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Loyola University Chicago School of Law

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

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CONTENTS

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Editor's Note

The *Annals of Health Law* is proud to present the Seventh Issue of our online counterpart, *Advance Directive*. Consistent with our goal of promoting student scholarship in the area of health law, this Issue features articles corresponding to the topic of the Fifth Annual Symposium on Access to Health Care presented by the Beazley Institute for Health Law and Policy: *Reinventing Medicaid in a Post-Health Reform America*.

The Issue begins by examining current conditions in the United States that demonstrate the need for Medicaid coverage. First, we analyze how the rise in unemployment over the past several years has impacted Medicaid spending. Second, we discuss how reimbursement payments have affected the relationship between Medicaid beneficiaries and primary care physicians.

The Issue then goes into specific provisions and approaches within Medicaid reform. Our authors first analyze the ambiguity of the equal access provision in the Medicaid Act and how courts across the country have interpreted it inconsistently. Next, our authors discuss the role of managed care in Medicaid. We discuss the various managed care models operated by the states, including Vermont's unofficial pilot program as its own public managed care entity for Medicaid. With primary care case management (PCCM) as a popular managed care model for the states, our authors analyze the successes and failures states have experienced in employing this model. Because primary care is emphasized in the managed care model, we then evaluate the difficulties that medical home implementation faces in transforming the primary care practice and how medical homes may be a viable primary care practice. In addition, our authors examine the managed care model and its role in Medicaid long-term care.

Next, our authors address the impact on individual states of Medicaid provisions within the Patient Protection and Affordable Care Act (PPACA). First, we examine how the Federal Medical Assistance Percentage (FMAP) will impact states' budgets. Specifically, we discuss President Obama's proposed "blended" FMAP and the strain it would impose on states as

Medicaid enrollment increases as a result of the PPACA. We then discuss the PPACA's maintenance of eligibility (MOE) provisions. In particular, our authors highlight the number of children covered under the provision, despite the cost it imposes on states.

The Issue then examines the impact that Medicaid reform has on specific populations. First, we address how the PPACA will expand Medicaid coverage for the mentally ill and the shortfalls in coverage for those with mental illness. Second, our authors analyze the five-year Medicaid ineligibility period for legally residing immigrants, along with initiatives undertaken by states to provide state-funded replacement programs during that period.

Next, our authors discuss Medicaid reform in specific states. We first compare the Medicaid plans in Ohio and Arizona to illustrate two vastly different approaches by the states. Ohio has focused on administrative and structural changes, while Arizona has focused on spending cuts. Then, our authors analyze Medicaid spending and reform in Illinois, focusing on the major reforms implemented by House Bill 5420.

Finally, the Issue concludes by examining the impact of making Medicaid a completely federal program, instead of a jointly administered program with individual states. Our authors suggest that Federalizing Medicaid would be advantageous for cost and quality reasons.

We would like to thank Gretchen Thomas, our *Advance Directive* Senior Editor, Cameron Webb, our Editor-at-Large, and Doriann Cain, our Technical Editor, for their invaluable contributions in launching this issue. We would specially like to thank our *Annals* Editor-in-Chief, Daniel Marino, for increasing access to *Advance Directive*. We are also grateful to our *Annals* Executive Board Members, Alexandria Ottens, Laura Ashpole, and April Schweitzer, for their editorial assistance. The *Annals* membership deserves particular recognition for writing timely, thoughtful articles and for editing the work for their peers. Finally, we extend our warmest appreciation to the Beazley Institute for Health Law & Policy and our faculty advisors, Professor Lawrence Singer, Professor John Blum, and Megan Bess for their continued support, encouragement, and mentorship.

We hope you enjoy our Seventh Issue of *Advance Directive*.

Sincerely,

Seth D. Knocke
Advance Directive Editor
Annals of Health Law
Loyola University Chicago School of Law

ANNALS OF HEALTH LAW
Advance Directive

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Following the Trend: Rise in Unemployment Leads to Rise in Medicaid Enrollment and Spending

Ashley Leonard[*]

I. INTRODUCTION

Medicaid is a state and federally funded form of health coverage that is available only to certain eligible individuals.[1] To be eligible for Medicaid, an individual must have a low income and meet a federal or state recognized eligibility group, such as persons with disabilities.[2] It is important to note that low-income families are not the only individuals who may be eligible for Medicaid.[3] Additionally, the elderly, young persons with physical disabilities, and developmentally or intellectually challenged persons may also qualify for Medicaid.[4] The federal government sets minimum requirements the states must meet in order to receive federal

[*] Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Ms. Leonard is a staff member of *Annals of Health Law*.

1. U.S. Dep't of Health and Human Serv, Ctr. for Medicare and Medicaid Serv., *Medicaid Program – General Information*, https://www.cms.gov/MedicaidGenInfo/; COURTNEY M. PERLINO, MEDICAID, PREVENTION AND PUBLIC HEALTH: INVEST TODAY FOR A HEALTHIER TOMORROW (George C. Benjamin & Susan L. Polan eds.), 3, AM. PUB. HEALTH ASS'N.

2. Medicaid Program – General Information, *supra* note 1.

3. MEDICAID & CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 8 (Mar. 2011) [hereinafter MACPAC REPORT] *available at* http://healthreform.kff.org/~/media/Files/KHS /docfinder/MACPAC_March2011_web.pdf.

4. *Id.* at 10.

funding.[5] Once the state meets the minimum requirements of the federal government, however, the state government can decide whether to cover other optional populations or to incorporate different care systems within its respective state.[6] Therefore, Medicaid is largely a state-run program with monetary assistance and minimum guidelines supplied by the federal government.[7]

Medicaid is an entitlement program that requires eligibility through low income.[8] Therefore, when unemployment is on the rise, more Americans meet the requisite low-income requirement for the program.[9] Additionally, many employed Americans receive private insurance through their employers, and when these individuals lose their jobs, they often lose their health insurance as well.[10] The United States population is in the midst of the Great Recession, which has caused significant job loss and decrease in family income.[11] As a result of the significant increase in job loss and subsequent health insurance loss, more individuals than ever have become eligible for Medicaid.[12] In fact, Medicaid enrollment surpassed fifty million enrollees between June 2009 and June 2010, creating the highest number of enrollees in the program's forty-six year history.[13]

An individual state customizes its Medicaid programs, including

5. PERLINO, *supra* note 1, at 6.
6. MACPAC REPORT, *supra* note 3, at 12.
7. *Id.* at 12-13.
8. PERLINO, *supra* note 1, at 3.
9. KAISER COMM'N ON MEDICAID AND THE UNINSURED, RISING UNEMPLOYMENT, MEDICAID AND THE UNINSURED 2 (2009) [hereinafter RISING UNEMPLOYMENT] *available at* http://www.kff.org/uninsured/upload/7850.pdf.
10. *Id.*
11. JOHN HOLAHAN ET AL., MEDICAID SPENDING GROWTH OVER THE LAST DECADE AND THE GREAT RECESSION, 2000-2009, KAISER COMM'N ON MEDICAID AND THE UNINSURED 4 (Feb. 2011) [hereinafter LAST DECADE AND THE GREAT RECESSION] *available at* http://www.kff.org/medicaid/upload/8152.pdf.
12. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID ENROLLMENT: JUNE 2010 DATA SNAPSHOT 1 (Feb. 2011) [hereinafter MEDICAID ENROLLMENT] *available at* http://www.kff.org/medicaid/upload/8050-03.pdf.
13. *Id.*

eligibility and how it functions.[14] Medicaid eligibility varies in each state because the federal government gives states the option to customize their Medicaid programs.[15] Enrollment in Medicaid programs is impacted by numerous factors, including changes in the following: individual state eligibility standards and health care costs; employer-offered insurance coverage; and income.[16] However, one common factor exists among states – Medicaid is an entitlement program that is tailored toward low-income individuals and families who would otherwise lack health insurance.[17] In fact, Medicaid and State Children's Health Insurance Programs (CHIP) accounted for 15.1% of health insurance coverage for Americans in 2010.[18] In comparison, private health insurance covers 60.8% of Americans, while Medicare covers 14%.[19]

II. THE GREAT RECESSION AND ITS IMPACT ON HEALTH INSURANCE COVERAGE

Throughout the last eleven years, the U.S. economy has endured three separate periods of economic fluctuation that has resulted in significant changes in the unemployment rate.[20]

Between 2000 and 2004, the economy fell into a recession which, while officially over in October 2001, continued to affect unemployment rates and incomes until 2004 . . . Between 2004 and 2007, the economy emerged from the recession and grew at a modest rate; the unemployment rate declined, GDP increased, and real median household and real per capita incomes grew. In 2007, the economy entered a sharp downturn that has become known as the Great Recession. Unemployment grew sharply, GDP

14. MACPAC REPORT, *supra* note 3, at 13.
15. *Id.*
16. RISING UNEMPLOYMENT, *supra* note 9, at 2-3.
17. MACPAC REPORT, *supra* note 3, at 9.
18. *Id.* at 17.
19. *Id.*

declined and then fell in 2009, and real per capita incomes declined.[21]

In 2000, the national unemployment rate stood at 3.97%, which rose slightly in 2001, then rose again in 2002.[22] In 2003, the unemployment rate reached 5.99%, but then declined somewhat in 2004.[23] This decline continued until 2008 when it began to rise dramatically.[24] Unemployment reached a record high in October 2010, peaking at 10.1%, but declined in December 2010 to 9.4%.[25] Since April 2011, the unemployment rate has remained steady at 9.1%.[26]

When the economy experiences declines, all state budgets, and their corresponding Medicaid programs, become severely distressed.[27] The national unemployment rate illustrates the vast number of Americans who have lost their jobs during the Great Recession. In losing their income, along with the accompanied health insurance, the unemployed population may become increasingly eligible for Medicaid.[28] Individuals who lose their income and become eligible for Medicaid typically take one of three actions: enroll in Medicaid and receive public coverage, purchase non-group coverage, or become uninsured.[29]

As more people lost jobs, income, and health insurance, the number of

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20. LAST DECADE AND THE GREAT RECESSION, *supra* note 11, at 4.
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. 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 1 (Jan. 2011) [hereinafter WAITING FOR ECONOMIC RECOVERY] *available at* http://www.kff.org/medicaid/upload/8137.pdf.
26. Press Release, U.S. Dep't of Labor Bureau of Labor Statistics, The Employment Situation – August 2011 (Sept. 2, 2011), *available at* http://www.bls.gov/news.release/pdf/empsit.pdf.
27. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S CONTINUING CRUNCH IN A RECESSION: A MID-YEAR UPDATE FOR STATE FY 2010 AND PREVIEW FOR FY 2011 2 (Feb. 2010) [hereinafter MEDICAID'S CONTINUING CRUNCH] *available at* http://www.kff.org/medicaid/upload/8049.pdf.
28. RISING UNEMPLOYMENT, *supra* note 9, at 2.
29. *Id.*

Medicaid enrollees rose dramatically.[30] From June 1998 to June 1999, the amount of people who enrolled in Medicaid increased by only 0.4%.[31] Medicaid reached its highest enrollment in June 2002, when it rose to 9.3% nationwide.[32] Monthly Medicaid enrollment began to decline annually, however, until a 3.6% increase in 2008.[33] Currently, unemployment rates remain high, and Medicaid enrollment rates continue to grow as a result.[34] In 2010, states projected Medicaid enrollment growth to be 6.6%.[35] However, it far surpassed this estimate when it reached 8.5%.[36] States expected that Medicaid enrollment would grow to approximately 6.1% for fiscal year 2011, a significant but somewhat slower rate.[37] These numbers demonstrate that as the unemployment rate increased, so too did Americans' dependence on Medicaid as their alternative to private health coverage.[38] For those who lost their jobs during the economic downturn, the comfort of employer-supplied health insurance no longer existed, and Medicaid became the only option aside from being uninsured.[39]

III. IMPACTS ON MEDICAID SPENDING

Medicaid funding comes from the federal government and the respective

30. EILEEN R. ELLIS ET AL., MEDICAID ENROLLMENT IN 50 STATES: JUNE 2008 DATA UPDATE, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 6 (Sept. 2009) [hereinafter MEDICAID ENROLLMENT IN 50 STATES] *available at* http://www.kff.org/medicaid/upload/7606-04.pdf.

