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# State Medicaid Agencies as Single Payers: An Innovative Approach to Medicaid Expansion Obligations Under the Patient Protection and Affordable Care Act

*Kristin Peterson*·

When Medicaid was created in 1965, the states reimbursed providers on a fee-for-service basis.[1] In the 1980s, to control costs, states began moving their Medicaid beneficiaries to managed care.[2] In the most recent decade, the number of Medicaid beneficiaries in managed care doubled.[3] Yet, by the mid-2000s, some states had chosen to move away from traditional risk-based managed care because it had become too costly under new federal rate-setting requirements.[4] Vermont even took the unprecedented step of obtaining federal approval to become its own public managed care entity for Medicaid.[5] In taking such action, Vermont became a single payer of healthcare for Medicaid.

· Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2014. Ms. Peterson is a staff member of *Annals of Health Law*.
[1] *See* KATHLEEN GIFFORD ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 9 (2011), http://www.kff.org/medicaid/upload/8220.pdf.
[2] *See id*.
[3] KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2010), http://www.kff.org/medicaid/upload/8046.pdf.
[4] *See* Bruce Spitz, *Medicaid Agencies as Managed Care Organizations, An "Actuarially Sound" Solution?*, 32 J. HEALTH POL. POL'Y & L. 379, 380 (2007).
[5] *Id.* at 402.

With the implementation of the Patient Protection and Affordable Care Act (PPACA) in 2010, Medicaid will expand to cover approximately sixteen million people.[6] The challenges inherent in meeting these coverage obligations will require states to employ innovation, a need apparently anticipated in the PPACA, which provides for new funding for Section 1115 demonstration waivers.[7] The step taken by Vermont could be one such innovation. If it proves successful, other states may follow Vermont's lead. States becoming single payers may prove to be the future of Medicaid.

Part I of this article provides a general description of the Medicaid program. Part II discusses the movement from fee-for-service to managed care. Part III discusses an interesting theory as to why some states, including Vermont, chose to abandon risk-based, capitated managed care after the implementation of the 1997 Balanced Budget Act in 2003. Part IV discusses Vermont's venture into becoming a single payer.

## PART I: MEDICAID OVERVIEW

Congress established the Medicaid program in 1965 under Title XIX of the Social Security Act.[8] Aptly titled "Grants to States for Medical Assistance Programs," the Medicaid statute provided for states to receive funding from the federal government to assist them in providing "medical assistance [to] families with dependent children and . . . aged, blind, or disabled individuals, whose income and resources [were] insufficient to meet the costs of necessary medical services."[9]

Medicaid is paid for jointly by federal and state funds.[10] Forty-seven states use some form of provider taxes to fund their portion.[11] The amount

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[6] KAISER COMM'N ON MEDICAID AND THE UNINSURED, KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS AND HEALTH REFORM 4 (2011), http://www.kff.org/medicaid/upload/8139.pdf.
[7] *See id.*
[8] The Medicaid Act, 42 U.S.C. §§ 1396-1396s (2006).
[9] *Id.* § 1396-1.
[10] THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID A PRIMER 2010 5 (2010), http://www.kff.org/medicaid/upload/7334-04.pdf.
[11] KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID FINANCING ISSUES: PROVIDER TAXES 1 (2011), http://www.kff.org/medicaid/upload/8193.pdf.

of the federal portion is determined annually based on a formula known as the federal medical assistance percentage, or FMAP.[12] FMAP is a statutory formula that has been in effect since Medicaid was enacted in 1965.[13] Designed to account for "income variation across the states," it is based on the personal income of the states' residents.[14] States with lower per capita incomes than the national average receive a larger FMAP.[15] The formula provides for a minimum FMAP of fifty percent and a maximum of eighty-three percent.[16] Once the FMAP is established, it becomes the federal government's matching rate.[17] If the FMAP is fifty, for example, both the federal government and the state will contribute fifty percent of the costs of covered services.[18] The FMAP was recently increased under the American Recovery and Reinvestment Act (ARRA), but the ARRA funding expired on June 30, 2011.[19] As of July 2011, the federal government's share was, on average, fifty-seven percent, with the states contributing the remaining forty-three percent.[20]

