Kentucky Law Journal

Volume 102
Issue 2 *Special Feature: Medicaid Matters*

Article 6

2014

Medicaid Evolution for the 21st Century

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THE Affordable Care Act is a complex statute intended to change American health finance and delivery in myriad ways over its multi-year implementation period.[2] Its core provisions, however, are directed at the overriding problem that drove its passage: reducing the number of Americans without health insurance.[3] Medicaid was intended to be a major vehicle in that expansion. One-half of the expansion in insurance coverage has been projected to come from an increase in Medicaid membership, with estimates of increased enrollments ranging from seventeen million to almost twenty-three million by the end of the decade.[4] The Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* transformed the Medicaid expansion from a required aspect of states' continued participation to a separate, optional add-on to current state Medicaid programs.[5] Nonetheless, the Congressional Budget Office estimates that the Court's decision reduced the number of likely new Medicaid enrollees under the ACA expansions to a smaller, but still significant, nine million in 2014, eventually growing to thirteen million by 2023.[6]

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1 Dorothea Dix Professor of Health Law & Policy, Seton Hall Law School. Thanks to the participants in the University of Kentucky College of Law's Medicaid Matters Conference for their acute insights in to the future of Medicaid.

2 The "Affordable Care Act" (ACA) is comprised of two separate acts: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 25, 26, 29 and 42 U.S.C.), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No.111-152, 124 Stat. 1029 (to be codified as amended in scattered sections of 20, 26 and 40 U.S.C.), which amended Public Law Number 111-148. These statutes will be referred to collectively as the "ACA."

3 *See* Barack Obama, *Securing the Future of American Health Care*, 365 NEW ENG. J. MED. 1377, 1379 (2012) (explaining that the ACA will expand health insurance availability through market reforms, Medicaid expansion, and subsidies for low-income Americans).

4 *Compare* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 5 fig.1 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (seventeen million), *with* JOHN HOLAHAN & IRENE HEADEN, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL, at 5 (May 1, 2010), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf (22.8 million under an "enhanced outreach scenario").

5 Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius, 132 S. Ct. 2566, 2604-05 (2012).

6 *See* CONG. BUDGET OFFICE, MAY 2013 ESTIMATE OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE tbls. 1 & 2 (2013) *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

Can the Medicaid program bear the weight of these expectations? Some critics argue that Medicaid is "broken" and is, therefore, an unsuitable vehicle for health system reform.[7] Even supporters of the Medicaid program have recognized that its recipients have historically fared less well in both access to care and health outcomes than privately insured persons, although research suggests that many of these shortfalls are due to the demographic makeup of the Medicaid program, and not the program itself.[8] Part I of this paper will examine the extent to which Medicaid differs from other health finance programs. It will then examine in Part II the assertion that Medicaid is "broken," and whether some of the unique aspects of Medicaid shed light on this debate. Part III will examine proposals for adapting Medicaid to the needs of twenty–first century health care in order to serve the poor and vulnerable Americans for whom Medicaid is intended, and who, to this point, have been relatively poorly served by the health finance and delivery systems. Finally, in Part IV, this paper will focus on Medicaid financing and delivery changes encouraged by the ACA that can serve an evolutionary function for the Medicaid program. It will address a central paradox facing Medicaid: in order to provide care for Medicaid's recipients that is equivalent to care delivered to privately insured patients—the governing vision of Medicaid from its inception[9]—the states and federal regulators properly point to the need for the adoption of evidence–based practices that improve outcomes and access. On the other hand, to serve the sickest, most vulnerable, and most socially marginalized segment of our population, we must embrace the leadership of local, trusted community leaders. The paradox is that top–down research–tested methods must be carefully blended with reliance on bottom–up leadership from civil society.

7 *See, e.g.*, Kevin D. Dayaratna, *Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured*, HERITAGE FOUND. BACKGROUNDER, No. 2740, Nov. 7, 2012, at 1, http://thf_media.s3.amazonaws.com/2012/pdf/bg2740.pdf (referring to Medicaid as a "broken program").

8 *See* Teresa A. Coughlin et al., *Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF., no. 4, 2005, at 1073, 1081 (explaining that the shortfall in access for Medicaid beneficiaries is largely due to demographic factors and health status, and not the structure of the Medicaid program).

9 *See* Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 675 (2006) ("Before 1965, healthcare services were described as 'dual–tracked': the wealthy received care from private physicians while the poor—if they accessed services at all—received care in ambulatory clinics and emergency rooms. Medicaid's goal was to eliminate the lower track, providing everyone with access to private physicians and high quality hospitals.").

I. Why is Medicaid Different From Other Health Finance Programs?

Medicaid was created in 1965 as a companion to Medicare. Unlike Medicare, which was intended as a contributory social insurance system for the elderly, Medicaid was intended to shore up the existing patchwork of state systems, and, funded in part by the federal government, to provide health care services to the poor.[10] From the beginning, Medicaid recognized the historical primacy of the states as providers for the poor, but also initiated an increased regulatory role for the federal government to enforce some basic coverage principles as conditions of states' receipt of the federal funds available under the program.[11] Like its sister program, Medicare, Medicaid did not interfere with the financial freedom of health care providers; like private health insurance coverage, it set about creating payment mechanisms that would lead providers to participate voluntarily in Medicaid as they did in private insurance programs.[12] Medicaid, then, deviated from precursor systems: "[I]n its essential structure, Medicaid resembled not a grant program to clinics and hospitals, but instead a 'third party payment' system structured to operate like insurance, paying 'participating' health care professionals and institutions for covered services furnished to enrolled persons."[13] Medicaid was set up as something akin to a public insurance system, but became increasingly cabined over time by statutory and regulatory provisions that bar the states' Medicaid programs from running, as private insurance does, on a market–oriented, risk–sensitive basis.[14] As Medicaid has developed, it has deviated more and more from the private insurance model on which it was loosely based, in three essential ways: first, those covered are mostly uninsurable in private markets; second, the services covered extend beyond those covered in commercial insurance; and third, the structure, adjusted by many amendments over the years, is much more complex than any private insurance product.

10 *See id.*; *see also* Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post–Deficit Reduction Act Era*, 9 J. Health Care L. & Pol'y 5, 8–9 (2006). *See generally* Robert Stevens & Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid 51–52 (Transaction Publishers 2003) (1974) (detailing the genesis of the Medicaid program and offering a thorough assessment of its implementation and evolution).

11 Rosenbaum, *supra* note 10, at 9.

12 *See* 42 U.S.C. § 1396a(a)(30)(A) (2012) (setting out principles of reimbursement). The extent to which Medicaid now, or indeed ever, lived up to this statutory requirement is discussed *infra*, Part II.

13 Rosenbaum, *supra* note 10, at 9.

14 *Id.* at 10.

