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On the Uneasy Relationship Between Medicaid and Charity Care

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Abstract
Medicaid and charity care have a lengthy relationship fraught with complications. These complications will remain and in some respects become even more acute following the implementation of the Patient Protection and Affordable Care Act.

This article focuses on the uneasy relationship between Medicaid and charity care, one that becomes particularly acute in the context of Medicaid reimbursement. It traces the lineage of Medicaid in charity, and uses Medicaid reimbursement and supplemental payments as lenses through which to examine the relationship between Medicaid and charity care. The tension that we uncover will need to be resolved if Medicaid is to come closer to achieving its arguable aim of placing the poor on the same footing in our health care system as enjoyed by wealthier, privately-insured Americans.

Keywords
Medicaid, Charity care, Supplemental payments, DSH, UPL

Disciplines
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ON THE UNEASY RELATIONSHIP BETWEEN MEDICAID AND CHARITY CARE

MERLE LENIHAN* & LAURA D. HERMER**

INTRODUCTION

Ethel Hines lost her health insurance when she divorced. She was admitted to a hospital in Ohio where the doctors discovered she needed a pacemaker, which was placed in her heart. After struggling to pay off as much of the bill as she could, the hospital and her physician "excused" the remaining balance. Ethel paid the doctor's fees for monthly checkups out of pocket until she moved to Tennessee. Now working as a newspaper delivery carrier and still uninsured, she went to a free clinic after over four years with no checkups. The doctors there noticed a skin problem on her face. It turned out to be skin cancer but she was eligible for TennCare, Tennessee's Medicaid program, so she was treated for cancer and started getting checkups for her pacemaker again.[1]

Ginny was five years old when she "met" her doctor on his first night as a pediatric cardiology fellow at a Virginia hospital. She had just gotten out of surgery to repair a congenital heart defect when her heart stopped and Dr. Garson revived her. Over the next several years Ginny did "beautifully." When she was sixteen, Ginny developed a serious heart rhythm problem that, after trying several medications, was controlled by an expensive one. The treatment kept her from developing a fatal rhythm and she did remarkably well. After high school Ginny applied for every possible job in her small town but no one would hire her, perhaps because she so willingly and proudly told potential employers about her heart condition. Then, a few months after Ginny turned nineteen, she died suddenly one night. The cause was a fatal heart rhythm. Lying in a drawer beside her bed was an empty pill bottle. Ginny had "aged out" of Medicaid and, knowing her parents could not afford the medication, she stopped taking it.[2]

Keeshun Lurk was twenty years old and working part-time at Washington Hospital Center in the nation's capital when he developed

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* M.D., University of Tennessee Health Science Center; Ph.D., Institute for the Medical Humanities, University of Texas Medical Branch. I would like to thank the members of my dissertation committee, especially Professor Hermer, for her encouragement and support as well as her attention to detail and for pressing me, when necessary, to shore up my arguments. This Article is substantially based on one chapter of my dissertation.

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1. ED KASHI & JULIE WINOKUR, DENIED: THE CRISIS OF AMERICA'S UNINSURED 35 (2003).

2. Arthur Garson, *Heart of the Uninsured*, 26 HEALTH AFF. 227 (2007).

debilitating headaches. Because he was a temporary worker, he was not offered health insurance. He went to the hospital's emergency department where he was diagnosed with migraines and an ear infection, which presumably was causing a lump on his neck. When his symptoms worsened, he became completely unable to work. He went to the Washington Free Clinic where they confirmed that Keeshun needed a biopsy of the lump that had not gone away. Their clinic used a network of volunteer providers and one agreed to do a biopsy. The lump was caused by brain cancer. Keeshun started receiving cancer treatment about a year after his symptoms began, though he did not know how he would pay for it. When his unemployment benefits ran out, he became eligible for Medicaid, which covered the cost of his treatment from that point. His medical debt, however, remained intact.[3]

The stories of these patients show some of the ways in which Medicaid, hospital charity care, free clinics, physician volunteers, and delaying or forgoing medical care interact in the lives of people who are ill and have a low income. Medicaid, when it was enacted, was arguably intended to bring qualifying members of the poor, who often relied on charity and public clinics for medical care, into the health care "mainstream" by providing them with a source of third party reimbursement.[4] Yet contrary to that intent, Medicaid may be seen as charity care to institutional and individual health care providers when costs for treating Medicaid patients exceed payment, or when payment otherwise fails to meet health care providers' expectations concerning remuneration.[5] People with a low income who are uninsured may visit a free clinic or receive charity or discounted care from hospitals or physicians and sometimes, because of their illnesses, either become eligible or find they are eligible for Medicaid. Historically, Medicaid has been linked to certain categories of low-income people, particularly people receiving cash welfare.[6] A lengthy history accounts for this connection, and despite attempts to delink Medicaid from welfare, if not charity, the association continues to this day.[7]

The connection between Medicaid and charity continues in other guises. Beginning in the 1980s, Medicaid became one of the most important sources of funding for hospitals that provide care not only to low-income Medicaid enrollees, but also to uninsured people with no direct connection to Medicaid whatsoever.[8] Medicaid payments also support other safety net providers such as community health centers that provide primary care to uninsured people.[9] In many instances at

3. Trudy Lieberman, *Second-Class*, 65 CONSUMER REP., Sept. 2000, at 42.

4. *See infra* notes 274–276 and accompanying text.

5. *See infra* notes 48-50, 52-57 and accompanying text.

6. *See infra* notes 40–47 and accompanying text; *see also infra* note 19 (discussing the language in Paul Ryan's proposed budget).

7. *See infra* notes 95–111 and accompanying text.

8. *See infra* notes 132–133,136 and accompanying text.

9. Medicaid is the largest source of revenue for community health centers, providing nearly 40% of their total revenue, and Medicaid payments to community health centers are higher than at other sites because they are prospective cost-based. About 75% of health center patients are uninsured or enrolled in Medicaid. *See, e.g.*, KAISER COMM'N ON

the state level, Medicaid and charity are closely intertwined in policy decisions.[10] The Affordable Care Act (ACA) promised to substantially reduce the categorical nature of the program by expanding access to all individuals earning up to 133% of the federal poverty level, but the 2012 Supreme Court ruling allows states the option not to implement Medicaid expansion.[11]

This Article explores these aspects of Medicaid. It focuses on the uneasy relationship between Medicaid and charity care. This relationship becomes particularly acute in the context of Medicaid reimbursement. In this Article, we trace some of the history of the Medicaid program, using Medicaid reimbursement and supplemental payments as lenses through which to examine the relationship between Medicaid and charity care. The tension that we will uncover will need to be resolved if Medicaid is to come closer to achieving its arguable aim of placing the poor on the same footing in our health care system as enjoyed by wealthier, privately-insured Americans. In Part I, we trace the origins of Medicaid in charity care and the impact of this origin as Medicaid developed in the United States. In Part II, we examine the creation and evolution of Medicaid Disproportionate Share Hospital (DSH) funding and Upper Payment Level (UPL) programs, with a particular focus on how the construction of the two supplemental payment programs encourages, or at least permits, abuse by both states and hos-

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MEDICAID & THE UNINSURED, COMMUNITY HEALTH CENTERS IN AN ERA OF HEALTH REFORM: AN OVERVIEW AND KEY CHALLENGES TO HEALTH CENTER GROWTH, 2, 4 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8098-03.pdf

10. At least two recent analyses have assessed the effects of states' decisions to expand Medicaid on hospital "uncompensated care." *See, e.g.*, John A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365–67 (2012); STAN DORN ET AL., THE FINANCIAL BENEFIT TO HOSPITALS FROM STATE EXPANSION OF MEDICAID (2013), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf405040; *see also infra* notes 63–65 and accompanying text. It is relevant here that "uncompensated care" is not equivalent to charity care and both terms have a variety of meanings. In general, uncompensated care is comprised of charity care for which no payment is expected because of financial inability to pay, and bad debt, for which a payment is expected. *See, e.g.*, AM. HOSP. ASS'N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET (2013), *available at* http://www.aha.org/content/13/1-2013-uncompensated-care-fs.pdf. This fact sheet reports that 5.8% of hospital expenses in 2010 were categorized as uncompensated care. The AHA does not report charity and bad debt separately. Bad debt expense is generally much greater than charity expense. For example, in the most recent analysis of data on nonprofit hospitals, 1.9% of expenses in 2009 were reported as charity care. *See* Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1522 (2013). The definition of uncompensated care in the Medicaid DSH program is defined differently from the AHA definition. *See infra* note 223 and accompanying text.

11. *See infra* note 14. Rosenbaum and Westmoreland point out that:

> [F]or the poor and near-poor, the Affordable Care Act's central achievement was the extension of Medicaid to all nonelderly low-income people who were previously ineligible for coverage. In the case of adults, as already has been accomplished for children and pregnant women, the expansion essentially renders irrelevant the demographic, financial, and personal factors that are the vestiges of cash welfare assistance.

Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?* 31 HEALTH AFF. 1665 (2012).

pitals and encourages the continued association and conflation of Medicaid with charity care. In Part III, we examine the state DSH reporting and auditing requirements, which recently went into effect, as well as the changes to DSH enacted in the ACA. We conclude that, if Medicaid DSH and UPL payments are to be retained, additional work must be done to ensure that the ultimate fate of Medicaid supplemental funding, once it gets to the states, is transparent, and that it is used to expand access for the underserved in a more logical, efficient, and productive manner. Changes to DSH funding in the ACA provide an opportunity to do some of this work.

I. THE ORIGINS OF MEDICAID AND LINKS TO CHARITY

Medicaid is a means-tested, joint federal-state entitlement program for certain low-income people that finances the delivery of primary and acute medical services as well as long-term care. In 2010, Medicaid financed health and long-term care services to more than 68 million people.[12] Medicaid provides benefits to more people than any other public or private insurance program, including Medicare.[13] Under the ACA, Medicaid will expand substantially. While originally mandatory, the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius* effectively makes the expansion optional for states by removing Centers for Medicare & Medicaid Services' (CMS) authority to withhold existing Medicaid funding as a measure to incentivize states to expand Medicaid.[14] Nevertheless, the Congressional Budget Office estimated after the Supreme Court's ruling that 11 million additional previously-uninsured individuals will have coverage through Medicaid by 2022.[15]

The importance of Medicaid cannot be overstated as a critical source of health insurance coverage for children, disabled people, residents of nursing homes, and other groups.[16] As the ACA is imple-

12. ELICIA J. HERZ, CONG. RESEARCH SERV., RL 33202, MEDICAID: A PRIMER 13 (2010), *available at* http://www.aging.senate.gov/crs/medicaid1.pdf.

13. In 2010, Medicare provided health insurance coverage to 47 million people. Although Medicaid covers more people than Medicare, it costs less. In 2010, spending on the Medicare program accounted for 12% of the federal budget whereas spending on Medicaid and the Children's Health Insurance (CHIP) combined accounted for 8%. *See, e.g.*, KAISER FAMILY FOUND., MEDICARE: A PRIMER, 1, 15 (2010), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-03.pdf.

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

15. CONGRESSIONAL BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION, (2012), http://www.cbo.gov/publication/43472. Estimates of the number of Medicaid enrollees vary widely, however. This is due to the methods used to make the estimates and to the uncertainty of the policies that will be put in place to either encourage or discourage enrollment. *See, e.g.*, Benjamin D. Sommers et al., *Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform*, 30 HEALTH AFF. 2186 (2011).

16. *See, e.g.*, KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER KEY INFORMATION ON THE NATION'S HEALTH COVERAGE PROGRAM FOR LOW-INCOME PEOPLE (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

mented, the program is poised to play an even more important role in essential health care coverage.[17] Yet its roots in public assistance that began in the early twentieth century have meant that it continues to be associated with a pejorative notion of "welfare." The journalist Niall Ferguson recently claimed that "[n]early 110 million individuals received a welfare benefit in 2011, mostly Medicaid or food stamps."[18] As he sees it, the people receiving these benefits are a drain on the country. He is not alone in expressing this sentiment.[19]

The origins of Medicaid can be traced to the "outdoor relief" of the American colonies, modeled after practices established in England. "Outdoor relief" referred to charity provided to indigent individuals and families without the requirement for recipients to live and work in an almshouse. During the colonial period, it was seen both as a public responsibility and a profoundly local practice to provide this "charity" or relief to the poor.[20] Taxes for poor relief were often collected separately, emphasizing the expense and enhancing resentment.[21] Proponents of outdoor relief often believed a small sum of money could tide over a distressed family and keep them together, whereas proponents of the almshouse or institutionalized care were not convinced that keeping poor families together was wise or that such a system could be protected from abuse.[22] The alleged effects of outdoor relief included "[t]he demoralization of the poor through the erosion of independence and self-respect; the spread of idleness and the loss of the will to work; the promotion of immorality in all its ugly forms; and the increase in public costs through the growth of poorhouses and jails."[23] Similar sentiments persist today.[24]

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17. *Id.* at 34.

18. Niall Ferguson, *Why Obama Must Go*, NEWSWEEK, Aug. 27, 2012, at 22.

19. As just one example, Congressman Paul Ryan compared his 2012 proposal to cut Medicaid payments by 75% by 2050 and block grant the program to the block-granting of and removal of entitlement status from cash welfare in 1996. Julian Pequet, *Pointing to '90s Welfare Reforms, Paul Ryan Defends His Medicaid Plan*, THE HILL (Apr. 17 2012), http://thehill.com/blogs/healthwatch/medicaid/221943-lawmakers-spar-over-welfare-reforms-lessons-for-medicaid-overhaul. However, a recent Kaiser/Harvard survey found that a majority of Americans support the Affordable Care Act's expansion of Medicaid, and nearly half support no cuts for Medicaid in addressing national deficit reduction. KAISER FAMILY FOUND., THE PUBLIC'S HEALTH CARE AGENDA FOR THE 113TH CONGRESS 2, 4 (2013), *available at* http://www.kff.org/kaiserpolls/upload/8405-F.pdf.

20. MICHAEL B. KATZ, IN THE SHADOW OF THE POORHOUSE: A SOCIAL HISTORY OF WELFARE IN AMERICA 14–15 (1996).

21. *Id.* at 17. From the earliest times, there has been a seemingly contradictory sense of charity. For instance, to what extent can taxes collected by local or other governments be considered charity? Taxes to support public education, police, and fire services are virtually never considered charity. Taxes that support services only or primarily for poor people, on the other hand, are almost always associated with charity by some.

22. *Id.* at 55–59.