31. *Id.*

32. *Id.*

33. *Id.*

34. VERONICA K. SMITH ET AL., HOPING FOR ECONOMIC RECOVERY, PREPARING FOR HEALTH REFORM: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS. RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2010 AND 2011 EXECUTIVE SUMMARY, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 4 (Sept. 2010) *available at* http://www.kff.org/medicaid/upload/8105_ES.pdf.

35. *Id.*

36. *Id.*

37. *Id.*

38. WAITING FOR ECONOMIC RECOVERY, *supra* note 25, at 4.

39. HOLAHAN ET AL., *supra* note 11, at 1.

state governments.[40]

Medicaid is a means-tested program and federally financed with general revenues; there is no federal trust fund or dedicated tax revenues to finance federal Medicaid expenditures. Medicaid spending is driven by enrollment growth, inflation, and policy changes. . . A key factor driving federal Medicaid expenditures is state coverage and payment decisions. Typically, the federal share of total Medicaid expenditures nationally is 57 percent and the state share is 43 percent.[41]

As an increased number of individuals become eligible for Medicaid, state Medicaid expenditures increase dramatically, where at the same time, state revenue declines because of job loss, which makes contributions to the Medicaid programs a strenuous task for the states.[42] Notably, as more individuals became uninsured as a result of job loss and subsequent low income, state revenue declined and the demand for Medicaid enrollment and spending increased.[43]

Unfortunately, the adverse cycle of increasing unemployment rates, decreasing state revenue earnings for Medicaid spending, and increasing reliance on Medicaid as primary health coverage results in less spending money available for the larger number of Medicaid recipients. States often reduce provider rates and program benefits to make up for the Medicaid funding shortfall.[44] In fact, in 2010, most states implemented mid-fiscal year cuts in provider rates and program benefits in order to keep their Medicaid programs afloat for the growing number of recipients.[45] Midway

40. MACPAC REPORT, *supra* note 3, at 13.
41. *Id.*
42. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, RISING UNEMPLOYMENT MEDICAID AND THE UNINSURED: A MULTI-YEAR SNAPSHOT OF STATE FINANCING EFFECTS 1 (Jan. 2009) *available at* http://www.kff.org/uninsured/upload/7850_FS.pdf.
43. *Id.*
44. MEDICAID'S CONTINUING CRUNCH, *supra* note 27, at 1.
45. *Id.*

through fiscal year 2010, a total of forty-four states, as well as the District of Columbia, reported Medicaid enrollment and spending levels well above those originally projected at the beginning of the fiscal year.[46] These important sacrifices took place in order to keep Medicaid functioning at the level required by federally set minimums.

As the U.S. economy continued to decline and Americans consequently lost jobs, the federal government intervened with the American Recovery and Reinvestment Act of 2009 (ARRA), "which provided a temporary increase in the federal Medicaid matching rate . . . from October 2008 through December 2010."[47] The implementation of this Act required states to refrain from making certain cuts in their Medicaid programs.[48] Although the federal government aided the struggling states when state revenue could not fund Medicaid,[49] the states still needed to act in order to curb Medicaid spending. Consequently, forty-eight states in fiscal year 2010 "implemented at least one new policy to control cost and [forty-six] states plan[ned] to do so in [fiscal year] 2011 with some states reporting program reductions in multiple areas."[50] Primarily, Medicaid officials relied on provider reimbursement rate cuts to reduce spending costs.[51] Decreasing provider rates can be a risky move, because these rates encourage and keep provider participation in the Medicaid program.[52] Lower rates, however, also allow enrollees access to certain services.[53] In making provider rate cuts, Medicaid officials look to the future in the hopes that when economic conditions improve, they can restore the previous provider rates, or even

46. *Id.*
47. SMITH ET AL., *supra* note 34, at 3.
48. *Id.* at 5.
49. *Id.* at 3.
50. *Id.* at 4.
51. *Id.*
52. *Id.*
53. *Id.*

increase them, to make the program more attractive to providers.[54]

States also implemented benefit restrictions for Medicaid enrollees in an effort to curb spending.[55] States restricted or limited available services without dipping below the federally mandated requirements for Medicaid.[56] In order to receive the funds allotted through the ARRA, the federal government required states to maintain their Medicaid eligibility standards, methodologies, or procedures that were in place on July 1, 2008.[57] Because states were prohibited from reducing the amount of individuals eligible for Medicaid, they had to look elsewhere to make cuts in spending as the number of enrollees continued to grow with rising unemployment.

Fiscal year 2010 saw a record number of benefit restriction implementations when twenty states reduced the benefits to their enrollees.[58] Fourteen additional states reported that they had planned benefit restrictions for fiscal year 2011 as well.[59] Benefit restrictions came in the form of eliminating certain previously covered benefits, in addition to putting controls on existing benefits.[60] "For example, several states eliminated all or some adult dental services including Arizona, California, Hawaii, and Massachusetts. A number of states also imposed limits on benefits such as imaging services, medical supplies or durable medical equipment, therapies or personal care services."[61] In fact, since the beginning of the recession, every state has "implemented provider rate cuts or freezes, benefit cuts and restrictions, provider taxes and assessments, utilization controls, fraud and abuse reduction strategies and numerous

54. *Id.*
55. *Id.* at 5.
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 5.

administrative cuts . . . to reduce Medicaid cost growth."[62] Overall, when unemployment rates remain high, Medicaid enrollment grows.[63] When Medicaid enrollment grows, Medicaid expenditures also increase.[64] This spending increase, coupled with the state budget shortfalls, causes Medicaid officials to consider difficult questions about where to make cuts in order to reduce Medicaid spending.[65]

IV. CONCLUSION

This article has examined the correlation between rising unemployment rates in the United States during the recent Great Recession and the corresponding rise in Medicaid enrollment. This article has also addressed the rise in the number of individuals eligible for Medicaid as a whole, primarily because Medicaid is a major source of coverage for the health care of low-income children and their families, low-income seniors, and low-income persons with disabilities, in addition to all other low-income individuals in the United States.[66] The origination of Medicaid stemmed from a welfare-based program in the 1960s and grew into a major payer in the United States healthcare system for individuals who could not afford health care on their own.[67] Without Medicaid, approximately 31.3% of Americans would be uninsured.[68]

If the data discussed in this article is any indication of the future, Medicaid enrollment will likely follow the same trend as the unemployment rate. That is, Medicaid enrollment and spending will increase when there is a rise in unemployment and decrease when there is a decline in

62. WAITING FOR ECONOMIC RECOVERY, *supra* note 25, at 4.
63. SMITH ET AL., *supra* note 34, at 4.
64. *Id.*
65. *Id.*
66. MACPAC REPORT, *supra* note 3, at 9.
67. *Id.* at 12.
68. *Id.* at 17.

unemployment. Undoubtedly, the rising unemployment rate reflects that Americans are significantly impacted when employer-sponsored insurance and income are taken away. Thus, often the only option for health insurance coverage is Medicaid.

ANNALS OF HEALTH LAW
Advance Directive

VOLUME 21 FALL 2011 PAGES 11-21

Physician Reimbursement, Impending Shortages, and Healthcare Reform

*Jennifer Lorio**

I. INTRODUCTION

Primary care physicians (PCPs) can serve a vital role in the lives of their patients. PCPs are often the first stop when patients have any healthcare concerns, and for some patients, have also become the gateway to every other type of specialty care. However, the supply of PCPs is increasingly unable to meet patient care needs. Largely overshadowed by the crisis of rising healthcare costs in the U.S. is the lack of PCPs who accept Medicaid patients.[1] The federal government has studied the distribution of PCPs and determined that, as of September 2011, it would take nearly 18,000 practitioners to meet the needs of Health Professional Shortage Areas (HPSAs), regions that are lacking in PCPs and other healthcare professionals to satisfy the current demand.[2] Given the limited supply of PCPs, the time they spend with patients has become more sought after and, consequently, more

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[1] Tricia McGinnis, Julia Berenzon, & Nikki Highsmith, *Increasing Primary Care Rates, Maximizing Medicaid Access and Quality,* CTR. FOR HEALTH CARE STRATEGIES, INC., 1, 2 (2011), *available at* http://www.chcs.org/usr_doc/PCP_Rate_Increase_Issue_Brief_FINAL.pdf.

[2] *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,* Health Resources and Service Administration (HRSA), *available at* http://bhpr.hrsa.gov/shortage/.

difficult to obtain.[3] The Patient Protection and Affordable Care Act (PPACA) has brought the issue of PCP shortage to the national headlines as its implementation looms and preparations to satisfy patient care demands seem insufficient.

The shortage of physicians affects everyone who seeks healthcare, especially individuals in rural areas or those insured by government programs such as Medicare and Medicaid.[4] Over sixty million Americans rely on Medicaid as a source of health insurance.[5] Of these, the geriatric population is anticipated to represent a significant portion of Medicaid recipients. It is estimated that by 2012, nearly 10,000 Americans will turn 65 years old everyday and by the year 2030, twenty percent of the population will be 65 and over, constituting half of physician visits and hospital stays.[6] In order to minimize the impact of the PCP shortage, changes must be implemented immediately to ensure that individuals are not faced with a lack of adequate healthcare. This paper will first discuss medical training and how medical students are drifting from seeking a career in primary care to more lucrative specialties. Second, this paper will address how nurses and foreign physicians could help, and how regardless of a shortage, quality of care must be monitored at a high standard. Finally, this paper will review the changes detailed in the PPACA that provide incentives for PCPs to continue to see Medicaid patients. If these programs are adopted and implemented, the shortage of PCPs may be at least partially addressed and quality healthcare for all brought more within reach.

II. AN IMPENDING SHORTAGE OF PHYSICIANS

In 2008, the total number of active medical doctors in the U.S. was

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[3] McGinnis, *supra* note 1.
[4] Stephanie Gunselman, *The Conrad "State-30" Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain*?, 5 J. HEALTH & BIOMEDICAL L. 91, 95-96 (2009).
[5] Deborah Bachrach, *Payment Reform: Creating a Sustainable Future for Medicaid*, CENTER FOR HEALTH CARE STRATEGIES, INC., 1, http://www.chcs.org/usr_doc/Medicaid_Payment_Reform_Brief.pdf (last visited September 30, 2011).