A. Who is covered?

Prior to the expansions permitted by the ACA, Medicaid enrollees have been limited to the most medically precarious: the poor and vulnerable.[15] In short, they are exactly the people private insurers do not wish to cover. They are poor, and also "categorically eligible." That is, in addition to meeting income and assets requirements, enrollees are required to be blind, disabled, elderly, pregnant women, children, or in families with children.[16] These groups represent predictably high-cost insureds. A child with disabilities, for example, requires about four times the health expenditures of a child without disabilities,[17] and people over the age of sixty-five are similarly expensive to cover.[18] In Medicaid, the elderly and people with disabilities comprise only about 25% of enrollees, but account for about 65% of the program's cost.[19] The distribution of health care usage generally, and predictably, is very skewed toward the elderly and people with disabilities and chronic illnesses, with the most-ill 5% utilizing about half of the health care resources, and the least-ill 50% accounting for only about 3% of annual health expenditures.[20] On the basis of their age and health history, then, Medicaid enrollees are likely to need a great deal of care and will be essentially uninsurable under the circumstances.

In addition, people in the Medicaid program raise identity issues beyond disability and age. The non-elderly enrollment in Medicaid is over 53% Black or Hispanic, although those two groups comprise only about 30% of the American population.[21] The long history of race- and ethnicity-based health disparities in American health care strongly suggests that the overrepresentation of people of color in Medicaid will reflect poorer health outcomes—regardless

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15 Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS J. HEALTH LAW & POL'Y 127, 127–28 (2011).

16 42 U.S.C. § 1396a(a)(10)(A)(i) (2012).

17 Paul W. Newacheck et al., *Health Services Use and Health Care Expenditures for Children with Disabilities*, 114 PEDIATRICS 79, 81 (2004).

18 *See* Uwe E. Reinhardt, *Does the Aging of the Population Really Drive the Demand for Health Care?*, 22 HEALTH AFF., no. 6, 2003, at 27, 27 ("Average per capita health spending for Americans age sixty-five and older was more than triple that for Americans . . . ages 34–44 in 1999.").

19 KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID: A PRIMER 26 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf [hereinafter MEDICAID PRIMER].

20 THE HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 8 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf; *see also* Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 22 HEALTH AFF., no. 2, 2001, at 9, 15–16 (citing similar figures).

21 *Compare* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012, at 107 tbl.148, *available at* http://www.census.gov/compendia/statab/2012/tables/12s0148.pdf (53.4% of non-elderly Medicaid recipients in 2009 were either Black or Hispanic), *with State & County QuickFacts*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/00000.html (last updated June 27, 2013) (30% of Americans were either Black or Hispanic in 2012).

of any faults of the Medicaid program itself.[22] "For example, relative to whites, African Americans and Hispanics are less likely to receive appropriate cardiac medication . . . or to undergo coronary artery bypass surgery, even when the variations in such factors as insurance status, income, age, co–morbid conditions, and symptom expression are taken into account."[23] In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.[24] Regardless of the causes of these effects, they establish that people covered by Medicaid are more medically fragile, have more complex health conditions, and are affected by determinants of poor health, independent of their access to health coverage or care.

B. What is covered?

Medicaid also differs from other health finance programs in the breadth of services covered. The program covers services included in commercial insurance, including preventive, curative, and restorative physician, pharmacy, and hospital services. In addition, however, Medicaid mandates that states cover long–term care services, home care services, transportation services to and from service providers, Federally Qualified Health Center services, and rural health clinic services.[25] In addition, many states have added "optional" services that are not mandated, but for which the federal government will provide funding if added by a state plan. The most common of these services include dental, eyeglass, prostheses, and personal care services, as well as intermediate care facility services for individuals with intellectual disabilities.[26]

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22 *See* David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327–30 (2005) (discussing how differences in socioeconomic status, neighborhood conditions, and medical care contribute to the poorer health of African–Americans); *see also* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 How. L.J. 855, 857 (2012) ("[H]ealth insurance and health care remain racially and ethnically segregated with one heath care system serving disproportionately white patients with private insurance and a different 'safety net' system serving minority patients with Medicaid and the uninsured."). *See generally* BRIAN D. SMEDLEY ET AL., INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2003) (assessing the reasons for racial disparities in health care and offering strategies for more equitable care).

23 SMEDLEY ET AL., *supra* note 22, at 30.

24 *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382–84 (2011) ("Finally, U.S. public health leaders and researchers have increasingly recognized that the dramatic health problems we face cannot be successfully addressed by medical care alone."); Williams & Jackson, *supra* note 22, at 327–28 ("Racial differences in socioeconomic status, neighborhood residential conditions, and medical care are important contributors to racial differences in disease.").

25 42 U.S.C. § 1396d(a) (2012); MEDICAID PRIMER, *supra* note 19, at 13.

26 MEDICAID PRIMER, *supra* note 19, at 14; *see also* Rosenbaum & Sommers, *supra* note 15, at 128–29 ("Medicaid compensates for Medicare's limitations for the poorest beneficiaries, paying program premiums and cost–sharing and covering Medicare–excluded services ranging from eyeglasses and hearing aids to long–term care.").

This broad coverage fits Medicaid's programmatic mission to assist the states in fulfilling their traditional mission of serving the health needs of the poor and vulnerable. Some of the additional services included in many Medicaid programs, such as coverage of eyeglasses and dental services, simply reflect a recognition that the poor do not have the disposable income to pay for services and devices that have a relatively low expected cost. Other benefits, like intermediate care facilities for people with intellectual disabilities and home care services, reflect the need to provide services for the very conditions that give rise to the vulnerability entitling individuals to Medicaid services. The slate of covered services, then, reflects the poor, elderly, or disabled condition of Medicaid enrollees.

C. Complex structure.

The structure of Medicaid is famously complex. Unlike Medicare, which is wholly federally funded and governed, Medicaid requires that the federal and state governments work in partnership[27]—a relationship that has been notably strained recently. Its basic structure, as leading historians of Medicaid have observed, lacked coherence and clarity as a social insurance system for three reasons: first, it failed to cover all of the poor, but extended only to the categorically eligible; second, the definition and scope of medical services covered were variable from state to state; and third, the income eligibility standards varied, in some cases dramatically, from state to state.[28] In sum, the program remained a balkanized system funded by the federal government but largely run by the states.[29] Perhaps most critically, states retained substantial power to determine how much to pay providers for their services, and states have taken advantage of that power.[30]

Medicaid was criticized as rather "ill-designed" and "vague" from the beginning.[31] It paid providers on a fee-for-service basis, as did insurers.[32] But federal payments, forming the majority of Medicaid financing, were structured as a grant-in-aid program for the states, which were largely in charge of maintaining a network of willing providers.[33] Unlike private insurance, the

27 *See* STEVENS & STEVENS, *supra* note 10, at 57–61 (describing the shared federal–state funding and regulatory responsibilities); *see also* Rosenbaum, *supra* note 10, at 9 ("Medicaid rested on a financial base consisting of a shared federal/state contribution arrangement . . . .").

28 STEVENS & STEVENS, *supra* note 10, at 57–58.

29 *Id.*

30 Moncrieff, *supra* note 9, at 673–74.

31 STEVENS & STEVENS, *supra* note 10, at 51.

32 *See* Rosenbaum, *supra* note 10, at 9 ("But in its essential structure, Medicaid resembled not a grant program to clinics and hospitals, but instead a 'third party payment' system structured to operate like insurance, paying 'participating' health care professionals and institutions for covered services furnished to enrolled persons.").