23. *Id.* at 41–42.

24. *See, e.g.*, Laura D. Hermer, *Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform*, 38 HASTINGS CENTER REP. 16 (May–June, 2008) (describing how, especially recently, paternalistic requirements in state Medicaid programs such as higher copayments and enhanced benefits for maintaining wellness metrics are often framed as fostering greater personal responsibility but that these are rooted in moralistic attitudes toward the poor).

By the early twentieth century, worry that providing relief to destitute people would promote idleness and the loss of morality was overcome for certain deserving groups, especially widows with children. For example, "mothers' pensions" were a "small, halting but consequential step away from charity and toward entitlement."[25] Thirty-nine states had enacted mothers' pension laws by 1919.[26] After the economic devastation caused by the Great Depression, the number of Americans surviving on some form of relief reached 40% in some states. Social insurance of some form, as had already been enacted in all of the countries of continental Europe, seemed inevitable as economic instability was seen as a result of forces beyond the individual's control.[27]

Acknowledgment that the federal government bears some responsibility for the economic well-being of its citizens occurred when President Franklin Roosevelt signed the Social Security Act in 1935. It was the "seminal event in the creation of entitlements in the United States."[28] The Social Security Act was an omnibus measure that included not only the Old Age Insurance program (now Old Age, Survivors, and Disability Insurance, otherwise known as Social Security), but also the Old Age Assistance program, Aid to the Blind, unemployment insurance, and Aid to Dependent Children ("ADC").[29] ADC was modeled directly after the mothers' pensions laws. ADC and other means-tested programs became known as "welfare."[30] Michael Katz observed that by the 1960s,

> "welfare" had become a code word for public assistance given mainly to unmarried mothers, mostly young women of color, under Aid to Families with Dependent Children [the successor to ADC]. No other public benefits carried the stigma of welfare. The political left, right, and center all attacked it. In the early 1990's, when President Bill Clinton promised to "end welfare as we know it," everyone knew that he meant AFDC—the most disliked public program in America.[31]

Despite the clear improvements that many Americans could claim regarding financial security and other benefits, in some respects, the Social Security Act set up a clear division between social insurance and public assistance. This became apparent, for example, in the role that

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25. KATZ, *supra* note 20, at 133.

26. MIMI ABRAMOVITZ, REGULATING THE LIVES OF WOMEN: SOCIAL WELFARE POLICY FROM COLONIAL TIMES TO THE PRESENT 197 (1996).

27. WALTER I. TRATTNER, FROM POOR LAW TO WELFARE STATE: A HISTORY OF SOCIAL WELFARE IN AMERICA 273–75 (1999).

28. TIMOTHY S. JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 74 (2003).

29. ADC was the forerunner to Aid to Families with Dependent Children (AFDC) and, later, Temporary Aid to Needy Families (TANF). In 1962, ADC was renamed AFDC. In 1996, AFDC was replaced with TANF. DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 1965–2007 13, 245–46 (2008).

30. LINDA GORDON, PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE, 1890–1935, at 253–60 (1994).

31. MICHAEL B. KATZ, THE PRICE OF CITIZENSHIP: REDEFINING THE AMERICAN WELFARE STATE 1 (2001).

discretion played in program procedures. Social Security criteria for eligibility were elaborately detailed, leaving little to bureaucrats' discretion. Discretion in the provision of ADC benefits, however, often involved intrusive, personal monitoring and judging of the trustworthiness and character of those receiving benefits.[32] ADC clients were required to be "needy," which resulted in constant surveillance by caseworkers who determined not only whether there was a need but also the amount of the need.[33] In essence, and in contrast to social insurance, there was "administrative discretion at the lowest levels of government."[34]

A. *The Kerr-Mills Act Creates Medical Vendor Payments for ADC Recipients*

The first suggestion of an entitlement to health care among ADC recipients came in the form of amendments to the Social Security Act in 1950. These amendments provided for federal matching funds to states for the purpose of paying medical vendors for health services for people receiving public assistance.[35] By 1960, spending on medical care through public assistance programs climbed to more than half a billion dollars and forty states were participating—albeit to vastly differing degrees—in a federally-approved vendor payment plan. The Kerr-Mills Act of 1960 used a similar framework to provide what was supposed to be comprehensive medical benefits to people receiving Old Age Assistance.[36]

The Kerr-Mills provisions were implemented slowly and many states did not participate, or participated only minimally. It was difficult to know how many additional people were covered by Kerr-Mills since states sometimes merely transferred the cost of care under less generous vendor payments to the program.[37] A particularly humiliating experience for elderly Kerr-Mills recipients was the requirement to provide their children's addresses, each of whom was subject to a means-test.[38] Hospitals were distressed at the delay between the provision of care and receipt of payment for Kerr-Mills patients. The result, according to Jonathan Engel, was that "Kerr-Mills patients began to be

32. Particularly during the 1940s and 1950s, ADC clients were subjected to frequent monitoring by caseworkers who would search for hidden resources and deduct any earnings that were found from the ADC stipends. Far more intrusive and moralistic was the practice of monitoring for a "suitable home." The presence of a man in the house, sometimes discovered through surprise raids, or the birth of an illegitimate child, made the home unsuitable and therefore not eligible for benefits. *Id.* at 298–99. Administratively, this process was called "deeming" by the caseworker. In 1958, the Supreme Court ruled in *King v. Smith* that such restrictions violated the Social Security Act. King v. Smith, 392 U.S. 309 (1958).

33. GORDON, *supra* note 30, at 293–99.

34. ROBERT B. STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 11 (2d ed. 2003).

35. Social Security Amendments of 1950, Pub. L. No. 81–734, 64 Stat. 551.

36. JOST, *supra* note 28, at 80.

37. *Id.* at 80–81.

38. STEVENS & STEVENS, *supra* note 34, at 35.

seen as glorified charity patients rather than private paying patients with government-subsidized insurance policies."[39]

B. *The Enactment of Title XIX*

When Congress took up the issue of health care for the elderly again in the mid-1960s, it ultimately enacted the social insurance program of Medicare, rather than a means-tested program. Medicaid, Title XIX of the Social Security Act, was enacted as a means-tested companion program to Medicare for the "deserving" poor.[40] In structure, Medicaid descended directly from Kerr-Mills. Like Kerr-Mills, federal funding for Medicaid was open-ended for enrollees who met both categorical and financial requirements. States have the rate of their matching funds determined yearly as in Kerr-Mills, based on the relative per capita income of the state.[41] States' participation has always been voluntary, but states choosing to participate must meet federal baseline requirements. States were required to include people enrolled in the federal public assistance programs, such as AFDC-eligible children and adults, the blind, and the disabled, rather than merely the elderly as in Kerr-Mills. Given the program's tight connection to public assistance, administering Medicaid was most often a responsibility of the states' welfare department.[42]

The Department of Health, Education, and Welfare (HEW) had the task of implementing both Medicare and Medicaid, even though Medicaid was ultimately a state-administered program.[43] The federal response was hampered by the lack of clarity on the goals of Medicaid: Was Medicaid primarily a "health" or a "welfare" program?[44] Historical precedence conflicted with aspirations of proponents: "Many in 1965 assumed that Medicaid would provide the basis for widespread health care for the poor, yet its historical evolution pointed clearly to the narrower welfare mold."[45] Medicaid was not a program based on medical need at its inception; it was a program based on categories linked to public assistance. Congress furthered the dichotomy and confusion by naming patients "beneficiaries" under Medicare and "recipients" under

39. JONATHAN ENGEL, POOR PEOPLE'S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965, at 37 (2006).

40. JOST, *supra* note 28, at 98. Jost describes the defining characteristics of social insurance entitlements as: eligibility requirements defined by federal law, entitlement is linked to contributions, and administrative review is available. *Id* at 75. See also JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE, AMERICAN POLITICS AND POLITICAL ECONOMY 28–31 (2003).

41. Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286, 351. The federal government funded about 57% of Medicaid spending overall in recent years with a range between 50-73% per state. *See also* KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 31.

42. Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FINANCING REV. 45 (2005), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05-06Winpg45.pdf.

43. HEW was the forerunner of the Department of Health and Human Services.

44. STEVENS & STEVENS, *supra* note 34, at xx.

45. *Id.* at 77.

Medicaid.[46] From the beginning, as the social historian Rosemary Stevens wrote in 1974, there was lack of clarity: "Recipients have never been clear about their 'rights;' providers have not been clear whether they are to treat Medicaid patients as 'real' patients or charity cases."[47]

C. *Provider Participation in Medicaid*

One of the pervasive problems in the Medicaid program has been its comparatively low payment rates, particularly for physicians. In most states, Medicaid physician reimbursement is much lower than Medicare or private health insurance, and has been so for much of the program's history.[48] A 1967 editorial in the *New England Journal of Medicine* makes this point:

> The welfare directors seeking cut-rate payments to physicians under Medicaid are virtually demanding that physicians subsidize the Government – a Government that has assumed the responsibility of paying for medical services to a large segment of the population. The traditional ethical principle that physicians should treat patients in need of medical care without regard to their ability to pay is noble in concept and practice. Once, however, the patient becomes the beneficiary of a federal or state program that guarantees that he will receive high-quality medical care, and that it will be paid for, he cannot justifiably be classed as a medical charity case. The concept of the federal Government as a charity case is ridiculous.[49]

Hospital reimbursement was different. While, according to Rosemary Stevens, states "could include the continuation of the long welfare tradition of reimbursing [physician services] at less than cost, in other words, expecting providers to donate out of charity," Medicaid hospital payments were originally based on "reasonable cost," as in the Medicare program—in other words, "paying the full costs at which each hospital delivers services to Medicaid recipients."[50] The provision of hospital care to poor patients on the basis of reasonable cost was not entirely hailed as an achievement. Medical educators sometimes considered the treatment of Medicaid patients as private patients to be a conundrum. A former president of the American Hospital Association worried in 1966 about "the clear probability of the disappearance of the 'ward service' patient—the 'charity patient'—the 'second class' patient—upon whom has rested nearly the whole reliance for graduate

46. ENGEL, *supra* note 39, at 49.

47. STEVENS & STEVENS, *supra* note 34, at 356–57.

48. *See generally State Health Facts, Medicaid-to-Medicare Fee Index*, KAISER FAMILY FOUND. *available at* http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/. Stephen Zuckerman et al., *Trends in Medicaid Physician Fees, 2003–2008*, 28 HEALTH AFF. (2009).

49. Editorial, *Resistance to Change under Medicaid*, 277 NEW ENG. J. MED. 765 (1967).

50. STEVENS & STEVENS, *supra* note 34, at 66; *see also* RANDALL R. BOVBJERG & JOHN HOLAHAN, MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES 38 (1982) (arguing that another method, state "rate-setting," or prospective payment, was occasionally used as an alternative to the reasonable cost method).

medical education and a major part of undergraduate medical education'"[51]

Hospital payment requirements for Medicaid patients changed in 1981 under an expansion of the Boren Amendment, which allowed states to pay an amount "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated institutions."[52] The result was that while forty states paid for Medicaid hospital services on the basis of Medicare rates in 1981, only four states did so by 1991.[53] The trend in hospital payments under Medicaid and Medicare have nevertheless converged as of 2010, with the American Hospital Association reporting that both programs' payments covered just over 92% of costs.[54] Medicaid physician fees, on the other hand, continue to lag significantly behind Medicare fees. In 2008, Medicaid physician fees were 72% of Medicare fees.[55] Among payments for specific services, Medicaid fees vary such that, on average, Medicaid pays 66% of Medicare fees for primary care services but 93% of obstetrical fees.[56] These averages smooth over substantial disparities among states. Medicaid fees vary among states such that, for example, Wyoming reimburses physicians for Medicaid services an average of 40% more than they receive under Medicare, whereas New York reimburses physicians, on average, more than 40% less than Medicare rates.[57]

Low physicians' fees are usually cited as the most important reason for low physician participation in the Medicaid program. About half of physicians nationwide accept all new Medicaid patients whereas more than 70% accept all new commercially insured or Medicare patients. Other reasons for low physician participation in Medicaid are delays in payment and high administrative burdens.[58] In older research, the attitudes and perceptions of providers have been shown to be a factor in Medicaid participation. For example, in the 1983 President's Commission Report on access to care, the authors included research demonstrating that additional contributing factors to low participation included physicians' personal dislike for Medicaid patients and political

51. STEVENS & STEVENS, *supra* note 34, at 99.

52. JOST, *supra* note 28, at 167. The Boren Amendment was repealed in 1997 after many "Boren lawsuits" had resulted in states being forced to increase their payment rates to hospitals and nursing homes when they were found not to be "reasonable and adequate." LAURA KATZ OLSON, THE POLITICS OF MEDICAID 60–61 (2010). When the Boren Amendment was repealed, the Medicaid DSH requirement, discussed subsequently, was retained. CHARLES LUBAND, RR. MEDICAID SUPPLEMENTAL PAYMENTS AND FINANCING ISSUES 2, (2011), *available at* http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM09/luband.pdf.

53. ENGEL, *supra* note 39, at 169.

54. In 2010, the payment to cost ratio for Medicare was 92.4%, for Medicaid 92.8%, and for commercial insurers 133.5%. *See Trendwatch Chartbook 2011 Table 4.4*, AM. HOSP. ASS'N, http://www.aha.org/research/reports/tw/chartbook/2012/table4-4.pdf.

55. Zuckerman, *supra* note 48, at w510, w515.

56. *Id* at w515.

57. *Id* at w513–w14.

