

Faculty Scholarship

2012

Federal/State Tensions in Fulfilling Medicaid's Purpose

Laura Hermer

Mitchell Hamline School of Law, laura.hermer@mitchellhamline.edu

Publication Information

21 *Annals of Health Law* 615 (2012)

Repository Citation

Hermer, Laura, "Federal/State Tensions in Fulfilling Medicaid's Purpose" (2012). *Faculty Scholarship*. Paper 389.
<http://open.mitchellhamline.edu/facsch/389>

This Article is brought to you for free and open access by Mitchell Hamline Open Access. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of Mitchell Hamline Open Access. For more information, please contact sean.felhofer@mitchellhamline.edu.

Federal/State Tensions in Fulfilling Medicaid's Purpose

Abstract

Medicaid has been subject to reconsiderations of the proper role of government in providing for the health and welfare of populations over recent decades. Over the last decade in particular, a number of states have transferred many functions that they once performed to private entities, including, in a number of cases, express policymaking functions. The Patient Protection and Affordable Care Act (ACA) takes some crucial steps towards readjusting the equilibrium of Medicaid. Rather than further prioritizing the market in its reforms, it gives the federal government stronger charge of Medicaid policy, refocusing the program more directly on expanding eligibility and providing secure care for beneficiaries in the process. I argue that this reprioritization is in better keeping with the purpose of Medicaid, in contradistinction to the market-driven reforms undertaken during the Bush administration and sought by some states today. It does, however, shift more power from the states to the federal government. This has raised concerns not only from states that oppose the new health reform law, but also from a number that support it. These two groups of states share a desire for greater flexibility in their Medicaid programs than the ACA permits. Yet only one of these groups should be permitted to use federal Medicaid funds to make the reforms they seek. Federal administrations need to be particularly careful, when considering whether to grant state Medicaid waiver requests, to uphold Medicaid's purpose of giving lower-income Americans genuine access to the same health care that other Americans receive.

Keywords

Medicaid, Administration of Human Resource Programs, Health programs, Medical care, United States.
Patient Protection & Affordable Care Act

Disciplines

Medical Jurisprudence | Social Welfare Law

Federal/State Tensions in Fulfilling Medicaid's Purpose

Laura D. Hermer*

INTRODUCTION

What role ought government to play in ensuring that the people it governs have the goods and services they need to survive? Politicians considering this question in recent decades have often concluded that government's role should be more scant, at least with respect to certain welfare programs. Rather than ensuring the provision of a particular amount of goods or level of services and taking part in program administration, state and local governments have increasingly sought to limit their role to the provision of funding for welfare services and delegating program administration and execution to private entities.¹

Medicaid has not been immune to these changes. It has become commonplace for states to contract with private entities to perform eligibility screenings, manage recipients' care, and handle claims and queries, among other services.² It would be one thing if this transfer

* Assistant Professor at the University of Texas Medical Branch. I would like to thank the participants in the symposium on "Reinventing Medicaid in a Post-Health Reform Era," presented by Loyola University Chicago School of Law's Beazley Institute for Health Law and Policy, where I presented a version of this paper, as well as participants at my presentations of a version of this paper at Widener University School of Law and Hamline University School of Law, for useful comments, criticisms, and questions. Any errors remain my own. I would also like to thank Sheena Eagan, M.P.H., for her able and diligent research assistance.

1. See, e.g., Wendy A. Bach, *Welfare Reform, Privatization, and Power*, 74 BROOK. L. REV. 275, 278-81 (2009) (discussing the transition to greater use of private firms in providing welfare benefits following the 1996 federal reform of Aid to Families with Dependent Children); Michele Estrin Gilman, *Legal Accountability in an Era of Privatized Welfare*, 89 CAL. L. REV. 569, 591-94 (2001) (same).

2. See, e.g., MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, REPORT TO CONGRESS: THE EVOLUTION OF MANAGED CARE IN MEDICAID 11, 42, 44 (2011), available at http://www.macpac.gov/reports/MACPAC_June2011_web.pdf?attredirects=0&d=1 (finding that 71% of Medicaid beneficiaries nationwide were enrolled in any form of managed care, with 47% in comprehensive, risk-based managed care plans); ROBERT HURLEY ET AL., UNDERSTANDING THE INFLUENCE OF PUBLICLY TRADED HEALTH PLANS ON MEDICAID MANAGED CARE 1 (2006), available at http://www.chcs.org/usr_doc/Publicly_Traded_Health_Plans.pdf (finding that, as of 2006, nine publicly traded health plans accounted for 25% of all Medicaid managed care plans and covered one-third of all

primarily involved routine functions. It often does, but not always. In a growing number of cases, states are contracting out policymaking functions, such as the power to determine what benefits Medicaid recipients are offered or how much recipients pay for services, to private entities.³

The Patient Protection and Affordable Care Act (ACA) takes crucial steps towards readjusting the equilibrium of Medicaid. Rather than further prioritizing the market in its reforms, it takes stronger charge of Medicaid policy, refocusing the program more directly on expanding eligibility and providing secure care for recipients in the process.⁴ This reprioritization is, I will argue, in better keeping with the purpose of Medicaid, in contradistinction to the market-driven reforms undertaken during the Bush administration and sought by some states today.

The ACA does, however, shift more power from the states to the federal government. This has raised concerns not only from states that oppose the new health reform law, but also from a number that support it. These two groups of states share a desire for greater flexibility in their Medicaid programs than the ACA permits. Yet only one of these groups should be permitted to use federal Medicaid funds to make the reforms they seek. Federal administrations need to be particularly careful, when considering whether to grant state Medicaid waiver requests, to uphold Medicaid's purpose of ensuring that lower-income Americans have genuine, reasonable, and affordable access to the same health care that Americans of greater means do.

I will start by briefly examining the purpose of the Medicaid program – one which may not be immediately obvious from the language of the statute

Medicaid beneficiaries in managed care plans); MICHAEL J. MCCUE & MICHAEL H. BAILIT, ASSESSING THE FINANCIAL HEALTH OF MEDICAID MANAGED CARE PLANS AND THE QUALITY OF PATIENT CARE THEY PROVIDE 3 (2011), *available at* http://www.commonwealthfund.org/%7E/media/Files/Publications/Issue%20Brief/2011/Jun/1511_McCue_assessing_financial_health_Medicaid_managed_care_plans_ib_FINAL.pdf (finding that, between 2004 and 2009, the percentage of Medicaid recipients in managed care who were enrolled in publicly traded plans rose from 32% to 41%); MAGELLAN HEALTH SERVICES, 2010 ANNUAL REPORT 2-3 (2011), *available at* http://cts.businesswire.com/ct/CT?id=smartlink&url=http%3A%2F%2Ffiles.shareholder.com%2Fdownloads%2FABEA-31T2WX%2F1126235530x0x457630%2FB4EFC04D-26DA-4EFD-8881-EC19C3C60FC6%2F2010_MHS_Annual_Report-Final.pdf&sheet=6682662&lan=en-US&anchor=2010+Annual+Report&index=1&md5=9030774359447d1aea00f8b6e03fe059 (showing substantial percentage of their business related to Medicaid administration, and Medicaid radiology, pharmaceutical, and behavioral health management); JOANNE RAWLINGS-SEKUNDA ET AL., EMERGING PRACTICES IN MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAMS 20 (2001), *available at* <http://aspe.hhs.gov/health/reports/pccm/report.pdf> (finding that six of the eight states in their case study contracted with private vendors to provide enrollment services for their PCCM programs).

3. *See infra*, Part III and associated text.

4. *See infra*, Part IV and associated text.

and the legislative history, but which can be pieced together with the assistance of comparison with its predecessor program, the Kerr-Mills Act, among other evidence. I will then discuss a number of changes to Medicaid undertaken at the federal and state levels during the Bush and the Obama administrations, in light of our evaluation of Medicaid's purpose. I will conclude with some guidelines for providing states with more flexibility in shaping their Medicaid programs, moving forward from the ACA.

I. CLUES CONCERNING MEDICAID'S ORIGINAL PURPOSE

To some extent, Medicaid's purpose is quite clear. Federal law provides federal funding for each state "to furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."⁵ This purpose is the one generally accepted by courts, albeit in a variety of formulations, when considering Medicaid's goals.⁶ States need not accept those funds, nor need to have any Medicaid program whatsoever. However, if they choose to do so, they must meet certain mandatory requirements regarding the populations they serve and the services they offer, among other matters.⁷ The program, while an entitlement for those who qualify, is not limitless. States can, and do, put restrictions on both mandatory and optional services provided under Medicaid.⁸ There are limits to this flexibility, however, as federal regulations require that "[e]ach service must be sufficient in amount,

5. 42 U.S.C.A. § 1396-1 (West 2011). *See also* S. REP. NO. 89-404, at 1 (1965).