Medicaid is administered by the states.[21] State agencies contract with entities in the private sector for the provision of healthcare services under Medicaid.[22] "State participation in Medicaid is voluntary but all states par-

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[12] Christie Provost Peters, *Medicaid Financing: How the FMAP Formula Works and Why It Falls Short,* NATIONAL HEALTH POLICY FORUM, 1, 4 (2008), *available at* http://www.nhpf.org/library/issue-briefs/IB828_FMAP_12-11-08.pdf.
[13] *Id.* at 5.
[14] *Id.* at 4.
[15] *Id.* at 5.
[16] *Id.*
[17] VICTORIA WACHINO ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS 3 (2004), http://www.kff.org/medicaid/upload/Financing-the-Medicaid-Program-The-Many-Roles-of-Federal-and-State-Matching-Funds-Policy-Brief.pdf.
[18] *See id.*
[19] KAISER COMM'N ON MEDICAID AND THE UNINSURED, WAITING FOR ECONOMIC RECOVERY, POISED FOR HEALTH CARE REFORM: A MID-YEAR UPDATE FOR FY 2011 - LOOKING FORWARD TO FY 2012 2 (2011), http://www.kff.org/medicaid/upload/8137.pdf.
[20] KAISER COMM'N ON MEDICAID AND THE UNINSURED, AN OVERVIEW OF CHANGES IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAPS) FOR MEDICAID 1 (2011), http://www.kff.org/medicaid/upload/8210.pdf.
[21] MEDICAID A PRIMER 2010, *supra* note 10, at 5.
[22] *Id*. at 18.

ticipate."[23] States administer Medicaid subject to oversight by the Center for Medicaid and Medicare Services (CMS), an agency within the U.S. Department of Health and Human Services.[24] States' Medicaid programs must meet minimum requirements under federal law, but states are given flexibility to define their programs in terms of benefits, providers, and other variables.[25]

States can apply with CMS for Medicaid waivers to operate their Medicaid programs outside of federal requirements.[26] A Section 1115 demonstration waiver, for example, is used to test and implement novel approaches that address public policy issues.[27] States negotiate with CMS to obtain the approval of the Secretary of HHS for their Section 1115 demonstration waivers.[28] Section 1115 demonstration waivers are usually approved for a five-year period.[29]

Medicaid is an entitlement.[30] "An entitlement program creates a legal obligation on the part of the government to provide benefits to any person, business, or other unit of government that meets the criteria set in law."[31] Under current law, to qualify for Medicaid, a person must meet certain financial criteria and belong to one of the groups eligible for the program.[32] The government has a legal obligation to serve any person who meets these eligibility requirements.[33]

Enrollment in Medicaid is increasing. As of 1999, approximately forty million people were enrolled in Medicaid.[34] As of the end of fiscal year

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[23] *Id.* at 5.
[24] *Id.*
[25] *Id.*
[26] *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS 1 (2011), http://www.kff.org/medicaid/upload/8196.pdf.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] WACHINO ET AL., *supra* note 17, at 4-5.
[31] *Id.*
[32] 42 U.S.C. § 1396-1 (2006).
[33] WACHINO ET AL., *supra* note 17, at 5.
[34] STEPHANIE E. ANTHONY ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID MANAGED CARE FOR DUAL ELIGIBLES: STATE PROFILES 2 (2000),

2007, Medicaid covered sixty million people.[35] In addition, nearly nine million low-income and elderly people "rely on Medicaid to help pay for Medicare premiums, gaps in Medicare benefits, and long-term care needs."[36] These beneficiaries are referred to as "dual eligibles" because of their eligibility for both Medicaid and Medicare.[37] Finally, Medicaid enrollment expands during economic recessions, when unemployed people, no longer eligible for employer-sponsored health insurance, turn to Medicaid for health coverage.[38] "It is estimated that for every one percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million."[39]

Under the PPACA, Medicaid will be expanded to cover all individuals under age sixty-five and with incomes up to 133% of the federal poverty level by January 1, 2014.[40] From 2014 through 2016, the federal government will provide 100% funding for people newly eligible for Medicaid.[41] By 2020, federal contribution for these enrollees will decrease to ninety percent.[42] States will, however, continue to be responsible for their share of the cost for those people eligible for Medicaid under the current rules.[43] To encourage states to employ innovation to meet their payment obligations under the PPACA, the PPACA provides new funding for demonstration programs.[44]

With this current and projected growth in Medicaid enrollment, states are seeking ways to contain costs.[45] Beginning in the 1980s, some states chose

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http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13759.