58. Peter J. Cunningham & Ann S. O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation by Physicians?*, 28 HEALTH AFF. w17, w18 (2008).

attitudes against the involvement of "government in medicine."[59] A letter from a Baltimore physician in 1982 described his experience with Medicaid patients in a nuanced way:

> The effort and time required for the care of a Medicaid patient is often greater than that for one's regular practice because of: (a) The tendency for many of the patients to ignore the making and keeping of appointments. They either don't show up, placing an additional burden on the physician for retrieval, or they arrive with four children instead of the one for whom the appointment was made; (b) The frequent lack of telephone facilities; (c) The restriction against telephoning prescriptions; (d) The additional and often cumbersome paperwork; (e) The usual delay of the agency in making payment to the physician; (f) the difficulty of securing consultation through the usual channels.[60]

In a 2000 survey of pediatricians, lower payments and a greater paperwork burden for physicians seeing patients enrolled in Medicaid-managed care were associated with reduced participation rates, suggesting a continuation of many of the same problems.[61] Managed care arrangements have increased over the past few decades such that three-quarters of Medicaid enrollees received all or some services through managed care in 2010.[62] In a 2001 survey, physicians tended to have negative attitudes toward Medicaid patients and Medicaid-managed care but these attitudes did not predict acceptance of new Medicaid patients. About half of the physicians in the survey believed that Medicaid patients were more likely to sue them, and almost three-fourths believed that Medicaid patients were likely to be noncompliant and require extra time. About 80% of physicians believed that Medicaid patients have complex clinical and psychosocial problems. Greater than one third of physicians believed that Medicaid patients "unsettle other patients in the waiting room."[63] On the other hand, in one 1997 survey almost 60% of physicians stated that participation in their state's Medicaid program was the "right thing to do."[64] The rise in the number of Medicaid patients enrolled in managed care is associated with

59. Janet B. Mitchell & Jerry Cromwell, *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare, in* SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES: VOLUME 3: APPENDICES, EMPIRICAL, LEGAL, AND CONCEPTUAL STUDIES 105–130 (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ed. 1983). While this survey is older, newer surveys do not tend to ask physicians about attitudes toward Medicaid enrollees that may imply biases and value judgments. *See, e.g.*, Sharon K. Long, *Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State*, 32 HEALTH AFF. 1560 (2013).

60. Stephen M. Davidson, *Physician Participation in Medicaid: Background and Issues*, 6 J. HEALTH POL. POL'Y & L. 703, 711 (1982).

61. Steve Berman et al., *Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, 110 PEDIATRICS 239, 243 (2002).

62. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 16–17.

63. Lisa Backus et al., *Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care*, 16 J. GEN. INTERNAL MED. 815 (2001).

64. Frank A. Sloan & Christopher J. Conover, *Physician Participation and Nonparticipation in Medicaid Managed Care: The Tenncare Experience*, 92 S. MED. J. 1064–65 (1999).

the concentration of Medicaid patients among smaller numbers of physicians and practice settings.[65]

Together, the low fees, delays in payment, and administrative burdens may act in synergistic ways with the already pervasive negative attitude among physicians about Medicaid patients. As Medicaid patients become increasingly concentrated among a shrinking number of practitioners, a question arises about how these factors may continue to perpetuate the strong historical ties between Medicaid and charity, and inhibit efforts to not only improve both access and quality of care, but also to make it possible for Medicaid recipients to receive the same care, from the same providers, that people with other types of health insurance receive. Although obvious, it bears noting that people who do have health insurance through Medicaid would likely be uninsured if Medicaid were not available. This is one of the reasons that Medicaid and charity care interact in a myriad of ways. For example, states often limit the number of days of hospital payment for patients enrolled in Medicaid as a cost-saving measure.[66] In 1983, the President's Commission wrote that "[i]f a patient is admitted and then needs to stay past the limit, the person must be covered as a charity case, moved to a public hospital—or forced to leave."[67] Little has changed since.[68]

Yet Medicaid is sometimes credited with dealing a blow to a traditional source of charity care—the public hospitals—in what has been called one of the "great paradoxes" of the program.[69] Both Medicaid and Medicare allowed patients who would have been charity patients to obtain services from private hospitals to a greater extent than prior to their enactment.[70] The mass closings of public hospitals that were predicted by some did not occur after the enactment of Medicaid and Medicare.[71] Changes in the distribution of care, however, did. From 1966 to 1980 the number of beds in urban public hospitals declined by

65. Peter Cunningham & Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians* (Aug. 2006), http://www.hschange.com/CONTENT/866/.

66. *See, e.g.*, 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.

67. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES VOLUME ONE: REPORT 157 (1983).

68. Galewitz, *supra* note 66.

69. ENGEL, *supra* note 39, at 126.

70. *See* Robert H. Ebert & Eli Ginzberg, *The Reform of Medical Education*, 7 HEALTH AFF. 10 (1988). Medicare and Medicaid provided a:

> massive infusion of money into the health care system. Whatever the initial concerns of the medical profession, these programs proved a bonanza for physicians and for most hospitals. Suddenly, there was public money to pay for the millions who had previously been medically indigent. Elderly persons, once forced to seek care in public hospitals or in the charity wards and outpatient departments of voluntary hospitals, now could pay for their care.

71. William Blaisdell, *Development of the City-County (Public) Hospital*, 129 ARCHIVES OF SURGERY 760, 763–64 (1994).

close to 40% while private hospital beds increased by 60%.[72] Additionally, the number of public hospitals declined from 1,700 in 1978 to 1,360 in 1995.[73]

Yet this is by no means the complete picture because public hospitals, in particular, have come to rely on Medicaid funds.[74] It is difficult to assess both the subtle and not so subtle influences of provider and institutional behaviors and their effect on the patient's choice of hospital. For example, in the 1970s three-fourths of the patients interviewed at Philadelphia General Hospital preferred that hospital even when they could go to other hospitals. It is unknown whether this was due to the history of hospital racial segregation in the city or some other combination of factors.[75] Feeling "welcome" at an institution is another such factor.[76] In other words, Medicaid has worked in both directions to dismantle some traditional sources of charity care and to simultaneously shore up those same sources. In 2010, the National Association of Public Hospitals reported that Medicaid provided 35% of total net revenue for member hospitals. In addition to regular Medicaid payments for services, supplemental Medicaid payments discussed below are considered essential to maintaining member hospitals' financial well-being.[77]

D. *Enrollment in Medicaid Affects uncompensated care*

It is difficult to determine how many people are potentially eligible for Medicaid yet are not enrolled, and whose care then results in uncompensated services.[78] The General Accounting Office studied this issue in two reports in the early 1990s.[79] In the first report, focusing on the District of Columbia, hospital officials estimated that they enrolled

72. *Id.* at 763.

73. BRUCE SIEGEL, PUBLIC HOSPITALS—A PRESCRIPTION FOR SURVIVAL 2 (1996), *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/1996/Oct/Public-Hospitals—A-Prescription-for-Survival.aspx.

74. *Id.*

75. Gary Henderson, *The Impact of National Health Insurance on the Public Hospital*, 9 HEALTH CARE MGMT REV. 55, 62 (1984).

76. SIEGEL, *supra* note 73, at 3.

77. OBAID S. ZAMAN ET AL., AMERICA'S SAFETY NET HOSPITALS AND HEALTH SYSTEMS, 2010: RESULTS OF THE ANNUAL NAPH HOSPITAL CHARACTERISTICS SURVEY, NAPH (2012), *available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf.

78. The term "uncompensated" services is used here because this is how the term for charity and bad debt is referred to in the literature cited. *See supra* note 10 and accompanying text. For estimates of the number of adults and children eligible for Medicaid and CHIP prior to 2014, see notes 112 and 113 and accompanying text. In a recent estimate of the total 47.6 million uninsured population, 29% would be eligible for Medicaid or CHIP and 10% would fall into the coverage gap created by states that do not implement the Medicaid expansion. KAISER COMM'N ON MEDICAID & THE UNINSURED, A CLOSER LOOK AT THE UNINSURED ELIGIBLE FOR MEDICAID AND CHIP (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/12/8533-a-closer-look-at-the-uninsured-eligible-for-medicaid-and-chip.pdf.

79. The General Accounting Office became the Government Accountability Office in 2004. *Our Name*, GAO: U.S. GOV'T ACCOUNTABILITY OFF., http://www.gao.gov/about/namechange.html (last visited Mar. 8, 2014).

one third of patients eligible for Medicaid during admission. Other research had shown that 17% of District residents, not just those entering hospitals, were eligible for Medicaid but not enrolled.[80] Most of the District's hospitals had hired proprietary vendors to enroll patients eligible for Medicaid. The vendors were paid on a contingency basis at a cost of up to 17% of the reimbursement gained by the hospital from the Medicaid program.[81] In a follow-up study in three states, about half of the denials for Medicaid coverage occurred for procedural reasons, such as the applicant not providing the necessary documentation or not appearing at a required interview.[82] It is not known how many of the denied applicants would have obtained Medicaid had they supplied the missing documentation or interview. When patients were asked, the most common reasons for not providing the completed application was the limited amount of time given, not understanding what was required, and being unable to attain the necessary documents. Hospital officials believed that some people were too sick or too embarrassed to go the welfare agency for the interview.[83] State welfare agencies face penalties for enrolling people who are not eligible but do not face a penalty for failing to enroll a person who is eligible because the application is incomplete.[84]

The second report examined the issue more broadly, and addressed the role of vendors in enrolling potential Medicaid beneficiaries. Significantly, no one can be enrolled in Medicaid without applying for it. Hospitals have a powerful incentive to ensure that people who have received care enroll in Medicaid when they are eligible because the costs are often uncompensated without enrollment.[85] Medicaid covers hospitalization for ninety days prior to enrollment if the applicant was eligible during that time.[86] Although hospitals in the follow-up study believed that the state Medicaid caseworkers should provide more help in enrolling patients, the caseworkers were generally too overworked and also faced prohibitions on patient advocacy since they were also charged with final eligibility determinations.[87] Two proprietary vendors at one hospital in 1992 obtained an additional $10 million in Medicaid reimbursement and were paid $2 million.[88] While hospitals employed staff to assist Medicaid applicants, the vendor firms

80. GENERAL ACCOUNTING OFFICE, DISTRICT OF COLUMBIA: BARRIERS TO MEDICAID ENROLLMENT CONTRIBUTE TO HOSPITAL UNCOMPENSATED CARE 5 (1992), *available at* http://www.gao.gov/assets/220/217378.pdf.

81. *Id.* at 6.

82. GOV'T ACCOUNTABILITY OFFICE, GAO-94-176, HEALTH CARE REFORM: POTENTIAL DIFFICULTIES IN DETERMINING ELIGIBILITY FOR LOW-INCOME PEOPLE 5 (1994), *available at* http://www.gao.gov/assets/230/220023.pdf.

83. *Id.* at 10.

84. *Id.* at 9.

85. *Id.* at 10.

86. *Id.*

87. *Id.* at 13.

88. *Id.*

provided more intensive assistance.[89] The General Accounting Office cited the following as one example:

> The child of a single uninsured working mother incurred a $20,000 hospital bill. The mother also had young twins at home. The hospital referred this case to an enrollment vendor firm after determining that it was a potential Medicaid case. After contacting the mother, the firm initiated and submitted a Medicaid application. The firm gave the applicant a list of the verification items she would have to provide. However, the applicant did not provide the requested items and Medicaid coverage was denied. Upon learning of the denial, the firm contacted the applicant twice weekly for a period of 2 months to get her to cooperate by either providing the verification document or signing a power of attorney that would allow the firm to obtain the documents. However, during this time, the applicant had pressing demands on her life. In addition to working, she was caring for her sick child and young twins. When the applicant stopped responding to the firm's many calls, the firm assigned another caseworker. Eventually, the applicant responded and submitted the verification items and a signed power of attorney to the firm. The verification items included copies of a birth certificate, a Social Security card, and pay stubs. According to an official at the firm, the applicant had been carrying these items in her purse for some time but did not attach any priority to providing them to the firm. The signed power of attorney allowed the firm to appeal the denial successfully and obtain Medicaid coverage for the children.[90]

Needless to say, while the benefit to hospitals and to patients in reducing uncompensated care and medical debt, respectively, is real, the net effect of paying proprietary vendors to enroll patients in Medicaid is a loss of public funds for medical care to a private for-profit business that does not provide any medical services.[91]

While it is important to recognize that people who are eligible for Medicaid may receive care that ends up as uncompensated, that is, as bad debt or charity care, it is also the case that uninsured people are significantly worse off than people with Medicaid coverage.[92] When people lose Medicaid coverage, they are three times more likely to lack a regular source of care and twice as likely to have no physician visits as compared to someone with health insurance.[93] Access to care in the Medicaid program comes close to the same level of access to care for

89. *Id.*

90. *Id.* at 24–25.

91. That being said, the General Accounting Office found not only that such firms were used by the majority of the small sample of hospitals they surveyed in the report, but also noted that HCFA considered them useful in helping to ensure that patients who qualify for Medicaid were enrolled. *Id.* at 15.

92. Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q. J. ECON. 1057, 1096 (2012).

93. Sara Rosenbaum, *Medicaid*, 346 NEW ENG. J. OF MED. 635, 637 (2002).

low-income, privately insured people, though this varies by state and between different categories of recipients.[94]

E. *Ending Welfare as We Know It Does Not Make Medicaid Free of Stigma*

Despite many similarities in access between people with Medicaid coverage versus private coverage, Medicaid tends to remain stigmatized through its historical connection to welfare. Amendments to Title XIX in the 1980s started to delink eligibility for Medicaid from eligibility for AFDC, the federal/state cash welfare program for impoverished families with dependent children. As already described, the 1935 Social Security Act established ADC based on the widely implemented mother's pensions.[95] Both mothers' pensions and ADC were linked in a pejorative sense to the notion of charity. When Medicaid was enacted, eligibility for AFDC, or "welfare," became one of the categories that determined Medicaid eligibility.[96] Many states accordingly used a single application to determine eligibility for both AFDC and Medicaid.[97]

In 1996, under pressure to reform welfare and live up to his promise to "end welfare as we know it," President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). PRWORA repealed AFDC, which had been an entitlement program, and replaced it with Temporary Aid to Needy Families (TANF), a block grant program with work requirements and strict time limits on eligibility.[98] At the same time, Medicaid eligibility was expressly delinked from cash welfare. States maintained the option to leave eligibility for parents with dependent children at their 1996 AFDC level, but could expand income eligibility at their discretion.[99] This change caused confusion about the new law on all sides as well as reports of states engaging in aggressive tactics to deter enrollees.[100] Proponents of severing the link between AFDC and Medicaid argued that not only would it allow states to expand their eligibility criteria, but it would also decrease the stigma associated with public assistance for those enrolled in Medicaid. A summary of this view follows:

> The decision to separate welfare and Medicaid eligibility was well intentioned; the goal was to protect poor families' Medicaid coverage from possible cutbacks in welfare. Further, this might allow Medicaid to begin to operate apart from welfare and some day

94. Teresa A. Coughlin et al., *Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073, 1073 (2005).

95. *See* GORDON, *supra* note 30 and accompanying text.

96. *See* Moore & Smith, *supra* note 42 and accompanying text.

97. Judith D. Moore, *Welfare Reform and Its Impact on Medicaid: An Update*, 732 NAT'L HEALTH POL'Y F. ISSUE BRIEF 1, 4 (1999), *available at* http://www.nhpf.org/library/issuebriefs/IB732_WelfRef&Mcaid_2-26-99.pdf.

