The Health Care Security Ordinance ultimately adopted by the city reorganized its safety net apparatus into an organized system of care in which uninsured San Franciscans earning up to 500% of the federal poverty level, regardless of health, employment, or immigration status, have a medical home from which to obtain necessary medical care.²⁰⁰ The set of available services includes primary, preventive, and specialty services, whether delivered in a physician’s office, clinic, or hospital on an outpatient or inpatient basis, as well as diagnostic, laboratory, and radiology services, and pharmaceuticals.²⁰¹ Participants can only receive services from participating health care entities, and only within San Francisco city limits.²⁰² Covered employers²⁰³ must make a minimum contribution to their employees’ health care expenses, whether through offering and contributing to health insurance coverage, funding a health reimbursement account, or paying the city directly to help cover the

196 UNIVERSAL HEALTHCARE COUNCIL, FINAL REPORT TO MAYOR GAVIN NEWSOM: SAN FRANCISCO HEALTH ACCESS PROGRAM: SERVING UNINSURED ADULTS 3 (June 23, 2006), available at http://laborcenter.berkeley.edu/healthpolicy/uhc_report.pdf.

197 *Id.* at 5.

198 *Id.*

199 *Id.*; S.F. ADMIN. CODE, S.F. HEALTH CARE SECURITY ORDINANCE § 14.2(a) (2013), (stating that “The Health Access Program is not an insurance plan for Health Access Program participants”). The Golden Gate Restaurant Association challenged the ordinance creating the program, alleging that it violated the Employee Retirement Income Security Act (ERISA). While the District Court held the ordinance violated ERISA, the 9th Circuit reversed, and the Supreme Court denied certiorari. *Golden Gate Restaurant Ass’n v. City & Cnty of San Francisco*, 546 F.3d 639 (9th Cir. 2008), *rev’d*, 535 F.Supp.2d 968 (N.D. Cal. 2007), *cert. denied*, 130 S.Ct. 3497 (2010).

200 S.F. ADMIN. CODE, S.F. HEALTH CARE SECURITY ORDINANCE § 14.2(c), (e) (2013).

201 *Id.* § 14.2(f). Vision, dental, infertility, and cosmetic services are not covered. *Id.*

202 CITY & CNTY OF S.F., DEP’T OF PUB. HEALTH, HEALTHY SAN FRANCISCO, PARTICIPANT HANDBOOK 14 (2009), available at http://healthysanfrancisco.org/files/HSF_Participant_Handbook_ENG.pdf. Emergency services are an exception to this rule. *Id.*

203 A “covered employer” is “any medium-sized [20–99 employees] or large business [100 or more employees] ... engaging in business within the City that is required to obtain a valid San Francisco business registration certificate from the San Francisco Tax Collector’s office or, in the case of a nonprofit corporation, an employer for which an average of fifty (50) or more persons per week perform work for compensation during a quarter.” S.F. ADMIN. CODE, S.F. HEALTH CARE SEC. ORDINANCE §§ 14.1(b)(3), (11), (12) (2013). Small employers are not “covered employers.” *Id.* § 14.1(b)(3).

costs of Healthy San Francisco, among other possible methods.²⁰⁴ Healthy San Francisco participants who earn more than 100% of the federal poverty level must also contribute to the cost of their care, on a sliding scale basis.²⁰⁵

The program has been very successful in reaching uninsured San Franciscans. In April 2013, there were 50,375 uninsured San Francisco residents participating in Healthy San Francisco.²⁰⁶ The percentage of the uninsured who are covered by Healthy San Francisco has been estimated between 70 and 89%.²⁰⁷ The estimated PMPM expenditure for fiscal year (FY) 2011–12 is \$255, which, like each of the other expansion programs examined here, is higher than the rate for comparable Medi-Cal population, at \$181 PMPM.²⁰⁸ In the case of Healthy San Francisco, the relative health of participants may be a factor: nearly 63% of enrollees had one or more chronic health conditions.²⁰⁹ Nearly 75% of participants had at least one physician visit, with participants averaging three such visits annually, and only 2% had an inpatient hospitalization.²¹⁰ While the program worries that the reporting may be low,²¹¹ in FY 2011–12, nearly 93% of Healthy San Francisco participants had no emergency department visits at all, and only 8% of the small number of emergency department visits made were “avoidable,” as compared to a rate of 18% for Medi-Cal adults.²¹² Healthy San Francisco has a relatively high disenrollment rate, which may be due in part