784,199, with 305,264 specializing in general primary care, which includes general practice, internal medicine, obstetrics, and pediatrics.[7] Of the general primary care specialists, only 93,761 were in general practice or family medicine.[8] The highest numbers of physicians were in internal medicine, with lesser numbers in primary care and pediatrics.[9] Medical school graduates are bypassing careers in primary care for higher paying jobs with shorter work hours in specialty and sub-specialty areas.[10] Specializations are known to pay more lucrative salaries, which help to offset the increasing costs of attending medical school in the U.S.[11]

III. MEDICAL TRAINING

To determine the cause of the increasing shortage of PCPs - an increasingly worrisome phenomenon given the challenges and hopes of upcoming health reform - it is worthwhile to focus on medical school training, the cornerstone of every physician's career. It is expected that by 2025 there will be a shortage of 45,400 PCPs.[12] The Association of American Medical Colleges has estimated a need for a thirty percent increase in medical school enrollment by 2015 to produce approximately 5,000 new Medical Doctors annually.[13] Unfortunately, medical school is demanding, expensive, and time-consuming. According to the American Medical Association, the av-

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[6] Fitzhugh Mullan, et al., *Aging, Primary Care, and Self-Sufficiency: Health Care Workforce Challenges Ahead*, 36 J.L. MED. & ETHICS 703, 704 (2008).
[7] National Center for Health Statistics. Health, United States, 2010. Table 108. *Doctors of medicine in primary care, by specialty: United States and outlying U.S. areas, selected years 1949-2008*.
[8] *Id.*
[9] National Center for Health Statistics. Health, United States, 2010. Table 107. *Doctors of medicine, by place of medical education and activity: United States and outlying U.S. areas, selected years 1975-2008*.
[10] Mullan, *supra* note 6, at 705.
[11] Gunselman, *supra* note 4, at 94.
[12] *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*, ASS'N OF MEDICAL COLLEGES, https://www.aamc.org /download/158076/data/updated_projections_through_2025.pdf (last visited September 29, 2011).
[13] *See Physician Shortages and the Medically Underserved,* COUNCIL OF STATE GOVERNMENTS (August 2009), http://www.csg.org/knowledgecenter/docs/TIA_ PhysicianShortage_Final_screen.pdf.

erage educational debt of a medical student in 2010 was $157,944.[14] Furthermore, once a student has graduated from medical school, an essential part of a physician's education, as well as a requirement for licensure, is residency training, which has not received financial support from Medicare since a cap was placed on funding in 1997.[15] A recent initiative is the Affordable Care Act Primary Care Residency Expansion Program, which provided $168 million in grant funding in 2010 and will continue to provide grants through 2014, to increase the number of physicians trained in family medicine.[16] This funding includes providing $80,000 per resident per year for those choosing residency training in family medicine.[17] Additionally, partial loan forgiveness or even forgoing interest payments on federal loans will be a persuasive incentive for graduate medical students deciding on whether they will pursue a specialty or primary care.[18]

Aside from the detrimental effect of medical student financial concerns on the choice of a career in primary care, the long duration of a physician's required education and training, typically taking seven years or more, also contributes to the inability to meet the increasing demand for PCPs.[19] As awareness increases regarding the inadequate supply of physicians to meet the high demand for their services, alternative approaches such as new incentives for medical students to choose a primary care practice and the use of physician assistants and nurse practitioners (mid-level providers) may

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[14] *Medical Student Debt,* AMERICAN MEDICAL ASS'N, http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt/background.page? (last visited September 28, 2011).
[15] *Physician Shortages to Worsen Without Increases in Residency,* ASS'N OF AMERICAN MEDICAL COLLEGES, Section on Data and Analysis, https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf (last visited Sept. 8, 2011) [hereinafter *Physician Shortages*].
[16] "Affordable Care Act (ACA) Primary Residency Expansion Program". Public Health Service Act (PL 111-148, July 2, 2010) Text from: *Catalog of Federal Domestic Assistance*, *available at* https://www.cfda.gov/?s=program&mode=form&tab=step1&id=60b24aff018b4e16ac048cd2d9bd6a65. (last visited on September 8, 2011).
[17] *Id.*
[18] Gunselman, *supra* note 4, at 106.
[19] *Physician Shortages*, *supra* note 15.

alleviate some of the problem.[20] "Task shifting" is a term used to describe the development of practice strategies and educational policies to assign certain clinical tasks to be assigned to lesser-trained practitioners, allowing physicians to focus on duties for which they are uniquely qualified.[21] In this way, patients can still be treated by qualified individuals through an equal distribution of tasks within the healthcare workforce. Additionally, physicians may work in collaboration with these mid-level practitioners in hospital and clinic settings and still be reimbursed by participating in shared/split visits, which requires both parties to have a face-to-face encounter with a patient of a substantive nature.[22] This lessens the responsibility of patient examination and testing by distributing it to both parties.

Although all states face some physician shortage, there is a serious concern regarding rural areas where the shortage is especially severe.[23] While twenty percent of the U.S. population resides in rural areas, only nine percent of physicians practice there.[24] Sixty million people, or almost one-fifth of the country's population, reside in one of 3,000 Health Professional Shortage Areas, which have population-to-primary care physician ratios of more than 3,500-to-1.[25] Rural areas are often less appealing to physicians and more difficult to staff because of less competitive salaries, less technological advancement, and geographical and security issues.[26] An approach to helping meet this physician demand in rural areas is the use of international medical graduates.[27] The Conrad "State 30" Program, initiated by Congress in 1994, provides states with visa waivers to bring up to thirty foreign physicians to practice in Medically Underserved Areas.[28] The J-1 visa waiver allows recipients to bypass the normal requirement of returning

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[20] Mullan, *supra* note 6, at 705.
[21] *Id.* at 706.
[22] Lori-Ann Rickard, *Helping Clients Increase Profits Through the Use of Non-Physician Practitioners*, 21 NO. 5 HEALTH L. 44, 45 (2009).
[23] *Physician Shortages and the Medically Underserved, supra* note 13.
[24] Gunselman, *supra* note 4, at 95.
[25] *Physician Shortages and the Medically Underserved*, *supra* note 13.
[26] Gunselman, *supra* note 4, at 96.
[27] Mullan, *supra* note 6, at 706.

to their countries of nationality for two years after completing medical school.[29] A physician sponsored by a federal or state government under this program is permitted to practice in a federally designated Health Professional Shortage Area or Medically Underserved Area.[30] The use of such creative approaches may alleviate some of the physician shortage. However, the need to maintain an adequate number of physicians willing to serve Medicaid clients and the need to increase the number of students entering the primary care workforce remain priorities without an adequate solution.

IV. REIMBURSEMENT INCENTIVES

Aside from the increasing shortage of PCPs for patients and areas in need, the other critical issue relevant to the expected changes from the implementation of the PPACA is how modifications to physician reimbursement will affect the number of Medicaid providers. With the ongoing Medicaid reforms, an estimated thirty-two million newly eligible Americans will be entering the Medicaid system and will likely need a primary care physician.[31] Medicaid is jointly financed by the federal government and the individual states, yet it is left to the state's discretion as to what their physician reimbursements rates will be, as long as they are within Title XIX ceiling and floor amounts on payments.[32] Medicaid represents seventy percent of state health expenditures and is one of the largest costs in every state budget.[33] The Medicaid Act "equal access provision" requires that payments to Medicaid providers be "consistent with efficiency, economy, and quality of care. . ." and suffice to give Medicaid recipients the same or equal access to healthcare as those who are privately insured.[34]

Medicaid has had the lowest physician payment rates within the U.S.

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[28] Gunselman, *supra* note 4, at 92.
[29] *Id.*
[30] *Physician Shortages and the Medically Underserved*, *supra* note 13.
[31] Bachrach, *supra* note 5, at 1.
[32] Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the" Equal Access" Provision*, 73 U. CHI. L. REV. 673, 676-677 (2006).
[33] Bachrach, *supra* note 5, at 3.
[34] Moncrieff, *supra* note 32, at 677.

health care system, and as a result, many physicians have been reluctant to accept Medicaid patients into their practices.[35] Medicaid pays physicians approximately seventy-two percent of Medicare rates, and only sixty-six percent of Medicare rates for primary care services.[36] Unfortunately, due to Medicaid's more common fee-for-service payment model, physicians often prioritize volume and the reimbursement value of services, rather than quality of care.[37] On the other hand, Medicaid's managed care plans are closer to Medicare levels and therefore, attract more physicians to participate.[38] Ultimately, "Medicare and Medicaid are infamous for low reimbursement levels and hassling paperwork and, therefore, discourage physicians from working in areas with large Medicare and Medicaid populations."[39]

In order to accommodate the rise in number of patients, in combination with the increasing aging population, the PPACA constructs a set of measures that incentivize physician participation. The PPACA's insurance provisions intend to expand the availability of insurance to a greater number of patients, while appropriately reimbursing physicians for this surplus of patient care without offsetting government expenditures to maintain the health insurance expansion.[40] First, Medicaid payments to PCPs for primary care services may not be lower than the Medicare fee schedule for calendar year 2013.[41] Additionally, the Medicare Incentive Payment Program allows for a ten percent bonus, quarterly or annual, if primary care services approximate at least sixty percent of allowed charges by the primary care practitioners from 2011 to 2015.[42] This ten percent bonus will be "calculated based on where the service is performed and what Medicare actually

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[35] Stephen Zuckerman & Robert Berenson, *How Will Physicians Be Affected by Health Care Reform? Timely Analysis of Immediate Health Policy Issues*, URBAN INSTITUTE, July 2010.
[36] Stephen Zuckerman, et al., *Trends in Medicaid Physician Fees, 2003-2008*, HEALTH AFFAIRS, w510 - w515 (2009).
[37] Bachrach, *supra* note 5, at 6.
[38] *Id.* at 7.
[39] Gunselman, *supra* note 4, at 96.
[40] Emily Jane Cook, *Pay Back*, L.A. LAWYER 20, 24 (2010).
[41] The Henry J. Kaiser Family Foundation, *Focus on Health Reform: Summary of New Health Reform Law*, http://www.kff.org/healthreform/upload/8061.pdf (last visited September 29, 2011).

paid the physician for the service," rather than the approved Medicare payment amount.[43] Even so, these incentives for PCPs represent only temporary solutions.