33 STEVENS & STEVENS, *supra* note 10, at 52.

Medicaid program has grown, adding components over the years ranging beyond traditional medical care to address the needs of the target population.[34] In addition, millions of low-income elderly persons and persons with long-term disabilities qualify for both Medicaid and Medicare, and use Medicare as the primary payer for services. They rely on Medicaid, however, to pay for Medicare's coinsurance and deductibles, and for those health care services covered by Medicaid but not Medicare.[35] One major source of Medicaid's complexity has been states' gradual movement away from the role of public insurer to the role of public payor, devolving many insurer functions to commercial HMOs.

The movement toward then-novel HMOs as fiscal and programmatic intermediaries began within five years of Medicaid's creation.[36] California was a pioneer in the use of Medicaid HMOs. Widespread claims of fraudulent sales practices and inadequate provider networks frustrated these efforts and led federal regulators to impose relatively stringent requirements for the use of Medicaid managed care.[37] By 1980, only about 1% of Medicaid enrollees were in HMOs.[38] During the 1980s, however, Medicaid officials in the Reagan and George H.W. Bush administrations relaxed many of the restrictions on the use of Medicaid HMOs, although these efforts only raised the percentage of enrollees to about 12%.[39] During the 1990s, mostly through the use of Section 1115 waivers[40] or Section 1915(b) waivers,[41] the number of Medicaid enrollees in HMOs grew dramatically "from 9.5 percent of total Medicaid enrollment in 1991 to 40.1 percent in 1996."[42] These waivers from usual Medicaid regulatory requirements were necessary because state managed care programs limited the range of enrollees' choice of providers and varied, by location within states, enrollees' access to services.[43] Then, as part of the Balanced Budget Act of

34 *See* Rosenbaum, *supra* note 10, at 10 ("Over its lifetime, Medicaid has been transformed by an astounding agglomeration of legislative provisions and interpretative guidelines and rules.").

35 *See id.* at 129.

36 STEVENS & STEVENS, *supra* note 10, at 229. Health Maintenance Organizations (HMOs) were initially devised as a health care reform. *Id.* Instead of purchasing insurance or making vendor payments, Medicaid would buy "health maintenance contracts," hich c 10, at 229. Medicaid woud- which specified services designed to protect the Medicaid recipient's health. *Id.*

37 *See* Michael Sparer, *Medicaid Managed Care: Costs, Access, and Quality of Care*, ROBERT WOOD JOHNSON FOUND. 3 (Sept. 4, 2012), http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106.

38 Maren D. Anderson & Peter D. Fox, *Lessons Learned from Medicaid Managed Care Approaches*, 6 HEALTH AFF., no. 1, 1987, at 71, 72.

39 Sparer, *supra* note 37, at 3.

40 Authorized under the Social Security Act, Pub. L. No. 74-271, § 1115, 49 Stat. 690 (1935) (codified as amended at 42 U.S.C. § 1315 (2012)).

41 Authorized under the Social Security Act, Pub. L. No. 74-271, § 1915(b), 49 Stat. 690 (1935) (codified as amended at 42 U.S.C. § 1396n(b) (2012)).

42 John Holahan et al., *Medicaid Managed Care in Thirteen States*, 17 HEALTH AFF., no. 3, 1998, at 43, 43 (citing data from the Health Care Financing Administration, which is now the Centers for Medicare and Medicaid Services).

43 U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID AND CHIP RISK-BASED MANAGED

1997,[44] states obtained the authority to mandate HMO enrollment for most Medicaid beneficiaries.[45]

In an effort to contain Medicaid costs, states have continued to move toward managed care.[46] By 2010, most states had moved the majority of their enrollees to HMOs, and almost two–thirds of Medicaid enrollees were in managed care.[47] For most states, the movement to HMOs for Medicaid enrollees has not resulted in the hoped–for cost savings,[48] and the shift seems not to have improved the quality of care or access to providers.[49] Medicaid programs have, then, largely moved from directly administering provider payments to purchasing insurance coverage for enrollees from private vendors. In other words, most states have largely privatized what had been among their most important programmatic functions: selecting, maintaining, monitoring, and compensating health care providers for many of their Medicaid enrollees. This "decentralization" of government function not only saved states the administrative and staffing costs of network formation and maintenance, but also, to some extent, relieved them of the always–delicate task of intermediating between providers and enrollees.[50]

II. Is Medicaid Broken?

As governors considered their options following the Supreme Court's conversion of the ACA's Medicaid expansion from a mandatory to an optional program, many expressed various reasons for resisting what appeared to be a good deal; the federal government will bear 100% of the costs of those newly eligible for Medicaid in the years 2014, 2015, and 2016.[51] The federal matching amount will reduce slightly after that, stabilizing at 90% in 2020 and thereafter.[52]

Care in 20 States: Experiences Over the Past Decade and Lessons for the Future 1–2 (2012), *available at* http://aspe.hhs.gov/health/reports/2012/medicaidandchipmanagedcarePayments/rpt.pdf.

44 Balanced Budget Act of 1997, Pub. L. No. 105–33, 111 Stat. 251 (1997).

45 42 U.S.C. § 1396m–2 (2012).

46 Sparer, *supra* note 37, at 4.

47 Teresa A. Coughlin et al., *Are State Medicaid Managed Care Programs Ready for 2014? A Review of Eight States*, Robert Wood Johnson Found. 2 (May 29, 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406305.

48 Sparer, *supra* note 37, at 11–12.

49 *Id.* at 15–21.

50 *See* Stevens & Stevens, *supra* note 10, at 229–30.

51 42 U.S.C. § 1396d(y) (2012).

52 *Id.* The Rand Corporation performed an economic analysis of participation versus non–participation in the ACA's Medicaid expansion and concluded that, from an economic perspective, states would benefit from participating, even taking into account many of the objections raised by skeptics. The conclusions of the study, more fully described, were:

> The bottom line is that the expansion of Medicaid eligibility is a key provision of the Affordable Care Act. If the fourteen states that have said they will opt out of Medicaid expansion do so, 3.6 million fewer people will have health insurance than would

Nevertheless, the governors' objections were several, with many based on fears of state costs[53] or skepticism that Congress would continue to fund the program as described in the ACA.[54] Other critics cited fraud within the Medicaid program as a reason to resist its expansion,[55] although they failed to acknowledge the presence of fraud in the private insurance system.[56] Other critics, including some governors, expressed concern that membership in Medicaid would "foster dependency."[57] In addition, it is often argued that enrollees have difficulty gaining access to care, and that they suffer bad outcomes from the care they receive.[58] Several of the objectors appear to overstate the evidence that the

> otherwise be the case. This would save the federal government around $8.4 billion a year compared to the full expansion of Medicaid. However, the states that opted out of Medicaid expansion would see a net increase in spending in the short term because they would spend more on uncompensated care. Furthermore, even states that opt out of the expansion will be subject to the reductions in Medicare payments and disproportionate-share hospital payments, as well as various other taxes and fees in the Affordable Care Act. Thus, there may be large net transfers of federal funds out of the states that do not expand Medicaid.

