Federalizing Medicaid; It Seems Logical Enough

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I. INTRODUCTION

Since its founding in 1965, Medicaid has been jointly financed and administered by both the federal government and the states. While the federal government provides some general guidelines for Medicaid benefits, the states are given wide discretion in deciding the type and scope of services provided, as well as how to administer them. This federal-state partnership has resulted in an inefficient and unnecessarily costly system with wide state-to-state variations in what medical options are available to beneficiaries. This paper suggests that making Medicaid a completely

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federal program, like Medicare, would not only be more administratively efficient, but would also help equalize quality of care for beneficiaries, while simultaneously alleviating individual states of costs that they are not sufficiently able to handle.

II. ADMINISTRATIVE EFFICIENCY

Medicaid operates as a vendor payment program, with states paying providers directly for medical services. The federal government then reimburses a portion of these costs pursuant to the Federal Medical Assistance Percentage (FMAP). The federal reimbursement rate is determined annually by a formula that compares the state’s average per capita income level with the U.S. per capita income. In addition to matching the states’ expenditures for medical services, states also receive Federal Medicaid matching funds for the costs of administering their programs. In fact, the federal government generally pays fifty to one-hundred percent of these administrative costs depending on the activity, and there is no ceiling on the amount of federal matching funds a state may claim. There are approximately fifty-one separate and distinct Medicaid programs, one in each state and the District of Columbia. Each of these programs has unique administrative rules and guidelines, and the federal government assists in funding all of them.

In addition to the states’ role in administering their respective Medicaid programs, the federal government has its own administrative functions. The Centers for Medicare and Medicaid Services (CMS) in the Department

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6. Id.
7. SCHNEIDER ET AL., supra note 2, at 131.
8. Id. at 133.
9. Id. at 130.
10. Id.
of Health and Human Services (HHS) and the Office of Management and Budget (OMB) are responsible for overseeing the proper expenditure of federal Medicaid matching funds, while the Center for Medicaid and State Operations (CMSO) is responsible for administering the Medicaid program.\textsuperscript{12}

It is interesting to note that the cost of administering the current Medicaid program is roughly $18.2 billion.\textsuperscript{13} That figure is more than twice the total administrative cost of Medicare ($7 billion).\textsuperscript{14} One likely explanation for this disparity is that the federal government’s payment for both states’ administrative costs in addition to administering Medicaid at the federal level is both inefficient and more expensive than it might otherwise be if Medicaid was a fully federalized program like Medicare.\textsuperscript{15}

If Medicaid was fully federalized, countless administrative functions could be eliminated.\textsuperscript{16} For instance, there would no longer need to be multiple levels of fraud prosecution or quality assurance.\textsuperscript{17} Providers would be paid directly by the federal government, eradicating the additional administrative costs associated with submitting claims for reimbursement based on complex state-specific formulas.\textsuperscript{18} Time and money would no longer be wasted on state waiver issues, disputes over the propriety of state claims, or Section 1983 lawsuits to enforce Medicaid entitlements.\textsuperscript{19} Moreover, providers and beneficiaries would be better served working with one administrative branch and one standardized set of payment policies.\textsuperscript{20}

\section*{III. INEQUALITY IN CARE}

Under the current Medicaid system, there are significant state-by-state

\begin{itemize}
\item[11.] \textit{Id.} at 135-36.
\item[12.] \textit{Id.} at 131, 133.
\item[13.] Huberfeld, \textit{supra} note 3, at 26.
\item[14.] \textit{Id.}
\item[15.] \textit{Id.}
\item[16.] \textit{Id.} at 26-27.
\item[17.] \textit{Id.}
\item[18.] \textit{Id.}
\item[19.] \textit{Id.} at 27.
\end{itemize}
inequalities with respect to medical services provided to beneficiaries. While certain states, like Massachusetts and New York, have generally offered generous benefits, other states, such as Mississippi, have traditionally offered significantly less. These discrepancies exist notwithstanding efforts by the federal government to offer higher matching rates to poorer states.

A completely federalized system would be likely to raise minimum standards in a number of states while simultaneously helping to eliminate the wide state-by-state disparities in benefits and coverage that currently exist. While it is true that the federalization of Medicaid could actually lessen quality of care for Medicaid in some states, the cumulative benefit of having consistent benefits across states would outweigh any decrease in benefits received. Furthermore, federalizing Medicaid would not necessarily preclude states from supplementing the basic program. In other words, states that currently offer generous benefits could continue to do so.