204 *Id.* § 14.3(a). See also Katz & Brigham, *supra* note 195, at 239 (discussing the present design and implementation of San Francisco’s health care plan “Healthy San Francisco”). For 2014, large employers must spend at least \$2.44 per hour paid, and medium employers \$1.63 per hour paid. *Health Care Security Ordinance: Overview*, CITY & COUNTY OF S.F. LABOR STANDARDS ENFORCEMENT, <http://sfgsa.org/index.aspx?page=418> (last visited Jan. 6, 2014).

205 *Visitors: Participant Fees*, HEALTHY S.F., <http://healthysanfrancisco.org/visitors/fees/> (last visited Jan. 6, 2014). Those earning up to the federal poverty level owe nothing other than a \$25 fee for non-emergent emergency department use (i.e., use that does not result in an inpatient admission); those earning more must pay between \$60 and \$450 per quarter to remain enrolled, in addition to Point of Service fees. *Id.*

206 *Id.* In 2011–12, an estimated 64,000 San Franciscans were uninsured. HEALTHY S.F., ANNUAL REPORT TO THE SAN FRANCISCO HEALTH COMMISSION (FOR FISCAL YEAR 2011–12) 12 (2012) (on file with author). When one includes SF PATH enrollees, the number of uninsured served rises to around 90%. *Id.* For further information about the SF PATH program see *infra* notes 224–26 and accompanying text.

207 Katz & Brigham, *supra* note 195, at 240.

208 HEALTHY S.F., ANNUAL REPORT, *supra* note 206, at 3. See CAL. HEALTHCARE FOUND., CALIFORNIA HEALTH CARE ALMANAC: MEDI-CAL FACTS AND FIGURES: A PROGRAM TRANSFORMATION 37 (2013), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf>.

209 HEALTHY S.F., ANNUAL REPORT, *supra* note 206, at 27. Nevertheless, 64% of surveyed participants rated their health status as “excellent,” “very good,” or “good” for FY 2011–12. *Id.* at 43.

210 *Id.* at 28, 29. The rate of physician office visits is comparable to the national Medicaid average. *Id.* at 29.

211 Of the participants who stated they had at least one emergency department visit, and who responded to the Healthy San Francisco FY 2011–12 survey, only 35% had such a visit recorded in the HSF data utilization warehouse. *Id.* at 47.

212 *Id.* at 31–32.

to the lack of penalties for disenrollment and ease of re-enrollment.²¹³ More than half of disenrollments occurred at the time of the annual renewal, and 20% for changes in eligibility.²¹⁴ Only 8% of disenrollments occurred due to failure to pay required fees.²¹⁵

Although over half of the medical homes in the Healthy San Francisco program were accepting new enrollees in FY 2011–12, over 23% of participants who were surveyed by the program reported problems accessing care.²¹⁶ A large majority of participants (75%) rated the quality of their medical care as “good,” “very good,” or “excellent.”²¹⁷ Nearly 80% reported that they had no delays in obtaining care or prescriptions, and that only 6.6% delayed care due to cost issues.²¹⁸

Until FY 2011–12, Healthy San Francisco was funded in large part by California Health Care Coverage Initiative funds.²¹⁹ These funds were allocated from the state’s Safety Net Care Pool (SNCP), which in turn was funded by DSH.²²⁰ Ten counties participated; San Francisco County was one of them.²²¹ As of FY 2011–12, however, the funds no longer support Healthy San Francisco. Instead, DSH funds help support the San Francisco Promotes Access to Health Care (SF PATH) program through the state’s Low Income Health Program.²²² SF PATH covers individuals currently eligible for Healthy San Francisco who, in 2014, will become eligible for coverage under the ACA’s Medicaid expansion due to their meeting of income and citizenship requirements.²²³ SF PATH’s benefits and structure are identical to Healthy San Francisco; the new program’s benefits include helping identify those who will become eligible for Medi-Cal under the expansion, and enrolling them automatically in Medi-Cal in time for

213 *Id.* at 13–14. As of FY 2011–12, the total disenrollment rate was 60%, which was due in part to the transfer that year of 10,116 enrollees to the SF PATH program. *Id.* at 13.