Carter C. Price & Christine Eibner, *For States That Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, 32 HEALTH AFF. 1030, 1035 (2013).

53 Although, this concern is apparently at odds with the Rand economic analysis. *See* Price & Eibner, *supra* note 51.

54 *See* Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion — No Quick Resolution in Sight*, 386 NEW ENG. J. MED. 496, 498 (2013); *see also* Robert Pear & Michael Cooper, *Reluctance in Some States over Medicaid Expansion*, N.Y. TIMES (June 29, 2012), http://www.nytimes.com/2012/06/30/us/politics/some-states-reluctant-over-medicaid-expansion.html.

55 Grace-Marie Turner & Avik Roy, *Why States Should Not Expand Medicaid*, GALEN INST. 7 (May 1, 2013), http://www.galen.org/assets/StatesshouldblockMedicaidexpansion.pdf (arguing that between 10–30% of Medicaid payments are based on fraudulent claims).

56 Sara Rosenbaum et al., *Health Insurance Fraud: An Overview*, GEORGE WASHINGTON MED. CTR. 1 (2009), http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_EFDAD1BC-5056-9D20-3D3D36632A4F2163.pdf (citation omitted). The authors of that study explained:

> What is absolutely clear from virtually every reliable source on the subject is that health care fraud is a systemic problem affecting public and private insurers alike, in the individual market, the employer-sponsored group market, and public programs. Because Medicare and Medicaid are government-sponsored and thus are required to report on fraud, the problem is perhaps better known, but combating fraud is a challenge that faces both public and private insurers. Indeed, one survey found that since 1995, 90% of all private insurers have launched anti-fraud campaigns.

Id.

57 Sommers & Epstein, *supra* note 54, at 498 ("For instance, [Governor] Dennis Daugaard (R-SD) declared that 'able-bodied adults should be self-reliant . . . .'"); Turner & Roy, *supra* note 55, at 5.

58 Sommers & Epstein, *supra* note 54, at 498 ("[Governor] Rick Perry (R-TX) said that adding uninsured Texans to Medicaid is 'not unlike adding a thousand people to the Titanic.'"); Dayaratna, *supra* note 7, at 1–5; Jonathan Ingram, *Medicaid Expansion Would Trap Illinoisans in Inferior Care*, ILL. POL'Y INST. 1 (Dec. 4, 2012), http://illinoispolicy.org/uploads/files/Medicaid_Expansion.pdf; Turner & Roy, *supra* note 55, at 2–3.

Medicaid program causes the bad outcomes they cite;[59] clearly, however, they are on to something.

It is a valid criticism of Medicaid that it has been unable "to assure appropriate access to care for the poor. Medicaid has historically suffered under serious limitations owing to the widespread physician non-participation, particularly in the case of specialty care."[60] The outcomes for Medicaid enrollees are worse than they are for the privately insured, although that difference appears to be largely attributable to the very demographic and health conditions that qualify enrollees for the Medicaid program.[61] "Access" in this context translates into provider participation; if physicians decline to participate in Medicaid, then access is denied. As with so many other aspects of Medicaid, the extent of the physician participation crisis varies from state to state.[62] In Wyoming, 99.3% of office-based physicians are accepting new Medicaid patients. In New Jersey, the rate stands at 40.4%.[63] Other states' numbers are smoothly distributed between those extremes.[64] That is, fewer than one in a hundred Wyoming physicians would turn down a new Medicaid patient, while sixty out of a hundred New Jersey physicians would turn a new Medicaid patient away.[65] Nationally, fewer than 70% of physicians are willing to accept new Medicaid patients, compared with the 81.7% willing to accept privately insured patients.[66]

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59 For example, critics like to point to a large study undertaken by researchers at the University of Virginia Health System relating the public or private insurer to the outcomes of surgery. *E.g.*, Turner & Roy, *supra* note 55, at 3; Press Release, Senator Tom Coburn, *Revealing New Study: Medicaid Patients More Likely to Die After Surgery, Have Longer Stay and Higher Costs* (Aug. 11, 2010), *available at* http://www.coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=2e9229e4-cef2-40a8-84f3-d9d59177ae9f. Both of these critics suggest that the cited study found a *causal* relationship between enrollment in Medicaid and the poor surgical outcomes, apparently mistaking correlation for causation. The study's authors drew no such conclusion, although the correlation was strong. Instead, the researchers drew attention to the determinants of ill health associated with Medicaid enrollees:

> In this study, we conclude that Medicaid and Uninsured payer status confers increased risk adjusted in-hospital mortality compared with Private Insurance for major surgical operations in the United States. Medicaid is further associated with higher postoperative in-hospital complications as well as the greatest adjusted length of stay and total costs despite risk factors or the specific major operation. These differences serve as an important proxy for larger socioeconomic and health system-related issues that could be targeted to improve surgical outcomes for US patients.

Damien J. LaPar et al., *Primary Payer Status Affects Mortality for Major Surgical Operations*, 252 ANNALS OF SURG. 544, 550 (2010); *see also* Damien J. LaPar et al., *Primary Payer Status Affects Mortality for Major Surgical Operations* 8 (Apr. 11, 2011) (unpublished extended manuscript), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071622/pdf/nihms279555.pdf.

60 Rosenbaum & Sommers, *supra* note 15, at 135-36 (citation omitted).

61 *See* Coughlin et al., *supra* note 8, at 1081; *supra* text accompanying notes 15-24.

62 Sarah L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFF. 1673, 1675-76 (2012).

63 *Id.*

64 *Id.*

65 *Id.*

66 *Id.* at 1675 (noting that the percentage is slightly lower for primary care physicians).

Low physician participation rates appear not to be a function of "the percent of Medicaid enrollees in the state, the percentage of the Medicaid population in capitated managed care plans, or the number of physicians per capita in the state."[67] Physicians are, however, more likely to accept new Medicaid patients in states with higher reimbursement rates relative to Medicare.[68] Wyoming, for example, has the highest physician participation rate, and its Medicaid rates are about 140% of the Medicare rate.[69] New Jersey, on the other hand, has the lowest physician participation rate, and its Medicaid rates are about 37% of Medicare.[70]

Physicians may decline to participate in Medicaid for reasons beyond low rates, including discomfort working with the poor, largely minority, and frequently disabled membership in the program.[71] Also, physicians in states with low reimbursement rates may be distrustful of their state Medicaid program after decades of low payment, broken promises, and administrative difficulties.[72]

Poor provider participation rates are certainly problematic to Medicaid going forward and are no doubt related to the quality problems Medicaid has experienced. The relationship should not be overstated, however. As is described above, Medicaid is a program for people with high levels of disability, socioeconomic markers for poor health status, and demographic factors closely correlated with illness.[73] However, critics' diagnosis that low provider participation rates, driven in part by low reimbursement rates, ill-serves Medicaid-eligible people cannot be dismissed. Since a major thread in the call for rejection of Medicaid expansion is the cost, is the logic of this access-based criticism persuasive? Not, recent research indicates, if the implication is that covering those disenfranchised from Medicaid in private insurance is cheaper.

67 *Id.* at 1676.

68 *Id.*

69 *Id.* at 1678.