In addition to state-by-state inequalities, the benefits and treatment options most Medicaid beneficiaries are eligible for are generally inferior to the benefits actually received. In fact, in 2008, Medicaid’s reimbursement level to health care providers nationwide was only seventy-two percent of that for Medicare. Thus, it is not surprising that many providers will not

20. Id. at 26-27.
22. Id. at 328.
23. Id.
24. Id.
25. Id. at 335.
26. Id.
27. Id. at 326.
28. Id.
30. Id. at 7.
even accept Medicaid patients because of its low reimbursement rates.\textsuperscript{31} In 2004-2005, for instance, only forty percent of doctors accepted all Medicaid patients, and about twenty percent of physicians said they were not accepting new Medicaid patients primarily because of low reimbursement rates and high administrative costs.\textsuperscript{32}

Why should Medicare beneficiaries have significantly better benefits than America’s Medicaid recipients? Federalization of Medicaid would help to eliminate this discrepancy, as it would likely result in Medicaid reimbursement levels being more closely tied to the reimbursement rates for Medicare.\textsuperscript{33} This would encourage providers to accept Medicaid patients and ultimately result in greater access to quality care.\textsuperscript{34}

IV. AFFORDABILITY

The benefits enrollees receive through Medicaid are not only contingent on where they live, but they can also be affected by fluctuations in the economy.\textsuperscript{35} States tend to “expand Medicaid when the economy is strong, adding benefits . . . and advertising the availability of Medicaid coverage.”\textsuperscript{36} However, in bad economic times, states receive fewer tax revenues and “struggle to fund their Medicaid programs,” while enrollment grows due to high unemployment.\textsuperscript{37} States often deal with these economic downturns by limiting eligibility and decreasing benefits offered.\textsuperscript{38}

The Patient Protection and Affordable Care Act (PPACA) expands eligibility to all people up to 133% of the federal poverty level.\textsuperscript{39} Moreover, the American Recovery and Reinvestment Act of 2009 (ARRA)
and additional funding that the states have received during the recent recession have temporarily prohibited states from weakening their eligibility criteria. Thus, states are no longer able to trim their budgets by adjusting Medicaid eligibility requirements. As a result, “states are scrambling to identify services they can trim from their Medicaid budgets.” “Some states . . . are cutting dental coverage for Medicaid enrollees.” Some have also cut hospice care, transplant services, and even basic services, such as annual physicals.

Other states have responded to economic downturns by cutting provider payments. “In fiscal 2010, 39 states either cut Medicaid provider rates or froze payments to hospitals and/or nursing homes.” Cutting payments to providers has a detrimental effect on Medicaid beneficiaries in terms of the treatment options available to them. The PPACA recognizes these access problems for Medicaid patients and includes a provision to require “states to pay full Medicare rates for primary care services in 2013 and 2014, with the payment increase entirely financed with federal money.”

Federalizing Medicaid would help lessen many, if not all, of the aforementioned inconsistencies and fluctuations in care while alleviating the states of the financial strain Medicaid puts on them during hard economic times. Although the federal government is certainly not immune to economic fluctuations, it is better equipped to handle downturns than are the states. Most states “must maintain balanced budgets pursuant to provisions in [their] state constitutions.” In fact, Vermont is the only

41. THE HASTINGS CENTER, supra note 37, at 1.
42. Id.
43. Id.
44. Id.; Huberfeld, supra note 3, at 29-30.
45. ANRIG, supra note 29, at 6.
46. Id.
47. Id.
48. Id. at 7.
49. See THE HASTINGS CENTER, supra note 37, at 1-2.
50. Id.; Moon, supra note 21, at 329.
state in the nation that is not legally obligated to maintain a balanced operating budget each year.52 Accordingly, every year states have to make hard choices in fulfilling their state constitutional responsibilities.53

This requirement of maintaining a balanced budget does not exist in the United States Constitution.54 Thus, in periods of economic downturn, “federal spending tends not to fall off as sharply as state and local government spending.”55 While spending during hard economic times is no doubt controversial, many economists believe that government spending can help counter recessionary forces56, and “the federal government can, and often does, use deficit spending as a means of bolstering the economy.”57 This is not to say that the federal government should not attempt to control spending and make cuts where they need to. It is simply meant to point out that the federal government is in a far better position than the states to provide quality health benefits during economic recessions, which are usually times when people need Medicaid the most.58