6. *See, e.g., Harris v. McRae*, 448 U.S. 297, 301 (1980) (Medicaid's purpose is to "provid[e] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons"); *Guzman v. Shewry*, 552 F.3d 941, 951 (9th Cir. 2009) (Medicaid's "freedom of choice" principle is consistent with "Medicaid's purpose of providing health care to the indigent in quantity and quality equivalent to the standard of care available to the general population"); *Three Lower Cnty. Cmty. Health Servs., Inc. v. Maryland*, 498 F.3d 294, 297 (4th Cir. 2007) ("The purpose of the Medicaid program is to enable States 'to furnish . . . medical assistance on behalf of families with dependent children . . . whose income and resources are insufficient to meet the costs of necessary medical services'") (citation omitted); *Lankford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006) ("Medicaid's goals [are to] provid[e] medically-necessary services, rehabilitation, or the capability of independence and self-care").

7. *See, e.g.,* 42 U.S.C.A. § 1396a(a) (1)-(3) (West 2011) (providing that state Medicaid programs must be implemented statewide, that the state must cover the non-federal share of program financing, and that individuals with Medicaid coverage have an administrative remedy in the event that their benefits are denied or not provided with reasonable promptness).

8. *See, e.g.,* ALA. ADMIN. CODE r.560-X-6-.14(1) (2011) (limits Medicaid coverage to no more than fourteen outpatient physician visits per year); 907 KY. ADMIN. REGS. 1:019 § 3(7)(a) (2011) (providing for coverage for no more than four prescriptions per month, with limited exceptions).

duration, and scope to reasonably achieve its purpose.”⁹

Medicaid’s legislative history provides few clues regarding Congress’s original intentions for the program. As noted in an earlier article, Medicaid was not the product of substantial legislative deliberation.¹⁰ Nevertheless, it is possible to make some inferences based on existing material. In contrast to its predecessor program, the Kerr-Mills Act, Medicaid’s mandatory baseline requirements suggest that Congress intended to correct some of the deficiencies of the prior law that helped make the Kerr-Mills Act unsuccessful in many states in providing health care for impoverished elderly people.¹¹ The Kerr-Mills Act made states responsible in nearly all respects for the creation of eligibility standards and benefit coverage. It specified only that state plans must provide for “some institutional and some noninstitutional care and services,” and “include reasonable standards . . . for determining eligibility” for individuals at least 65 years of age.¹² Programs differed dramatically from state to state, assuming a state chose to have a program at all. Those states that already provided a substantial amount of assistance for the elderly poor took advantage of Kerr-Mills, while those that provided scant or no assistance for the most part continued largely as they had before.¹³ According to Stevens and Stevens, only five states provided “comprehensive” services under Kerr-Mills.¹⁴

Medicaid, however, was quite different in several key respects. While it drew heavily from the language of Kerr-Mills, the federal government deviated from Medicaid’s predecessor by mandating that states choosing to participate in Medicaid must cover specific categories of people.¹⁵ It set mandatory income floors for each set of recipients rather than allowing states to set lower income limits.¹⁶ The law required states to cover a broad range of specific benefits rather than merely “some” institutional and non-institutional services.¹⁷ States could no longer offer different benefits to one group of recipients as compared to another; rather, the same standards had

9. 42 C.F.R. § 440.230(b), (d) (2011).

10. Laura Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 *GEO. J. ON POVERTY L. & POL’Y* 405, 407 (2010).

11. See ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 32-36 (Transaction Publishers 2d ed. 2003) (1974); DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY: 1965-2007*, at 40-41 (2008).

12. Act of Sept. 13, 1960, Pub. L. No. 86-778, 74 Stat. 924, 988-89. See also STEVENS & STEVENS, *supra* note 11, at 32.

13. STEVENS & STEVENS, *supra* note 11, at 33.

14. *Id.*

15. 42 U.S.C.A. §§ 1396a(a)(10)(A), 1396d(a) (West 2011).

16. 42 U.S.C.A. § 1396a(a)(10)(A), (a)(17).

17. 42 U.S.C.A. § 1396d(a).

to apply to all recipients throughout the state.¹⁸ Under Medicaid, state plans still vary, but far less dramatically than they did under Kerr-Mills.

The original Medicaid statute also provided that payments would not be made to states unless they had, within the first decade of the program, succeeded in furnishing “comprehensive care and services to substantially all individuals who meet the plan’s eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self care.”¹⁹ While this provision was never enforced and was ultimately repealed, it strongly suggests an expansive view of providing care to broad categories of low-income Americans, bordering on universal access for those who qualify. This broad view was taken as well by the Johnson administration, which characterized Medicaid’s

ultimate goal [as] the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose, will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.²⁰

Rather than taking the tack of the Kerr-Mills Act by deferring to the states and allowing their desires to prevail, the balance, clearly, was tilted much more directly toward prioritizing the health care needs of the poor.

Medicaid has been amended in many respects since its enactment. For example, in 2006, Congress loosened federal Medicaid requirements by giving states the ability to simply amend their state Medicaid plan to require certain recipients to enroll in “benchmark” plans, without respect to comparability of benefits among different categories of recipients or uniform statewide application, and to raise recipient cost-sharing substantially above prior limits.²¹ But these and other amendments have not tipped the balance entirely back to prioritizing deference to state prerogatives over the needs of the populations that Medicaid serves. That

18. 42 U.S.C.A. § 1396a(a)(10)(B).

19. Act of July 30, 1965, Pub. L. No. 89-97, 79 Stat. 350, 350 (1965) (current version at 42 U.S.C.A. § 1396a (West 2011)).

20. STEVENS & STEVENS, *supra* note 11, at 79 (quoting BUREAU OF FAMILY SERVICES, U.S. DEP’T OF HEALTH, EDUCATION, AND WELFARE, MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION supp. D (1966)).

21. 42 U.S.C.A. §§ 1396u-7(a)(1)(A), 1396o-1(a)-(b) (West 2011). For more detailed information about the changes to Medicaid made by the Deficit Reduction Act of 2005, see, e.g., Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 35-46 (2006).

arguably would have been accomplished, for example, through the Medicaid Transformation Act of 1995 (“Medigrant”). Medigrant would have changed Medicaid into a program intended “to provide block grants to States to enable them to provide medical assistance to low-income individuals and families in a more effective, efficient, and responsive manner.”²² It would have expressly recognized and respected the priorities of each state with respect to the health and management of their low-income populations, and the financial contribution each state chose to devote to these purposes.²³ States would have been given broad flexibility to set their own standards concerning eligibility, benefits, cost sharing, and other matters.²⁴ The Medigrant bill, however, was vetoed by President Clinton, and did not become law.²⁵ Its proposed goals, while invoked since that time by various parties in different contexts, have never enjoyed the force of law in any context.

Yet this does not mean that states, and at least one administration, have not tried to use these goals as the relevant standards to guide the Medicaid program. The passage of time has obscured many of the original goals for Medicaid, facilitating the use of others as substitutes. This is unfortunate, as Medicaid’s objectives become particularly relevant when considering not just the development of the program at the federal level, but also – and especially – state requests for waivers from federal rules. The history of disputes between the states and the federal government over the contours of national and state Medicaid programs is lengthy.²⁶ The focus here will be on more recent events.

II. STATE PROGRAMMATIC FLEXIBILITY UNDER THE BUSH ADMINISTRATIONS

In the recent past, particularly during the two most recent Bush administrations, states have arguably had substantially greater leeway to alter their Medicaid programs than they ever have before. Many of these changes were accomplished through §1115 waivers.²⁷ Section 1115 gives the Secretary of Health and Human Services the power to waive certain federal Medicaid statutory provisions at a state’s request so that the state

22. Balanced Budget Act of 1995, H.R. 2491, 104th Cong. § 2100(a) (1995).

23. § 2101(a)-(c).

24. § 2111(a).

25. SMITH & MOORE, *supra* note 11, at 242-43.

26. For more information about some of these disputes *see generally* MICHAEL S. SPARER, *MEDICAID AND THE LIMITS OF STATE HEALTH REFORM* (1996) (discussing variation in state Medicaid programs through a comparative case study of those of California and New York).

27. 42 U.S.C.A. § 1315 (West 2010).

may test a “demonstration project” or experiment within the program.²⁸ Without the waiver, the demonstration project would be out of compliance with federal Medicaid law and hence ineligible for federal matching funds.²⁹ The Secretary may grant a proposed waiver only when s/he believes the state’s proposed plan “is likely to assist in promoting [Medicaid’s] objectives.”³⁰ Accordingly, the nature of those objectives becomes – or should become – quite relevant when considering a §1115 waiver request. At least one circuit has held specifically on this point that “the administrative record ‘must be sufficient to support the agency action . . . and enable the court to review the agency’s decision.’”³¹

As some have noted, it is not at all clear that the Bush administration adhered to this requirement in some of the §1115 waivers it granted.³² As part of President Bush’s promise to “make federalism a priority” for his administration, the HHS developed its Health Insurance Flexibility and Accountability (HIFA) waiver initiative.³³ This initiative sought applications proposing to expand Medicaid eligibility to populations earning up to 200% of the federal poverty level, with a focus on using private coverage to do so.³⁴ It promised a fast track for applications and

28. 42 U.S.C.A. § 1315(a)(1), (2)(A). *See also* *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (“First, § 1315(a) requires that the state project be an ‘experimental, demonstration or pilot’ project. The statute was not enacted to enable states to save money or to evade federal requirements but to ‘test out new ideas and ways of dealing with the problems of public welfare recipients.’ Thus, the Secretary must make some judgment that the project has a research or a demonstration value. A simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement. Rather, the ‘experimental or demonstration project’ language strongly implies that the Secretary must make at least some inquiry into the merits of the experiment—she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration.”) (internal citations omitted). Section 1115 waivers are distinct from demonstration projects granted by the Center for Medicare and Medicaid Innovation (CMI), newly enacted as part of the Patient Protection and Affordable Care Act. For more information on CMI waivers, *see infra*, notes 76-80 and associated text.