98. SMITH & MOORE, *supra* note 29, at 243–44. In the initial years of the program, recipients in many states had an option of either working or receiving education or training; however, many states that started with that option eventually dropped it.

99. *See, e.g.*, 42 U.S.C.A § 1396a(a)(10) (West 2013).

100. JOST, *supra* note 28, at 168–70.

> evolve into a freestanding health insurance system for low-income persons.[101]

In actual fact, however, a variety of direct and indirect factors led to a reduction in health insurance even among the people who remained eligible for cash assistance through TANF. After TANF implementation, women eligible for TANF were 8% and children were 3% less likely to have health insurance coverage than they were under AFDC.[102]

Although PRWORA allowed states to expand Medicaid eligibility and was seen as both a practical and symbolic severing of the link between welfare and Medicaid, its passage was largely attributable to a national abhorrence of "dependency."[103] The entitlement status of AFDC ended with the enactment of PRWORA. Its fate was more a matter of political mobilization than a well-thought-out plan to improve the opportunities for people with a low income. Politically, the loss of entitlement status meant that cash assistance "would become, instead, a form of public charity. Asked what would happen to the children of women denied cash assistance, Speaker Gingrich recommended orphanages."[104] The implementation of TANF occurred during the same period of time that President Clinton vetoed proposals to turn Medicaid into a block grant program that would have ended its fiscal entitlement status as well.[105] As Michael Katz noted, the word "'entitlement' had developed a connotation nearly as negative as 'welfare.'"[106] Often using racially coded language, the problem as many conservatives saw it, was "[n]ot jobs, wages, or globalization, but the collapse of family threatened America's future, and its major source was welfare."[107] According to this view:

> [T]he welfare system has paid for non-work and non-marriage and has achieved massive increases in both. By undermining the work ethic and rewarding illegitimacy, the welfare system insidiously generates its own clientele . . . . Welfare bribes individuals into courses of behavior which in the long run are self-defeating to the individual, harmful to children, and increasingly a threat to society.[108]

Perhaps the threat of welfare faded somewhat with its loss of entitlement status but the sentiments may not have. According to Laura Katz Olson, views of poverty have had sticking power:

> Poverty in the United States is characterized as stemming from personal inadequacies, with welfare recipients viewed as "lazy and

101. Marilyn R. Ellwood & Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, 17 HEALTH AFF. 137, 148 (1998).

102. John Cawley et al., *How Did Welfare Reform Affect the Health Insurance Coverage of Women and Children?*, 41 HEALTH SERVS. RES. 486 (2006).

103. SMITH & MOORE, *supra* note 29, at 246.

104. KATZ, *supra* note 20, at 328.

105. JOST, *supra* note 28, at 169.

106. KATZ, *supra* note 20, at 328.

107. *Id.* at 319.

108. *Id.*

> shiftless," "welfare queens," "deceitful," "immoral," and "conniving." For the most part, it is assumed that young adults receiving income assistance are gaming, cheating, and abusing the system. Government's main role has thus been to "motivate," "educate," "control," and even "punish" individuals and their families who have not attained sufficient funds to meet their basic needs. Blaming victims, especially black and Hispanic low-income, single mothers, has become the national norm among Democrats and Republicans alike.[109]

But again, there were many people who hoped that severing Medicaid eligibility from AFDC would result in greater access and less stigma. A 1999 publication from the Health Care Financing Administration (HCFA), the organization that was created in 1977 to oversee both Medicare and Medicaid, described the changes as "an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low-income families, improving the possibility of destigmatizing Medicaid and enhancing the potential of the program to reach families that come into contact with the TANF system."[110] In the intervening years, with as much as Medicaid has been able to accomplish, it has not shed its status as somehow connected to charity.[111]

Estimates prior to the implementation of the ACA showed that over 70% of uninsured children were eligible for Medicaid or the Children's Health Insurance Program (CHIP), yet not enrolled.[112] In 2004, about 14% of uninsured adults were eligible for Medicaid.[113] When New York's United Hospital Fund studied the Medicaid eligibility process in 2008, the program was still administered by local social service agencies that were also responsible for cash assistance and food stamp programs. Yet other states had adopted new health insurance processes to eliminate any stigma of "welfare" that might discourage people from applying for coverage.[114] The ACA establishes processes that streamline eligibility determinations, enrollment and renewals of coverage, providing a "no-wrong-door" system through health insurance Marketplaces. Individuals and families seeking coverage through Marketplaces are screened not only for eligibility for federal subsidies to help them purchase private coverage, but also for eligibility for Medicaid and CHIP.[115]

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109. OLSON, *supra* note 52, at 67.

110. SMITH & MOORE, *supra* note 29, at 247. For information on the creation of HCFA, see OBERLANDER, *supra* note 40, at 125–26.

111. *See, e.g.*, OLSON, *supra* note 52, at 230–31.

112. KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 10.

113. Diane Rowland & Adele Shartzer, *America's Uninsured: The Statistics and Back Story*, 36 J.L. MED. & ETHICS 618, 624 (2008).

114. BARBARA COULTER EDWARDS ET AL., MEDICAID INST. AT THE UNITED HOSP. FUND, REFORMING NEW YORK'S MEDICAID ELIGIBILITY PROCESS: LESSONS FROM OTHER STATES 8 (2008), *available at* http://www.medicaidinstitute.org/assets/516.

115. 42 U.S.C. § 18083(a) (2012). See also KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 12.

F. *The Medicaid Program from the Patient's Point of View*

In 2005, the Kaiser Family Foundation surveyed the American public on their views of the Medicaid program. While more than half of the people surveyed did not know about details of the program, about the same number knew someone who was enrolled in Medicaid or had been covered by Medicaid at some point. According to the news release: "Perhaps surprisingly given years of debate about Medicaid, frequent references to the program as the 'Pac Man' of state budgets, and periodic calls for reform, public attitudes toward Medicaid are remarkably positive, and opposition to cuts is reasonably strong."[116] More than three-quarters of the people surveyed said they would be willing to enroll in Medicaid if they were eligible. Medicaid was viewed almost as favorably as Medicare and Social Security among those surveyed.[117] More recently, after the economic recession began, researchers from the Kaiser Family Foundation conducted focus groups in four communities about concerns related to their health care. Many people who had recently lost their jobs could not understand why Medicaid was not available when they needed it. One woman who lost her job and health insurance coverage said: "It would be wonderful [to have Medicaid]. It would be such a relief to know that if you had a problem, you'd be able to have that taken care of and not go into the hole even further."[118] Researchers also recently conducted a study on people in Oregon who had been selected by lottery in 2008 to be eligible for Medicaid. Although the effects on health were difficult to determine based on objective data because of the short time frame, self-reported health did improve. They report that "[t]here is . . . an overwhelming sense from the survey outcomes that individuals feel better about their health and . . . their interactions with the health care system."[119] Medicaid coverage improved financial well-being, and even happiness.[120]

At the same time, people insured through Medicaid do often perceive that their care is less than it should be. When the American Academy of Family Physicians published their endorsement of extending Medicaid coverage to more people in 1991, a mother of an adult son with Down's syndrome on Medicaid wrote a letter describing how "he was refused care by several primary care physicians and was denied admission by two highly respected hospitals because they did not want

116. *Kaiser Family Foundation Releases National Survey of the Public's Views About Medicaid*, WEBWIRE (June 29, 2005), http://www.webwire.com/ViewPressRel.asp?aId=3137#.UxuH-_33DR0.

117. *Id.* Correspondingly, a large majority of Americans whom Kaiser polled about the issue reported that they either would not support any cuts whatsoever to Medicaid to reduce the federal deficit (47%) or would support only "minor" reductions (39%). Drew Altman, A Public Opinion Surprise, KAISER FAMILY FOUND. (Apr. 4, 2011), http://kff.org/health-reform/perspective/pulling-it-together-a-public-opinion-surprise/.

118. MICHAEL PERRY ET AL., KAISER FAMILY FOUND. RISING HEALTH PRESSURES IN AN ECONOMIC RECESSION: A 360° LOOK AT FOUR COMMUNITIES 8 (2009), *available at* http://www.kff.org/uninsured/upload/7949.pdf.

119. Finklestein, *supra* note 92, at 1096.

120. *Id.* at 1082–99; *see also* Katherine Baicker & Amy Finkelstein, *The Effects of Medicaid Coverage—Learning from the Oregon Experiment*, 365 NEW ENG. J. MED. 683, 684 (2011).

'another Medicaid patient.'" Although he had a fever, was severely dehydrated, and was vomiting, the mother wrote: while "[a]drift in a sea of white coats, the only mercy we were shown was a towel to catch the vomitus."[121] When Medicaid managed care was being initiated widely in Connecticut, an advocate related the following story about her child:

> I had a child who was on Medicaid and who needed to see a specialist . . . So I went out for a nine o'clock appointment . . . I was put in this big waiting room with a hundred people, all women and children. And by about 10:30 I went over and knocked on a window and said to the woman, "I have a 9:00 appointment." And the woman said, "So does everyone else. . . ." It was a very dehumanizing experience.[122]

Ronald Angel, Laura Lein, and Jane Henrici provide a nuanced account of the situation faced by poor Americans in obtaining health care in *Poor Families in America's Health Care Crisis.* The book provides details from an ethnographic study of mostly minority families in three cities along with supporting data and commentaries from other research. The authors describe a rarely studied, though significant, aspect of the lives of these families that affects the health care that people receive and whether they are enrolled in Medicaid. This is an account from the authors:

> [T]he lives of the people we worked with were often confusing and chaotic. Unlike fictional accounts, the story plots are not complete and there are often large gaps in the narratives. Although for the most part the mothers we interviewed were remarkably candid about their lives and were forthcoming with information, we could not always be sure when members of the family were employed and when they had health insurance because their lives were simply too complex and confusing to be easily entered into the sort of time and activity matrix that researchers often use (or that a well crafted novel might portray). Even in directed interviews, the sequence of events and the identification of who did what when was often unclear to us and probably to the mothers themselves.[123]

Throughout the book, what has been called "churning" or the cycling on and off Medicaid is a constant.[124] The complexity and insta-

121. Jane A. Zanca, *Letter to the Editor*, 266 J. AM. MED. ASS'N 2560–61 (1991).

122. COLLEEN M. GROGAN & MICHAEL K. GUSMANO, HEALTHY VOICES, UNHEALTHY SILENCE: ADVOCACY AND HEALTH POLICY FOR THE POOR 105 (2007).

123. RONALD J. ANGEL ET AL., POOR FAMILIES IN AMERICA'S HEALTH CARE CRISIS 5 (2006).

124. KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 11. Sommers and Rosenbaum project that, after the health exchanges begin operating in 2014, half of adults with income below 200% of the poverty level will experience changes in their eligibility status for Medicaid or health insurance exchanges, as a result of income fluctuations. Benjamin D. Sommers & Sara Rosenbaum, *Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges*, 30 HEALTH AFF. 228, 232 (2011). State-administered "basic" health plans are intended to act

bility of the families' circumstances were daunting and reached all aspects of living including employment, housing, other basic necessities, and health care. One family's example of churning occurred in the family of a single mother, "Cecilia." She lost Medicaid coverage as well as food stamps and TANF benefits when she missed a meeting with a caseworker during her second pregnancy. Later, Medicaid was discontinued for one child because his immunizations were not up to date.[125] When Cecilia was not eligible for Medicaid, she used a local public program but she owed hundreds of dollars to the program. Even though the local program was intended for low-income uninsured people and the price was discounted, it was certainly not free.[126] Medical debt was mentioned by many of the people interviewed for the book. This is not unusual even for extremely impoverished people. Less than half of uninsured people receive discounted prices when they pay for medical care.[127]

Particularly given the expansion of Medicaid in many states and its role in health care reform, the question of the degree to which people may associate the program with stigma is important. Although in the recent Kaiser Foundation interviews many participants wanted to enroll in Medicaid but were not eligible, some effect of stigma has been a part of research on enrollment during previous expansions of Medicaid and CHIP.[128] Certainly the family members interviewed in the Angel, Lein, and Henrici study often felt humiliated. In 2000, researchers interviewed 1,400 people who received health care at community health centers in order to study dimensions of stigma associated with the use of public benefits such as cash assistance and Medicaid. The researchers also identified ways in which stigma and other factors affected actual enrollment. The belief that applying for Medicaid would involve unfair questions and that Medicaid enrollees would not receive the same treatment by physicians as people with private health insurance were associated with lower decisions to enroll. The researchers did not find evidence of what some have called "welfare stigma," which is the belief that the enrollee will feel bad about herself or that others will look down upon her, as separate causes for not enrolling. Changes in the enrollment process such as applying for Medicaid at places other than a welfare office were associated with much less stigma.[129] While the "no

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as a bridge for this population, so they experience stability in coverage even as the source of coverage funding changes from Medicaid to federal subsidies and private financing. *See e.g.*, Ann Hwang et al., *Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning between Medicaid and Exchanges*, 31 HEALTH AFF. 1314 (2012).

125. This disenrollment should only have affected cash assistance, not Medicaid.

126. ANGEL, *supra* note 123, at 3.

127. EMILY CARRIER ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED AND THEIR HEALTH CARE NEEDS: HOW HAVE THEY CHANGED SINCE THE RECESSION? (2011), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8246.pdf

128. Lisa Dubay & Genevieve Kenney, *The Impact of CHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families*, 44 HEALTH SERV. RES. 2040 (2009).

129. JENNIFER P. STUBER ET AL., GEO. WASH. U. MED. CENTER, BEYOND STIGMA: WHAT BARRIERS ACTUALLY AFFECT THE DECISIONS OF LOW-INCOME FAMILIES TO ENROLL IN MEDI-

wrong door" process through health insurance Marketplaces will likely help to reduce stigma, additional measures, such as changing organizational culture at enrollment offices to promote a welcoming attitude, are also needed.[130] States have tended to increase outreach efforts and simplify enrollment in Medicaid when budgets are strong and to dampen such procedures or create other barriers to enrollment and retention during economic downturns. The recent attempts by some states to create barriers for people who need assistance with the health insurance Marketplace seems, however, to be primarily driven by political opposition.[131]

II. THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM IS CREATED

Another way that charity care and Medicaid became linked in complex ways that continue to be debated is through the use of Medicaid supplemental payments. When Congress extended the Boren Amendment payment standards to hospitals in 1981, which largely resulted in states lowering Medicaid hospital payments, it also required states to "take into account" hospitals that serve a "disproportionate number of low-income people with special needs" when determining reimbursement.[132] The law explicitly allowed these funds to help pay for care of uninsured patients, an indeterminate number of whom were receiving charity care. Since states were primarily interested in their new ability to lower payments to hospitals, they largely ignored this provision.[133] Only seventeen states had a designated Medicaid Disproportionate Share Hospital (DSH) program by 1985.[134]

Congress amended the Medicaid DSH provisions in 1987 out of concern that states were not implementing these additional payments. States were now required to submit a plan describing their DSH policy. The law also set minimum criteria for defining a hospital as a DSH hospital and minimum criteria for calculating DSH adjustments. States were, and still are, required to designate a hospital as a DSH hospital based either on having a Medicaid inpatient utilization rate greater than one standard deviation above the mean for that state or based on

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CAID?, (2000), *available at* http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/beyond_stigma_no3.pdf.