While some may argue that increasing federal spending for Medicaid is highly undesirable, it is important to recognize that the federal government already pays the great majority of Medicaid costs59, and “Americans would have to pay the Medicaid bill one way or the other, whether out of their federal or state taxes.”60 Additionally, the federal government’s progressive tax structure may be better suited to handle the cost.61 Because the federal income tax is much more progressive than state revenue systems, federalization would move a higher portion of Medicaid’s costs onto

52. ANRIG, supra note 29, at 9.
54. Id.
55. Moon, supra note 21, at 329.
56. The Hastings Center, supra note 37, at 2.
57. Moon, supra note 21 at 329.
58. Id.
59. Huberfeld, supra note 3, at 25.
60. ANRIG, supra note 29, at 9.
61. See id.
wealthier Americans who can better afford to bear them.\textsuperscript{62}

Despite many of the obvious benefits of having a fully nationalized Medicaid system, many disapprove of the idea, whether it be on grounds of ideology, policy, or otherwise.\textsuperscript{63} States’ rights advocates are likely to point to the idea that states serve as “laboratories for the development of new social, economic, and political ideas,” a concept supported by Justice O’Connor.\textsuperscript{64} They contend that a uniform approach to Medicaid would actually threaten beneficiary well-being, arguing that it suppresses innovation, inhibits states from being able to adapt to changing market conditions, and prevents states from engaging in creative, customized solutions to their own particular problems.\textsuperscript{65} However, “[i]n practice, the results of states as laboratories for innovation are mixed.”\textsuperscript{66} While select states have had some success “experimenting” in the area of managed care plans, for instance, many other states have done little in terms of trying new ways of providing and delivering care.\textsuperscript{67}

Perhaps if healthcare was truly a local issue, as some maintain it is, then states’ rights advocates would have some merit in saying that the states should be allowed to customize their own Medicaid programs.\textsuperscript{68} Indeed, some parts of the country do have much higher rates of hospitalization than others, and certain procedures are performed more frequently in some regions than others.\textsuperscript{69} However, healthcare is national in nature, and the practice of medicine generally recognizes uniform standards.\textsuperscript{70} Physicians “are not trained within a state to practice only within that state’s borders.”\textsuperscript{71}

\begin{thebibliography}{99}
\bibitem{62} Id.
\bibitem{65} Hurley & Zuckerman, supra note 63, at 18-19.
\bibitem{66} Moon, supra note 21, at 333.
\bibitem{67} Id.
\bibitem{68} See Moon, supra note 21, at 331-32.
\bibitem{69} Id. at 331.
\bibitem{70} Id.
\bibitem{71} Id.
\end{thebibliography}
This is evidenced by the fact that those who want to practice medicine in the United States typically must pass a national licensing exam administered by the Federation of State Medical Boards of the United States and the National Board of Medical Examiners.\footnote{72. U.S. Med. Licensing Examination, \textit{About USMLE}, U.S. MED. LICENSING EXAMINATION, http://www.usmle.org/about/.

73. \textit{See generally} Holahan, \textit{supra} note 3, at 111-17; \textit{Schneider}, \textit{supra} note 2, at 111-43.

74. \textit{See} Huberfeld, \textit{supra} note 3, at 29-30.}

V. CONCLUSION

The dual federal-state nature of Medicaid has resulted in an inefficient system with significant state-to-state disparities in medical care.\footnote{73. \textit{See generally} Holahan, \textit{supra} note 3, at 111-17; \textit{Schneider}, \textit{supra} note 2, at 111-43.

74. \textit{See} Huberfeld, \textit{supra} note 3, at 29-30.} The federal government is better suited to control Medicaid due to its progressive tax structure and ability to ensure access to care, even in the most difficult economic times, which is something the states have been unable to do.\footnote{74. \textit{See} Huberfeld, \textit{supra} note 3, at 29-30.} States’ rights activists must recognize that nationalization of Medicaid is in the best interests of the very people it is meant to serve. Making Medicaid a completely federal program, like Medicare, would help to equalize access to care while creating a more efficient and less costly system for all.