70 *Id.* Even with respect to enrollees in Medicaid HMOs, it is the states, and not the market or the federal government, that control physician reimbursement rates. States contract with HMOs for Medicaid business, and can contract for network adequacy terms that directly or indirectly lead to higher or lower physician payment rates.

71 *See* Jessica Greene et al., *Race, Segregation, and Physicians' Participation in Medicaid*, 84 THE MILBANK Q. 239, 262–63 (2006) available at http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2006.00447.x/full; Mari-Lynn Drainoni et al., *Cross-Disability Experiences of Barriers to Health-Care Access*, 17 J. OF DISABILITY POL'Y STUD. 101, 110–111 (2006) *available at* http://dps.sagepub.com/content/17/2/101.short.

72 *See* Peter J. Cunningham & Ann S. O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, 28 HEALTH AFF. w17, w18 (2009) *available at* http://content.healthaffairs.org/content/28/1/w17.full.pdf+html.

73 *See supra* notes 15–24 and accompanying text.

A recent study by Coughlin and colleagues of the Urban Institute examined this precise question: Would it be less expensive to insure adults in the private market or in the Medicaid program?[74] The researchers studied adults with household income "at or below 138 percent of the federal poverty line," reflecting the income levels of newly eligible adults.[75] They compared this group with adults covered by employment-based insurance in terms of "demographic, socioeconomic, and health status dimensions" by including a realistic assessment of the "demographic and socioeconomic characteristics of the individual and family; the individual's health and disability status, health conditions and limitation; and characteristics of the local community such as provider supply, health care cost variation, local economy and local demand for health services."[76]

The researchers concluded that the cost of opting for private insurance—even at premiums for employment-based coverage—would be enormous.[77] The per-person cost, "(excluding out-of-pocket spending) would be higher by about $1,700, going from $6,052 to $7,752, over a 25 percent increase,"[78] a difference almost entirely attributable to the higher reimbursement rates in private insurance as compared to Medicaid.[79] The personal cost would also be higher, with out-of-pocket costs rising to $784 per person, compared with $257 in Medicaid.[80] The researchers did not neglect the network adequacy problems with Medicaid, noting that Medicaid participants were more likely than the privately insured to use hospital emergency departments for primary care.[81] They also noted barriers in access to specialty care.[82]

To the extent, then, that "privatization" of Medicaid were to simply subsidize enrollees' entry into commercial insurance, the results would be unfavorable. Medicaid is a program with problems but simply shifting enrollees to commercial plans seems not to solve those problems. The recent study by Coughlin and colleagues raises fundamental issues with simple privatization. The crippling increase in out-of-pocket costs for low-income persons inherent in a switch from Medicaid to private insurance alone suggests that such a move would be problematic. As the ACA's subsidy systems demonstrate, however,

74 TERESA A. COUGHLIN ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., WHAT DIFFERENCE DOES MEDICAID MAKE? ASSESSING COST EFFECTIVENESS, ACCESS, AND FINANCIAL PROTECTION UNDER MEDICAID FOR LOW-INCOME ADULTS 7 (May 3, 2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (study funded by Kaiser and conducted by the Urban Institute).

75 *Id.* at 3.

76 *Id.*

77 *Id.* at 7.

78 *Id.*

79 *Id.*

80 *Id.* at 7.

81 *Id.* at 9.

82 *Id.*

programs can limit out-of-pocket spending on the basis of income status,[83] although such a switch would only add to the cost of privatization.

Leaving out-of-pocket costs aside, however, critics of existing Medicaid seem to be left with three choices for the expansion population: traditional Medicaid, private insurance (at a substantially more expensive price), or an undisclosed insurance package that is stripped down enough to pay providers private-market reimbursement rates at premium levels below Medicaid's. The critics of Medicaid are correct that it often provides lesser access to care than does private insurance due to limitations in provider participation. It is likely, however, that "privatizing" Medicaid would require either high cost-sharing for beneficiaries with little disposable income, substantially higher provider reimbursement, or stripped-down benefits for vulnerable patients. The way forward, in the absence of a broader national health reform in which all receive the level of care enjoyed by privately insured individuals, must be to fix Medicaid. In particular, as described in the following sections, a fix is necessary in those locations where state inaction and crumbling health care systems imperil American patients as well as in settings in which complex, vulnerable, and high-cost patients experience fragmented, episodic care.[84]

III. How Does the ACA Promote a More Effective Medicaid?

As is suggested in the previous section, Medicaid is not irredeemably broken, but, nevertheless, is in need of improvements if it is to serve the needs of its enrollees. This section will address three promising improvements to the Medicaid program, largely fostered by the ACA: the shoring up of primary care, fostering case management and coordinated care for people with chronic illnesses, and broad collaborations to provide care to Medicaid beneficiaries. These improvements go a long way toward addressing the genuine concerns regarding the strength of the Medicaid program.

83 42 U.S.C. § 18071 (2012); The Henry J. Kaiser Family Found., Explaining Health Care Reform: Questions about Health Insurance Subsidies 1 (July 1, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf.

84 *See* Stevens & Stevens, *supra* note 10, at xviii–xix (relating similar problems in the early years of Medicaid).

A. Primary Care

The discussion in the previous section explained that the shortfall in physician participation in Medicaid is not entirely the result of low reimbursement rates.[85] At the same time, there appears to be at least some dose–response effect related to fee increases.[86] That is, it appears that relatively substantial fee increases could draw at least some physicians into the program.[87] In order to create incentives to increase enrollees' access to primary care, the ACA increased Medicaid primary care reimbursements for a two–year period to the Medicare rate:

> The health reform law requires states, in 2013 and 2014, to pay at least 100 percent of Medicare physician fees for close to 150 different primary care services provided to Medicaid enrollees by certain physicians. Physicians in the specialties of family medicine, general internal medicine and pediatrics are designated to qualify for the increased fees, and federal regulations clarify that subspecialists can also receive the enhanced rates. To qualify, physicians must attest that they are Board-certified and/or that at least 60 percent of their Medicaid services in the previous year were primary care services to which the fee increase applies. The enhanced Medicaid rates are also available for services delivered by nurse practitioners and physician assistants under the personal supervision of a qualified physician.[88]

The increases will raise fees for covered services by an average of 73%, although the increases will be greater in those states in which provider fees have been the lowest.[89] Although those increases have been delayed, they are expected to begin by fall of 2013, and payments will be made retroactive to January 2013.[90]

In addition to this general increase in primary care reimbursement rates, the ACA specifically targets Federally Qualified Health Centers ("Health Centers") for financial support.[91] These centers form "one of the largest safety net systems

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85 *See supra* notes 60–66 and accompanying text.

86 *See* Decker, *supra* note 62, at 1676 (relating provider payment to participation rates).

87 *See id.*

88 STEPHEN ZUCKERMAN & DANA GOIN, KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., HOW MUCH WILL MEDICAID PHYSICIAN FEES FOR PRIMARY CARE RISE IN 2013? EVIDENCE FROM A 2012 SURVEY OF MEDICAID PHYSICIAN FEES 4 (Dec. 13, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf.