130. *See, e.g.*, KAISER COMM'N ON MEDICAID & THE UNINSURED, KEY LESSONS FROM MEDICAID AND CHIP FOR OUTREACH AND ENROLLMENT UNDER THE AFFORDABLE CARE ACT 7 (2014) *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8445-key-lessons-from-medicaid-and-chip.pdf.

131. *See, e.g.*, Lizette Alvarez and Robert Pear, *Florida Among States Undercutting Health Care Enrollment*, N.Y. TIMES (Sept. 17, 2013), http://www.nytimes.com/2013/09/18/us/florida-among-states-undercutting-health-care-enrollment.html?pagewanted=all.

132. Omnibus Reconciliation Act of 1981, Pub. L. 97-35, 95 Stat. 808 (1981); *See also* SMITH & MOORE, *supra* note 29, at 168.

133. MICHAEL S. SPARER, MEDICAID AND THE LIMITS OF STATE HEALTH REFORM 51 (1996).

134. Robert Mechanic, *Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments*, NAT'L HEALTH POL'Y F. 5 (Sep. 4, 2001) *available at* http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf.

having a low-income utilization rate above 25%.[135] The Medicaid low-income utilization rate is specifically calculated in part on the basis of the percentage of charity care provided by the hospital after subsidies for such care are subtracted.[136] Beyond this minimum, states originally had great latitude in defining other hospitals as eligible for DSH funds.

The federal match, or Federal Medical Assistance Percentage (FMAP), is calculated based on a state's per capita income relative to the national average. Although FMAP differs from state to state, on average states pay 43% and the federal government 57% of the Medicaid program's cost.[137] The FMAP applies to Medicaid DSH payments, but as originally written there was no upper limit or ceiling on the federal match for DSH payments as long as the requirements were met.[138] In 1983 HCFA issued regulations that prohibited Medicaid federal matching payments for inpatient hospital and nursing home care to no more than what would be paid under the Medicare program, referred to as the "Medicaid upper payment limit."[139] This limit did not have to be adhered to in the DSH payments.

The intended purpose of the law was clearly to provide states with matching payments for hospitals that were providing the most care to low-income patients, whether or not the patients were covered under Medicaid or were receiving charity care.[140] What actually happened over the next few decades was at times quite different. A sizeable fraction of DSH funds were, in a number of states, used for general revenue purposes. In a 1995 survey of the Medicaid DSH program in thirty-nine states, the primary beneficiaries of the program were state governments. One third of the DSH funds were retained by states, suggesting that "only a small share of the funds currently generated by DSH programs are actually used to cover uncompensated care."[141] Since, according to officials, "money is fungible" at the state level, the funds could be used to balance overall state budgets.[142] The *Washington Post* called the program in 1994 "a worthy idea gone terribly awry."[143] Rand

135. *See* 42 U.S.C.A. § 1396r-4(b)(1) (West 2013).

136. 42 U.S.C.A. § 1396r-4(b)(3)(B) (West 2013). The law specifies that the Medicaid DSH low-income utilization rate is the sum of two ratios. The first is the share of the hospital's total revenue for patient services that are paid by Medicaid or by state and local subsidies. The second is the percent of total hospital charges for charity care minus any subsidies for such care. BARBARA WYNN ET AL., RAND CORP. ANALYSIS OF THE JOINT DISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS, 10 (2002).

137. KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 16, at 31.

138. JEAN HEARNE, CONG. RESEARCH SERV., 97–483, MEDICAID DISPROPORTIONATE SHARE PAYMENTS (2005).

139. TERESA A. COUGHLIN & DAVID LISKA, URB. INST., THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAM: BACKGROUND AND ISSUES 6 (1997), *available at* http://www.urban.org/UploadedPDF/anf_14.pdf.

140. Wynn, *supra* note 136 at vii.

141. LEIGHTON KU & TERESA A. COUGHLIN, KAISER FAMILY FOUND., MEDICAID DISPROPORTIONATE SHARE AND OTHER SPECIAL FINANCING PROGRAMS 33 (1994) *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14748.

142. *Id.* at 24.

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

Rosenblatt's observation, made in a somewhat different context, is apposite here: "in the name of the poor," funds may flow "[m]ost ironically" back to those with the most political power while the "poor's 'social account'" is charged.[144]

Federal dismay over this problem concerned only secondarily the failure of the funds to be used for uncompensated care. The primary concern involved the use of the funds to increase the federal share of Medicaid payments. The ability of states to increase the federal share of payments arose in part from a regulation issued in 1985 by HCFA which allowed states to receive donations from private medical care providers or to tax providers and use these funds to draw down federal Medicaid dollars according to the federal matching rate.[145] For example, in West Virginia the state began collecting millions of dollars in donations from large nonprofit hospitals. The funds became state funds, which were then given back to the hospitals in an amount that exceeded the original donation. Once the hospitals were paid, the state received a federal match but most of the match was retained by the state. While there was a net gain by the hospital, the largest gain was to the state budget.[146] An illustration of how the program could work follows:

> State A requests a donation or imposes a tax on a hospital of $10 million. The state then makes a DSH payment of $12 million to the hospital, either as lump sum or by means of increased Medicaid rates. This nets the hospital $2 million and "costs" the state $2 million. The state then claims the $12 million as a "legitimate" Medicaid expense and, assuming a fifty percent match, receives $6 million from the federal government. Final result: the provider netted $2 million from the transaction; the state is ahead by $4 million; the federal government is out $6 million; and Medicaid recipients may or may not benefit from this transaction.[147]

Once states understood the possibility of these financing strategies, the DSH program payments shot from less than $600 million in 1989 to $17.4 billion in 1992.[148] Program costs increased so rapidly that federal officials became alarmed. The Inspector General called the use of provider donations and taxes an "uncontrollable virus" and "egregious."[149] The genesis of the problem was the failure of Congress to tie the bestowal of DSH funding to care given to specific beneficiaries and services and to cap the total funds provided.[150] Officials in the George H.W. Bush Administration at the Office of Management and Budget,

144. Rosenblatt attributes this insight to Edward Sparer. Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 60, 110 (1994).

145. COUGHLIN & LISKA, *supra* note 139, at 2–3.

146. *Id.* at 5–6; *see also* Mechanic, *supra* note 134.

147. SMITH & MOORE, *supra* note 29, at 208–09

148. Hearne cites $17.4 billion in 1992. HEARNE, *supra* note 138, at 4. Mechanic cites $600 million in 1989. Mechanic, *supra* note 134, at 4.

149. HEARNE, *supra* note 138, at 6.

150. *Id.*

and HCFA, saw the program as "highly irregular if not illegal."[151] The political implications were powerful, threatening alliances between state and federal government officials at both the political and budgetary level. As a result, Congress embarked on measures over the next two decades that clamped down on program loopholes, while lessening the blow by increasing available funds.[152]

In 1991 Congress enacted the first legislative reform of DSH with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments.[153] The law was intensely negotiated between the Bush Administration and the National Governor's Association, and was a compromise measure.[154] The law prohibited the use of donations and provider taxes that were not broad based. The taxes had to be "bona fide" and could not be written to hold providers harmless for the cost.[155] The law set a national limit of 12% of total Medicaid spending for the DSH program, thereby curtailing further escalation of a program that had risen from about 2% of spending in 1990 to over 13% in 1992.[156] State DSH payments were also capped at the 12% level but were to be phased up or down based on the individual state's allotment since some states had much higher or lower percentages of DSH.[157]

One effect of the cap was to lock in the highly inequitable distribution of DSH funds at the state level. For example, by 2001 there were five states that reported a DSH payment of at least $1,000 per resident below the poverty level and sixteen states that reported DSH payments of less than $100 per poverty level resident.[158] The law also specifically protected the use of intergovernmental transfers as a source of financing, considered by some to be another "loophole," which had not been in wide use prior to the legislation.[159]

A. *The Growth of Medicaid DSH is Curtailed*

The effect of the law was to limit the growth in the DSH program, though the controversies were far from over. The DSH program by this time had become politically explosive and a vehicle for fundamentally divergent strategies among powerful stakeholders.[160] As David Smith and Judith Moore put it,

> [T]he DSH experience provides a good example of how the flexibility and loopholes in our American system of fiscal federalism

151. John K. Iglehart, *The American Health Care System—Medicaid*, 328 NEW ENG. J. MED. 896, 898 (1993).

152. OLSON, *supra* note 52, at 210.

153. COUGHLIN & LISKA, *supra* note 139, at 3.

154. *Id.*

155. 42 U.S.C.A. § 1396b(w)(2)(B) (West 2013); *see also* Teresa A. Coughlin et al., *Reforming the Medicaid Disproportionate Share Hospital Program*, 22 HEALTH CARE FIN. REV. 137, 139 (2000).

156. Teresa A. Coughlin & David Liska, *Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals*, 17 HEALTH AFF., 118, 118–19 (1998).

157. HEARNE, *supra* note 138, at 6.

158. Mechanic, *supra* note 134, at 9.

159. HEARNE, *supra* note 138, at 6–7.

160. Morgan, *supra* note 143.

> enable venturesome and public-spirited officials to work a power of good. They also reward the shrewd and greedy, punish those who live by the rules and make do with their share, and breed lies, hypocrisy, distrust, and cynicism.[161]

The use of intergovernmental transfers in which states use public funds from state, local, or county health care facilities as the state match works in much the same way as we saw above, with the provider donations and taxes that federal law had partially curtailed. Inventive states willing to push the line also began to use other practices. Some states, for example, reported grossly inflated charges at public hospitals, or paid significantly more in DSH payments to certain hospitals than the total cost of caring for Medicaid and uninsured patients.[162] Others provided DSH payments to hospitals with few Medicaid patients, especially at mental hospitals where most care for adults is the financial responsibility of the state.[163] As a response to these continued problems, in 1993 Congress imposed a hospital-specific limit to DSH payments, which could be no more that the total cost of unreimbursed care to Medicaid enrollees and uninsured patients for an individual hospital.[164] The 1993 amendments also prohibited DSH payments to hospitals, such as mental health institutions, that did not have at least a 1% Medicaid utilization rate.[165]

The hospital-specific limits were transitioned such that certain, usually state-owned, hospitals could continue to receive DSH payments of up to 200% of their Medicaid shortfall and uninsured cost. Congress made exceptions to the hospital-specific limit on DSH payment several times. In 2000, for example, the hospital-specific limit for public hospitals for the years 2003 and 2004 was increased from 100% to 175% of the unreimbursed Medicaid and uninsured cost.[166] The Office of the Inspector General, upon review of this prospective increase, concluded that it should either be delayed or repealed, finding multiple irregularities.[167] CMS agreed, yet the increase in DSH limits for public hospitals was left intact for those years.[168]

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161. SMITH & MOORE, *supra* note 29, at 208.

162. HEARNE, *supra* note 138, at 7.

163. Mechanic, *supra* note 134, at 8.

164. HEARNE, *supra* note 138, at 7.

165. *Id.* at 7–8.

166. The Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA 2000) required that public hospitals in all states have a DSH limit of 175% of uncompensated care cost for the two fiscal years beginning after September 2002. California's public hospitals already had this higher limit. Memorandum from Inspector General Janet Rehnquist for Administrator for Centers for Medicare and Medicaid Services Thomas Scully (Dec. 27, 2001), *available at* https://oig.hhs.gov/oas/reports/region6/60100069.pdf.

167. These included findings that as much as 90% of DSH payments to some hospitals were returned to the state; the calculation of uncompensated care costs varied widely; many hospitals overstated uncompensated care costs; and some states included the cost of providing care to prisoners even though this was not supposed to be allowed. *Id.* at 6–9.

168. *Id.* This is consistent with the history of the DSH program as "intensely political and rife with special deals." Mechanic, *supra* note 134, at 8.

When forty states were surveyed about their DSH programs in 1997, states were netting 40% of the financial gains while hospitals were receiving about 60% of new additional funds.[169] As mentioned, Congress continued to pay attention to DSH payments to hospitals, though it still vacillated between curtailing and expanding the program. Reliable and detailed information on DSH programs did not exist, and states resisted attempts to develop accurate reporting systems.[170] In the 1997 Balanced Budget Amendment, Congress required states to report to HCFA the methodology it used to identify and make payments to DSH hospitals on the basis of the proportion of low-income and Medicaid patients served by the hospitals, and to include individual hospital information.[171] In a 2002 RAND/Urban Institute report, however, researchers found that "compliance with this requirement appears lax and federal enforcement is limited."[172] Even the most minimal information was often not provided by states, such as accurate hospital identification.[173] The state DSH payment reports also sometimes correlated poorly with information generated by HCFA providing an accounting of state DSH expenditures, calling the former's accuracy into question.[174]

B. *Other Medicaid Maximization Strategies Are Utilized*

In response to the tightening federal strictures on DSH payments, states began to use other "Medicaid maximization" strategies to increase the federal share of funds. One of the primary ways states could do this was through creative exploitation of the upper payment limit rules (UPL). While the Medicaid DSH program is mandatory for states, UPL "programs" are not. The schema underlying funding of the state portion of UPL resembles that of the DSH program in DSH's early years. A Louisiana journalist described the process: "Borrow $20 from a friend. Show it to your Dad. He gives you $50. Give the $20 back to your friend. Walk away with a wallet $50 fatter."[175] The UPL payments

169. Coughlin, *supra* note 155, at 155.

170. Mechanic, *supra* note 134, at 9.

171. Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4721 (1997):

> A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and Medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

172. WYNN, *supra* note 140, at 107.

173. *Id.* at 107–08.