[35] KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS AND HEALTH REFORM, *supra* note 6, at 5.

[36] *Id.*

[37] MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES, *supra* note 3, at 4.

[38] MEDICAID A PRIMER 2010, *supra* note 10, at 4.

[39] *Id.*

[40] KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS AND HEALTH REFORM, *supra* note 6, at 4.

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] *See* WACHINO ET AL., *supra* note 17, at 22.

to move from traditional fee-for-service financing models to managed care models to contain costs.[46]

## PART II: STATES' MOVEMENT FROM FEE FOR SERVICE TO MANAGED CARE MODELS

When the Medicaid statute was enacted in 1965, health care was delivered and reimbursed by the state primarily on a fee-for-service basis.[47] Under the fee-for-service delivery model, state Medicaid programs reimbursed health care providers for each service they provided.[48] The model relied on state Medicaid programs finding health care providers willing to accept Medicaid patients.[49] Because Medicaid fee-for-service rates were often too low, however, there were few doctors willing to accept such patients and Medicaid beneficiaries' access to care was not assured.[50]

In the 1980s, states began to turn to managed care models for Medicaid service, with the goals of increasing access to care, improving the quality of services, and containing costs.[51] The Balanced Budget Act of 1997, which became effective in 2003, gave states the authority to mandate enrollment in managed care Medicaid without a waiver, with some exceptions.[52] The number of Medicaid beneficiaries in managed care nearly doubled in the most recent decade, growing from 17.8 million in June 1999 to 33.4 million in June of 2008.[53] During that same period, the share of Medicaid beneficiaries in managed care increased from 56% to 71%.[54] By June 2009, the share of beneficiaries enrolled in managed care was 71.7%.[55]

The term "managed care" is often synonymous with health maintenance

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[46] *See* GIFFORD ET AL., *supra* note 1, at 9.
[47] *See id*.
[48] *See id.*
[49] *Id.*
[50] *See id.*, *c.f.,* MEDICAID A PRIMER 2010, *supra* note 10, at 20.
[51] GIFFORD ET AL., *supra* note 1, at 9.
[52] *Id.*
[53] MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES, *supra* note 3, at 1.
[54] *Id.*
[55] GIFFORD ET AL., *supra* note 1, at 9.

organizations (HMOs) in the private health insurance world.[56] In the Medicaid world, however, managed care involves a wider variety of arrangements.[57] Three basic models for managed care are recognized under federal law and regulations: managed care organizations (MCOs), primary care case management programs (PCCMs), and non-comprehensive prepaid health plans (PHPs).[58]

The MCO model is risk based.[59] The state contracts with the MCO and pays the MCO a per-member-per-month premium for a defined set of services (the "capitation rate").[60] The MCO in turn pays the service provider.[61] The MCO thus assumes the financial risk of the provision of services to the Medicaid beneficiary, meaning that the MCO absorbs the loss if the provision of services costs more than the capitated rate.[62] Federal regulations require that the capitation rate be "actuarially sound," i.e., "developed in accordance with generally accepted actuarial principles and practices [and] . . . appropriate for the populations to be covered, and the services to be furnished. . ."[63] Some MCOs include both private and Medicaid beneficiaries, but most are Medicaid-only MCOs.[64]

MCOs provide a comprehensive set of benefits to Medicaid beneficiaries.[65] Federal regulations require that states "[maintain] . . . a network of appropriate providers that is . . . sufficient to provide adequate access to all services . . ."[66] States may "carve out" certain services from MCO coverage, which are provided through other arrangements (e.g., fee-for-service