Reimbursement rates are not entirely controlling of physicians trends in care of Medicaid patients, but often take precedent over other factors.[44] Compensation is a pillar of maintaining a successful business. A study in 1999 examined changes in the volume of privately insured services in response to reductions in Medicare physician payments.[45] The primary research question was to determine how significantly, if at all, physicians increased the provisions of privately insured services as a result of Medicare reductions in payment rates for surgical procedures (i.e. shifted their services away from Medicare patients). [46] Data from 182 hospitals was collected, covering a range of major procedure groups before the reduction in Medicare fees and twenty-one months after the reduction.[47] Ultimately, the study found that financial considerations influence which patients physicians treat.[48] Higher Medicaid fees increase probability that a physician will treat Medicaid patients.[49] Physicians with a significant amount of Medicare and Medicaid patients are usually minimally impacted by reductions in reimbursement due to continuously high volume of patients. However, a physician could be adversely affected if a substantial share of its patients shifted from private coverage to Medicaid, resulting in an overall reduction of reimbursement.[50] Regardless of the payment rates, the use of physician services as a whole does not significantly fluctuate because program beneficiaries tend to seek needed care in emergency rooms or com-

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[42] Cook, *supra* note 40, at 26.
[43] Gunselman, *supra* note 4, at 107.
[44] Bachrach, *supra* note 5, at 7.
[45] Thomas Rice, et al., *A Tale of Two Bounties: The Impact of Competing Fees on Physician Behavior*, 24 J. HEALTH POL. POL'Y & L. 1307, 1307 (1999).
[46] *Id.* at 1314.
[47] *Id.* at 1307-1308.
[48] *Id.* at 1326.
[49] Anne Lenhard Reisinger, David C. Colby & Anne Schwartz, *Medicaid Physician Payment Reform: Using the Medicare Fee Schedule for Medicaid Payments*, 84 AM. J. PUB. L. 553, 554 (1994).

munity clinics, in addition to an office setting.[51]

As Medicaid reimbursement rates decrease, practice costs remain the same or higher with the continuing need for information technology and electronic adaptations.[52] In 2008, Medicare implemented a 10.6% payment cut, which resulted in physicians reducing staff, referring complex cases to specialists and hospitals, discontinuing certain services such as nursing home visits, and even leaving the practice as a whole.[53] However, physicians have looked to other areas in the past to make up for these losses, such as cost-shifting and increasing the volume of patients.[54] Physicians have often cited other administrative reasons for hindrance in participation in Medicaid as well, such as delayed reimbursement and time-consuming billing requirements.[55] It has been found that reimbursement delays can offset any advantages that states try to achieve by introducing higher fee payments to physicians.[56]

V. QUALITY AS A REIMBURSEMENT FACTOR

The existing issues with low reimbursement rates have resulted in concerns regarding provider participation, quality outcomes and patient satisfaction.[57] In order to keep their practices financially sound, physicians practice "hamster-wheel medicine", where visits are kept brief and only focus on acute health problems, instead of prevention and management of chronic conditions.[58] Chronic disease among the elderly is responsible for greater demands on the healthcare workforce.[59] Additionally, as the aging

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[50] Zuckerman, *supra* note 35, at 1.
[51] Rice, *supra* note 45, at 1312.
[52] *Member Connect Survey: Physicians' Reactions to the Medicare Physician Payment Cuts*. AMERICAN MEDICAL ASS'N, DIVISION OF MARKET RESEARCH AND ANALYSIS, http://www.ama-assn.org/ama1/pub/upload/mm/399/mc_survey.pdf (last updated February 2008) [hereinafter *Physicians' Reactions]*.
[53] *Member Connect Survey, supra* note 52.
[54] Rice, *supra* note 46, at 1328.
[55] McGinnis, *supra* note 1, at 2.
[56] Zuckerman, *supra* note 36, at 517.
[57] Moncrieff, *supra* note 32, at 684.
[58] McGinnis, *supra* note 1.
[59] Mullan, *supra* note 6, at 704.

population seeks medical attention from PCPs, many of these patients demand special diagnostic and treatment needs, as well as overall management of care.[60]

Measuring quality can often be difficult due to lack of investment in information technology and research. Additionally, patients are often unaware or uninformed regarding how to assess quality of care, making it difficult to monitor quality and patient satisfaction.[61] To ensure a high measure of quality, the PPACA has added provisions that will track quality outcomes with Medicaid patients.[62] The Physician Quality Reporting Initiative will become mandatory in 2015, and if physicians fail to report data on their use of quality measures for certain covered services, their payment rates will be reduced by up to two percent per year.[63] In addition, value-based modifiers will be implemented in 2015, which will adjust to payment rates under the physician fee schedule, based on how quality compares with costs.[64] These programs are crucial to incorporating quality into the payment system and measuring overall success in healthcare reform.[65] However, they will likely prove time-consuming for physicians and their staff as well as costly to implement.[66]

IV. CONCLUSION

It is Congress' hope that the PPACA's projected increase in reimbursement will not only ensure that physicians will see Medicaid patients, but also provide physicians with the time and resources necessary to provide in-

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[60] Mullan, *supra* note 6, at 705.
[61] SEAN NICHOLSON, PH.D., *Will the United States Have a Shortage of Physicians in 10 Years?,* Changes in Health Care Financing & Organization (November 2009), http://www.academyhealth.org/files/publications/HCFOReportDec09.pdf (last visited September 30, 2011).
[62] *See* Cook, *supra* note 40, at 25.
[63] Paul B. Ginsburg, *Rapidly Evolving Physician-Payment Policy – More than the SGR*, 364 N. ENGL. J. MED. 172, 175 (2011) (The Physician Quality Reporting Initiative is a physician-feedback program that allows consumers to report quality based on episodes of care.)
[64] *Id.*
[65] *Id.*
[66] Jason Fodeman, *The New Health Law: Bad for Doctors, Awful for Patients*, Galen Institute, http://www.galen.org/fileuploads/NewHealthLaw_BadForDoctors_AwfulForPatients.pdf (last visited September 28, 2011).

creased quality of care. In addition, Congress anticipates that addressing the issue of PCP shortage will improve access to care for Medicaid patients. Approaches for keeping physicians engaged in maintaining Medicaid clients such as improvements in reducing medical school debt and investing in an efficient workforce to support physicians will equate a workload reduction for physicians. It will also allow for flexibility, which will allow for physicians to see a reasonable number of patients while maintaining quality care. Adjusting reimbursement rates, along with providing bonuses, should further advance the goal of incentivizing PCPs to accept Medicaid patients. Finally, measures to ensure quality will also be implemented in the hopes of monitoring the effectiveness of such new programs and provisions. It is likely that if all these programs and initiatives are implemented, the shortage of physicians will be reduced in the upcoming years and new recipients of Medicaid will also be able to secure quality healthcare.

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The Equal Access Provision: A Destiny of Ambiguity

Peter Nozicka·

I. INTRODUCTION

Medicaid is a joint federal-state welfare program in which the federal government shares costs with states that choose to participate in the program.[1] To participate, a state must submit a "plan for medical assistance" to the Secretary of Health and Human Services. The plan must describe the scope and nature of the state's Medicaid program and demonstrate that it complies with the requirements of the Medicaid Act.[2] If the Secretary approves the state's plan, they can submit quarterly expense reports and be reimbursed of a portion of the administrative costs and a portion of the costs paid to healthcare providers for their services.[3] If a state fails to comply with the Medicaid Act's requirements, including those related to provider reimbursement rates, the Secretary is authorized to revoke federal funding.[4]

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[1] Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 794 (2009).
[2] 42 U.S.C. § 1396a (2006) (listing the requirements for state Medicaid plans to receive federal funding).
[3] Rosemary B. Guiltinan, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipients' Access to Healthcare*, 51 B.C. L. REV. 1583, 1590-91 (2010).
[4] 42 U.S.C. § 1396c (2006) (describing when the Secretary may refuse to make payments to a state's Medicaid program).

One such requirement is a provision in the Medicaid Act requiring payments to be "consistent with efficiency, economy, and quality of care" and "sufficient" to ensure that Medicaid patients' access to services is equivalent to the access of the general population of the same geographic area.[5]

This article will attempt to show the problem of state decisions to cut Medicaid reimbursement rates to providers, which leads to unequal access to the Medicaid program. It will also highlight the statutory ambiguity that has prevented the states from developing a proper metric to ensure compliance with the equal access provision. This paper will further address the circuit court decisions that have attempted to resolve the ambiguity of the equal access provision. Then, it will address the proposed rules recently promulgated by the Office of Health and Human Services, which attempt to provide the states with guidance on data measures to be used to gauge compliance with the equal access provision. Finally, this paper will attempt to show that the proposed regulations, as they stand today, do not help the states solve the aforementioned ambiguity of the provision, but create additional ambiguities for the state to overcome in order to comply with the regulations themselves.

II. THE PROBLEM: WHEN REIMBURSEMENT RATES LEAD TO DISPARATE ACCESS

In 2008, Medicaid reimbursement rates were, on average, only seventy-two percent of Medicare rates, while reimbursement rates for primary care services were even lower, at around sixty-six percent of Medicare rates.[6] "During the same period, Medicare itself paid twelve percent less than private insurers."[7] Within the bounds of the Federal Medicaid Act, states frequently use the cost-saving strategy of reducing reimbursements to healthcare providers for services that Medicaid recipients consume.[8] Cog-

[5] 42 USC § 1396a(a)(30)(A) (hereinafter "the equal access provision").
[6] Guiltinan, *supra* note 3, at 1585.
[7] *Id.*
[8] Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 673-74 (2006).

nizant of the temptation to pay providers too little, Congress included the equal access provision in the Medicaid Act, a key safeguard, which requires payments to be "consistent with efficiency, economy, and quality of care" and "sufficient" to ensure that Medicaid patients' access to services is equivalent to the access of the general population of the same geographic area.[9]

The sweeping and ambiguous "equal access provision" has led to frustration for states and litigation for Medicaid stakeholders.[10] The equal access provision has led to litigation by providers and patients, challenging states' Medicaid reimbursement payment rates.[11] The federal appellate courts have thus far been inconsistent in their interpretations of the equal access provision.[12] The Centers for Medicare & Medicaid Services (CMS) "points out that states currently do not have [any real] guidance on how to determine compliance with the statutory access requirements. . . ."[13] This is a dangerous proposition as, due to the recent economic downturn, "most states have experienced a decrease in revenues coupled with a sharp increase in Medicaid enrollment."[14] This disparity has led a number of states to further explore provider payment reductions as an answer to their budget imbalances.[15] Budget pressure led thirty-three states to cut or freeze reimbursement rates in fiscal year 2009; thirty-nine states did so in fiscal year 2010, and thirty-seven states are planning reimbursement rate restrictions for fiscal

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[9] 42 USC § 1396a(a)(30)(A), *supra* note 5.
[10] *See* Moncrieff, *supra* note 8, at 674.
[11] *Id.*
[12] *Id.*
[13] Debra A. McCurdy, *CMS Proposed Rule on Methods for Assuring Access to Covered Medicaid Services*, HEALTH INDUSTRY WASHINGTON WATCH (May 13, 2011), http://www.healthindustrywashingtonwatch.com/2011/05/articles/regulatory-developments/hhs-developments/other-cms-developments/cms-proposed-rule-on-methods-for-assuring-access-to-covered-medicaid-services/.
[14] Am. Ass'n. of Med. Colleges, *CMS Releases Medicaid Equal Access Proposed Rule*, (May 20, 2011), https://www.aamc.org/advocacy/washhigh/highlights2011/189868/cmsreleasesmedicaidequalaccessproposedrule.html.
[15] VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FUND., THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE AND POLICY IN THE MIDST OF A RECESSION; RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2009 AND 2010 5-6 (2009), *available at* http://www.kff.org/medicaid/upload/7985.pdf.

year 2011.[16]

A Government Accountability Office survey has found that physicians nationwide who participate in Medicaid and Children's Health Insurance Program (CHIP) are generally less willing to accept children covered by CHIP as new patients than privately insured children.[17] For example, about seventy-nine percent participating physicians are accepting all privately insured children as new patients, while only accepting forty-seven percent of children in Medicaid and CHIP.[18] Further, according to a survey of physicians, those surveyed experienced unique and significant difficulties when they attempted to refer children covered by Medicaid and CHIP to specialty care.[19] As such, reimbursement rate cuts leading to disparate access becomes a very real problem, and the equal access provision is the key safeguard to ensure that beneficiaries are getting the care they need.