174. *Id.* at 108. The authors cite to one example, in which "Pennsylvania's hospital specific report for FY 1998 showed a total of $41 million in DSH payments whereas the state claimed $546 million in DHS payments on Form HCFA-64."

175. Steve Ritea, *Transfer System Could Save Medicaid, but It Might Be Too Late for LA to Get on Board*, TIMES-PICAYUNE (Apr. 2, 2000) (quoted *in* ANDY SCHNEIDER & DAVID ROUS-

are based on the difference between what Medicare pays and what Medicaid pays for comparable services.[176] Federal law provides that such aggregate Medicaid expenditures may not exceed what Medicare would have paid for the same services.[177] Because states' Medicaid rates are generally much lower than Medicare, these states can make large payments—UPL payments—to a specific hospital or category of hospitals without violating the aggregate upper payment limits. As long as the aggregate limit is not breached, a single hospital or class of hospitals does not have a limit on the UPL funds received.[178] When these UPL payments are made to public hospitals, some states' general funds ultimately reap most of the benefits. For example, a 2004 General Accounting Office (GAO) report described how Michigan provided $122 million to county hospitals as a UPL payment.[179] The federal match for these payments was $155 million, making a total of $277 million that was provided to the county hospitals under the UPL program.[180] Later the same day, the county hospitals, through an intergovernmental transfer, sent all but about $6 million of the funds back to the state through an intergovernmental transfer. These funds were deposited into a separate general fund that "recycled" the resulting $149 million in now-"state" dollars to generate additional federal matching dollars.[181] The GAO found that some states clearly used the funds for non-Medicaid purposes, such as K-12 education.[182] The "absence of reliable data protects states that engage in questionable practices and limits the momentum of efforts to change the program in ways that would benefit low-income patients."[183]

Although the Medicaid DSH and UPL programs have been described as a "tug-of-war" between the federal and state governments, over time the federal government has curbed some of the most fiscally problematic practices.[184] In the case of DSH, Congress capped total funding for states on several different occasions, most recently under the ACA.[185] In a 2006 survey of thirty-five states, Teresa Coughlin and

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SEAU, KAISER COMM'N ON MEDICAID & THE UNINSURED, UPPER PAYMENT LIMITS: REALITY AND ILLUSION IN MEDICAID FINANCING 2 (2002), *available at* http://www.kff.org/medicaid/4043-index.cfm.).

176. Other supplemental Medicaid payments are made on the basis of 1115 Waivers which are state specific demonstrations approved by CMS. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-614, MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS 6 (2008), *available at* http://www.gao.gov/new.items/d08614.pdf.

177. 42 C.F.R. § 447.272(b)(2) (2013).

178. Mechanic, *supra* note 134, at 9.

179. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-04-574T, INTERGOVERNMENTAL TRANSFERS HAVE FACILITATED STATE FINANCING SCHEMES 5–6 (2004), *available at* http://www.gao.gov/new.items/d04574t.pdf.

180. *Id.*

181. *Id.*

182. *Id.* at 8–9.

183. Mechanic, *supra* note 134, at 14.

184. SONYA SCHWARTZ ET AL., MOVING BEYOND THE TUG OF WAR: IMPROVING MEDICAID FISCAL INTEGRITY 6 (2006), *available at* http://nashp.org/sites/default/files/Medicaid_Fiscal_Integrity.pdf?q=Files/Medicaid_Fiscal_Integrity.pdf.

185. 42 U.S.C.A. § 1396r-4(f) (West 2013).

colleagues found that the intergovernmental transfer of funds back to the state had greatly decreased and accounted for less than 1% of spending. Yet at the same time, if the IGTs and provider taxes that the state used to fund the supplemental payments are subtracted from the total being paid to providers, the share of the spending in these programs attributable to federal funds was 80%, suggesting that some of the problems that most interested federal officials were continuing.[186] With respect to UPL, while the federal government limited UPL payments by tightening the state methodology for calculating them, the government's ability to assess the payments being made was particularly difficult because of the lack of accurate reporting methods.[187] The GAO was unable to provide any estimate of the total national 2006 non-DSH supplemental payments such as UPL, stating "the total amount and distribution of payments made in fiscal year 2006 is unknown because states did not separately report all their payments to CMS."[188]

While Medicaid supplemental payment programs may have allowed federal funds to stabilize state budgets and maintain Medicaid services in difficult economic circumstances, the evidence is mixed. As mentioned earlier, it is clear that in some states the funds were not used for health care purposes, and were instead used for general revenue purposes.[189] Even though some of these funds are presumably used to make positive changes, states as well as hospitals have had wide discretion and little accountability for the use of the funds over much of the life of the program.[190] Supplemental funds "count" toward total Medicaid spending, yet are not always used, as we have seen, to provide actual care for Medicaid recipients. This discrepancy not only distorts the relationship between Medicaid spending and care provided through the program,[191] but also may increase the likelihood of cuts to the program, to the extent they cause taxpayers to view the Medicaid program as both profligate and overfunded.[192] It may be convenient to "charge" supplemental payments, in all their myriad uses, to the "social account" of the poor, but the injustice is manifest.

C. *Medicaid, DSH, and the Safety Net*

Even though it has been difficult to trace all the ultimate uses to which DSH and UPL funds have been put, proponents of the health

186. Teresa A. Coughlin et al., *Restoring Fiscal Integrity to Medicaid Financing?*, 26 HEALTH AFF. 1469, 1478 (2007).

187. *See, e.g.*, GAO-08-614, *supra* note 176, at 21–22. The UPL regulations may be found at 42 C.F.R. § 447.321 (2012).

188. GAO-08-614, *supra* note 176, at 6. The report states that CMS had determined that $23 billion was spent on DSH and non-DSH supplemental payments in 2006, but the information was incomplete.

189. SCHNEIDER & ROUSSEAU, *supra* note 175.

190. Karen Matherlee, *The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy*, 760 NAT'L HEALTH POL'Y F. 7 (2000), *available at* http://www.nhpf.org/library/issue-briefs/IB760_MedicaidMatch_12-15-00.pdf.

191. SCHNEIDER & ROUSSEAU, *supra* note 175.

192. *See, e.g.*, Ed Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1, 2–3 (1981).

care safety net have become one of the biggest stakeholders in the debate concerning the funds. Patricia Gabow, the chief at Denver Health, described her state's reluctance to fully take advantage of federal DSH payments in the late 1990s when a legislator claimed that "DSH is the cocaine of public hospitals."[193] Gabow's view was different:

> We saw it more like penicillin. How do you transform cocaine into penicillin? And why shouldn't the federal government support safety-net hospitals like ours, when these institutions provide our national health insurance by default? We needed to convince one of the smartest and most powerful legislators who opposed DSH to support accessing these dollars.[194]

When the DSH program was enacted, the term "safety net" was not often used to refer to health care.[195] President Reagan used the metaphor "social safety net" in 1981, with William Safire declaring in that year that "[a]dministration spokesmen carry the safety net around as a kind of security blanket."[196] In the midst of severe cuts to social welfare programs, Safire proclaimed: "Using the circus metaphor of a 'safety net,' the budget cutters seek to allay fears of many of the 'truly needy' (but not, one assumes, of the 'falsely needy') that society is not about to shove them off the high wire onto the sawdust below."[197]

By 1999, the "health care safety net" was firmly entrenched in the health policy and medical literature. Writing for the National Association of Public Hospitals and Health Systems (NAPH) in 1999, Lynne Fagnani and Jennifer Tolbert described "safety net hospitals" as "those whose stated mission is to provide care to anyone in need regardless of their ability to pay."[198] These authors explain that the major sources of funding for unreimbursed care provided at safety net hospitals are state and local tax appropriations, and the Medicare and Medicaid DSH programs. Even though hospitals that were members of NAPH transferred almost 70% of their Medicaid DSH payments back to their state treasuries in 1996, the Medicaid DSH program still managed to raise Medicaid payments above costs to member hospitals.[199] The authors take particular note of how the DSH program lacked accountability for how the funds were spent and that this was a major barrier to reforming the program. There was simply no national data on "how states spend DSH

193. Patricia A. Gabow, *Making a Public Hospital Work*, 20 HEALTH AFF. 182, 186 (2001).

194. *Id.* at 186.

195. SMITH & MOORE, *supra* note 29, at 157.

196. William Safire, *On Language; Safety Nets*, N.Y. TIMES, Mar. 29, 1981 § 6 (Magazine Desk), at 9.

197. *Id.*

198. LYNNE FAGNANI & JENNIFER TOLBERT, NAT'L ASS'N OF PUB. HOSPS. AND HEALTH SYS., THE DEPENDENCE OF SAFETY NET HOSPITALS AND HEALTH SYSTEMS ON THE MEDICARE AND MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAMS 1 (1999).

199. *Id.* at 9, 19.

funds, who receives them, how much individual entities receive, and how states finance their share of the program."[200]

As mentioned above, little is known as well about how hospitals that receive DSH payments use the funds. In a 1995 survey, hospital officials told surveyors that DSH revenue usually was placed in the hospital's general operating fund where the money could have indirectly covered the cost of uncompensated care and Medicaid underpayments.[201] Some hospital officials told surveyors that the funds were used specifically to expand services in the clinics. Some hospitals used the funds as "short-term windfalls" and made many types of capital expenditures.[202] Since the Medicaid and DSH funds cannot usually be traced, there are few ways, other than surveys, to determine the impact of the funds. Such surveys necessarily depend on the reliability of the reporter. The answers may indeed have been accurate, though unverifiable. One study has provided evidence that patient mortality rates decline in inverse proportion to the availability of DSH funds at public hospitals.[203] This effect was hypothesized to be due to greater resources as a result of the funds.[204] Another study found that the nonprofit hospital provision of uncompensated care in California fell following the 1997 DSH reductions, but the reduction was inelastic in value, that is, only loosely correlated with the size of the reduction.[205] Studies such as these provide indirect support for the hospital officials' likely veracity in the survey. There is the possibility, however, that responses to the survey question about the use of DSH funds could, for example, reflect social desirability bias.[206] The safety net hospital officials may have perceived that it would be expected and socially desirable to report that the funds were used to provide services related to the needs of Medicaid and uninsured low-income patients. Without objectively verifiable data, a definitive determination cannot be made.

In other research, subsidies provided to hospitals in New York in the 1980s on the basis of the cost of uncompensated care did increase the provision of charity care modestly when matching payments were provided.[207] When lump sums were provided, however, charity care did not increase.[208] The authors concluded that "hospital subsidies appear relatively inefficient in targeting revenues toward the uninsured

200. OBAID S. ZAMAN ET AL., NAT'L. PUB. HEALTH AND HOSP. INST. AMERICA'S SAFETY NET HOSPITALS AND HEALTH SYSTEMS, 2010: RESULTS OF THE ANNUAL NAPH HOSPITAL CHARACTERISTICS SURVEY (2012).

201. KU & COUGHLIN, *supra* note 141.

202. *Id.*

203. Katherine Baicker & Douglas Staiger, *Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality*, 120 Q. J. ECON. 345 (2005).

204. *Id.*

205. Hui-Min Hseih & Gloria J. Bazzoli, *Medicaid Disproportionate Share Hospital Payment: How Does It Impact Hospitals' Provision of Uncompensated Care?*, 49 INQUIRY J. 254 (2012).

206. Robert A. Pearlman & Helene E. Starks, *Quantitative Surveys, in* METHODS IN MED. ETHICS 233–40 (Jeremy Sugarman & Daniel P. Sulmasy eds., 2010).

207. Kenneth E. Thorpe & Charles E. Phelps, *The Social Role of Not-for-Profit Organizations: Hospital Provision of Charity Care*, 29 J. ECON. INQUIRY 482 (1991).

208. *Id.*

patient. Hospitals use some of the revenues received from the pool to support uncompensated care, but a substantial fraction went to support other hospital activities or were simply retained."[209] This is worrisome with respect to supplemental payments, as they much more closely resemble lump sum payments than matching payments made on the basis of the cost of uncompensated care. As already discussed, UPL payments have no connection with the cost or volume of uncompensated care that a hospital provides, and DSH payments, while capped at the total amount a hospital expended on uncompensated care, often have little connection with that figure, and, like UPL payments, are often diminished through IGTs. Toward that point, in another study of all hospitals nationwide in the decade from 1990 to 2000, researchers found that Medicaid DSH spending had no statistically significant effect on hospital uncompensated care. The estimate was considered to be robust and left the researchers asking, "where are the (marginal) Medicaid DSH dollars going?"[210]

Not all hospitals that receive supplemental payments are in similar circumstances with respect to the role the funds play in their organizations. NAPH (renamed America's Essential Hospitals in 2013) continues to be a vocal stakeholder in the Medicaid DSH discussion, and the organization makes a strong case for DSH funds improving the financial status of safety net hospitals. In 2010, nearly 20% of the care NAPH hospitals provided was delivered to uninsured patients, and nearly 30% was provided to Medicaid patients—numbers far in excess of those at non-safety net hospitals.[211] Medicaid DSH payments covered almost a quarter of the cost of NAPH member hospitals' unreimbursed care that year, and other Medicaid supplemental payments covered more than 10% more.[212] The definition of unreimbursed care used by NAPH, however, is not the same as the cost of Medicaid shortfalls and uninsured costs (the costs that DSH payments are directed toward) because it includes losses from Medicare patients as well.[213] A 2010 NAPH report observed that "Medicaid DSH and other supplemental Medicaid payments are essential to the financial viability of safety net hospitals."[214] Reflecting the generally more precarious financial status of safety net hospitals, the average margin for NAPH members was just over 2% in 2010 while the average margin for all hospitals was just over 7%.[215] Without Medicaid DSH, the overall NAPH member margin would have dropped to negative 6%, and even further to negative 10% without UPL payments.[216]

209. *Id.*

210. *See* Anthony T. Lo Sasso & Dorian G. Seamster, *How Federal and State Policies Affected Hospital Uncompensated Care Provision in the 1990s*, 64 MED. CARE RES. & REV. 731, 740 (2007). The authors were unable to determine at what point the funds became untraceable, that is, the funds were not traceable at either the state or hospital level.

211. ZAMAN ET AL., *supra* note 77, at 13.

212. *Id.*

213. *Id.* at 19.

214. *Id.* at 15.