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[56] *Id.* at 12.
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *See, e.g., Medicaid/Medical Assistance Overview*, MARYLAND MEDICAL PROGRAMS, http://www.dhmh.state.md.us/mma/Eligibility/med_medical%20asst%20overview_Doc%202/medasstov.html (last visited September 27, 2011).
[62] *See* Presentation by Katie Dunn, Medicaid Director, N.H. Dep't of Health & Human Services, to the Senate Fin. Comm., *Medicaid Managed Care: Assessing the Potential in NH* 3 (Feb. 17, 2011), *available at* http://www.dhhs.state.nh.us/ocom/documents/mmc.pdf.
[63] 42 C.F.R. § 438.6(c)(1)(i)(A-B)(2011).
[64] MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES, *supra* note 3, at 3.
[65] GIFFORD ET AL., *supra* note 1, at 12.
[66] 42 C.F.R. § 438.206(b)(1) (2011).

arrangements).[67] Prescription drugs, for example, were traditionally "carved out."[68] However, because the PPACA permits states to take rebates on prescription drugs covered by MCOs, some states are choosing to carve prescription drugs back in.[69]

The PCCM model is an alternative managed care model for comprehensive services built on the traditional fee-for-service model.[70] With PCCM, the state contracts directly with Primary Care Providers (PCPs) who agree to provide case management services (e.g., coordination of health care) to the Medicaid beneficiaries assigned to them.[71] The state reimburses the PCPs on a fee-for-service basis for services rendered and pays the PCPs a small case management fee (e.g., $3.00 per patient).[72] States choose the PCCM over the MCO model for different reasons.[73] States with large rural areas, for example, may choose PCCMs because the rural population is too small to attract MCOs.[74] States may also implement "enhanced" PCCM programs, which involve additional contractual requirements regarding case management.[75]

States contract with PHPs for both comprehensive and non-comprehensive services.[76] MCOs are considered comprehensive PHPs under federal regulations.[77] Non-comprehensive PHPs include those that provide certain inpatient or outpatient services.[78] Non-comprehensive PHPs may also cover the services that are "carved out" from traditional managed care arrangements (e.g., dental services).[79]

In 2010, the Kaiser Commission on Medicaid and the Uninsured

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[67] GIFFORD ET AL., *supra* note 1, at 24.
[68] *See id.*
[69] *Id.* at 25.
[70] *Id.* at 12.
[71] *Id.*
[72] *Id.* at 29.
[73] *Id.* at 28.
[74] *Id.*
[75] *Id.* at 30.
[76] *Id.* at 12.
[77] *Id.*
[78] *Id.*
[79] *Id.*

(KCMU) and Health Management Associates (HMA) surveyed the Medicaid directors in all fifty states and the District of Columbia for the purpose of determining state Medicaid policies and programs as of October 1, 2010.[80] Based on survey responses, the majority of states were using some form of managed care for Medicaid (see Table 1).[81] Only three states (Alaska, New Hampshire, and Wyoming) used the traditional fee-for-service model.[82] Almost the same number of states used MCOs only (17) as used PCCMs only (12).[83] More states (19), however, used both an MCO and a PCCM than one or the other.[84] PHPs were utilized by twenty-five (25) states.[85]

[80] *Id.* at 1-73.
[81] *Id.* at 14.
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*

**Table 1: Medicaid Managed Care Models Operated by States, October 2010[86]**

| Managed Care Model | No. of States | States |
|---|---|---|
| MCOs only | 17 | AZ, CA, DC, DE, HI, MD, MI, MO, MN, MS, NE, NJ, NM, NV, OH, TN, WI |
| PCCM only | 12 | AL, AR, IA, ID, LA, ME, MT, NC, ND, OK, SD, VT |
| MCOs and PCCM | 19 | CO, CT, FL, GA, IL, IN, KS, KY, MA, NY, OR, PA, RI, SC, TX, UT, VA, WA, WV |
| PHPs | 25 | AL, AZ, CA, CO, DC, FL, GA, IA, ID, KS, MA, MD, MI, MS, NC, ND, NM, OR, PA, RI, TN, TX, UT, WA, WI |
| FFS | 3 | AK, NH, WY |

Source: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

## PART III: STATES' INNOVATIVE RESPONSES TO A FEDERALLY IMPOSED MEDICAID BUDGET CRUNCH

In the JOURNAL OF HEALTH POLITICS, POLICY & LAW, Bruce Spitz asserted that it was states' adherence to the federal requirements that capitation rates be "actuarially sound" that resulted in some states deciding to abandon traditional, risk-based, HMO-style managed care.[87] Four states, Michigan, New Hampshire, Oklahoma, and Vermont, were profiled in his 2007 article.[88] Interestingly, the decisions made by these states regarding whether to stay with or abandon the HMOs remained unchanged as late as October 1, 2010, as evidenced by the type of Medicaid arrangement for those states as presented in Table 1 above.