III. THE CONFUSION, HOW CIRCUIT COURTS HAVE INTERPRETED THE EQUAL ACCESS PROVISION

The circuit courts have been less than consistent in their interpretations of the equal access provision of the Medicaid Act.[20] In deciding cases that have been brought by either providers or patients against state health agencies, the courts have disagreed as to the proper analytical framework for determining the legal adequacy of reimbursement rates in the context of their compliance with the language of the equal access provision.[21]

The Seventh Circuit and the Fifth Circuit have focused their analyses on the language of the last clause of the equal access provision.[22] Under this type of analysis, the only issue in determining state compliance with the

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[16] *Id.*
[17] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-624, MEDICAID AND CHIP: MOST PHYSICIANS SERVE COVERED CHILDREN BUT HAVE DIFFICULTY REFERRING THEM FOR SPECIALTY CARE 11 (2011).
[18] *Id.* at 11.
[19] *Id.* at 20.
[20] *See* Moncrieff, *supra* note 8, at 674.
[21] *See generally,* Moncrieff, *supra* note 8, at 673.
[22] *See Evergreen Presbyterian Ministries, Inc v. Hood*, 235 F.3d 908, 927–32 (5th Cir. 2000); *see also Methodist Hosp., Inc v. Sullivan,* 91 F.3d 1026, 1029 (7th Cir. 1996).

equal access provision of the Medicaid Act is whether Medicaid patients have the same access to services that their private-market counterparts do.[23] This interpretation of the equal access provision has led the Seventh Circuit and the Fifth to apply what has been called an "access metric."[24] Under the access metric scheme, plaintiffs must prove that Medicaid recipients are less able to access healthcare services than their privately insured counterparts.[25] In *Methodist Hospitals, Inc. v. Sullivan*, hospitals challenged the state of Indiana's amended reimbursement scheme, claiming that the state violated the equal access provision by failing to conduct adequate cost studies prior to setting a new reimbursement rate.[26] Prior to the challenged amendment, Indiana reimbursed hospitals based on their "customary billing" rate.[27] The amendment proposed to reimburse hospitals on a flat rate, irrespective of the hospital's actual costs.[28] This flat rate was calculated by adding fifty percent of Medicare's rate plus fifty percent of the statewide median amount paid for service.[29] In this oft-cited opinion, the Seventh Circuit stated that the equal access provision does not require states to conduct studies before setting reimbursement rates.[30] The court was not concerned with the methodology; only the result of each State's scheme, stating that the equal access provision "requires each state to produce a result, not to employ any particular methodology for getting there."[31] The test, simply stated, is whether enough providers are participating in Medicaid, and focuses exclusively on the equal access language of the equal access provision stating, "[u]nder §1396a(a)(30), . . . states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not,

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[23] *Id.*
[24] *See* Moncrieff, *supra* note 8, at 678.
[25] *Id.*
[26] *Sullivan*, 91 F.3d at 1026.
[27] *Id.* at 1028.
[28] *Id.*
[29] *Id.*
[30] *Id.* at 1030.
[31] *Id.*

the state may (and under §1396a(a)(30), must) raise the price until the market clears."[32]

The Fifth Circuit later adopted the same reasoning and test in *Evergreen Presbyterian Ministries v. Hood*.[33] This action arose from a state decision by Louisiana to cut payments by seven percent in order to recover from budgetary shortfalls.[34] The Fifth Circuit rejected a district court opinion that would have required the state to take into account the impact of the cut on providers.[35] Instead, the court framed the issue as, "whether evidence exists in the record that supports a finding that after the reimbursement rate reduction, recipients will not have access to medical care equal to that of the non-Medicaid population in the same geographic area."[36] In the same vein as the Seventh Circuit's test, the Fifth Circuit's interpretation of the equal access provision is not concerned with the "economy, efficiency, or quality" considerations of a state's chosen rate. Thus, state plans in these jurisdictions need not make any showing of these considerations. They must only show that the state plans do not impair access.[37]

Unlike the Fifth and Seventh Circuits' interpretations of the equal access provision, which are preoccupied with the result of the rate setting procedure, the Ninth Circuit has set forth an interpretation that addresses the procedure of rate setting itself through "all four factors included in §30(A)—efficiency, economy, quality, and access—giving this interpretation a more solid textual foundation than the access metric."[38] To comply with the equal access provision, states would need to create a payment rate that is both consistent with efficiency and economy and reflects the actual costs to the providers.[39] Further, the court added that the reimbursement rates "must bear a reasonable relationship to provider costs, unless there is some justifi-

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[32] *Id.*
[33] *Evergreen Presbyterian Ministries, Inc.*, 235 F3d at 932.
[34] *Id.* at 909.
[35] *Id.*
[36] *Id.* at 932.
[37] *Id.*
[38] *See* Moncrieff, *supra* note 8, at 689.

cation for rates that do not substantially reimburse providers their costs."[40] This ruling established what has been called the "cost metric"[41] and was affirmed by the Ninth Circuit in 2009.[42] In the Ninth Circuit, plaintiffs must show that the state neglected to study or consider providers' costs when setting rates, and thus the question becomes whether the state based its reimbursement rates on "reliable cost studies."[43] This creates a duty on state plans to conduct such studies.[44]

Other litigation over compliance with the equal access provision has occurred in the Eighth and Third Circuits.[45] These Circuits have declined to set forth a bright-line metric for compliance and instead give great deference to state rate-setting designs, holding such rate setting to an "arbitrary and capricious" standard.[46] These holdings have left states without any bright line guidance and have subjected the states to additional burden as they attempt to design new payment schemes that satisfy the equal access provision.[47]

IV. A MISSED OPPORTUNITY FOR CLARITY, THE PROPOSED RULES

In 2009, Congress created the Medicaid and CHIP Payment and Access Commission (MACPAC)[48] "specifically to study and make recommendations on beneficiary access to care in

Medicaid and CHIP."[49] MACPAC created a recommended method on

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[39] *Orthopedic Hospital v Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).
[40] *Id.* at 1499.
[41] *See* Moncrieff, *supra* note 8 at 688-89.
[42] *See*, *Independent Living of Southern California v. Maxwell-Jolly*, 572 F.3d 644, 652 (9th Cir. 2009)
[43] *Id.*
[44] *Orthopedic Hospital*, 103 F.3d at 1496.
[45] *See Rite Aid of Pennsylvania, Inc v. Houstoun*, 171 F.3d 842, 851 (3rd Cir. 1999); *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).
[46] *See Rite Aid of Pennsylvania*, 171 F.3d at 853 (3rd Cir. 1999); *Arkansas Medical Society, Inc.*, 6 F.3d at 529 (8th Cir. 1993).
[47] *See* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 88, 26343 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447) [hereinafter Medicaid Program].
[48] Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 506, 123 Stat. 8, 91 (2009).
[49] *See* Medicaid Program, *supra* note 47, at 26343.

how to measure access to care for beneficiaries after reviewing decades of research and significant consulting with key Medicaid stakeholders.[50] As a result, the MACPAC recommendation promulgated a three-pronged analytical framework for states to adopt in order to be sure their plans are in compliance with the equal access provision.[51] The MACPAC-recommended framework adopted in the proposed rule considers: "(1) enrollee needs; (2) the availability of care and providers; and (3) utilization of services."[52]

In the May 6, 2011 edition of the Federal Register, CMS published "Methods for Assuring Access to Covered Medicaid Services."[53] In the proposed rules, CMS adopts the MACPAC three-part framework, providing the first Congressionally authorized expert guidance on how to analyze beneficiary access to care.[54] A first look at these proposed regulations reveals that the rule is more concerned with data gathering strategies for states to implement than setting forth strategies that would provide criteria for compliance with the equal access provision.[55]

The access metric has been criticized as being difficult for courts to administer, too narrow and thus against congressional intent, and in violation of Medicare because it does not compare Medicaid rates with those of private insurers or Medicare.[56] The rules themselves seem to work towards alleviating this criticism because contrary to the access metric, the proposed rules deal with factors other than just results of the rate-setting procedures.[57] In fact, they deal with the data methods states use in ensuring compliance with the equal access provision, and do not set any criteria or goals for states in terms of the results.[58]

The cost metric has been criticized as being "too restrictive of state au-

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[50] *Id.*
[51] *Id.* at 26344.
[52] *Id*.
[53] Am. Ass'n. of Med. Colleges, *supra* note 14
[54] *See* Medicaid Program, *supra* note 47, at 26344.
[55] Medicaid Program, *supra* note 47, at 26349 (the agency notes that it considered and rejected uniform data measures as well as uniform substantive access thresholds).
[56] *See* Moncrieff, *supra* note 8*,* at 681-82.
[57] Medicaid Program, *supra* note 47*,* at 26344.

tonomy, preventing the states from using reimbursement rates as a means of controlling utilization," and thus creating administrative burdens on state agencies.[59] The logic behind this criticism is that "the state carries a substantial administrative burden because it must conduct or acquire 'responsible cost studies' and must justify any deviation from providers' costs if it wants to implement a creative payment scheme."[60] The rule states that one of its principal goals is to "develop a coordinated and streamlined data solution aimed at reducing redundancy, administrative burden, and to maximize business value."[61] The rule replaces the duty imposed under the cost metric to conduct reasonable cost studies with a duty to make ongoing reports about how states are gathering data that will ensure compliance with the equal access provision.[62] Thus, it seems to replace one administrative burden with another. However, CMS does estimate modest state administrative costs associated with the rule.[63]

The proposed regulation text also describes the timeframe for states to conduct the data

review and make the information available to the public.[64] States must review a subset of Medicaid services each year, with all covered services undergoing a full review at least once every five years.[65] The rationale behind providing for the five-year window is to "allow States to determine the best use of available State resources in conducting the access review and to prioritize the review in light of program changes or particular access con-

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[58] *Id.* at 26349.
[59] *See* Moncrieff, *supra* note 8, at 691.
[60] *Id.* at 694.
[61] Medicaid Program, *supra* note 47, at 26346.
[62] *Id.* at 26361.
[63] *Id.* at 26354-57 (estimating that each access data review will cost slightly more than $18,000, with an entire estimated annual cost for state reviews of slightly more than $900,000. Ongoing access monitoring would cost slightly less than $90,000 annually for affected states, beneficiary feedback mechanisms, slightly less than $230,000 for all states, and annual corrective actions about $37,000 annually for all affected states.)
[64] *Id.* at 25353.
[65] *Id.* at 26345.

cerns."[66] However, if a state proposes reducing or restructuring provider rates, the state must submit, along with its state plan amendment, a completed access review.[67] In addition to the access review that states will be required to submit when proposing to reduce or restructure provider rates, states considering such measures will be required to solicit input from affected stakeholders as to the likely impact of the proposed changes.[68] The Rule would put a duty on states to set up sufficient channels for ongoing access input from beneficiaries and other stakeholders.[69] Promoting the use of electronic media to fulfill this, CMS recommends surveys, hotlines, and ombudsmen.[70]

If the access review or such ongoing monitoring shows impediments to access below the standard required in the equal access provision, the state will now be required to submit, within ninety days, a corrective action plan that details specific steps and dates to remedy the identified problems.[71] In instances when the access reviews identify conflicts between the state plan and the equal access provision, the rule does not impose an affirmative duty on states to consult directly with beneficiaries, but rather leaves it to the discretion of the states.[72] Instead, "in circumstance[s] when changes [to provider rates] could result in access issues," the agency must submit the results of its access review along with any proposed state plan amendment to reduce or restructure provider rates.[73] These reviews "must demonstrate sufficient access for any service for which the State agency proposes to reduce payment rates or restructure provider payments in circumstances when

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[66] *Id.* (further stating that the burden associated with an annual review would likely be high and may not demonstrate any changes in access to care if the payment rates and service delivery systems remain stable.)
[67] *Id.* at 26354. (stating that CMS believes this is appropriate so that States consider the impact that such proposals may have on access to care and demonstrate compliance with the equal access provision.)
[68] *Id.* at 23360.
[69] *Id.*
[70] *Id.*
[71] *Id.* at 26347.
[72] *Id.* at 26360-61.
[73] *Id.* at 26361.

the changes could result in access issues."[74]

While stating that payment levels are a factor to consider in their analysis under the rule and imposing a duty to collect specific information on payment levels, CMS also claims that access can be improved through improving provider enrollment and retention, offering incentive payments for allowing off-hours appointments, or structuring rates to encourage the development or expansion of clinics in underserved areas.[75] State reviews would be required to include specific data on payment levels, including: Medicaid rates as percentages of average customary provider charges; Medicaid rates as a percentage of Medicare rates, average commercial payer rates, or the applicable Medicaid allowable cost of the service; and an estimate of the average percentage increase or decrease resulting from any proposed change in payment rates within one year.[76]

While these measures are laudable in that they force the states to give heavy consideration to how their potential reimbursement cuts will affect beneficiary access to services, they do not address the core problem of the statutory ambiguity itself. As such, while states will be forced to collect data on the extent to which their plans are in compliance with the statute, the rule gives no guidance on how to apply these data.[77] This problem becomes daunting for beneficiaries as there is pending litigation in front of the Supreme Court that could end beneficiaries' and providers' rights to bring judicial challenges to state Medicaid provider payment reductions that threaten to reduce access to care.[78] With no guidance on requirements of compliance, and no judicial review of decisions, there will be no effective means to ensure that the safeguard of the equal access is anything other than a dead letter.