214 *Id.* at 14. Of note, 77% of disenrollees due to failure to re-enroll at the annual enrollment earned less than the federal poverty level, and hence owed no money for participation in the program, implying that failure to re-enroll was for a non-financial reason. *Id.* at 16.

215 *Id.* at 14.

216 *See id.* at 46.

217 *See id.*

218 *Id.* at 47.

219 *Id.* at 55. Employer and participant contributions make up the bulk of the remaining revenue for the program. *Id.*

220 *See, e.g.,* CAL. WELF. & INST. CODE §§ 15900(b), 15903 (West 2011) (allocating funds for the initiative, and describing the initiative’s purpose).

221 *Health Care Coverage Initiative: Coverage Initiative Programs*, CAL. DEP’T HEALTH CARE SERVICES, <http://www.dhcs.ca.gov/services/pages/CoverageInitiative.aspx> (last visited Jan. 6, 2014).

222 *See, e.g.,* PETER HARBAGE & MEREDITH LEDFORD KING, CAL. HEALTHCARE FOUND., A BRIDGE TO REFORM: CALIFORNIA’S SECTION 1115 WAIVER 8–9, 19 (2012), available at <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BridgeToReform1115Waiver.pdf>.

223 *See generally* *Who Qualifies*, SF PATH, http://www.sfp PATH.org/visitors/Who_Qualifies.aspx (last visited Jan. 6, 2014) (listing the qualifications for SF Path).

the expansion.²²⁴ Following the expansion, Healthy San Francisco will remain in place for the estimated 20,000 San Franciscans who will not qualify for coverage under the ACA, due to immigration status or other matters.²²⁵

III. THE PATIENT-CENTEREDNESS OF FOUR PARTIALLY DSH-FUNDED HEALTH CARE COVERAGE INITIATIVES

As described earlier, when DSH funds are used in the traditional manner to reimburse hospitals for all or a portion of their uncompensated care, it can be difficult or impossible to translate the dollars on an accounting ledger to any individual patient or group of patients. In this sense, in each of the four state coverage initiatives discussed, the first identified goal of patient-centered care—that payments should be directed toward care for people with a low income, whether such persons are enrolled in Medicaid or are uninsured—is met for those enrolled in the programs. People such as Myrlene Stimphil's son, on the other hand, may have had some portion of their account covered by DSH funds but it is doubtful that even the hospital could trace this fact. In the case of traditional DSH payments that are returned to a state's general fund or are provided to hospitals with little evidence of disproportionately caring for Medicaid and uninsured patients, then patient-centered goals of care are not being met because of the misuse of funds.

When comparing the four programs, the most relevant information related to the goal of using funds for low-income patients includes the number of people enrolled in the program and the percentage of the uninsured population covered by the program. Commonwealth Care in Massachusetts covers 175,000 residents, which is 44% of the state's uninsured population.²²⁶ Healthy San Francisco covers 50,375 residents, which is between 70% and 89% of the uninsured population.²²⁷ IowaCare has enrolled 61,918 residents, or 17% of the uninsured in the state.²²⁸ Healthy Indiana, on the other hand, covered only 4% of the state's uninsured population, about 37,316 people.²²⁹

Since the number of people enrolled in a program is, at least, in part a matter of the cost of the program, we review this information here as well. The yearly costs of IowaCare per beneficiary are \$2,640 per enrollee in 2013 (\$220 per month), whereas Medicaid benefits for adults in Iowa in 2010 averaged \$2,204 (\$184 per month).²³⁰ Healthy Indiana costs per month, according to

224 See, e.g., Lindsey Angelats, *GGHI Update: HSF/SF PATH and Health Reform*, S.F. HEALTH PLAN (2013), available at http://www.sfhf.org/files/Community/HSF_SFPath_Health_Reform_Update_GGHI_February_2013.pdf.