29. 42 U.S.C.A. § 1315(a)(1), (2)(A).

30. 42 U.S.C.A. § 1315(a). *See also* *Beno*, 30 F.3d at 1070 (“ . . . [I]n determining that a state project is ‘likely to further the goals of the Act,’ the Secretary must obviously consider the impact of the state’s project on the children and families the [public welfare] program was enacted to protect”).

31. *Newton-Nations v. Betlach*, 660 F.3d 370, 380-81 (9th Cir. 2011) (quoting *Beno*, 30 F.3d at 1074).

32. *See, e.g.*, Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J.L. & SOC. PROBS. 91, 131-32 (2003).

33. *Id.* at 92; *Remarks by the President at National Governors’ Association Meeting*, THE WHITE HOUSE OFFICE OF THE PRESS SEC’Y, (Feb. 26, 2001), <http://georgewbush-whitehouse.archives.gov/news/releases/2001/02/20010226-8.html>.

34. *See, e.g.*, *Innovative Health Care Options in Medicaid and the State Children’s Health Insurance Program*, THE WHITE HOUSE, <http://georgewbush-whitehouse>.

substantially expanded state flexibility with respect to benefit packages, cost-sharing, and other features for expansion populations.³⁵

During this time, states took advantage of the new flexibility, some in dramatic ways. For example, Florida negotiated a waiver permitting it to allow private health maintenance organizations (HMOs) and provider service networks (PSNs) in five counties to design “customized,” risk-adjusted benefits packages among which families and certain other recipients receiving Medicaid must choose as coverage.³⁶ Recipients who fail to choose a plan can only get Medicaid reimbursement for emergency care, and after a month are automatically assigned to a plan.³⁷ Those with access to employer-sponsored coverage may opt-out of Medicaid and receive premium assistance instead.³⁸

Evidence suggests that Florida Medicaid Reform has resulted in substantial dislocations in the market, with severe churning in both plans and providers.³⁹ Recipients’ satisfaction with both their care and their health plan declined significantly in the first two years of the demonstration – the only years for which such data are available.⁴⁰ Recipients have been poorly informed about features of the program, have been unable to obtain care from prior providers, and unable to get in to see allegedly participating

archives.gov/infocus/medicare/health-care/health-medicaid.html (last visited Feb. 12, 2012).

35. U.S. GEN. ACCOUNTING OFFICE, MEDICAID AND SCHIP: RECENT HHS APPROVALS OF DEMONSTRATION WAIVER PROJECTS RAISE CONCERNS 8-9 (July 2002), available at <http://www.gao.gov/new.items/d02817.pdf>; CINDY MANN, THE KAISER COMM’N ON MEDICAID & THE UNINSURED, THE NEW MEDICAID AND CHIP WAIVER INITIATIVES 19, 23-24 (Feb. 2002), available at <http://www.kff.org/medicaid/upload/The-New-Medicaid-and-CHIP-Waiver-Initiatives-Background-Paper.pdf>.

36. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID REFORM SECTION 1115 DEMONSTRATION: SPECIAL TERMS AND CONDITIONS, at 1-2, 11, <http://www.nachc.com/client/documents/issues-advocacy/state-issues/1115-waivers/FISTC.pdf> (last viewed Dec. 8, 2011). Fee-for-service plans delivered through provider service networks, however, may not offer “customized” benefit packages. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MEDICAID REFORM: 1115 RESEARCH AND DEMONSTRATION WAIVER 11 (2011), available at http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/FL_1115_YR_5_Final_Annual_Report_07-01-10_06-30-11_sent_11-18-11.pdf.

37. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 36, at 11.

38. *Id.* at 10.

39. *See, e.g.*, AGENCY FOR HEALTH CARE ADMIN, *supra* note 36, at 6-8, 43-45 (noting entrance and withdrawal dates for plans and providing transition information).

40. R. PAUL DUNCAN ET AL., UNIV. OF FLA., MEDICAID REFORM ENROLLEE SATISFACTION: YEAR 1 FOLLOW-UP SURVEY 37-38 (2008), available at <http://mre.phhp.ufl.edu/publications/Medicaid%20Reform%20Enrollee%20Satisfaction%20Year%20One%20Follow%20Up%20Survey.pdf>; *see also* OFFICE OF PROGRAM POLICY ANALYSIS & GOV’T ACCOUNTABILITY, MEDICAID REFORM: LEGISLATURE SHOULD DELAY EXPANSION UNTIL MORE INFORMATION IS AVAILABLE TO EVALUATE SUCCESS 4 (2009), available at <http://www.oppaga.state.fl.us/Summary.aspx?reportNum=09-29>.

providers.⁴¹ Only 21 have enrolled in the “opt-out” program.⁴² Plans differ little, if at all, in the benefits they offer.⁴³ Providers left the program in large numbers after experiencing significant increases in paperwork, lack of payment, and inability either to obtain authorization to provide necessary care or refusal to honor prior approvals of care.⁴⁴ There have been documented cost savings in comparison with control counties. However, those savings are small, and it is unknown, among other factors, how quality of care and access to care have been affected in the process.⁴⁵

The stated goals for the Florida waiver, as originally submitted, have little to do directly with ensuring that Americans who lack the means to pay for their health care needs receive comprehensive care. Under Florida Medicaid Reform, recipients (“Medicaid consumers”) are “expected to take an active role in their health care.”⁴⁶ The state’s role is to change from one of “centralized decision maker that creates and manages health care services to a purchaser of health care services.”⁴⁷ Individuals with access to employer-sponsored insurance can choose to be given a premium subsidy rather than Medicaid coverage.⁴⁸ “Medicaid will move to a premium-based system and . . . expenditures will become more predictable.”⁴⁹ The state

41. JOAN ALKER ET AL., JESSIE BALL DUPONT FUND, FLORIDA’S EXPERIENCE WITH MEDICAID REFORM:

WHAT HAS BEEN LEARNED IN THE FIRST TWO YEARS? 5-6 (2008), available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/state-specific/floridas%20experience%20with%20medicaid%20reform.pdf>.

42. JOAN ALKER & JACK HOADLEY, JESSIE BALL DUPONT FUND, AS LEGISLATORS WRESTLE TO DEFINE NEXT GENERATION OF FLORIDA MEDICAID, BENEFITS OF REFORM EFFORT ARE FAR FROM CLEAR 4 (2011), available at http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/state-specific/florida-2011/medicaid_reform_fl_2011.pdf.

43. See, e.g., OFFICE OF PROGRAM POLICY ANALYSIS & GOV’T ACCOUNTABILITY, *supra* note 40, at 5.

44. JOAN ALKER ET AL., *supra* note 41, at 4-5. See also ALLYSON HALL ET AL., HEALTH FOUND. OF S. FLA., MEDICAID REFORM: BROWARD COUNTY PHYSICIANS’ EXPERIENCES 13-15 (2010), available at <http://hfsf.org/HFSF/UserFilesUpload/file/Physicians%20Experiences%20with%20Medicaid%20Reform%20in%20Broward%20County.pdf>.

45. JEFFREY S. HARMAN & R. PAUL DUNCAN, UNIV. OF FLA., AN ANALYSIS OF MEDICAID EXPENDITURES BEFORE AND AFTER IMPLEMENTATION OF FLORIDA’S MEDICAID REFORM PILOT DEMONSTRATION 10 (2009), available at <http://mre.phhp.ufl.edu/publications/An%20Analysis%20of%20Medicaid%20Expenditures%20Before%20and%20After%20Implementation%20of%20Floridas%20Medicaid%20Reform%20Pilot%20Demonstration.pdf>.

46. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 36, at 1; see also FLA. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MEDICAID REFORM 3 (2005), available at http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf.

47. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 36, at 1.

48. *Id.* at 2.