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[74] *Id.*
[75] *Id.* at 26347.
[76] *Id.* at 26361.
[77] *Id.* at 26349 (the agency notes that it considered and rejected uniform data measures as well as uniform substantive access thresholds).
[78] *See* Sara Rosenbaum, *Medicaid and Access to the Courts*, 16 NEW ENG. J. MED. 364, 1489-91 (2011).

V. SHORTFALLS OF THE PROPOSED RULE

The first major criticism of the proposed rules is that they have only a narrow reach, as they only apply to fee-for-service arrangements.[79] Thus, they are completely inapplicable to other arrangements, such as risk-based managed care arrangements, as those arrangements are governed by separate regulatory requirements.[80] Approximately seventy percent of all Medicaid beneficiaries are in managed care arrangements.[81] While CMS notes that managed care is governed by separate regulatory requirements, nothing in the Medicaid statute exempts such arrangements from the requirements of the equal access provision.[82] Next, the proposed rule requires public notice when "significant" changes in payment standards are proposed.[83] However, CMS fails to define what a "significant" change might be anywhere in the proposed

rule.[84] Also, there is a disconnect between the wording of the proposed rule and the wording of the equal access provision itself. The rule focuses on enrollee needs and provider availability for Medicaid beneficiaries, but the equal access provision focuses on availability in relation to other populations in the same geographic area.[85] Thus, the rule does not provide the states any guidance on compliance with an essential element of the statute.

Finally, a state must submit access reviews of relevant information gathered within the year preceding the date of a proposed rate reduction only if its changes "could result in access issues."[86] This statement is similarly vague to the aforementioned "significant change" language and could cause additional problems for states seeking to be in compliance with the equal

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[79] Medicaid Program, *supra* note 47, at 26344.
[80] *Id.*
[81] KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FUND., MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2010), *available at* http://www.kff.org/medicaid/upload
/8046.pdf.
[82] 42 USC § 1396a(a)(30)(A), *supra* note 5 (1396a applies to all state plans, this necessarily includes both fee-for-service and managed care arrangements).
[83] Medicaid Program, *supra* note 47, at 26347.
[84] *Id.* (specifically stating that the term "significant" is undefined).
[85] 42 USC § 1396a(a)(30)(A), *supra* note 5.

access provision. While it should be noted that this is only a proposed rule that is subject to change, the rule is more focused on procedures to obtain data to promote compliance with the equal access provision and misses an opportunity to provide criteria or outcome goals to ensure that the states are actually in compliance with the equal access provision.

VI. CONCLUSION

In the midst of the epidemic state budget shortfalls, one of the major ways states are trimming their bottom-line is by cutting reimbursement rates for healthcare providers who participate in Medicaid. These cuts lead to less provider participants, which in turn create problems for beneficiaries who are seeking access to the provider's services. They key safeguard against the extreme consequences of this cycle is the equal access provision. However, the language of the provision is broad, and as such courts have not provided consistent guidance on the measures states need to take to comply with the provision. HHS and CMS have released regulations that charge states with mandatory data collection and reporting on compliance with the equal access provision, but these regulations are unlikely to be helpful as they only apply to fee-for-service arrangements, and because they do not provide any uniform data measures or uniform substantive access thresholds. Thus, the ambiguity of this vital provision is likely to continue.

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[86] Medicaid Program, *supra* note 47, at 26345.

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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.

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[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.

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Primary Care Case Management as an Option for Medicaid Managed Care

Brian Troutman[*]

I. INTRODUCTION

Primary care case management (PCCM) originated in the 1980s and involves creating a link between Medicaid beneficiaries and primary care providers (PCPs) and then paying those PCPs a monthly fee to administer a wide range of care management services. [1] The care management activities usually involve the providers authorizing emergency room (ER) and specialist visits.[2] Additionally, the PCPs and other providers are paid a fee for each service that they perform.[3] Recently, states have begun enhancing their PCCM programs with new features, including more thorough care management and coordination for high-need beneficiaries, disease management, medical home initiatives, improved financial incentives for PCPs, and an increase in the use of performance and quality measures.[4]

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1. James M Verdier, et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, CENTER FOR HEALTH CARE STRATEGIES 1 (2009), *available at* http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf.

2. *Id.*

3. KAISER FOUNDATION, MEDICAID AND MANAGED CARE (2001), *available at* http://www.statehealthfacts.org.

4. Verdier, *supra* note 1.

This paper will begin by identifying the purpose of Medicaid and how states can customize their Medicaid benefit delivery systems. Then this paper will introduce how Medicaid managed care is administered through a PCCM model. Following that discussion, this paper will focus on the successes and failures that individual states have experienced following implementation of a PCCM model in their Medicaid managed care system. To determine whether a state has experienced benefits or problems from the implementation of a PCCM program, three metrics will be used: overall quality of care, level of access to care, and cost containment.

II. MEDICAID AND STATE WAIVERS

In 1965, Congress enacted Medicaid and Medicare simultaneously in an amendment to the Social Security Act of 1935.[5] Medicaid is an entitlement program that comprises a large amount of mandatory spending in the federal budget and is financed by both the federal and state governments.[6] The purpose of Medicaid is to provide medical assistance to families with dependent children, the elderly, blind, and permanently disabled people who have insufficient income and resources to meet the costs of necessary medical care.[7] Participation by states is optional, and all fifty states have opted in.[8] Once a state opts-in, it must follow certain federal rules to receive federal funding, unless the state receives a waiver from the Secretary of Health and Human Services.[9] These waivers, once approved by the Centers for Medicare and Medicaid Services (CMS), grant a state greater flexibility in administering Medicaid coverage and costs.[10]

In 1997, Congress enacted §4701 of the Balanced Budget Act, which allowed states to put most Medicaid beneficiaries into managed care

5. Social Security Act of 1935, *amended by* Social Security Amendments of 1965, Pub. L. No. 89-97, §1901, 79 Stat. 288.
6. Elicia J. Herz, *MEDICAID: A PRIMER*, CONG. RES. SERV. 1 (2010), *available at* http://aging.senate.gov/crs/medicaid1.pdf.
7. Social Security Amendments of 1965 § 1901.
8. Herz, *supra* note 6.
9. *Id.*

programs, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), without requesting a federal waiver.[11] Frequently, a state will try to move certain existing Medicaid populations into managed care arrangements, which will help to free up funds to provide coverage for individuals that would not otherwise be eligible for Medicaid under an approved waiver.[12]

III. MANAGED CARE AS A WAY OF ADMINISTERING MEDICAID

Managed care is a method used to deliver Medicaid benefits to beneficiaries. Generally, managed care is "[a] medical delivery system that attempts to manage the quality and cost of medical services that individuals receive."[13] States manage such costs by attempting to "improve access and reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care."[14] Medicaid managed care is a way for states to work with third party payers, such as HMOs and PPOs, to provide treatment to beneficiaries and payment for those provided medical services.[15] In most states, beneficiaries are encouraged to use HMOs and PPOs that are offered by the state's managed care system for the beneficiary's needed health care services.[16] There are two major Medicaid managed care models.[17] In the risk-based model, the state pays a managed care organization (MCO), such as an HMO, a fixed monthly fee per enrollee (also known as capitation) and the MCO assumes all or some of the financial risk for the services provided.[18] In the PCCM model, PCPs or other providers are paid a monthly case management fee

10. *Id.* at 12.
11. DEAN M. HARRIS, CONTEMPORARY ISSUES IN HEALTHCARE LAW AND ETHICS 133 (2008).
12. Herz, *supra* note 6, at 12.
13. HEALTH INSURANCE RESOURCE CENTER, HEALTH INSURANCE GLOSSARY, *available at* http://www.healthinsurance.org/glossary.
14. KAISER FOUNDATION, *supra* note 3.
15. *Id.*
16. HEALTH INSURANCE RESOURCE CENTER, *supra* note 13
17. KAISER FOUNDATION, *supra* note 3.
18. *Id.*

per-patient and a set fee for each service provided (also known as fee-for-service or FFS), thus the provider does not assume any of the financial risk associated with unpredictable costs.[19] In mid-2007, PCCM models were in use in twenty-nine states and accounted for 13.6% of Medicaid enrollees.[20]

IV. HOW PRIMARY CARE CASE MANAGEMENT WORKS

Basic Structure

PCCM is a way of administering Medicaid without the use of HMOs.[21] In a PCCM system, a recipient chooses a PCP to act as their "medical home."[22] As the recipient's medical home, the PCP has a larger role in the oversight of a patient's care by becoming responsible for managing the care of the recipient by providing all routine preventative care and providing 24-hour access to information, emergency treatment and referrals.[23] The PCPs can include primary care physicians, clinics, group practices, nurse practitioners, and others.[24] In some states, PCPs may also act as a "gatekeeper" for specialty services.[25] As a gatekeeper, the job of the PCP is to "approve and monitor the provisions of services to beneficiaries."[26]

Additionally, state Medicaid PCCM programs have been providing medical homes for their beneficiaries since their establishment over two decades ago.[27] While PCCM programs follow the same general structure, many states have made "enhancements" to their programs.[28] Currently, medical homes usually include "pay-for-performance (P4P) financial incentives for physicians, patient-focused and practice-focused care

19. *Id.*
20. Verdier, *supra* note 2.
21. Sakena Abedin, *Primary Care Case Management and Medicaid: 2006 Update*, CONNECTICUT HEALTH POLICY PROJECT, *available at* http://www.cthealthpolicy.org/pccm/pccm_medicaid.pdf.
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. KAISER FOUNDATION, *supra* note 3.
27. Verdier, *supra* note 1, at 9.

management improvements, greater use of information technology, and more extensive monitoring and performance reporting."[29] While the current concept of medical homes has become more elaborate and multi-faceted than when PCCM programs began, many state PCCM programs still maintain some of the original elements of medical homes.[30]

While a PCCM program is mostly FFS, there are also elements of capitation. In most state PCCM programs, physicians are paid on a monthly per-member basis for care coordination services and all physicians and other providers are then paid on a FFS basis for services performed.[31]