Prior to 2003, the year the 1997 Balanced Budget Act was implemented, capitated payments to HMOs were thought to cost states less than paying for the services on a fee-for-service basis.[89] The Balanced Budget Act, however, required capitation rates to be actuarially sound, i.e., "developed in accordance with generally accepted actuarial principles and practices

[86] *Id.*
[87] Spitz, *supra* note 4, at 379-80.
[88] *Id*. at 380.
[89] *Id.* at 386.

[and] . . . appropriate for the populations to be covered, and the services to be furnished . . ."[90] Guidelines were issued by the American Academy of Actuaries, which clarified the expenses to be considered when calculating the rates but provided only a "nonbinding, nondefinitive definition for actuarial soundness . . ."[91] Spitz asserted that the nondefinitive nature of the guidelines allowed calculations to favor the HMOs at the expense of the states (and the Medicaid beneficiaries), resulting in capitation rates that could be higher in cost than equivalent services reimbursed on a fee-for-service basis.[92] The four states profiled in the article each had a unique response to the increased rates. Vermont even took the unprecedented step of becoming its own public managed care entity.[93]

Michigan faced a budget crisis with the new capitation rates and appealed to the federal government to have them restructured.[94] In 2001, Michigan had the lowest capitation rates in the country.[95] In 2004, Michigan hired the actuarial consultants Milliman USA to determine an actuarially sound rate by analyzing historic managed care trends and fee-for-service rates.[96] Milliman found that Michigan would need to increase its capitation rates by 14.2% to 27.3% over a two-year period.[97] In response, Michigan obtained permission from the federal government to restructure the way the capitation fee was calculated (statewide vs. regional).[98] Under the new structure, Michigan "was able to certify actuarial soundness without a rate increase . . ."[99] Table 1 shows Michigan to have continued to use the MCO model as late as October 1, 2010.

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[90] 42 C.F.R. § 438.6(c)(1)(i)(A-B) (2011).
[91] Spitz, *supra* note 4, at 392-3, 395.
[92] *See id.* at 393-5.
[93] *Id.* at 402; *see also Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet,* MEDICAID.GOV 2 (Aug. 25, 2011), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By Topics/Waivers/downloads/VermontGlobalCommitmenttoHealth FactSheet.pdf.
[94] Spitz, *supra* note 4, at 399-401.
[95] *Id.* at 399.
[96] *Id.*
[97] *Id*.
[98] *Id.* at 400-01.
[99] *Id.* at 401.

In the mid-2000s, New Hampshire, Oklahoma, and Vermont, upon facing a discrepancy between actuarially sound rates and their budget, chose to abandon the HMO model completely.[100]

New Hampshire became aware that it would cost the state nine to twelve percent more to provide services through an HMO than it would to provide the same benefits through fee-for-service.[101] It also discovered that the sole HMO in the region had refused to re-contract at the actuarially sound, reduced rates.[102] In response to these events, New Hampshire eliminated its managed care program.[103] Table 1 shows New Hampshire to have still used the fee-for-service model as of October 1, 2010.

Oklahoma's legislature refused to appropriate sufficient funds for actuarially sound rates, choosing instead to switch its HMO beneficiaries to PCCM programs.[104] This was, in Spitz's view, "a significant step toward making the Medicaid agency behave as if it were an HMO."[105] In other words, Spitz believed that in switching to PCCM programs, Oklahoma was moving towards acting as its own HMO, for the reason that it would be taking over administrative functions previously left to the HMO.[106] Table 1 shows Oklahoma to have used the PCCM model as of October 1, 2010.