49. *Id.*

expects that these changes will “[i]ntroduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost,” and “[i]mprove health outcomes and reduce inappropriate utilization,” among other less recipient-oriented objectives.⁵⁰ Florida’s goals for the program assume that a market-based approach, one that turns Medicaid into a defined contribution program rather than a defined benefits program and that subjects recipients more directly to the health insurance marketplace, will result in better care for recipients. Facially, at least some of these objectives comport with Medicaid’s goals as discussed above. Yet it is clear that ideological concerns are more pressing, particularly when one considers Florida’s current plans for the waiver, in light of the project’s outcomes to date, as will be discussed further below.⁵¹

Rather than seeking to privatize a portion of its Medicaid program as Florida did, Vermont received permission through its “Global Commitment to Health” waiver to operate a state-run managed care program for its Medicaid recipients, offer a subsidized insurance product or, alternatively, subsidies for employer-sponsored insurance to lower-income Vermonters who earn too much to qualify for Medicaid coverage, and expand enrollment and services beyond those permitted in Medicaid under federal law.⁵² Chronic care management programs were created to coordinate primary care for Vermonters with chronic health conditions.⁵³ In exchange, it accepted a conversion from open-ended federal funding to a block grant, which caps the total share of federal funding.⁵⁴

Evidence suggests this program is working out relatively well for both Vermont and its residents. The percentage of uninsured Vermonters has declined since the waiver’s inception.⁵⁵ The Global Commitment fund, which funds the premiums for services under Vermont’s waiver, had an \$80 million balance at the end of FY 2011.⁵⁶ Nearly all Vermont physicians

50. *Id.*

51. *See infra*, notes 113-17 and associated text.

52. *See, e.g., Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., 2-5, <https://www.cms.gov/MedicaidStWaivProgDemoPGL/downloads/Vermont%20Global%20Committment%20to%20Healthcare%20Fact%20Sheet.pdf> (last viewed Dec. 8, 2011).

53. RONALD DEPREZ ET AL., STATE HEALTH ACCESS REFORM EVALUATION, ACHIEVING UNIVERSAL COVERAGE THROUGH COMPREHENSIVE HEALTH REFORM: THE VERMONT EXPERIENCE 2 (2009), *available at* <http://www.shadac.org/files/shadac/publications/VermontComprehensiveReform.pdf>.

54. *Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet*, *supra* note 52, at 9.

55. DEPREZ, *supra* note 53, at 2-3.

56. VT. LEGISLATIVE JOINT FISCAL OFFICE, REPORT ON MEDICAID FOR FISCAL YEAR 2011, at 3 (2011), *available at* http://www.leg.state.vt.us/jfo/jfc/2011/2011-7-21/2011_7_21_Medicaid_Report.pdf.

participate in Medicaid, and, in contradistinction to the situation in many states, a substantial majority of them accept new Medicaid patients.⁵⁷ Although 27% of Vermonters participate in Vermont's Medicaid program, as compared to 20% of Americans nationally,⁵⁸ America's Health Rankings once again ranked Vermont first among all the states in overall good health in 2011.⁵⁹

The terms and outcomes for Vermont's waiver appear to comport well with the waiver's stated goals: (1) "Increasing access to affordable and high quality health care;" (2) "Improving access to primary care;" (3) "Improving the health care delivery for individuals with chronic care needs;" and (4) "Containing health care costs."⁶⁰ On their face, the goals stated in Vermont's Global Commitment to Health waiver proposal appear generally to comport with the goals discussed above for Medicaid. Unlike many of Florida's waiver goals, the emphasis of most of the objectives is on Vermont's Medicaid recipients and expansion populations, and the effects that the demonstration project will have on their access to health care and health care outcomes.

Indiana went a very different direction with its waiver proposal. It obtained permission from CMS to use, among other revenue sources, a substantial portion of its disproportionate share hospital (DSH) funds, or federal supplemental Medicaid funding for uncompensated hospital care, to instead offer a private, high-deductible health plan with a health savings account to a limited number of low-income, uninsured adults who do not qualify for Medicaid.⁶¹

Preliminary data from the Healthy Indiana Plan (HIP) suggest that it may work reasonably well for those Indianans who manage to obtain coverage

57. VT. DEP'T OF HEALTH, 2010 PHYSICIAN SURVEY STATISTICAL REPORT 39 (2011), available at <http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys10bk.PDF> (finding that, in 2010, 72% of primary care physicians accepted new Medicaid patients, and 88% of specialists did).

58. *Vermont: Medicaid Enrollment as a Percent of Total Population 2008*, THE KAISER FAMILY FOUNDATION, <http://www.statehealthfacts.org/profileind.jsp?ind=199&cat=4&rgn=47> (last viewed Dec. 8, 2011).

59. UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS 16 (2011), available at <http://www.americashalthrankings.org/SiteFiles/Reports/AHR%202011Edition.pdf>.

60. CTRS. FOR MEDICARE & MEDICAID SERVS., GLOBAL COMMITMENT TO HEALTH SECTION 1115 DEMONSTRATION: SPECIAL TERMS AND CONDITIONS, at 2 (2007), available at <http://www.vermont.gov/global-commitment-to-health/vt-1115.pdf>.

61. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTHY INDIANA PLAN: SPECIAL TERMS AND CONDITIONS, at 2 (2007), 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 IND. FAMILY & SOC. SERVS. ADMIN., THE HEALTHY INDIANA PLAN: SECTION 1115 AFFORDABLE CHOICES DEMONSTRATION PROPOSAL at 41-42 (2007).

under it. In 2009, only 46,000 of the 365,600 uninsured Indianans earning less than 139% of the federal poverty level were enrolled in HIP, far less than the 127,000 Indianans that the waiver application contemplated covering.⁶² While a long-awaited, state-commissioned study examining recipients' experiences in HIP has still not been released, available data suggests that a majority of HIP recipients remain in the program, and most utilized care at least once in the first year of their enrollment.⁶³ Yet, HIP has proved to be inordinately expensive for the state – far more so than the state contemplated, and more than it would be to simply provide Medicaid coverage for the same population.⁶⁴ Additionally, at least one 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.⁶⁵ However, the hospitals receiving business from HIP were not identical to the ones that would have received DSH funds.⁶⁶ Over half of the hospitals received no DSH payment in 2009.⁶⁷ Some of the hospitals were even out of state.⁶⁸ It appears HIP has resulted in a transfer of funds from some traditional safety net hospitals, which are the ones that tend to receive DSH funds, to other non-safety net hospitals.

There are some discrepancies in the stated goals of Indiana's Healthy Indiana Plan waiver. CMS reported that Indiana sought to “[e]nsure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals”; “[e]ncourage individuals to stay healthy and seek preventive care”; “[g]ive individuals control of their health care decisions and incentivize positive

62. HIP MONTHLY DASHBOARD DRAFT (2009) (on file with the author); THE HENRY J. KAISER FAMILY FOUNDATION, INDIANA: HEALTH INSURANCE COVERAGE OF ADULTS WITH INCOMES UNDER 139% OF THE FEDERAL POVERTY LEVEL (FPL), STATES (2009-2010), U.S. (2010), State Health Facts (2012), available at <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=16&ind=779&sub=177>; IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 61, at Attachment 6, p. 8.

63. CAROL IRVIN, HEALTH FINANCE COMM'N, HEALTHY INDIANA PLAN: THE FIRST TWO YEARS, at 23, 37 (2010), available at http://www.mathematica-mpr.com/publications/redirect_PubsDB.asp?strSite=PDFs/health/healthyIndiana_Irvin.pdf.

64. See Hermer, *supra* note 10, at 419-20 (noting that between January and August of 2009, an average HIP enrollee who did not have a specified, high-cost health condition cost the state \$413/month, and one that did cost \$1007/month, in comparison with comparable Medicaid beneficiaries, who cost an average of \$350/month.).

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

66. *Id.*

67. *Id.* at 23.

68. *Id.* at 22.

health behaviors”; “[m]ake individuals aware of the cost of health care services”; and “[e]ncourage provision of quality medical services to all enrollees.”⁶⁹ The stated goals appear focused on recipients, and yet they are rather different from those provided by Indiana itself in its waiver application. The goals in the Healthy Indiana Plan waiver include “Promoting Healthier Hoosiers”; “Promoting Personal Responsibility”; “Using Private Market Solutions”; “Promoting System Efficiency and Quality”; “Promote [sic] Price Transparency by Using Overt, Not Covert Subsidies”; “Practicing Fiscal Responsibility”; “Helping Hoosier Businesses”; and “Pro-Work” [sic].⁷⁰ Indiana’s stated goals in its waiver application unguardedly emphasized the importance of the waiver to private, commercial interests and to the inculcation of recipients in market practices. As with the Florida waiver, one must stretch to find a correlation between support and emphasis of the market and improved health care for lower-income state residents. Depending on the outcome of the demonstration project, this alleged correlation might be refuted.