Enhancements

Not only have states enhanced their medical homes, but they have also enhanced their overall PCCM programs to provide for better quality of services and to reach more people. States that have enhanced their PCCM programs have made the changes from the basic model to something that is better tailored to meet the needs of the individual beneficiaries within the state.[32] For example, in Massachusetts the per-member per-month (PMPM) fee paid to physicians for coordination of care was raised from three dollars to ten dollars in exchange for an increased level of certain primary care services.[33] Maine introduced a version of P4P reimbursement system by "paying providers additional amounts for reducing inappropriate ER visits and providing more preventive services."[34] Oklahoma raised its capitation arrangement above the expected cost of additional services in an effort to encourage more rural physicians to enter the program and thus provide greater access to health care.[35] In addition to increasing payments to induce greater physician participation, a number of states have implemented

28. *Id.*
29. *Id.*
30. *Id.*
31. Abedin, *supra* note 21.
32. *Id.* at 1.
33. *Id.* at 8.
34. *Id.* at 8-9.

disease management programs to target chronic long-term diseases.[36]

V. BENEFITS AND PROBLEMS FOLLOWING ADOPTION OF PCCM

States have cited different reasons for adopting PCCM programs within their borders, and it appears that adoption of the program has usually helped increase access to care and quality of care to Medicaid beneficiaries. For example, "North Carolina and Florida turned to PCCM[s] to increase provider options in rural areas where there was no HMO coverage," and Vermont adopted a PCCM program after HMOs left the state. [37]

Accessibility

States that have adopted PCCM programs as a solution to their Medicaid woes have had varying degrees of success following implementation. Two groups that states have been successful in expanding coverage to are children and those that live in rural areas. For example, Alabama and Georgia saw an increase in accessibility of children covered by Medicaid.[38] A study in those states showed that children that resided in "communities with higher Medicaid physician-to-enrollee ratios were more likely to use health care services than children living in communities with fewer Medicaid physicians per enrollee."[39] Where there is an increase in the availability of physicians participating in Medicaid there is also a greater ability for child beneficiaries to utilize health care services.

Additionally, Texans have benefited from an increase in the accessibility of care because their PCCM program covers 202 counties that were not previously covered by an MCO.[40] The counties in Texas that are covered under the PCCM program are primarily rural areas, whereas the

35. *Id.* at 9.
36. *Id.*
37. Abedin, *supra* note 21.
38. Karen VanLandeghem & Cindy Branch, *Impact of Primary Care Case Management Implementation on Medicaid and SCHIP*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 2 (March 2009), *available at* http://www.ahrq.gov/chiri/chiribrf8/chiribr8.pdf.
39. *Id.*
40. TEX. HEALTH & HUMAN SERVS. COMM'N, *Chapter 6: Medicaid Managed Care* 6-15

metropolitan areas are covered by standard MCOs.[41] By locating the PCCM facilities in rural areas, the populations in those areas are likely able to receive care that they may not have been able to obtain without traveling long distances to the closest metropolitan areas. Furthermore, Florida implemented a PCCM program because it was apparent that "HMOs were not willing to expand into some of the less populated counties."[42] By expanding the geographic coverage area of Medicaid plans more physicians were able to participate in Medicaid managed care.[43] Many other states, including Oklahoma, have seen an expansion of coverage to rural areas.[44]

However, not all states have experienced an increase in accessibility following adoption of a PCCM system. In Alabama and Georgia, the proportion of office-based physicians that participated in Medicaid declined with the adoption of a PCCM delivery system.[45] This is likely due to the increased requirements that providers had to meet to participate in the PCCM system, such as taking on a minimum number of Medicaid enrollees and providing 24/7 phone or office access.[46]

Quality

In addition to changes in accessibility to a state's Medicaid beneficiaries, states that have implemented PCCM programs have seen an increased level in quality of care. Children, in particular, have seen a substantial increase in their quality of care. One group in particular that has experienced an increase is quality of care is children. In Texas in 2008, seventy-six percent of children aged three through six "received the recommended number of well-child visits. . ." and adolescent well-child visits exceeded the national Medicaid mean of forty-two percent with a sixty-one percent visitation

(2011), *available at* http://*www.hhsc.state.tx.us/medicaid/reports/PB8/PDF/Chp-6.pdf.*

41. *Id.*
42. Abedin, s*upra* note 21.
43. *See, e.g.,* Verdier, *supra* note 1, at 5.
44. *Id.*
45. VanLadeghem, *supra* note 38.
46. *Id.*

rate.[47] Furthermore, a Consumer Assessment of Health Plans Survey (CAHPS) of Texas PCCM child beneficiaries reported high scores showing that children usually or always received the type of care needed.[48] The Texas survey was mirrored in another CAHPS survey of Vermont's PCCM program.[49] The Vermont PCCM scored considerably better than the national average for Medicaid in all five areas covered under the survey.[50] Similar results have been shown in Oklahoma's PCCM program.[51]

Additionally, when given a choice, it appears that patients prefer the PCCM programs to other alternatives. For example, Massachusetts Medicaid beneficiaries had a choice between a PCCM or HMO and the beneficiaries "overwhelmingly" chose to participate in the PCCM program.[52] Similarly, a survey of Vermont consumers found that their PCCM program performed "very well" compared to other Medicaid managed care plans across the country.[53]

Furthermore, beneficiaries covered under a PCCM program receive higher quality care than they received under a different plan. In Virginia, a study revealed that children enrolled in a PCCM plan had higher immunization rates than those in HMO programs.[54] Virginia implemented a disease management program as a part of their PCCM program and as a result saw a reduction in ER visits for asthma.[55] In 1999, North Carolina reported a "significant improvement" in quality of care for asthmatic

47. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, at 6-17. A well-child visit consists of a visit to a health care provider on a set schedule that coincides with the developmental stages of a child. During these visits, the provider will conduct a complete physical exam while checking on the growth and development of the child to ensure that the child is healthy and developing properly. Jennifer K. Mannheim et al., *Well-Child Visits: MedlinePlus Medical Encyclopedia,* NATIONAL INSTITUTE OF HEALTH, *available at* http://www.nlm.nih.gov/medlineplus/ency/article/001928.htm.

48. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, at 6-17.

49. Abedin, *supra* note 21.

50. *Id.* (noting the five criteria for the survey are: ". . .getting needed care, getting care without long waits, doctors who communicate, helpful and courteous office staff and customer service.")

51. Verdier, *supra* note 1, at 35.

52. Abedin, *supra* note 21.

53. *Id.*

54. *Id.*

children as a result of their disease management program.[56] Sixty-seven percent of asthmatic children were on long-term controller medication, as opposed to only fifty-three percent of asthmatic children in a FFS program.[57]

However, not all states experience an increase in the quality of care following implementation of PCCM programs. Although children in Alabama and Georgia were less likely to visit the ER, they were also less likely to use well-child and other primary care, such as a visit to a PCP for an acute illness or a chronic condition.[58] One reason given for this decline is that in many cases Medicaid beneficiaries were assigned to a PCP instead of choosing one, which damaged the doctor-patient relationship.[59] Although families had the ability to choose their PCP under state law, many families were unaware how to change their assigned provider or found it to be too difficult.[60]

Cost Containment

Many states that have implemented a PCCM for their Medicaid beneficiaries have reduced the costs associated with delivery of medical services. PCCM programs aim to lower costs through an increase in preventative services while simultaneously reducing the use of costly services, like ER visits.[61] A cost-effectiveness analysis of Virginia's asthma management program "projected a $3-$4 saving to Medicaid for every incremental dollar spent providing disease management support. . ."[62] This projection is due to the decrease in ER visits of enrollees with asthma.[63] Similarly, a cost analysis of Iowa's PCCM program showed that

55. *Id.*
56. *Id.*
57. *Id.*
58. VanLandeghem, *supra* note 38, at 1.
59. *Id.* at 3.
60. *Id.*
61. Abedin, *supra* note 21.
62. *Id.*
63. *Id.*

the PCCM program "was associated with substantial aggregate cost savings over an eight-year period."[64]

North Carolina contracts with Mercer Government Human Services Consulting (Mercer) to provide estimates of savings that the state will realize from its PCCM program.[65] In 2009, an analysis by Mercer revealed that North Carolina's PCCM program created a savings of $147 million in 2007, representing a total savings of around eleven percent of Medicaid costs.[66] Mercer did a similar study in Pennsylvania, which concluded that, from July 2005 through June 2006, Pennsylvania's PCCM program had medical costs six percent below the MCO program.[67] The same study showed that the administrative costs associated with Pennsylvania's PCCM program were forty-five percent lower than the MCO program.[68] Both cases represent an enormous overhead reduction that could free up money to be spent on the actual provision of medical services to Medicaid beneficiaries.

VI. CONCLUSION

PCCM programs are a viable option for states considering overhauling their current Medicaid programs to increase quality and access while decreasing costs. Many states that have implemented PCCM programs have had an increase in quality of care for children and beneficiaries with chronic diseases, such as asthma.[69] Several states that have surveyed their Medicaid beneficiaries have shown that the PCCM program is favorable when compared to other options.[70] PCCM programs also enable Medicaid beneficiaries in rural areas to receive needed care when HMOs or other managed care options decide not to expand their geographical coverage

64. *Id.*
65. Verdier, *supra* note 1, at 27.
66. *Id.*
67. *Id.* at 28.
68. *Id.*
69. Abedin, *supra* note 21.
70. *Id.*

area.[71] Finally, PCCM programs enable cost savings through increasing prevention and decreasing use of more costly alternatives, like ER visits.[72] For cost-conscious states looking for a way to increase access to care while also increasing quality of care the PCCM model is a great alternative to other Medicaid managed care programs.

71. TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 40, *see also,* Abedin, s*upra* note 21.

72. Abedin, *supra* note 21.

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You Can't Go Home Again – Difficulties of Medical Home Implementation Within Health Reform

Ashley Craig·

I. IDEAL PATIENT CARE: THE PATIENT CENTERED MEDICAL HOME

Patient centered medical homes (medical homes) aim to provide patients with higher quality access to healthcare at a lower cost by employing a novel, collaborative method of care.[1] This white knight of healthcare is expected to revolutionize primary care, healthcare collaboration, referrals, and patient involvement.[2] However, the healthcare community has heard these claims and promises before. Managed care similarly focused on cost containment and the use of primary care physicians as gatekeepers, yet the system disappointed the high expectations.[3] Furthermore, the burden placed on primary care physicians is great and potentially unattainable due to the current shortage of primary care physicians.[4]

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1. Amanda Cassidy, *Health Policy Brief: Patient-Centered Medical Homes*, HEALTH AFFAIRS (Sept. 14, 2010), *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_25.pdf.

2. *Id.*

3. Robert J. Stenger et al., *Policy Challenges in Building the Medical Home: Do We Have a Shared Blueprint?*, 23 J. AM. BOARD OF FAM. MED. 384, 389-90 (2010).

4. Cassidy, *supra* note 1, at 1.

The premise behind the medical home concept is that responsibility to integrate patient care across all medical institutions and organizations to provide safe, quality care for the patient would fall to one single person; a physician.[5] According to the seven basic tenants of the medical home, the patient is entitled to: a personal physician; physician-directed medical practice; whole person orientation; coordinated or integrated care; quality and safety; enhanced access; and value payment.[6] Recently, under the Patient Protection and Affordable Care Act, medical homes received a great deal of attention as a potential vehicle for primary care reform.[7] However, medical homes, originally called health homes, were first introduced in 1967 in order to provide a location, or home, for children's medical records.[8] Medical homes now endeavor to provide effective primary care to all patients, not just children, including individuals with special needs and chronic care patients.[9] According to legislation in various states, medical homes still retain their original purpose.[10] Furthermore, the National Center for Quality Assurance (NCQA) standards assume all patients are affected by medical home implementation while Medicaid legislation indicates that the medical home target population only includes chronic care patients.[11]

5. CLAYTON M. CHRISTENSEN ET AL., THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTHCARE 129-30 (McGraw Hill, 2009).