89 *Id.* at 7–8; *see also* Karen Davis et al., *How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation*, 26 J. GEN. INTERNAL MED. 1201, 1202 (2010) (explaining that increased reimbursement rates under the ACA will have a "differential impact on physicians depending on where they practice").

90 *See* Bruce Japsen, *Obamacare's 73% Medicaid Pay Raise for Doctors Is Delayed*, FORBES (Mar. 15, 2013, 8:43 AM), (payment increase scheduled for January 1, 2013 delayed) http://www.forbes.com/sites/brucejapsen/2013/03/15/obamacares-73-medicaid-pay-raise-for-doctors-is-delayed; *More delays expected for Medicaid parity reimbursements*, MEDICAL ECONOMICS (August 25, 2013), http://medicaleconomics.modernmedicine.com/medical-economics/news/more-delays-expected-medicaid-parity-reimbursements (explaining that payment increases are being made in some states, whereas other states plan to increase payments soon).

91 *The Affordable Care Act and Health Centers*, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF

of primary and preventive care in the country."[92] The Health Centers serve a high proportion of members of minority groups and are an essential component in providing Medicaid's services to vulnerable communities.[93] The ACA will provide $9.5 billion for operations of existing Health Centers, creation of new sites in medically underserved areas, and expansion of primary care services.[94] In addition, it will provide $1.5 billion "to support major construction and renovation projects at community health centers nationwide."[95]

B. Coordinated Care for People with Chronic Conditions

A high percentage of people on Medicaid have chronic conditions. "More than 9 million people qualify for Medicaid based on a disability, and many of these individuals have particularly complex needs—almost one-half of them suffer from mental illness and 45% are diagnosed with three or more chronic conditions."[96] Enrollees with chronic conditions are disproportionately expensive to treat.[97] The higher cost of treating the chronically ill in Medicaid squares with general chronic care research, which has established that the costs of care for people with one chronic condition are about twice that of people without such conditions, and the costs of care for people with two or more chronic conditions are almost six times as much.[98] Chronic illness is on the rise generally in the United States and as a result, Americans' health care needs have shifted in recent decades from acute care, focusing on one or a few clinical encounters, to chronic care, which often requires long courses of care from professionals with a variety of competencies.[99]

HEALTH & HUMAN SERVS. 1 (Aug. 11, 2013), http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf ("For more than 45 years, health centers have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay.").

92 *Id.*

93 *Id.* at 1–2.

94 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10503(c), 124 Stat. 119, 1004 (2010); *The Affordable Care Act and Health Centers*, *supra* note 91, at 2.

95 § 10503(c); *see The Affordable Care Act and Health Centers*, *supra* note 91, at 2.

96 MIKE NARDONE ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS 4 (Aug. 1, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8340.pdf.

97 *Id.*

98 Catherine Hoffman et al., *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1476 (1996).

99 ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 7–9 (2005).

One of the barriers to providing high-quality care to people with chronic illnesses is the frequent failure to coordinate their various caregivers.[100] Robert Kane, one of the leading clinical researchers into care for people with chronic conditions, has described the problem in the following terms:

> Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, (i.e., treat disease in the patient rather than treat the patient with disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.[101]

Such fragmentation is common, and creates health dangers to patients with chronic illnesses through lost opportunities for appropriate care and conflicting treatments that can do more harm than good:

> Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinical responsibility increases the chance that some services . . . may not be provided at all. Among people with chronic conditions 71% report having no help coordinating their care . . . and 17% say they have received contradictory medical information from health care professionals.[102]

Models of coordinated care, aimed at correcting the ill effects of this fragmentation, have developed in recent years.[103] Coordinated care models tend to include multidisciplinary teams using evidence-based treatments, frequent clinical visits, and periodic meetings with the patient and his or her family.[104] In addition to promising clinical improvements and gains in patient satisfaction, there is growing evidence suggesting that well-designed coordinated care for patients with chronic conditions can be cost-effective as well.[105]

States have been experimenting with various coordinated care models for Medicaid enrollees with chronic illnesses.[106] These programs were initiated

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100 *Id.* at 49.

101 *Id.* at 50–51.

102 *Id.* at 50.

103 *See* Katie Coleman et al., *Untangling Practice Redesign from Disease Management: How Do We Best Care for the Chronically Ill?*, 30 ANN. REV. PUB. HEALTH 385, 385 (2009).

104 *See* Jennifer L. Wolff & Chad Boult, *Moving Beyond Round Pegs and Square Holes: Restructuring Medicare to Improve Chronic Care*, 143 ANNALS INTERNAL MED. 439, 439 (2005) (discussing coordinated care in the Medicare context).

105 *See* Katie Coleman et al., *Evidence on the Chronic Care Model in the New Millennium*, 28 HEALTH AFF. 75, 81 (2009); *see also* John V. Jacobi, *Chronic Care and Prevention: Evolution in Practice and Finance*, 12 MARQUETTE ELDER'S ADVISOR 33, 42 (2010).

106 *See* Mary Takach & Jason Buxbaum, *Care Management for Medicaid Enrollees Through Community Health Teams*, COMMONWEALTH FUND 7 (May 21, 2013), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/May/1690_Takach_care_mgmt_Medicaid_enrollees_community_hlt_teams_520.pdf (assessing coordinated care models in Alabama, Maine, Minnesota, Montana, New York, North Carolina, Oklahoma, and Vermont) [hereinafter

relatively recently, most since 2006, and robust evaluative data are not yet available.[107] Preliminary evaluations, however, suggest that coordinated care models control costs for their complex enrollees.[108] In addition, these models can stretch the capacity of the limited number providers engaged in treating complex Medicaid patients:

> [C]ommunity health teams can help increase capacity in small and medium-sized primary care practices that have faced challenges meeting the intense behavioral health, chronic illness, and social needs of their Medicaid patients. Sharing resources allows small and medium-size practices to enhance their capacity and fulfill aspirations to participate in medical home, health home, or accountable care programs.[109]

These programs were templates on which the ACA's "health home" provision was based.[110] The ACA's health home provision permits states, at their option, to add services for home care for people with chronic illnesses.[111] The services included in the home care program include: "comprehensive case management; care coordination and health promotion; comprehensive transitional care . . . ; patient and family support; referral to community and social support services; [and] use of health information technology to link services, as feasible and appropriate."[112] The Department of Health and Human Services has provided guidance to states, further describing the structure of the program.[113] The ACA encourages states to adopt health home models by providing planning grants to assist states in evaluating these programs,[114] and by providing federal

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Takach & Buxbaum, *Community Health Teams*]; *see also* Mary Takach, *About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations*, 31 HEALTH AFF. 2432, 2432 (2012) ("Since 2006 twenty-five states have implemented new payment systems or revised existing ones so that primary care providers can function as patient-centered medical homes.") [hereinafter Takach, *State Patient-Centered Medical Homes*]; KELLY DEVERS ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., INNOVATIVE MEDICAID INITIATIVES TO IMPROVE SERVICE DELIVERY AND QUALITY OF CARE: A LOOK AT FIVE STATE INITIATIVES 1 (Sept. 1, 2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8224.pdf (discussing efforts in Alabama, Oklahoma, Oregon, Pennsylvania, and Washington).