Most significantly, however, Vermont responded to its fiscal crisis by obtaining the approval of the federal government to become its own public managed care entity, and in doing so was exempted from the actuarially sound requirement.[107] As such, it received a capitated payment from the federal government and reimbursed providers on a fee-for-service basis.[108] Table 1 shows Vermont to have employed the PCCM model in 2010, per-

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[100] *See id*. at 380.
[101] *Id.* at 397; *see also* Dunn, *supra* note 62, at 10 (confirming the twelve percent figure).
[102] Spitz, *supra* note 4, at 398; *see also* Dunn, *supra* note 62, at 10 (confirming the existence of only one insurer in 2003).
[103] Spitz, *supra* note 4, at 398; *see also* Dunn, *supra* note 62, at 10.
[104] Spitz, *supra* note 4, at 401.
[105] *Id.*
[106] *Id.*
[107] *Id.* at 402; but see *Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet*, *supra* note 93, at 2.
[108] Spitz, *supra* note 4, at 402.

haps because it was a managed care entity that reimbursed on a fee-for-service basis. Vermont, thus, became the first public managed care entity for Medicaid in the country.[109]

## PART IV: VERMONT'S VENTURE INTO BECOMING A SINGLE PAYER

Vermont's venture into becoming a public managed care entity has shown an interesting trajectory. First, CMS approved an extension of the program, perhaps as an acknowledgement of its effectiveness.[110] CMS initially approved Vermont's Medicaid managed care program, Global Commitment to Health, through a Section 1115 federal waiver in 2005.[111] CMS approved an extension of the program through December 31, 2013.[112]

Second, CMS recently approved a proof-of-concept expansion of Vermont's public managed care agency into Medicare.[113] On January 31, 2011, Vermont applied to CMS for Medicare authority to allow Vermont's Agency of Human Services to act as a state-run managed care entity for "dual eligibles," beneficiaries who receive coverage from both Medicaid and Medicare.[114] In its application to CMS, Vermont cited its five-year successful management of the Global Commitment to Health program.[115] CMS approved the program to move forward to the design phase.[116]

If the final program is approved, Vermont will be a single payer with respect to dual eligibles. Perhaps this arrangement will serve as an unofficial pilot program for a government-funded, single-payer healthcare system.

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[109] Application to Centers for Medicare and Medicaid Services (CMS) by Patrick Flood, Vt. Agency of Human Services, *State Demonstrations to Integrate Care for Dual Eligible Individuals* 3 (Jan. 31, 2011), *available at* http://www.familiesusa2.org/assets/pdfs/VT_Dual_Integration_Proposal.pdf.
[110] *Id.* at 3*; see also Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet*, *supra* note 93, at 1.
[111] *Vermont Global Commitment to Health Section 1115 Demonstration Fact Sheet*, *supra* note 93, at 1.
[112] *Id.; see also* Flood, *supra* note 109, at 3.
[113] EpsteinBeckerGreen, *Health Reform: CMS Announces State Demonstration Project Initiative for Dual Eligibles: Is Your State on the List?* (Apr. 25, 2011), http://www.ebglaw.com/showclientalert. aspx?Show=14249.
[114] Flood, *supra* note 109, at 1-11.
[115] *Id.* at 7.
[116] EpsteinBeckerGreen, *supra* note 113.

## PART V: CONCLUSION

Medicaid is an entitlement. States have a legal obligation to serve any person who meets the Medicaid eligibility requirements. Enrollment in Medicaid is increasing today, and under the PPACA millions more will be required to enroll in 2014. Although the federal government will fund the majority of the Medicaid expansion, states will need to proactively manage the costs of administering their Medicaid programs to support all their Medicaid beneficiaries.

States have explored many models of cost containment. Beginning in the 1980s, many states adopted managed care models for their Medicaid programs. Managed care proved to be a popular model: the number of Medicaid beneficiaries doubled in the most recent decade. However, by the mid-2000s some states had moved away from traditional, risk-based MCOs because of budget constraints caused in part by new federal rate-setting requirements.

Vermont was one such state, and it took the unprecedented step of becoming its own public managed care entity for Medicaid. CMS approved an extension of Vermont's Medicaid program and is considering a proposal to allow Vermont to act as a public managed care entity for both Medicaid and Medicare with respect to dual eligibles, beneficiaries eligible for both programs. Other states may apply for federal approval for similar programs.

The PPACA provides challenges and opportunities for innovative state approaches to Medicaid. The future of Medicaid may include more states choosing to become single payers, a fundamental change in American health care delivery.