III. A RETURN TO STRONGER FEDERAL CONTROL UNDER OBAMA

During the two most recent Bush administrations, states moved in widely disparate directions with their respective Medicaid programs, but this trend began to change with the Obama administration. Just a few months into its term, the Obama administration implemented a more centralized vision for Medicaid by overseeing the creation of the federal Medicaid and CHIP Payment and Access Commission (MACPAC) in the CHIP Reauthorization Act of 2009 and expanding MACPAC’s mandate under the Affordable Care Act.⁷¹ MACPAC is charged with examining both state and federal policies that affect recipients’ access to services and quality of care, including eligibility, enrollment, retention, quality of care, and payment.⁷² MACPAC also examines the effect of Medicaid and CHIP policies on health care access and delivery generally, and makes reports and recommendations to Congress.⁷³ Ultimately, MACPAC has the potential to offer stronger and better-informed federal oversight of both Medicaid and CHIP than they ever previously received.

The Obama administration continued the trend toward increased federal oversight with the introduction of the Patient Protection and Affordable Care Act (ACA). The ACA will expand baseline Medicaid eligibility to

69. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 61, at 3.

70. IND. FAMILY & SOC. SERVS. ADMIN., *supra* note 61, at 9-10.

71. 42 U.S.C.A. § 1396(a) (West 2011).

72. 42 U.S.C.A. § 1396(b)(1)(A), (b)(2)(A)-(E).

73. 42 U.S.C.A. § 1396(b)(1)(B), (b)(2)(F), (b)(3)(B).

133% of the federal poverty level for all nonelderly Americans and qualifying legal residents in 2014; currently eligibility is limited only to certain categories of people and is often more restricted by income level.⁷⁴ The ACA offers an expansive vision of Medicaid's role in the country's coverage universe. It is no accident that half of those who will newly obtain coverage under the ACA will obtain it through Medicaid.

One can see this as a normalizing and centralizing response to the wide diversity among each state's Medicaid program's structure and governance, as well as to the often piecemeal way in which Medicaid has developed at the federal level. The creation of the Center for Medicare and Medicaid Innovation (CMI) under the ACA could be viewed in a similar fashion. CMI will disburse up to \$10 billion from 2011 through 2019 to test a wide variety of innovations.⁷⁵ The criteria for determining the appropriateness of a CMI demonstration project are better defined than they are in §1115. The Secretary of HHS is charged with choosing proposed models "where . . . there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures," and where the model is expected to preserve or enhance care while reducing costs.⁷⁶ HHS must test each demonstration project according to specific metrics and make the information publicly available.⁷⁷ Judicial review is limited.⁷⁸ Most notably, however, the statute gives the Secretary the ability to expand the duration and scope of certain demonstration projects – even up to nationwide implementation – without obtaining prior congressional approval. To be eligible for such expansion, projects must reduce spending without reducing quality of care, or improve quality of care without increasing spending, and also cannot compromise benefits for applicable populations.⁷⁹ This degree of federal administrative discretion is unprecedented in Medicaid.

Notwithstanding the generous federal funding for newly-eligible populations, many states are wary of the new federal Medicaid mandates. First, there are millions of uninsured residents who will become eligible for Medicaid under the ACA.⁸⁰ Some states will need to absorb a substantial

74. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended in 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII) (West 2011)).

75. 42 U.S.C.A. § 1315a(f)(1)(B) (West 2011).

76. 42 U.S.C.A. § 1315a(b)(2)(A); *see also* § 1315a(b)(2)(C) (providing additional factors for consideration).

77. 42 U.S.C.A. § 1315a(b)(4)(A)-(B).

78. 42 U.S.C.A. § 1315a(d)(2).

79. 42 U.S.C.A. § 1315a(c).

80. *See, e.g.*, Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, at Table 2 (Mar. 18, 2010), *available at*

number of new Medicaid recipients. Although not all people who become newly eligible will take up coverage, the current average take-up rate of approximately sixty-two percent could be exceeded, depending on a variety of factors.⁸¹

It would be one thing if the federal government were to pick up 100% of the costs of the expansion permanently. It will only do so, however, from 2014 through 2016.⁸² Thereafter, the federal contribution shrinks until stabilizing in 2020 at a ninety percent matching rate.⁸³ Accordingly, states will ultimately need to pay a portion of the costs, including administrative expenses, for the newly eligible.⁸⁴ While this will have only a modest impact on some states, especially for those that already have expansive Medicaid eligibility, others will be harder hit. Texas is one notable example. According to the Texas Health and Human Services Commission, the state will have to pay \$27 billion in new Medicaid costs as a result of the ACA between 2014 and 2023.⁸⁵ This calculation presumes the take-up rate for Medicaid among the newly eligible will be over ninety percent, far in excess of the current average take-up rate.⁸⁶ This figure also includes those individuals who were already eligible for Medicaid, but who have not taken it up.⁸⁷ Additionally, it assumes that Texas will continue to fund the increase in reimbursement to primary care physicians that the federal government will fully fund in 2014 and 2015 and will also authorize a five percent provider rate increase for all specialties.⁸⁸ The Health and Human Services Commission report rationalizes – quite reasonably so, if only Texas applied this reasoning consistently throughout the rest of its Medicaid program – that coverage is worthless if providers are not willing to assume care due to perceived inadequacies in reimbursement.

Other analysts have come to a quite different conclusion about the likely costs of expanding Medicaid in Texas. In a study funded by the Kaiser

<http://netadvisor.org/wp-content/uploads/2011/05/2010-03-18-CBO-Letter-to-Pelosi-tricky-math.pdf>.

81. Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion – The Soft Underbelly of Health Care Reform?*, 363 *NEW ENG. J. MED.* 2085, 2085-86 (2010).

82. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 272-73 (2010) (codified as amended at 42 U.S.C.A. § 1396d(y)(1) (West 2011)).

83. *Id.*

84. *See id.* Administrative expenses, even for the newly eligible, will continue in most cases to be matched at 50%, rather than at the increased rate. The increased rate applies only to health care expenses. 42 U.S.C.A. §§ 1396b(a)(7), 1396d(y)(1) (West 2011).

85. THOMAS M. SUEHS, TEX. HEALTH & HUMAN SERVS. COMM'N, FEDERAL HEALTH CARE REFORM – IMPACT TO TEXAS HEALTH AND HUMAN SERVICES 7 (2010), available at <http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf>.

86. *Id.* at 11.

87. *Id.* at 6.

88. *Id.* at 7, 13.

Family Foundation, John Holahan and Irene Headen found that, between 2014 and 2019, Texas's costs would total only \$4.5 billion for the cost of covering both the newly-eligible and those who were previously eligible for Medicaid but who did not take up coverage.⁸⁹ In this "high participation" scenario, they assume that seventy-five percent of both the newly- and previously eligible populations in question take up Medicaid.⁹⁰ Ultimately, they predict that Texas' Medicaid spending would increase by only 5.1%.⁹¹ The Lewin Group forecasts an even smaller spending increase of only \$4 billion dollars, a four percent increase.⁹²

The problem is that the ACA's Medicaid expansion comes at a time when many, if not most, states are deeply concerned about their budgets and the impact their Medicaid programs have on them. While certain features of the Great Recession and its aftermath are improving, 8.2% of Americans remain unemployed, and many others are involuntarily working fewer hours than they would prefer.⁹³ Tax revenues declined sharply during the period of protracted, high unemployment.⁹⁴ Although they have picked up again in most states, they are forecast nationally to remain over \$20 billion below 2008 levels in 2012.⁹⁵ Meanwhile, state Medicaid rolls rose sharply during the economic downturn, and remain quite large.⁹⁶ This, in itself, is problematic. Yet as an additional issue, most states are required to maintain a balanced budget, and hence cannot incur debt to pay for most programs funded through general revenue.⁹⁷ Medicaid's countercyclical

89. JOHN HOLAHAN & IRENE HEADEN, KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL, at 46 (2010), available at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>.

90. *Id.* at 8.

91. *Id.* at 46.

92. JOHN SHEILS ET AL., THE LEWIN GROUP, THE IMPACT OF THE MEDICAID EXPANSIONS AND OTHER PROVISIONS OF HEALTH REFORM ON STATE MEDICAID SPENDING 14 (2010), available at http://www.lewin.com/~media/lewin/site_sections/publications/lewin_impact_of_medicaid_expansions_on_state_spending.pdf.

93. Bureau of Labor Statistics, *Employment Situation Summary*, U.S. DEP'T OF LABOR (Apr. 6, 2012, 8:30 AM), <http://www.bls.gov/news.release/empsit.nr0.htm>.

94. NAT'L GOVERNORS ASS'N & NAT'L ASS'N OF STATE BUDGET OFFICERS, THE FISCAL SURVEY OF STATES 44 (2011), available at <http://www.nasbo.org/sites/default/files/2011%20Fall%20Fiscal%20Survey%20of%20States.pdf>.

95. *Id.*

96. JOHN HOLAHAN & VICKY CHEN, KAISER COMM'N ON MEDICAID & THE UNINSURED, CHANGES IN HEALTH INSURANCE COVERAGE IN THE GREAT RECESSION, 2007-2010, at 15 (2011), available at <http://www.kff.org/uninsured/upload/8264.pdf>.