225 See *id.*

226 See *supra* note 165 and accompanying text.

227 See *supra* notes 206–07 and accompanying text.

228 See *supra* note 93 and accompanying text.

229 See *supra* note 128 and accompanying text.

230 See *supra* note 96.

the latest data, were about \$416 for people without a predetermined high-cost health condition and \$2,437 per month for those who did have a high-cost condition whereas a comparable Medicaid enrollee cost only \$293 per month.²³¹ In Massachusetts, Commonwealth Care enrollees cost approximately \$375 per month whereas adults in Medicaid (MassHealth) cost only about \$263.²³² For Healthy San Francisco, the monthly expenditure is \$255, higher than the rate for a comparable Medicaid (Medi-Cal) patient, at \$181 per month.²³³ Efficiency is a patient-centered goal in that it can allow greater numbers of program participants. At the same time, however, in the case of Medicaid program costs when lower provider payments decrease cost but also lessen provider participation, timely and even respectful access to care may be jeopardized by excessively low reimbursements.²³⁴

The variation in cost among the programs is striking, as is the excess cost compared to each state's Medicaid expenditure, and not fully explained by increased provider reimbursement. We should also note that, for Massachusetts and San Francisco, a significant number of current program enrollees will become the group of newly eligible Medicaid enrollees whose entire cost will be paid in 2014–2015 by the federal government.²³⁵ If the governors in Iowa and Indiana expanded Medicaid, the same would be true for many of their respective current program enrollees. For example, up to 92% of IowaCare enrollees would be eligible for Medicaid if the expansion was implemented as originally intended under the ACA, according to Iowa's Department of Human Services.²³⁶ At least one estimate suggests that the cost of the Medicaid

231 See IND. OFFICE OF MEDICAID POLICY & PLANNING, IND. FAMILY & SOC. SERVS. ADMIN., QUARTERLY FINANCIAL REVIEW *supra* note 142 at 13.

232 See *supra* notes 176, 178 and accompanying text.

233 See *supra* note 208 and accompanying text.

234 Rosenbaum notes that programs are “less attractive to healthcare providers [when] they cover less, pay less, and carry unpleasant connotations and associations, such as bureaucratic hassles and the status of a ‘poor people’s program.’ This lesser form of coverage in effect validates on business grounds what may be underlying prejudicial leanings on the part of members of the medical care industry.” Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, in *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 664, 666 (Brian D. Smedley, et al. eds., 2003) (National Academy of Sciences CD-ROM, 2003). Of course, low provider reimbursement is not the only factor affecting whether physicians will accept new Medicaid patients. Delays in reimbursement and administrative hassles are some of the additional reasons that physicians cite in not accepting Medicaid patients. See, e.g., Peter J. Cunningham & Ann S. O’Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, 28 HEALTH AFF. w17 (2008), available at <http://content.healthaffairs.org/content/28/1/w17.full.pdf>; Anna S. Sommers et al., *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians*, 2 MEDICARE & MEDICARD RES. REV. E1 (2011).

235 See HOLAHAN ET AL., *supra* note 93, at 36–37.

236 Among IowaCare enrollees, only 8% had an income above 133% of the federal poverty level. See Jennifer Vermeer, *IowaCare — Iowa’s 1115 Demonstration Waiver*, IOWA LEGIS. 6 (Feb. 10, 2011) https://www.legis.iowa.gov/DOCS/LSA/SC_MaterialsDist/2011/SDJRBo27.pdf. Iowa is

expansion would be approximately \$100 billion less, nationwide, than the cost of covering the same population through health insurance exchanges in the ACA.²³⁷

We also proposed that, through interactions with clinicians and within health care organizations, Medicaid supplemental payments should encourage patient-centered attributes of care such as treating each patient as a whole person and with respect, dignity, and transparency. Since these attributes of care can be difficult to measure directly, we briefly discuss some of the more readily quantifiable characteristics of patient-centeredness that reflect the needs and preferences of the whole person. Some of these characteristics include the comprehensiveness of benefits, the degree of protection from financial insecurity, the cost of care to the enrollee, and whether there are strict or harsh inconveniences. Since information is not available consistently across programs, we highlight some of the best and least patient-centered attributes of care among the programs.