107 *See* Takach, *State Patient-Centered Medical Homes*, *supra* note 106, at 2438.

108 *See* Takach & Buxbaum, *Community Health Teams*, *supra* note 106, at 15 (discussing studies conducted in North Carolina and Vermont).

109 *Id.* at 15–16 (citation omitted).

110 ACA, Pub. L. No. 111-148, § 2703, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1396w-4 (2012)).

111 42 U.S.C. § 1396w-4(a) (2012). For purposes of this provision, "people with chronic conditions" include enrollees with two chronic conditions, one chronic condition and at risk of another, or one "serious and persistent mental health condition." 42 U.S.C. § 1396w-4(h)(1)(A)(ii).

112 42 U.S.C. § 1396w-4(h)(4)(B).

113 *Health Homes*, CTRS. FOR MEDICARE & MEDICAID, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html (last visited Nov. 16, 2013).

114 42 U.S.C. § 1396w-4(c)(3).

matching funds for the program's health home services,[115] many of which are not otherwise services subject to federal match.[116] In addition, for the first two years of operation of the health homes, states receive an enhanced federal match of ninety percent for the health home payments.[117]

The health homes encouraged by the ACA, should they perform as early prototypes appear to indicate, offer innovative mechanisms for providing cost–effective, clinically appropriate services to the high–cost enrollees driving much of the Medicaid program's costs. They accomplish this by encouraging twenty–first century coordinated clinical care—rather than twentieth century acute care—for the growing number of enrollees with complex chronic illnesses. This method has a threefold promise: it can reduce cost, improve outcomes, and stretch the limited provider resources available to many states' Medicaid programs.

C. Accountable Care–Like Models

Accountable care organizations (ACOs) build on the coordinated care models described above. According to a definition by leaders in their development, "ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth."[118] These ends are to be achieved by using:

> [S]everal mechanisms, including disease management programs; improved care coordination; alignment of incentives for physicians and hospitals via shared savings; use of nonphysician providers, such as nurse practitioners and other health professionals; and the formation of patient–centered medical homes. Other key mechanisms are the use of health care information technology and pay–for–performance.[119]

In concept, ACOs are intended to perform like long–established integrated health care entities, such as the Geisinger Health System or the Cleveland Clinic, which over many years or decades have developed true, functioning clinical and business integration, thereby permitting them to deliver excellent care at an efficient cost.

The ACA authorized the operation of ACOs in the Medicare system and set up mechanisms for their formation and processes by which ACOs would share savings, if any, garnered from their efficient and effective operation with the Medicare program.[120] As the description of the means by which ACOs

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115 42 U.S.C. § 1396w–4(h)(4)(B).

116 42 U.S.C. § 1396w–4(c)(1).

117 *Id.*; *Health Homes*, *supra* note 113.

118 Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 982 (2010).

119 Lawton R. Burns & Mark V. Pauly, *Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s*, 31 HEALTH AFF. 2407, 2407 (2012).

120 ACA, Pub. L. No. 111–148, § 3022, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1395jjj (2012)).

will attempt to achieve efficiencies makes clear, they are to some extent built upon a base of coordinated care in physician practices.[121] The ACA provisions governing ACOs build upon that model, however, to include a wider range of providers, like hospitals, because controlling the cost of hospital utilization is important to cost containment.[122] The ACO model will be a challenge for many organizations as they attempt to achieve clinical and financial integration. The challenge will be heightened by attempts to achieve those steps in an environment in which Medicaid HMOs continue to occupy central positions. After all, HMOs and other previous integrative models were also intended to improve affordability and quality through clinical and financial integration,[123] and it is not clear that both models can coexist.[124]

The ACA does not include a provision for ACOs in the Medicaid program. Nevertheless, some versions of Medicaid ACOs are in the planning or formation stages.[125] These organizational structures are in their infancy. Researchers have identified state goals for Medicaid ACOs as similar to the federal government's interest in Medicare ACOs—that is, a combination of improving the quality of care and containing cost:

> The structure of Medicaid ACO initiatives is influenced by individual states' history and experience with managed care, other existing care delivery arrangements within Medicaid, and the challenges inherent in serving low-income and chronically ill populations. While Medicaid ACOs are a strategy to more directly engage providers and provider communities in improving care, cost-containment is also a significant motivating factor for many states.[126]

The lure of the Medicaid ACO structure is understandable. Just as the adoption of a coordinated care medical home model serves several goals in reforming

121 *See* McClellan et al., *supra* note 118, at 985.

122 *See id.* at 983.

123 *See* Burns & Pauly, *supra* note 119, at 2408.

124 *See* MARSHA GOLD ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., EMERGING MEDICAID ACCOUNTABLE CARE ORGANIZATIONS: THE ROLE OF MANAGED CARE 4 (May 1, 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf.

125 *See* Tara Adams Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, 42 SETON HALL L. REV. 1443, 1443–44 (2012) (citations omitted) (discussing states' efforts to develop Medicaid ACOs); *County-Based Accountable Care Organization for Medicaid Enrollees Features Shared Risk, Electronic Data Sharing, and Various Improvement Initiatives, Leading to Lower Utilization and Costs*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (May 8, 2013), http://www.innovations.ahrq.gov/content.aspx?id=3835 (discussing efforts in Minnesota); Gold et al., *supra* note 124, at 9; Tricia McGinnis & David Marc Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES, INC. 1 (Feb. 2012), http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf; Kitty Purington et al., *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, COMMONWEALTH FUND 1–2 (Feb. 4, 2011), http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Feb/On-the-Road-to-Better-Value.aspx (discussing development efforts in Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont, and Washington).

126 Gold et al., *supra* note 124, at 1.

physician practices in Medicaid, so too could ACOs employ broad cooperation among Medicaid providers to improve the quality of care delivered and enhance the capacity of strained providers, all while reducing the cost of the program. As the following section describes, however, the complexity of the Medicaid program suggests that the path to a successful ACO model will be even more challenging than the path for successful Medicare ACOs. Reaching that goal in Medicaid will require employment of new models of evidence-based care delivery, but also a rather old-fashioned sounding reliance on the community-spirited motivations of the participants. This paradoxical mix of technical proficiency and dedication to civil society values will be a challenge to achieve.

IV. Civil Society May Hold the Key to the Effectuation of Improvements in Medicaid

The Medicaid program, while not broken, falls short of its goal to provide appropriate health care services to society's most vulnerable members. The previous section sketched out how developments in health care finance and delivery, facilitated by provisions in the ACA, might improve the clinical services provided in the program while containing costs. Specifically, the use of coordinated care medical homes for people with chronic illnesses could improve the delivery of services, extend provider resources, and improve the cost-efficiency of care provision.[127] Additionally, ACOs, by aggregating many coordinated care medical home practices and wrapping them in an organization with hospitals and other necessary providers, could extend these gains to a wider group of Medicaid enrollees.