97. NAT'L CONFERENCE OF STATE LEGISLATURES, NCSL FISCAL BRIEF: STATE BALANCED BUDGET PROVISIONS 4-5 (2010), available at <http://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf>. Note that what different states mean by

nature invites grave difficulties and difficult choices in state budgets.

When this last happened in 2002, many states made significant cuts in their Medicaid eligibility standards, services, reimbursement, and other measures.⁹⁸ Thirty-eight states cut Medicaid eligibility in at least one of the years between 2002 and 2005.⁹⁹ The Bush administration refrained from helping states until late in the recession.¹⁰⁰ In the most recent recession, the Obama administration quickly offered relief to the states in the form of the American Recovery and Reinvestment Act (ARRA).¹⁰¹ ARRA offered increased federal Medicaid matching funds, to states that agreed, among other measures, not to cut Medicaid eligibility from the levels in place as of July 1, 2008.¹⁰² The baseline Federal Medical Assistance Percentage (FMAP) increase of 6.2% proved sufficiently enticing for states to consent to keep their eligibility levels intact.¹⁰³

ARRA funding was still in place when the ACA was signed on March 23, 2010. The ACA, too, contains a “maintenance of eligibility” requirement.¹⁰⁴ Except under limited circumstances, a state may not reduce its Medicaid eligibility levels from that in place as of March 23, 2010, until at least January 1, 2014.¹⁰⁵ Therefore, between the ARRA requirements and the ACA requirements, states are locked in to the eligibility levels they had in place as of July 1, 2008. This would perhaps be acceptable to more states if the ARRA FMAP increase was still in place, but the enhanced FMAP

“balanced budget” can differ substantially from state to state. Most states (41 states, according to a 2008 NCSL report) require the budget passed by the legislature to be balanced. *Id.* at 4. In a majority of states with such a provision, this means that a deficit cannot be carried over from one year to the next. *Id.* at 5. Yet in other states, this might mean only, for example, that the governor’s proposed budget must be balanced. *Id.*

98. VERNON SMITH ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, THE CONTINUING MEDICAID BUDGET CHALLENGE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2004 AND 2005, at 20-33 (2004), available at <http://www.kff.org/medicaid/upload/The-Continuing-Medicaid-Budget-Challenge-State-Medicaid-Spending-Growth-and-Cost-Containment-in-Fiscal-Years-2004-and-2005-Results-from-a-50-State-Survey.pdf>.

99. *Id.* at 26.

100. *See id.* at 9.

101. *See* U.S. GOV’T ACCOUNTABILITY OFFICE, RECOVERY ACT: AS INITIAL IMPLEMENTATION UNFOLDS IN STATES AND LOCALITIES, CONTINUED ATTENTION TO ACCOUNTABILITY ISSUES IS ESSENTIAL 12 (2009), available at <http://www.gao.gov/new.items/d09580.pdf>.

102. *Id.* at 13-14.

103. *See* VERNON K. SMITH ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, HOPING FOR ECONOMIC RECOVERY, PREPARING FOR HEALTH REFORM: A LOOK AT MEDICAID SPENDING, COVERAGE, AND POLICY TRENDS 24 (2010), available at <http://www.kff.org/medicaid/upload/8105.pdf>. States with high unemployment rates received an even greater FMAP increase. *Id.*

104. 42 U.S.C.A. §1396a(gg)(1) (West 2011).

105. 42 U.S.C.A. §1396a(gg)(3).

ended on June 30, 2011.¹⁰⁶ No state to date has reduced its Medicaid eligibility requirements in direct violation of federal requirements.¹⁰⁷ Their programs, however, have not been left unscathed. When money is tight, states must make cuts somewhere.

This time, while a surprisingly large number of states have expanded eligibility for certain populations during the latest recession and its aftermath, many have also been putting limits on mandated services, and cutting provider reimbursement, optional services, and, in a couple states, eligibility for certain higher-income adults.¹⁰⁸ Hawaii and Arizona have most recently proposed placing caps or further caps on covered days of hospitalization.¹⁰⁹ California has proposed limiting physician visits, on top of a 10% provider rate cut.¹¹⁰ While eligibility has not been curtailed for most Medicaid recipients, cuts such as these may have a negative effect on access to services.¹¹¹

Yet, these are not the biggest changes taking place. For example, several states briefly considered, and then discarded, the “nuclear option,” popularized by the Heritage Foundation in late 2009, of exiting the Medicaid program altogether.¹¹² A number of other states are considering or

106. KAISER COMM'N ON MEDICAID & THE UNINSURED, UNDERSTANDING THE MEDICAID AND CHIP MAINTENANCE OF ELIGIBILITY REQUIREMENTS 1 (2011), *available at* <http://www.kff.org/medicaid/upload/8204.pdf>.

107. *See, e.g.*, MARTHA HEBERLEIN, TRICIA BROOKS, JOCELYN GUYER ET AL., PERFORMING UNDER PRESSURE: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP, 2011-2012 8, 12 (2012), *available at* <http://www.kff.org/medicaid/upload/8272.pdf> (finding that, during the study period, only two states reduced Medicaid eligibility, and that both did so in ways that were permissible under the exceptions to the ACA's maintenance of eligibility requirements).

108. SMITH ET AL., *supra* note 103, at 32.

109. Phil Galewitz, *States are Limiting Medicaid Hospital Coverage in Search for Savings*, KAISER HEALTH NEWS (Oct. 31, 2011), <http://www.kaiserhealthnews.org/Stories/2011/October/24/States-Are-Limiting-Medicaid-Hospital-Coverage-In-Search-For-Savings.aspx>.

110. *Id.*; *see also* Associated Press, *California Doctors Sue Government Over Medi-Cal Cuts*, SAN DIEGO UNION-TRIBUNE (Nov. 21, 2011), <http://www.utsandiego.com/news/2011/nov/21/calif-doctors-sue-government-over-medi-cal-cuts/>.

111. *See, e.g.*, JoAnne Young, *Medicaid Providers Warn Rate Cuts Would Have Dismal Consequences*, LINCOLN JOURNAL STAR (Mar. 15, 2011, 7:30 PM), http://journalstar.com/news/unicameral/article_fdd38430-73bc-56ac-90b6-46d6425a957b.html; Darren Barbee, *Texas May Cut Medicaid Reimbursements to Healthcare Providers*, STAR-TELEGRAM.COM (Nov. 20, 2011), <http://www.star-telegram.com/2011/11/20/3540533/texas-may-cut-medicare-reimbursements.html#tvq>.

112. Dennis Smith, a former director of the Centers for Medicare and Medicaid Services under George W. Bush, proposed that states opt-out of Medicaid in a Heritage Foundation paper. Dennis G. Smith & Edmund F. Haislmaier, *Medicaid Meltdown: Dropping Medicaid Could Save States \$1 Trillion*, THE HERITAGE FOUNDATION (2009), http://s3.amazonaws.com/thf_media/2009/pdf/wm2712.pdf. A number of states, including

attempting less dramatic but still significant changes. For instance, Florida's legislature approved an expansion of the demonstration program described earlier to the entire state, and is presently waiting for CMS to approve or deny a corresponding waiver.¹¹³ While it approved a continuation of the existing five-county demonstration described above, CMS imposed new standards concerning medical loss ratios, benefit standards, and cost-sharing.¹¹⁴ It is uncertain whether CMS will approve the statewide expansion and, if so, in what form.¹¹⁵ Placing recipients – even frail, elderly recipients – into HMOs is one thing. Most states have taken to using managed care for most of their Medicaid populations, and there is even a trend toward doing so for those who are eligible for both Medicare and Medicaid, who tend to be among the frailest and sickest people Medicaid serves.¹¹⁶ Yet, as noted earlier, Florida's demonstration project also gives private health insurers discretion to alter or even eliminate benefits that would otherwise be mandatory.¹¹⁷ This step moves beyond even the discretion given to states under the Deficit Reduction Act to offer “benchmark” plans to specific Medicaid populations.¹¹⁸ Under the Deficit Reduction Act, the state is still ultimately in charge of determining benefits. Florida's proposed waiver, however, would cede that control to private insurers. In all, Florida's program currently represents one of the more

Texas, Nevada, and Wyoming, went so far as to study the issue following the paper's publication. *See, e.g.*, STRATEGIC DECISION SUPPORT, TEX. DEP'T OF HEALTH & HUMAN SERVS. COMM'N, IMPACT ON TEXAS IF MEDICAID IS ELIMINATED (2010), available at www.hhsc.state.tx.us/hb-497_122010.pdf; NEV. DEP'T OF HEALTH AND HUMAN SERVS. & DIVISION OF HEALTH CARE FINANCING AND POLICY, MEDICAID OPT-OUT (2010), available at <http://media.lasvegassun.com/media/pdfs/blogs/documents/2010/01/28/medicaid0128.pdf>; WYO. DEP'T OF HEALTH, MEDICAID OPT-OUT IMPACT ANALYSIS (2010), available at www.health.wyo.gov/Media.aspx?mediaId=9529.