The two states that are planning on fully implementing the ACA's Medicaid expansion, Massachusetts and California, have taken the most steps to streamline enrollment and protect enrollees from financial insecurity. Transitioning Healthy San Francisco to a program that will remain available to people, especially undocumented immigrants, who will not be eligible for Medicaid or subsidies on the health insurance exchanges is particularly noteworthy.²³⁸ On the other hand, the Healthy Indiana Plan, while incorporating a comprehensive benefit plan, offers the least financial security since benefits are capped yearly and over the lifetime of enrollees.²³⁹ The patient-centered goal of transparency is a concern as well since not all of the commissioned data on the program has been released publicly.²⁴⁰ HIP also includes the harsh provision of disenrollment for one year if the required contribution is not made.²⁴¹ IowaCare has recently expanded the availability of primary care medical homes throughout the state but still relies on the University of Iowa Hospitals for tertiary care, which likely

among the eight states expected to see state savings from implementing the Medicaid expansion in part, as already mentioned, because many of the IowaCare enrollees will be newly eligible. HOLAHAN ET AL., *supra* note 93, at 3.

237 Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U.J. HEALTH L. & POL'Y 127, 130–31, n.18 (2011) (reporting an exchange between Rosenbaum and Mark Hayes, former Staff Dir., Senate Finance Comm., Subcomm. on Health).

238 See *supra* note 225 and accompanying text.

239 See *supra* text accompanying note 122; IND. CODE ANN. § 12–15–44.2–10(a)–(c) & § 44.2–11(b)(2)(A). To date, very few Healthy Indiana participants have reached these caps. HEALTHY INDIANA ANNUAL REPORT, *supra* note 130, at 24. However, the top 10% of health care users account for 65% of health care spending. Such spending is unlikely to be discretionary and, therefore, caps are more likely to be unduly burdensome. THE HENRY J. KAISER FAMILY FOUND., CONCENTRATION OF HEALTH CARE SPENDING IN THE U.S. POPULATION, 2010, (Mar. 13, 2013), <http://kff.org/health-costs/slide/concentration-of-health-care-spending-in-the-u-s-population-2010/>.

240 See *supra* note 130 and accompanying text.

241 See *supra* note 126 and accompanying text.

remains a severe hardship for some enrollees.²⁴²

Our third assertion was that Medicaid supplemental payments should encourage the active engagement of patients in their own care processes through shared power to influence them. Incorporating patient surveys about their experiences of care with planned responses to identified concerns is one way to promote patient-centered care in processes. Most programs do report patient satisfaction as a metric, though it is not apparent that programs go beyond this to ask for more robust information that could be acted upon. The inclusion of consumers on the boards or commissions responsible for oversight of the programs was not readily apparent from available data but this would be another way to share power and influence with patients.²⁴³

CONCLUSION

The Medicaid program currently funds more than 30% of hospital uncompensated care, primarily through supplemental payments such as DSH. The history of the DSH program is replete with evidence of a lack of accountability and transparency in DSH payments and an inability to assess whether care for individual patients or patient groups are improved by the payments.²⁴⁴ Medicaid supplemental funds should be used in a more organized manner to prospectively support access to regular, dependable, and patient-centered care for those who are uninsured. The examples of Iowa, Indiana, Massachusetts, and California, each of which have a waiver to use DSH funds to support extended coverage or care for the uninsured, provide insights into how to devise systems that are more, or less, patient-centered.

While generalizations are difficult, particularly given discrepancies in available data, the evidence suggests that systems such as California's and Massachusetts' fare better than those of Indiana and Iowa in providing enrollees with coverage or care that offers necessary benefits, financial security, transparency, and respect to the largest number of potential enrollees. More study is needed. However, as the nation moves forward with health care reform and as the states studied here, among others, seek waiver renewals and amendments for their respective programs, we suggest that CMS carefully scrutinize the history and outcomes to date of the demonstration programs in question, and give ample consideration to the programs' effectuation of the principles of patient-centeredness.

²⁴² See *supra* note 94 and accompanying text.

²⁴³ See *supra* note 30 for an example of Medicare ACO's inclusion of beneficiaries in their governance structure and of the requirement that patient survey results are incorporated into planned changes.

²⁴⁴ See *supra* notes 43-49 and accompanying text.