The success of a Medicaid ACO venture would require excellence in two areas that might seem strange bedfellows: the adoption and disciplined infusion throughout the organization of up-to-date, evidence-based clinical and business methods on one hand, and deeply rooted dedication to community consultation and orientation on the other. The first requirement is apparent to all observers of ACOs in other settings and has been set out by commentators on the needs of Medicaid ACOs. For example, McGinnis and Small, researchers for thenonprofit Center for Health Care Strategies, included as core competencies of a successful Medicaid ACO:

> a. *Patient-Centered Care Management and Coordination*: ACOs should provide medical home and broader health home services. In ACOs, care management resides at the point of care and is directed by the primary care team (as opposed to the managed care organization (MCO)). Care is coordinated, with the primary care team and hospitals jointly planning transitions from inpatient and emergency rooms to more appropriate care settings. ACOs should monitor the overall quality of care across their patient population, identify health trends and issues, and use predictive modeling to identify high-risk subsets.

127 *See* Coleman et al., *supra* note 103, at 81.

b. *Targeted and Intensive Complex Care Management*: ACOs are structured to serve a large patient population, ranging in acuity levels. But in order to substantially reduce costs, ACOs must identify, outreach to, and manage a smaller subset of high–need, high–cost patients, with high–intensity care approaches tailored to each patient. For low–income patients, this requires the development of cross–functional care teams that span the continuum of physical health, behavioral health, and social services, including long–term supports and services.

c. *Data Infrastructure and Analytics*: The first two capabilities outlined above require robust data infrastructure and analysis skills, which are frequently lacking at the point of care. At a minimum, ACOs need timely access to claims–based data (particularly for emergency room visits), the skills to effectively analyze the data, and the ability to translate that information into care management activities. Ideally, providers will have electronic health records (EHR) that feed electronic disease registries, clinical decision support, predictive modeling, and other analytic software. A health information exchange across delivery system partners is essential for efficient care coordination.[128]

Purington and her associates from the Center for State Health Policy advised states on what they should recognize in their regulatory capacities as to the structural requirements for Medicaid ACOs and focused on five factors with strikingly similar themes: data, new payment methods, accountability measures, promoting new (presumably evidence–based) systems of care, and supporting coordinated care medical home models for provider practices.[129] These are common–sense recommendations for any ACO, and they align with the descriptions of the Medicare ACO model.[130]

As difficult as these steps are, they are the easy part of developing an organization that can act as a truly coordinated care provider serving a community of people with demographic and socioeconomic vulnerabilities and personal characteristics bespeaking particular vulnerability, including minority or disability status. These community challenges are typical of an area with a concentration of Medicaid enrollees, as is the long history of poor provider access endemic in the Medicaid program. In addition, the communities served by such organizations are likely to have experienced a history of the health care delivery system's unequal treatment. In short, there may well be a trust deficit that is likely to frustrate even the most technically proficient and professionally dedicated management and clinical team.

A foundational tension faces these community organizations as they organize to improve community care. The adoption and disciplined infusion throughout the organization of up–to–date, evidence–based clinical and business methods is the first requirement of a successful Medicaid ACO, and

128 McGinnis & Small, *supra* note 125, at 2.

129 Purington et al., *supra* note 125 at viii.

130 *See, e.g.*, McClellan et al., *supra* note 118, at 985–87 (noting the importance of supporting development of evidence–based care and care coordination in primary care; performance measurement to ensure progress toward quality improvement; and the adoption of payment reforms that enhance clinical and business integration).

this requirement seems to require top–down, clear–eyed management. The second requirement, embracing a deeply rooted dedication to community consultation and orientation, seems to require bottom–up, consultative, and flexible management. This foundational tension is likely to trouble the organization in its initial stages, and perhaps throughout its life.

Indeed, there is support for this dichotomy in the literature. McGinnis and Small, after describing three sophisticated clinical and business competencies necessary to success, advise that regulators responsible for approving or supporting a Medicaid ACO should act with the recognition that:

> In low–income populations, poor health outcomes are often driven by poverty and related social issues, including unstable housing and employment, problems getting transportation, and insufficient access to a nutritious diet. A recent survey found that physicians believe that unmet social needs directly lead to compromised health status, but do not feel confident in their capacity to help their patients meet those needs.
>
> ACOs serving low–income populations are uniquely positioned to engage community–based organizations and patients to help bridge these gaps. Starting with the ACO certification or application process and continuing through implementation, states and health plans can foster provider–community partnerships by:
>
> - Requiring ACO governance structures to include meaningful community and patient representation;
> - Asking ACO applicants to provide a detailed community engagement strategy;
> - Requiring community and social services participation in care teams; and
> - Using community–level performance metrics to assess ACO performance.[131]

Similarly, Purington and her colleagues recommend that regulators recognize the perils of too technocratic an approach and advise requiring an organic, bottom–up Medicaid ACO formation strategy: "Look for community–based and regional opportunities. Experts agree it is unwise to start an ACO from the top down. ACOs should start with provider–driven, locally developed discussions and opportunities. States can assist in identifying, convening, and supporting such opportunities."[132]

The structure, clinical capability, and business sophistication of a well–resourced Medicaid ACO hold the promise of advancing the goal of improving care for vulnerable Medicaid recipients. But constituents will likely raise concerns about the likely scale of the organization and its need to bring together a broad range of the community's health resources to break out of historical patterns of care delivery. To be successful, a Medicaid ACO must exhibit the technical proficiency of a top–down, clinically and managerially integrated delivery system, as well as the community roots and orientation to develop and maintain the trust of Medicaid enrollees who have experienced broken promises in the past from both the health care delivery system and Medicaid.

131 McGinnis & Small, *supra* note 125, at 3–4.

132 Purington et al., *supra* note 125, at x.

Conclusion

Medicaid is a large, enormously important platform for bringing twenty–first century health care to the underserved, poor, and vulnerable. It is a program with a complicated past—one that has too often earned the distrust of providers and enrollees alike. However, it is too glib by far to conclude from this that Medicaid ought not be used as a vehicle for improving the health care of the poor and vulnerable now shut out of health coverage. Instead, Medicaid should be improved. The ACA provides tools for that improvement. It gives states the tools with which to strengthen primary care services. Building on that, it provides encouragement and ongoing funding for primary care–driven health homes for the most vulnerable enrollees—those with chronic illnesses. Building still further, it encourages clinical and reimbursement innovations that can be used by dedicated health care providers as they attempt to knit together twenty–first century systems of coordinated care for all members of their community. These new organizations, organized to counter the fragmentation of services that have so long plagued many communities of Medicaid enrollees, hold hope for real progress.

Medicaid has been a bulwark of health care finance for the medically vulnerable for nearly fifty years. It is imperfect, but it has created a lasting health care financing structure for communities that otherwise are without sufficient resources to support health care delivery. The imperfection in Medicaid is thanks in part to haphazard tinkering with its statutory structure, and in part to a fragmented, uncoordinated health delivery system. The ACA provides tools to improve Medicaid. The lion's share of the improvement must come, however, not from statutory design, but from the promise of communities and their health care providers to rededicate themselves to instantiating a Medicaid reinvigoration that melds community engagement with sophisticated, evidence–based care. The three essential pieces of that system progress from small to large in scale: improved primary care, care management for enrollees with chronic illness, and broad, community–driven systems of care dedicated to counter fragmentation and embrace life–saving care coordination.