113. Lizette Alvarez, *Florida Legislators Pass H.M.O. Plan for Medicaid*, N. Y. TIMES (May 6, 2011), <http://www.nytimes.com/2011/05/07/us/07florida.html>.

114. Carol Gentry, *Medicaid Waiver Coming Soon, with Patient Protection Rules*, HEALTH NEWS FLORIDA (Dec. 14, 2011), http://www.healthnewsflorida.org/hnf_stories/read/medicaid_waiver_coming_soon_with_patient_protection_rules.

115. CMS denied the portions of the plan seeking to impose a \$10 premium on most Medicaid beneficiaries and a \$100 co-payment on all beneficiaries eligible for Medicaid under the waiver who make non-emergent use of emergency department services. Letter from Victoria Wachino, Director, Family and Children's Health Programs Group, CMS, to Justin Senior, Deputy Secretary for Medicaid, State of Florida, Feb. 9, 2012, available at http://ahca.myflorida.com/medicaid/statewide_mc/fsdocs/Final_signed_FL_amend_02-09-12.pdf.

116. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1, 3-4 (2010), available at www.kff.org/medicaid/upload/8046.pdf (finding seventy-one percent of beneficiaries in managed care as of 2008, and that nearly one-third of dual-eligibles received at least some services via managed care).

117. *See supra*, note 37 and associated text.

118. *See supra*, note 21 and associated text.

pronounced grants of power to private interests in Medicaid. The state has, in the process, expressly sought to become merely a funder of services with certain quality oversight functions.¹¹⁹

Meanwhile, the Supreme Court has agreed to review the 11th Circuit's decision in *Florida v. HHS*, regarding the constitutionality of the ACA's Medicaid expansion.¹²⁰ The 26 state appellants claimed that the expansion of Medicaid eligibility to Americans and qualifying legal residents earning no more than 133% of the federal poverty level constitutes unconstitutional coercion in a grant-in-aid program.¹²¹ They argue that the ACA gives them a Hobson's choice of either accepting an allegedly "radically changed" Medicaid program, or leaving the program altogether while nevertheless continuing to have their residents' tax dollars used to support other states' Medicaid programs.¹²² The state appellants want far more flexibility to determine the priorities of their Medicaid programs than the statute allows.¹²³ They argue that if the federal government wants states to accomplish certain ends with their Medicaid programs, Congress ought to "encourage[] rather than force[]" states to act accordingly.¹²⁴ A new mandate such as the ACA's Medicaid expansion, in the context of a program as large and costly as Medicaid, amounts to an unconstitutionally

119. As in its original waiver application, Florida forthrightly expressed its desire to fund rather than direct care in its application for a statewide expansion of its current demonstration program. FLORIDA AGENCY FOR HEALTH CARE ADMIN., STATEWIDE MANAGED MEDICAL ASSISTANCE PROGRAM: 1115 RESEARCH AND DEMONSTRATION WAIVER 4 (2011), available at http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf ("The State's role has changed so that it is largely a purchaser of care, providing oversight focused on improving access and increasing quality of care"); FLORIDA AGENCY FOR HEALTH CARE ADMIN., FLORIDA MEDICAID REFORM: APPLICATION FOR 1115 RESEARCH AND DEMONSTRATION WAIVER 3 (2005), available at http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_083005.pdf ("Under Medicaid Reform, the state's role will change so that it is largely a purchaser of care..."). Other states, such as Wisconsin, are also considering some substantial and limiting changes. See, e.g., Jason Stein, *State Wants to Shift Some Medicaid Recipients to Lower-Cost Plans*, JOURNAL SENTINEL (Sept. 30, 2011), <http://www.jsonline.com/news/statepolitics/walkers-administration-to-announce-plan-to-cut-444-million-from-medicaid-130853728.html>.

120. *Florida v. Dep't of Health & Human Servs.*, 132 S.Ct. 604 (2011) (mem.).

121. *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1264 (11th Cir. 2011).

122. Memorandum in Support of Plaintiffs' Motion for Summary Judgment at *19, 2010 WL 4564355, *Florida ex rel. Bondi v. HHS*, Case No. 3:10-cv-91-RV/EMT.(N.D. Fla. Nov. 4, 2010); Brief of State Petitioners on Medicaid at 21-24, 33-39, *Florida v. HHS*, No. 11-400 (Jan. 10, 2012), available at http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/11-400_petitionerstate.pdf.

123. See, e.g., Brief of State Petitioners on Medicaid, *supra* note 122, at 7-8.

124. *Id.* at 24.

“extreme and unprecedented abuse of Congress’ spending power.”¹²⁵ Such arguments, while certainly not identical, fit hand-in-glove with ones made by the Republican Governors’ Association, in which many of the same states participate, to turn Medicaid into a block-grant program.¹²⁶ Block-granting Medicaid would give states a fixed amount of federal funding. Leading states to have greater discretion than under the current Medicaid program in choosing how to fund some health coverage or care for some low-income populations.¹²⁷

At the other end of the spectrum, Vermont, Oregon, and Montana are each, in their own ways, seeking not to expand Medicaid per se, but rather to transform their entire state health care systems into universal or near-universal, single-payer coverage with integrated care delivery. Vermont’s proposed system, “Green Mountain Care,” will establish single-payer coverage for all state residents except those working for employers who offer a self-insured health plan.¹²⁸ The program would be administered either by the state, or through public-private partnerships.¹²⁹ The plan would require Medicaid, Medicare, and ACA waivers from the federal government to both fund and administer health coverage for all Vermonters, including those eligible for Medicare and Medicaid.¹³⁰

While Vermont is the only state to date that has successfully enacted single-payer legislation, other states, such as Oregon and Montana, may be moving toward doing so as well. Legislators in Oregon continue to push for “Affordable Health Care for All,” which would establish public, tax-funded health coverage for all Oregonians.¹³¹ In the meantime, the state will be seeking permission from CMS to move its Medicaid program toward a “coordinated care” model, which would use a team- and community-based approach to delivering health care to enrolled Medicaid recipients under a global budget.¹³² Montana’s plan is perhaps the most inchoate of the three.

125. *Id.* at 23.

126. *See, e.g.*, Letter from the Republican Governors Ass’n to Rep. Paul Ryan (Apr. 5, 2011) (on file with author), available at <http://www.rga.org/homepage/rga-leadership-supports-house-gop-budget-calls-for-medicaid-block-grants/>.

127. *See, e.g.*, Jeanne M. Lambrew, *Making Medicaid a Block-Grant Program*, 83 MILBANK Q. 41, 41-42 (2005).

128. Act of May 26, 2011, No. 48, § 2(a)(1), 2011 Vt. Acts & Resolves 1, 8, available at <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf>.

129. *See* VT. STAT. Ann. tit. 33, § 1827 (West 2011).

130. Act of May 26, 2011 § 2(a)(1); tit. 33, §§ 1822(b), 1827(g), 1829(b)(2).

131. *See* H.B. 3510, 76th Legis. Assemb. Reg. Sess. (Or. 2011).

132. Or. Rev. Stat. §414.625(1) & (2) (2012). *See also, e.g.*, Jonthan J. Cooper, *On Health Care, Oregon Picks up where Obama Left Off*, ASSOCIATED PRESS (Mar. 6, 2012), available at <http://news.yahoo.com/health-care-ore-picks-where-obama-left-off-092411788.html>.

In public form, it currently consists largely of some comments by Governor Schweitzer lambasting the ACA, and asserting that Montana will instead seek to establish a universal, single-payer system resembling that in the Canadian province of Saskatchewan.¹³³ The governor said the state is working on relevant waiver requests to CMS now, and that he expects the state to finish preparing and submitting the waivers in the next few months.¹³⁴

IV. CONCLUSION

One might wonder if much of the rhetoric at the state level is largely driven by a desire to extract more money and concessions from Washington. But it would likely be a mistake to think that this is all that is going on. Rather, it appears instead that many states believe the transformational potential of the ACA is limited, and that it puts inappropriate limits on state prerogatives. While the ACA substantially increases federal control over state health affairs on a variety of fronts, the ACA's acceptance of the status quo, with a few notable exceptions with respect to health care finance and delivery clearly has left many states disappointed. Congress, moreover, is unlikely to be able to deal responsively to states' concerns, at least in the near future. Lacking the federal leadership they desire, some states are seeking to forge their own paths.

Although federalizing Medicaid could be a good idea, it is unlikely that Medicaid will be federalized anytime in the near future.¹³⁵ In the absence of federalization, we will need to continue to deal with struggles between the federal and state governments over Medicaid policy and funding. It is difficult under such circumstances to responsibly advocate that states like Texas, Florida and Indiana should, for example, be given largely unfettered leeway to further limit and privatize their programs, as they likely would if given a block grant, or, to a lesser but still substantial extent, if the standards employed by the Bush administration were used to evaluate waiver applications they might submit. The goals of Medicaid ought not to include such novelties, and with good reason. As discussed earlier,

133. Marnee Banks, *Schweitzer Wants Universal Health Care for Montana*, KRTV (Sept. 28, 2011, 5:11 PM), <http://www.krtv.com/news/schweitzer-wants-universal-health-care-for-montana/>.