215. *Id.*

216. *Id.*

III. MEDICAID DSH REPORTING REQUIREMENTS ARE FINALLY IMPLEMENTED IN 2010

In an effort to obtain data that had long been missing, Congress added a provision to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that required states to report specific data on their DSH programs to CMS and to obtain an independent certified audit verifying certain data concerning uncompensated care and payments to hospitals.[217] This requirement was to be implemented beginning in 2004, but CMS did not issue proposed regulations implementing the law until 2005. The proposed rule was not finalized until 2008, and was to be implemented in 2009 with states reporting on their DSH programs for the years 2005 and 2006.[218] In a letter to state Medicaid directors, however, states were told they would not be considered out of compliance unless they failed to provide the reports by 2010.[219] In the letter, CMS went even further to ensure compliance by stating that the information from the years 2005 to 2010 in the reports "will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter."[220]

As mentioned previously, the DSH rules specify that one method for determining which hospitals must receive payments is based in part on the amount of uncompensated care provided by the hospital.[221] DSH payments, by statute, are directed toward hospitals that "serve a disproportionate number of low-income patients with special needs."[222] The first component of uncompensated care, for the purpose of the state DSH report required under 42 U.S.C. § 1396r-4, is the unreimbursed cost of care for Medicaid patients, and the second component is the unreimbursed cost of care for uninsured patients.[223] Since 1993, federal matching DSH payments may be made to a hospital up to its hospital-specific limit, which consists of these two components of uncompensated care.[224]

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217. 42 U.S.C.A. §§ 1396r-4(j)(1)-(2) (West 2013).

218. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-69, MEDICAID: ONGOING FEDERAL OVERSIGHT OF PAYMENTS TO OFFSET UNCOMPENSATED HOSPITAL CARE COSTS IS WARRANTED (2009).

219. Letter from Jackie Garner, Acting Director, Center for Medicaid & State Operations, to State Medicaid Directors (July 27, 2009), *available at* http://www.wsha.org/files/65/Final_DSH_7.27.09.pdf.

220. *Id.*

221. 42 U.S.C.A. § 1396r-4(b)(3)(B) (West 2013).

222. 42 U.S.C.A. § 1396r-4(a)(1) (West 2013).

223. *See, e.g.*, 42 C.F.R. § 447.299(c)(11), (15); 73 Fed. Reg. 77,904, 77,904 (2008) ("Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ('uncompensated care costs').").

224. As already mentioned, in some years, public hospitals could receive federal matching payments for up to 200% of their uncompensated care costs, though these increased payments ended in 2004. Mechanic, *supra* note 134, at 14.

A point of considerable controversy has been the definition of "patients who have no health insurance or source of third party payment for services provided" for the purpose of calculating a hospital's DSH limit. Since 1994, based on guidance from HCFA, states have been permitted to use their definition of "allowable costs" from their Medicaid state plan or from any other definition they choose.[225] Accordingly, most states included costs incurred by patients who had no coverage for the specific service provided, rather than including only costs due to a patient's complete lack of health insurance. This allowed hospitals to count the cost of services that were uncompensated because an individual exceeded his annual or lifetime coverage limits, for example, or because his policy expressly did not cover the service in question. When the Bush Administration published the final rule on the MMA's DSH reporting requirements in 2008, however, this convention was changed. Under the 2008 final rule, "patients who have no health insurance or source of third party payment for services provided" referred not to coverage of the services, but to coverage of the individual him- or herself, whether or not his or her insurance covered the services in question.[226] The 2008 rule also did not consider whether the costs are attributable to charity care or bad debt; rather, CMS required hospitals to segregate charges based on an individual's insurance status alone for the purpose of calculating a hospital's DSH limit.[227]

The American Hospital Association and other hospital organizations decried the change in the definition of an uninsured person in the 2008 regulations.[228] In response, in January 2012, CMS proposed a rule that would return the definition to its 1994 meaning. The definition clarifies that the calculation of the DSH limit includes costs for services provided to patients when a cap has been reached or when a

225. Letter from Sally K. Richardson, Dir., Ctr. for Medicaid & State Operations, Health Care Fin. Admin., to all State Medicaid Dirs. (Aug. 17, 1994), *available at* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081794.pdf (stating that "HCFA believes it would be permissible for states to include in this definition individuals who do not have health insurance which would apply to the service for which the individual sought treatment").

226. Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77,904, 77,911 (Dec. 19, 2008). This did not include payments made under a state or local program for the indigent or uninsured. *Id.* at 77,913.

227. *Id.* at 77,914.

228. *See, e.g.*, Letter from Rick Pollack, Exec. Vice President, Am. Hosp. Ass'n., to Marilyn Tavenner, Acting Adm'r., Ctrs. for Medicare & Medicaid Servs., Re: CMS 2315-P: Medicaid; Disproportionate Share Hospital Payments–Uninsured Definition, (Vol. 77, No. 11) (Jan. 18, 2012) (on file with author) *available at* http://www.aha.org/advocacy-issues/letter/2012/120216-cl-cms-2315-p.pdf; Letter from Bruce Siegel, President & CEO, Nat'l Ass'n of Pub. Hosps., to Marilyn Tavenner, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., Re: CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments –Uninsured Definition, (Feb. 17, 2012) (on file with author) *available at* http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/DSH-Reporting-and-Audit-Rule/NAPH-Submits-Comments-on-Proposed-Rule-Regarding-Medicaid-DSH-Uninsured-Definition-January-2012.aspx?FT=.pdf.

specific service is not covered under the patient's health plan.[229] It would expressly bring costs of care for the underinsured into the ambit of the DSH limit. CMS, however, has not finalized the rule, and instead issued a technical correction and clarifying language in May 2012 that is consistent with an interpretation that the uninsured definition refers to the service provided and not the person.[230] It may be that with the ultimate elimination of annual and lifetime limits from most health insurance policies and "essential health benefit" requirements for individual and small group policies enacted through the ACA, the issue of whether or how to count uncompensated costs of care provided to the underinsured will dwindle to relative insignificance.[231] In the meantime, however, the 2008 rule remains in effect with only the May 2012 changes having been made.

Given Medicaid's long history of determining eligibility for benefits in part by examining an applicant's income and assets, it is perhaps surprising that neither income nor assets are considered in determining whether an individual has "no health insurance or source of third party payment for services provided," for the purpose of a hospital's DSH limit. It is insurance status and scope of coverage that are relevant in determining the DSH program hospital-specific limit, and not the fact of being indigent.[232] Allowable costs, according to the final rule, may be on the books as bad debt or charity. As long as the cost is from an uninsured person, no matter what her income or wealth might be, it is allowable.[233] On the other hand, bad debt related to nonpayment of deductibles and co-pays is not an allowable cost because it is attributable to people with health insurance coverage for the service provided.[234] Insurance claims that are denied as a result of improper billing are not allowed to be included for the same reason.[235] On the payment side, supplemental payments such as UPL payments must be counted as reimbursement when calculating a hospital's total uncompensated care costs.[236] Yet, when a service is provided to a patient whose care is paid for by a state or local indigent health care program,

229. For the text of the proposed rule, see Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition, 77 Fed. Reg. 2500, 2506–07 (Jan. 18, 2012) (to be codified at 42 C.F.R. § 447.295).

230. 77 Fed. Reg. 31,499, 31,504, 31513 (May 29, 2012).

231. *See* 42 U.S.C.A. §§ 300gg-11(a)(1)(A), (B) (West 2013); 42 U.S.C.A. § 18022(b)(1) (West 2013).

232. Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77,904, 77,911 (Dec. 19, 2008).

233. *Id.*

234. *See, e.g.*, 42 C.F.R. § 447.299(c)(15)(iii) (2013):

> The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package.

235. Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77,904, 77,913 (Dec. 19, 2008).

236. 42 C.F.R. § 447.299(c)(11) (2013).

the costs are not counted as amounts that are received on behalf of patients for the purpose of DSH limits.[237] Presumably, this is because the DSH program payments are not intended to diminish the state and local commitment to indigent care, though this means that in some cases there could be substantial double payments to a hospital for patients covered under an indigent care program.[238]

A. *Medicaid DSH and the Affordable Care Act*

When health care reform began to be seriously negotiated in 2009, hospital associations agreed to reductions in Medicaid DSH payments as one part of a deal under which over 90% of the nation's population would become insured.[239] When enacted, the ACA reduced Medicaid DSH payments beginning in 2014 with two years of relatively small reductions followed by larger reductions. By 2019, the reductions represent nearly half of the federal matching payments that would have been available without reform.[240] The total reduction in federal DSH spending was $18.1 billion through 2020 but Congress extended the reductions twice through 2022 for a total reduction of $22 billion.[241]

The Government Accountability Office (GAO) recently reported that $17.6 billion in federal and state DSH payments were made in 2010.[242] About $14.4 billion in non-DSH supplemental payments, some of which were UPL payments, were made in 2010, but the exact amount is not known because some states did not separately report non-DSH payments. The federal share of the combined total of the roughly $32 billion in DSH and other Medicaid supplemental payments was approximately $19.8 billion.[243] These payments were equal to roughly one

237. *Id.*

238. States and counties support public hospitals in a patchwork fashion and also target programs for people not eligible for Medicaid through various efforts. For example, by 1985, thirty-four states had indigent health care programs. RANDOLPH A. DESONIA & KATHLEEN KING, INTERGOVERNMENTAL HEALTH POLICY PROJECT, GEO. WASH. U., STATE PROGRAMS OF ASSISTANCE FOR THE MEDICALLY INDIGENT (1985).

239. Matthew DoBias & Jennifer Lubell, *The Numbers Game: DSH Payments, Uninsured Counts Roil Senate*, 39 MODERN HEALTHCARE 8 (2009), *available at* http://www.modernhealthcare.com/article/20090928/NEWS/909259995.

240. Deborah Bachrach et al., *Toward a High Performance Health Care System for Vulnerable Populations: Funding for Safety-Net Hospitals*, Commonwealth Fund (Mar. 8, 2012), http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Vulnerable-Populations.aspx. *See also*, CHRISTIE PROVOST PETERS, THE BASICS: MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM (2009).

241. Katherine Neuhausen et. al., *State Politics and the Fate of the Safety Net*, 369 New Eng. J. Med.1675 (2013). See also U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-694, MEDICAID: STATES REPORTED BILLIONS MORE IN SUPPLEMENTAL PAYMENTS IN RECENT YEARS 7 (2012); Alison Mitchell, Cong. Research Serv. R42865 Medicaid Disproportionate Share Hospital Payments 11,22 (2013) *available at* http://www.healthreformgps.org/wp-content/uploads/dsh-crs-12-9.pdf (describing the extensions of the DSH reductions enacted by Congress and the updated total reduction.

242. *Id.*

243. *Id.* at 9.

third of Medicaid hospital fee-for-service payments.[244] DSH and UPL payments, in other words, are a significant part of hospital reimbursement. In some states, the importance of Medicaid supplemental payments is particularly great. For example, in 2002, five states reported that their DSH payments exceeded regular Medicaid payments for inpatient hospitalizations.[245]

Hospital associations, researchers, and advocates for the safety net increasingly urged policymakers to reconsider the DSH reductions following the Supreme Court ruling and with only about half of the states planning to expand Medicaid.[246] Two proposed bills before Congress postponed the reductions and the President's budget proposal included a one-year delay in the reductions.[247] Therefore it was not surprising that the bipartisan budget agreement signed by President Obama in December included a two year delay in the reductions. The Medicaid DSH reductions remain budget neutral through a doubling of the reduction for 2016 and an extension of the reductions through 2023.[248]

Prior to the enactment of the two year delay, CMS had finalized its proposed rules on the Medicaid DSH Health Reform Methodology (DHRM) which are substantively largely the same as the proposed rules.[249] The final rules were to be in effect for only two years.[250] As directed under the ACA, CMS imposed the largest percentage reductions on either (1) states with the lowest percentage of uninsured residents, or (2) those which fail to target their DSH payments to hospitals with high Medicaid inpatient and uncompensated care volumes.[251] "Low DSH" states would be subject to a smaller reduction.[252] Finally, CMS must "[take] into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009."[253] In the final rules, CMS expressly did not consider what effect, if any, a state's decision to take up the ACA's Medicaid expansion would have

244. Deborah Bachrach & Melinda Dutton, Center for Health Care Strategies, Medicaid Supplemental Payments: Where Do They Fit in Payment Reform? (2011), *available at* http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf.

245. HEARNE, *supra* note 138, at 13.

246. Neuhausen, *supra* note 241, at 1675.

247. Mitchell, *supra* note 241, at 12.

248. Bipartisan Budget Act of 2013, Pub. L. No. 113-67, 127 Stat. 1165 § 1204.

249. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 57,293 (Sept. 18, 2013) (to be codified at 42 C.F.R. pt. 447). The proposed rules were published four months earlier: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, 78 Fed. Reg. 28,551 (May 15, 2013) (to be codified at 42 C.F.R. pt. 447).

250. 78 Fed. Reg. 57,293 (Sept. 18, 2013).

251. 42 U.S.C.A. § 1396r-4(f)(7)(B)(i) (West 2013); 78 Fed. Reg. 57, 293, 57,294, 57,304-57,308, 57,311-57,313 (Sept. 18, 2013).

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

253. 42 U.S.C.A. § 1396r-4(f)(7)(B)(iii) (West 2013); 78 Fed. Reg. 57, 293, 57,294, 57,308-57,309, 57,313 (Sept. 18, 2013).

on the size of its DSH reduction.[254] CMS did note, however, that "hospitals in states implementing the new coverage group that serve Medicaid patients may experience a deeper reduction in DSH payments than they would if all states were to implement the new coverage group."[255] At the same time, at least one study has found that even in states that do not expand Medicaid, there will be (or would have been in the case of DSH funding for 2014 and 2015) a nontrivial decrease in DSH funds.[256]

The delay in DSH reductions will potentially allow CMS to substantively alter the methodology, particularly in regard to states' decisions on whether to expand Medicaid. While it may be beyond CMS's authority to expressly consider a state's decision on expansion, there are alternative ways to weight the three factors in the current rule: the percentage of uninsured people in each state, the extent to which the state targets DSH payments to hospitals serving high volumes of Medicaid patients, and whether states target DSH payments to hospitals with high levels of uncompensated care. The final rule gives equal weight to each of these factors.[257] The Secretary may wish in the next iteration of regulations, for example, to provide detailed criteria for allocating DSH funds to the most active and generous safety net hospitals within each community, and allow states additional time to target their DSH payments accordingly in order to maximize their share. Doing so may help to maintain at least a certain amount of care for individuals who would have Medicaid coverage but for the decision of their state to forego the expansion, despite the correspondingly minimal cost to the state.[258] Advocates for the safety net tend to favor rewarding states that make "good" use of their DSH funds, whether or not the state participates in the expansion. The NAPH, for example, recommends that CMS take special measures to both incentivize states to provide more of their DSH funds to true safety net hospitals and protect DSH payments to hospitals with a high rate of uninsured uncompensated costs and/or a high Medicaid inpatient utilization rate.[259]

Alternatively, CMS may wish to provide no such consideration to states that forego the expansion, their hospitals, and their uninsured

254. 78 Fed. Reg. 57,293, 57,295 (Sept. 18, 2013).