134. *Id.*

135. See, e.g., Nichole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 473-84 (2011) (detailing reasons to completely federalize the program); Michael Birnbaum, *The Landscape in 2009: A Conversation with Bruce C. Vladeck*, 34 J. HEALTH POL. POL'Y & L. 401, 411 (2009) (arguing for a reallocation of federal and state responsibility in Medicaid, though not for complete federalization).

Medicaid is supposed to be about furnishing “medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.”¹³⁶ It is about providing comprehensive medical care for those who need it the most, yet have the least resources with which to do it. Nothing in the statute would suggest that we should, instead, allow states to place inordinate limits on eligibility and coverage, or to transfer even more programmatic design, oversight, and concordant public funding from the state to private entities. States wanting to use Medicaid dollars for such purposes have, as they always have had, the option to create their own, wholly state-funded programs.

Rather, as a matter of policy, federal administrations should encourage Medicaid demonstration projects that further Medicaid's recipient-oriented goals. The ACA provides a sound floor for the Medicaid program, with its substantial eligibility enlargement. The federal government should allow states with expansive and inclusive visions for their health care systems to build upon it. States such as Vermont should accordingly be permitted to use Medicaid funds to rationalize and simplify their health care systems in the process of expanding coverage and coordinating care delivery for all residents. Other measures should also be prioritized, such as plans to establish greater equity in provider reimbursement between Medicaid and other forms of coverage to help break down disparities in health care access between Medicaid recipients and other state residents. Although we might not see further legislation enacted at the federal level to expand upon the ACA in the short term, the administration should assist those states that wish to do so within their own borders, consistent with an expansive vision of Medicaid's purpose.

136. 42 U.S.C.A. § 1396-1 (West 2011).

**The Beazley Institute for Health Law and Policy
at Loyola University Chicago School of Law**

THE BEAZLEY INSTITUTE

The Beazley Institute for Health Law and Policy was created in 1984 to recognize the need for an academic forum to study the burgeoning field of health law and to foster a dialogue between the legal and health care professions. Since that time, the Beazley Institute has grown to offer one of the most comprehensive and respected health law programs in the country. The Institute today is comprised of students, faculty, researchers, practitioners, lecturers, librarians and staff working together to fulfill a common mission: **We educate the health law leaders of tomorrow.**

ADVANCED DEGREES FOR ATTORNEYS

The Master of Laws (LLM) in Health Law degree is a post-JD master's degree program for attorneys who wish to develop or enhance a special expertise in health law. This 24-credit degree program can be completed on-campus or online. All students enrolled in the LLM in Health Law degree program take courses from cutting-edge curriculum developed in conjunction with a committee of leading health lawyers, industry professionals, and national experts. Courses focus on the legal, regulatory, political, ethical and economic aspects of health care delivery.

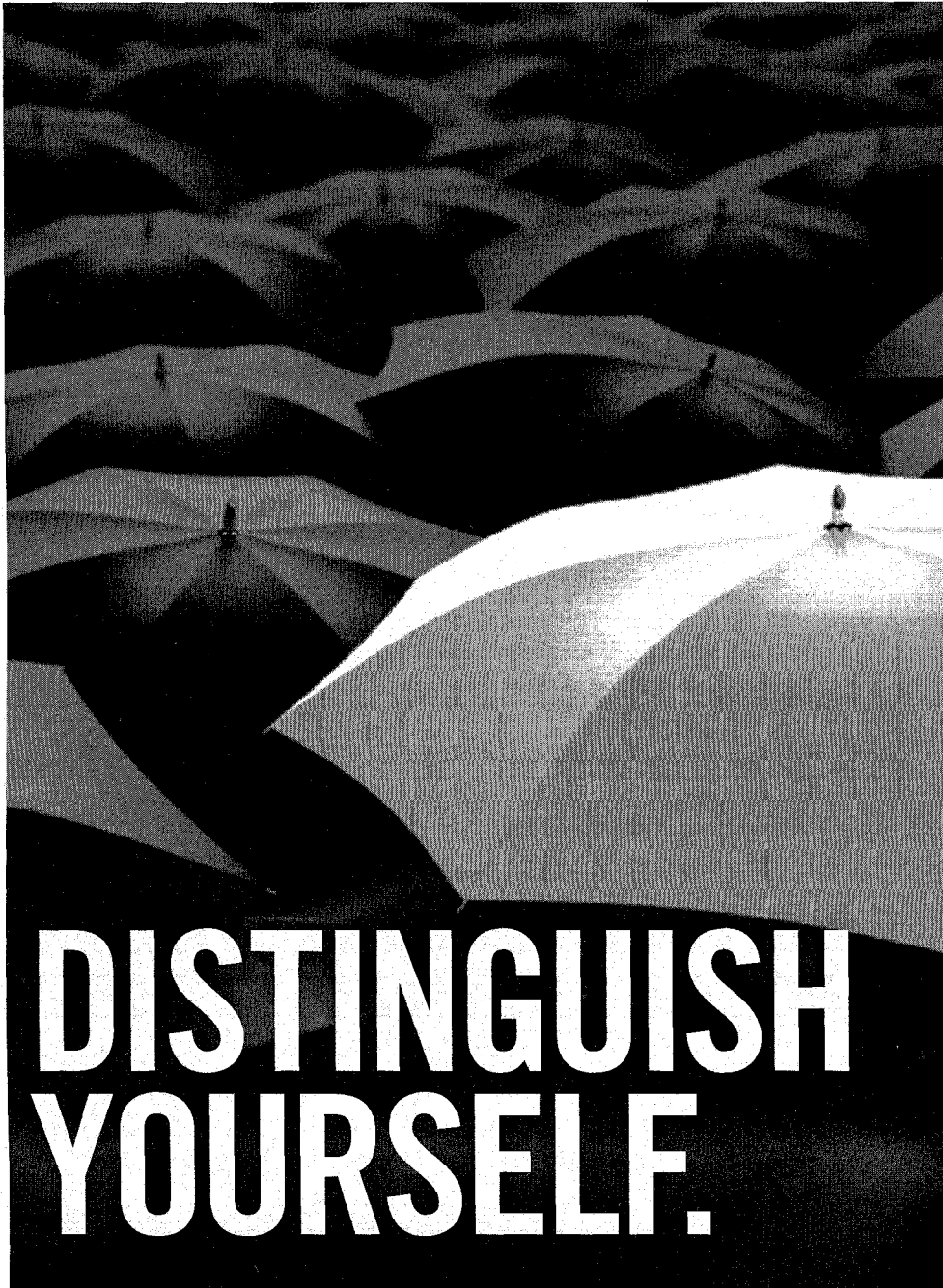
The Doctor of Juridical Sciences (SJD) in Health Law and Policy program provides qualified attorneys with the opportunity to pursue a doctoral degree, using legal research methods as the tools for analyzing key issues in health law and policy. Loyola is proud to be one of a handful of law schools across the nation to offer an SJD degree, and the first to offer such a degree in health law.

ADVANCED DEGREE FOR HEALTH CARE PROFESSIONALS

Loyola University Chicago School of Law created the Master of Jurisprudence (MJ) in Health Law degree in 1986 to provide health care professionals with the opportunity to gain a sophisticated knowledge of the laws and regulations that govern the health care industry without having to attend law school and sit for the bar examination. Now, through an affiliation with Concord Law School, this unique degree offering is now available exclusively online to any health care professional in the world who wants to study health law. Our MJ classes are taught by law professors, practicing health lawyers, and health care professionals who have first-hand experience with the issues that affect care-givers, administrators, and patients everyday. Subjects include informed consent, Medicare reimbursement, right-to-die questions, and access to health care.

FOR MORE INFORMATION

Beazley Institute for Health Law and Policy
Loyola University Chicago School of Law
25 East Pearson Street, Chicago, Illinois, 60611
Telephone: 312.915.7174 **Fax:** 312.915.6212
Email: health-law@luc.edu **On the Web:** LUC.edu/healthlaw



DISTINGUISH YOURSELF.

LLM IN ADVOCACY • BUSINESS LAW • CHILD AND FAMILY LAW • HEALTH LAW • TAX LAW

Stand out in today's increasingly competitive legal market with a graduate law degree from Loyola University Chicago. Whether you want to refocus your career, teach, or increase your visibility with clients and colleagues, one of our five specialized LLMS can help you reach your goal.

LUC.edu/llm



SCHOOL of LAW

Mitchell Hamline Open Access

Mitchell Hamline Open Access is the digital archive of Mitchell Hamline School of Law. Its mission is to preserve and provide access to our scholarly activities, for the benefit of researchers and members of the legal community.

Mitchell Hamline Open Access is a service of the Warren E. Burger Library.
open.mitchellhamline.edu

MH

MITCHELL | HAMLINE

School of Law

© Mitchell Hamline School of Law
875 Summit Avenue, Saint Paul, MN 55105
mitchellhamline.edu