255. *Id.* at 57,294.

256. John A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365, 2365–67 (2012).

257. 78 Fed. Reg. 57,294, 57,312 (Sept. 18, 2013).

258. *See, e.g.*, JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 20, 24 (2012) (finding that, e.g., states in the East South Central region of the country could reduce their uninsured population by 58.3% with only a 5.8% average increase in state Medicaid spending), *available at* http://www.kff.org/medicaid/upload/8384.pdf.

259. BRUCE SIEGEL, NAPH, EQUITABLE, SUSTAINABLE, RELIABLE SAFETY NET FINANCING: MEDICAID DSH 3–4 (2012), *available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/May-2012-Medicaid-DSH-Policy-Brief.aspx?FT=.pdf; *see also* Dennis P. Andrulis & Nadia J. Siddiqui, *Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients*, 30 HEALTH AFF. 1830, 1832 (2011).

populations. The decision to decline to offer special subsidies for states that expand their Medicaid programs to a lesser degree than required under the ACA may be indicative of CMS's thinking in this regard.[260] One might wonder why CMS would be interested in providing more generous supplemental funding to states that fail to expand Medicaid, particularly given the troublesome opacity in how such payments are used and, indeed, to what extent such payments even ultimately remain in hospitals' coffers rather than reverting to states.[261] For example, despite improvements in accountability, officials in Texas very recently stated that DSH funds are retained by the state's general fund.[262]

At the same time, some health policy researchers believe that the reduction in DSH funding and the enhanced reporting for both DSH and UPL or other supplemental payments provide an opportunity to increase transparency and accountability for these critical sources of funding. As discussed previously, "a general problem with the Medicaid DSH program is the lack of transparency and accountability for documenting the direct impact of federal spending on care for vulnerable populations."[263] DSH and UPL payments are generally lump sum payments unconnected to any specific patient or service and untied to quality measures, cost-effectiveness, or improvements in patient care. Therefore researchers have suggested that Medicaid supplemental payments may "weaken or undermine comprehensive payment reform efforts and sound purchasing strategies."[264] That is, when supplemental Medicaid payments are made independent of patients' experiences and without tying the payment to the provision of high quality and cost-effective care, "their use squanders an opportunity" to improve care.[265]

The Commonwealth Fund Commission on a High Performance Health System made several recommendations recently to sustain safety net hospitals financially while promoting high quality care for vulnerable populations.[266] Specifically, the Commonwealth Fund Commission recommended first that enhanced payment through Medicaid should reflect both a disproportionate number of Medicaid patients "*and* the delivery of high-quality, coordinated, and efficient care."[267] It recommended that states target increased Medicaid payments to safety net

260. CMS, FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS AND MEDICAID 12 (2012), http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

261. *See supra* notes 141–144 and accompanying text.

262. . Harvey Rice, *State Takes Charity Care Money from UTMB.*, HOUST. CHRONICLE, Apr. 1, 2013, *available at* http://www.houstonchronicle.com/news/houston-texas/houston/article/State-takes-charity-care-money-from-UTMB-4398633.php.

263. Aaron McKethan et al., *Reforming the Medicaid Disproportionate-Share Hospital Program*, 28 HEALTH AFF. w926, w927 (2009).

264. Bachrach & Dutton, *supra* note 244, at 8.

265. *Id.* at 6–7.

266. The Commonwealth Fund Commission recognized that some safety net hospitals have the ability to cross-subsidize care to low-income patients because their status as academic medical centers attracts larger numbers of privately insured patients and allows for higher negotiated rates from commercial payers. The focus of their report is accordingly on the hospitals that do not have this ability. Bachrach et al., *supra* note 240, at 6.

267. *Id.* at 10 (emphasis in original).

hospitals that utilize care delivery models that are the most effective in coordinating services for vulnerable populations. This could be achieved by increasing the rate that hospitals are paid through a transparent and accountable process.[268] Finally, in targeting Medicaid DSH funds, the Commission recommended as a best approach that hospitals "bill" for each uninsured patient and receive a percentage of the Medicaid rate in exchange for these services. This ensures that payments are tied to specific patients.[269] While the last suggestion promotes transparency rather than improved quality of care, it offers the opportunity to ultimately tie DSH payments to individual or aggregated outcome measurements, a step which may ultimately prove worthwhile.

B. *What Are the Complexities For Advocates of Medicaid Enrollees and Charity Patients?*

Criticizing Medicaid supplemental payments, even in the service of reform that seeks to preserve and better target, rather than slash, funding may be a dangerous game. Broadly speaking, criticisms of Medicaid, even by advocates of improved care for low-income people, can encourage efforts to dismantle the program.[270] There are several constant problems facing advocates of Medicaid enrollees and other low-income patients who need medical care. Some of these difficulties were encountered in Utah when the state decided to implement a § 1115 Medicaid waiver that provided reimbursement for primary health care services for a limited number of uninsured Utahns, but which depended upon charity care from physicians and hospitals for specialty care and paid for the program in part by cutting benefits for certain Medicaid recipients. A spokesperson from a Utah nonprofit health advocacy group stated that there was no opportunity to stop the waiver: "It became clear to us that this was a train without brakes, and it was going to happen."[271] A Boston advocacy group concluded concerning the situation that "opposition is futile and more likely to harm ongoing working relationships than to produce any concrete benefits."[272] Another subtle source of conflict among advocates was the waiver's strategy, whether intentional or unintentional, of pitting current Medicaid enrollees' needs against those of uninsured people.[273] Other national health care advocacy organizations, such as Families USA, were more vocal about their concerns, stating the waiver would "do consider-

268. *Id.* at 12.

269. *Id.* at 20.

270. David E. Rogers et al., *Who Needs Medicaid?*, 307 NEW ENG. J. MED. 13, 15 (1982).

271. Mark Taylor, *When More Means Less. Utah Gets Federal Approval Limiting Medicaid Services to Some to Provide a Basic Health Package to 25,000 Low-Income Uninsured*, 32 MODERN HEALTHCARE 6 (2002).

272. MICHAEL MILLER, COMMUNITY CATALYST, WAIVER WATCH ISSUE BRIEF #2: THE UTAH PRIMARY CARE NETWORK, (2002), *available at* http://www.communitycatalyst.org/doc_store/publications/waiver_watch_issue_brief2_the_utah_primary_care_network_apr02.pdf.

273. *Id.*

ably more harm than good for low-income families."[274] Advocates, then, may have difficulty because of the possibility of unintended harm arising from necessary criticisms; from the need to maintain working relationships even when enrollment or services are cut; and from the way winners and losers are carved out among people with low income.

In the book, *Healthy Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor*, Colleen Grogan and Michael Gusmano explore why advocates may be silent about major issues that are a concern to them.[275] The authors also offer some ways to overcome such silences. The book studied the actions of the staff members of several nonprofit organizations in Connecticut during a transition to Medicaid managed care. Although the advocates were subject to a situation of political inequality and unequal power, this did not seem to account for all of the observations of the authors.[276] Even under the circumstances, the advocates were not docile concerning several aspects of program details.[277] This fact led the authors to consider the practical and theoretical reasons for public silence on certain topics. The primary concern that the advocates would not express publicly was whether the services provided under Medicaid managed care would be "mainstream." The use of the word "mainstream" by advocates meant that they were concerned about the possibility of "apartheid" care or access to providers that differed between people enrolled in Medicaid managed care and people enrolled in commercial managed care plans.[278] The assumption among policymakers that simply enrolling Medicaid patients in managed care would be equivalent to obtaining care that is "mainstream," when this term refers to access to providers and treatments equivalent to that of commercially insured patients, has not proven valid.[279] As one of us noted in another context, "[T]he concept of 'mainstreaming' has evolved so that it no longer appears to pertain to the locus and nature of the care provided, but rather to the nature of coverage."[280]

The concern of the advocates centered on their realization that providing care through managed care organizations was not the same as improving access to a broad range of providers. In fact, in later interviews enrollees "were angry and hurt to find that their access was restricted to the same Medicaid providers they have always had access to."[281] Political infeasibility, lack of data, and lack of a solution all contributed to the silence of the Connecticut advocates.[282] Many of the organizations were also "resource dependent" on the agencies where

274. *Id.* at 8.
275. GROGAN & GUSMANO, *supra* note 122.
276. *Id.* at 98.
277. *Id.* at 98–102.
278. *Id.* at 4.
279. Colleen M. Grogan, *The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns*, 22 J. HEALTH POL. POL'Y & L. 815, 837 (1997).
280. Laura D. Hermer, *Medicaid, Low-Income Pools, and the Goals of Privatization*, 17 GEO. J. ON POVERTY L. & POL'Y 405, 421 (2010).
281. Grogan, *supra* note 279, at 837.
282. GROGAN & GUSMANO, *supra* note 122, at 124.

their advocacy efforts would need to be addressed, leading to both perceived and actual conflicts of interest.[283] The small number of people and groups involved and the close ties among these people also sometimes made deliberation more difficult.[284] Despite—and in part because of—these challenges, the authors conclude that the process of public deliberation can lead to greater understanding among participants and improvements in policy outcomes.[285]

Grogan and Gusmano note that only about 1% of the organizations attempting to influence policy in Washington claim to represent the poor.[286] In general, providers tend to be more interested in reimbursement rates as compared to enrollees or potential enrollees who may be relatively more interested in eligibility.[287] Often, safety net providers are assumed to represent the interests of poor or other vulnerable people. Yet these providers have a clear conflict of interest in many circumstances.[288] For example, there is no legal requirement that DSH funds must be used for any specific purpose and this may be one reason that the funds have not consistently been shown to lead to greater provision of uncompensated care.[289] Institutional safety net providers have a financial incentive to capture the Medicaid population in part because of the supplemental funds. Thus the providers' interests may not be aligned with the best interests of the Medicaid population.[290]

When cutbacks in care for vulnerable people are made, most often, safety net hospitals claim that whatever was undertaken "had" to be done: "[S]afety net administrators respond by pointing out that if they do not take these steps, their basic viability will be threatened, resulting essentially in no care for anybody."[291] This reasoning can be problematic because it is rarely the case that only one certain set of actions must be undertaken or even that institutional financial problems are primarily attributable to one cause. There is also the problem that the people most affected by policy decisions are rarely, if ever, actively involved, and even advocates, as mentioned above, may not be effective when their own survival, whether political or economic, is at stake. Some of the more recent publications on health care reform seem to better recognize these potential conflicts, an important first step in ameliorating them.[292]

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283. *Id.* at 6–7. *See also* Colleen M. Grogan & Michael K. Gusmano, *Political Strategies of Safety-Net Providers in Response to Medicaid Managed Care Reforms*, 34 J. HEALTH POL. POL'Y & L. 5 (2009).

284. GROGAN & GUSMANO, *supra* note 122, at 126.

285. *Id.* at 130.

286. *Id.* at 125.

287. Karl Kronebusch, *Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making*, 22 J. HEALTH POL. POL'Y & L. 839, 862 (1997).

288. Gloria J. Bazzoli et al., *The Influence of Health Policy and Market Factors on the Hospital Safety Net*, 41 HEALTH SERVS. RES. 1159, 1177 (2006).

289. *See supra* notes 200–206 and accompanying text.

290. SIEGEL, *supra* note 73.

291. Bruce Siegel et. al., *Health Reform and the Safety Net: Big Opportunities; Major Risks*, 32 J. L. MED. & ETHICS 426, 430 (2004).

292. *See, e.g.*, Bachrach et al., *supra* note 240.

IV. CONCLUSION

The importance of Medicaid in the provision of medical care for many Americans, some of whom are the most vulnerable among us, cannot be overstated. At the same time, Medicaid has not provided health coverage on the basis of impoverishment alone or on the basis of any consistent measure of vulnerability or need—even though the ACA initially held out the promise of finally covering most people with the lowest income. Inconsistency, whim, and discretion have pervaded all aspects of the program and have kept the program firmly rooted in a nineteenth century conception of charity.

Medicaid supplemental funding mirrors much of this inconsistency and whim, though the reasons for the inconsistency may differ. Whatever their actual benefits to vulnerable Medicaid and uninsured populations and to the safety net hospitals who shoulder the largest load in treating them, DSH and UPL represent insufficiently considered solutions to gaps in the funding and delivery of health care for low-income Americans who lack private coverage. Congress, rather than addressing the vast disparities in care between the privately insured on the one hand and Medicaid enrollees and the uninsured on the other, instead chose an opaque and oblique partial solution that allowed enterprising states to funnel funds to hospitals that could point to uncompensated care on a balance sheet, if not to a person who received needed care.

Perhaps most disturbing is that much of the substantial amount of funding through the Medicaid program that does potentially cover the cost of uncompensated care has for years simply disappeared like a glass of water poured onto the desert sand. And wherever the money goes, it is tallied to the poor's social account. It may be that this non-traceable funding was viewed as necessary initially given the backlash against public programs associated with "dependence." The fact remains that the entities with the most power have gained from these payments with little ability to assess the benefits to the people behind the uncompensated care numbers. The process has been deeply enmeshed in the political complexities of federal and state relationships. As such, Medicaid program details and funding for uncompensated care have been subject to a largely unintentional mercilessness, a byproduct of power struggles.

Yet there are many reasons to expect changes for the better in the future. The Medicaid program continues to have the broad base and flexibility to expand under the ACA and recalcitrant states may ultimately find the enticement of federal funds too attractive to reject. After decades of struggles back and forth, supplemental payments are on a trajectory toward much greater transparency and accountability. History shows that declaring Medicaid to be a program not linked to welfare or tainted with charity was not enough to change the program's image. Yet many improvements related to processes of enrollment and coordination of care that are currently available could be used to make Medicaid "mainstream" in the sense that counts for enrollees. Still

there are many uncertainties, not the least of which is how to enhance the public voice of the people who are enrolled in Medicaid or who may need charity. As the ACA is implemented at both the federal and state levels, we should be cognizant of these issues.

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