6. *Joint Principles of the Patient Centered Medical Home*, PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (2007), http://www.pcpcc.net/content/joint-principles-patientcentered-medical-home.

7. Cassidy, *supra* note 1, at 3.

8. *Patient Centered Medical Home*, IMPROVING CHRONIC ILLNESS CARE (2006-10), http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224.

9. Robert A. Berenson et al., *A House Is Not A Home: Keeping Patients At The Center Of Practice Redesign*, 27 HEALTH AFFAIRS 1219, 1223 (2008).

10. Okla. Admin. Code § 310:550-1-2 (2008) (describing of 'medical home' as a place for infant to receive care); R.I. Gen. Laws Ann. § 42-12.3-2 (West 2007) (stating that every child and pregnant mother is given access to medical home regardless of coverage).

11. Berenson, *supra* note 9, at 1226, 1227.

II. PCMH STANDARDS

The NCQA promulgates six standards for medical homes, allotting points for each element.[12] The factors enumerated by the NCQA are the medical home's (1) ability to enhance access and continuity; (2) identify and manage patient populations; (3) plan and manage care; (4) provide self-care and community support; (5) track and coordinate care; and (6) measure and improve performance.[13] Under the rating system, NCQA qualified medical homes receive additional bonuses or payments.[14] Health plans and employers also entice medical homes to comply through the use of financial incentives.[15] While these factors are easily evaluated, they are not sufficient to solve the primary care systematic problems.[16] Instead, the standards are "data-centered" versus "patient-centered."[17] Specifically, the standards misplace emphasis on documentation requirements rather than the needs of the patient.[18] The hope of medical homes is that they will revolutionize shortcomings within the primary healthcare system. Unfortunately, the NCQA standards, "do not necessarily correspond to the seven 'joint principles' that define the [medical homes]."[19]

Furthermore, each community places significant emphasis on certain standards, not necessarily in accordance with the NCQA points system.[20]

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12. *Patient-Centered Medical Home*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Sept. 29, 2011), http://www.ncqa.org/tabid/631/default.aspx.

13. *PCMH 2011 Content and Scoring Summary*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Oct. 1, 2011), http://www.ncqa.org/tabid/631/default.aspx.

14. *NCQA Patient-Centered Medical Home: PPC-PCMH*, NATIONAL CENTER FOR QUALITY ASSURANCE (last visited Oct. 30, 2011), *available at* http://www.ncqa.org/Portals /0/PCMH%20brochure-web.pdf.

15. *Id*.

16. Cassidy, *supra* note 1, at 4.

17. Berenson, *supra* note 9, at 1225.

18. *Id*.

19. Bruce E. Landon et al., *Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home*, 29 HEALTH AFFAIRS 827, 828 (2010).

20. Anton J. Kuzel & Elaine M. Scoch, *Achieving a Patient-Centered Medical Home as Determined by the NCQA – At What Cost, and to What Purpose?*, 7 ANNALS FAM. MED. 85, 85 (2009).

Each medical home is unique, and encouraging compliance with a set standard may discourage their unique characteristics and ability to meet varied community needs. Utilizing standards encourages medical homes to adhere to those named principles, but the overall goal of primary care transformation is hindered or abandoned.[21] The transformation itself preaches consistency within the NCQA standards, while also indicating that each practice tailors the transition to their particular goals.[22]

III. PCMH WITHIN MEDICAID

Several states, including Nebraska, employ their own standards governing Medicaid medical home pilot projects.[23] Nebraska's pilot program requires five core competencies be met prior to receiving both the medical home designation and Medicaid reimbursement.[24] Unfortunately, the implementation of standards for Medicaid reimbursement poses the same risks as those referenced regarding the NCQA standards. In particular, the Nebraska Medicaid medical home pilot entices physicians to transform their practice, yet the enhanced Medicaid reimbursements incentives only apply if the practices adhere to the program standards.[25] Once a participating practice achieves a certain standard level, the practice then receives an additional 5% enhanced fee-for-service payment for select

21. Landon, *supra* note 19, at 829.

22. Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*, 7 ANNALS FAM. MED. 254, 257-58 (2009).

23. *See generally* NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES, http://dhhs.ne.gov/medicaid/Pages/med_pilot_progress.aspx (last visited Oct. 11, 2011) (presenting information regarding Nebraska's Medicaid Medical Home pilot).

24. *Nebraska Medicaid Patient-Centered Medical Home Pilot Standards*, NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES (Nov. 3, 2010), *available at* http://dhhs.ne.gov/medicaid/Documents/standards.pdf.

25. *Nebraska Medicaid Patient-Centered Medical Home Payment Methodology*, NEB. DEPARTMENT OF HEALTH AND HUM. SERVICES (Jul. 26, 2010), *available at* http://dhhs.ne.gov/medicaid/Documents/payment-methodology.pdf.

procedures and evaluations.[26] This particular Medicaid reimbursement method exacerbates existing problems with the fee-for-service method of reimbursement as only specified evaluations receive the enhanced rate, which may circumvent a physician's incentives to become more accessible to patients.

IV. FEES & REIMBURSEMENT

The current fee-for-service method of primary care reimbursement is highly criticized.[27] Many commentators believe a change in payment policy is necessary.[28] In fact, moving primary care away from fee-for-service payment will provide medical homes with stronger finances.[29] Healthcare reform legislation cites medical homes as the vehicle for change in payment and reimbursement.[30] Yet the fee-for service/capitation methods of payment remain the prototypical payment method for medical homes.[31] This poses a large barrier to the success of medical homes, as physicians strive for payment reform and may not support the medical home proposals without payment adjustment.[32] Initial state medical home legislation indicates the fee-for-service model is a jump-off point for additional reimbursement.[33]

Currently, fee-for-service is the preferred method of payment for providers, and many providers fear changing their reimbursement

26. *Id.*
27. Landon, *supra* note 19, at 829.
28. *Id*.
29. *Id*. at 833.
30. Katie Merrell & Robert A. Berenson, *Structuring Payments for Medical Homes*, 29 HEALTH AFFAIRS 852, 852 (2010).
31. *Id*. at 858.
32. Stenger, *supra* note 3, at 390.
33. *See generally* NAT'L ACAD. FOR STATE HEALTH POLICY, http://nashp.org/med-home-states (last visited Sept. 29, 2011) (presenting information regarding each state's current policy and legislation regarding medical homes).

methods.[34] Fee-for-service payments encourage skyrocketing healthcare costs in both primary care and hospital organizations.[35] Accordingly, providers are hesitant to change to a new payment model if reimbursement may be jeopardized.[36]

Moreover, the fee-for-service model is an inappropriate payment method for a successful medical home. Because one tenet of a successful medical home is the collaboration of the physician and all medical personnel, the fee-for-service method is ludicrous. Aspects of the collaborated care within medical homes have not traditionally used the fee-for-service method of payment, which generally only reimburses physicians for face-to-face visits.[37] Such payments do not cover phone calls, or additional services provided by other medical staff.[38] Therefore, the use of fee-for-service is additionally inappropriate for auxiliary services.

Fee-for-service payments encourage a "more is better" mentality; [39] while capitation, the traditional alternative, encourages the opposite mantra of less is more.[40] Most providers are not enthusiastic about employing capitation payment models, as physicians are not reimbursed for frequent visits, which sometimes leads to the avoidance of sicker patients.[41] Conversely, under the fee-for-service method, primary care physicians desire to see their patients more so they can bill for each service provided.[42] A successful (and imaginary) payment model must reach a healthy balance where physicians are paid appropriately and provide the appropriate number

34. Stenger, *supra* note 3, at 387.
35. *See* CHRISTENSEN, *supra* note 5, at 233.
36. Stenger, *supra* note 3, at 390.
37. David Margolius & Thomas Bodenheimer, *Transforming Primary Care:From Past Practice to Practice of the Future*, 29 HEALTH AFFAIRS 779, 783 (2010).
38. *Id*.
39. Merrell & Berenson, *supra* note 30, at 856.
40. *Id*. at 853.
41. Landon, *supra* note 19, at 829.
42. Margolius & Bodenheimer, *supra* note 37.

of services rendered. Until such a payment model is created, medical homes are unable to function successfully.

Clearly, healthcare reform calls for an innovated payment method, yet pilot medical homes were implemented without any resolution in this area. "New" payment methods attempt to solve the need for augmenting reimbursement.[43] Two such methods, the supplement fee and boosted fee, require a level of compliance with NCQA standards.[44] Furthermore, boosted fees exacerbate the underlying healthcare issue: too high of fees for too little service, as this method simply increases the fee-for-service method of payment.[45] This change is not revolutionary; it is just more expensive. Medical homes cannot fulfill the lofty expectations of revolutionizing primary healthcare unless this issue is addressed.

Accordingly, medical home legislation ambiguously discusses payment methods for medical homes. As a result, various forms of payment are implemented in the current pilot medical homes.[46] For example, Maryland retains a traditional fee schedule and added reimbursement for extra visits and after-hours appointments.[47] Similarly, a North Carolina Medicaid program pays participating physicians an additional small monthly fee to the usual fee-for-service.[48] Conversely, numerous states, like New Mexico[49], chose not to legislate on the payment topic at all.[50]

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43. Paula Haas, *Medical Home Model Calls for New Payment Methods: Experimentation is the Name of the Game*, AAFP (Feb. 17, 2009, 3:55 PM), http://www.aafp.org/online/en/home/publications/news/news-now/pcmh/20090217pcmhpayment.html.

44. *Id*.

45. *Id.*

46. *Id.*

47. *State Involvement in Multi-Payer Medical Home Initiatives*, NAT'L ACAD. FOR STATE HEALTH POLICY , (November 2009), http://nashp.org/sites/default/files/MedHomes_State_Chart_11-2009.pdf.

48. Berenson, *supra* note 9, at 1224.

49. *See generally* NAT'L ACAD. FOR STATE HEALTH POLICY, http://nashp.org/med-home-states/new-mexico (last visited Sept. 30, 2011) (demonstrating that no legislation was enacted regarding payment and reimbursement).

Aside from the substantive problems within each model of payment, the lack of regulation regarding payment and reimbursement methods is also troublesome. As previously mentioned, most hospitals and primary care providers are currently fee-for-service. Medical homes face the daunting task of incorporating multipayer systems without standardizing the method of payment. Confusion will ensue if medical homes must deal with one payer using per-patient-per-month payment and another preferring enhanced fee-for-service.[51] "[The Centers for Medicaid and Medicare Services (CMS)] has indicated that it will join multipayer advanced primary care demonstrations only if there is also 'substantial participation' by Medicaid and private payers and if there is a consistency in payment methods across the payers in each initiative."[52]

V. IMPLEMENTATION

Primary care physicians should not be asked to bear the burden of patient care throughout the healthcare system. Implementation of medical homes requires coordination inside and outside the primary care physician's practice.[53] Most practices, both independent and affiliated with hospitals, are not currently equipped to shift to medical homes.[54] Primary care physicians are already overwhelmed, and many may balk at the undertaking medical homes require.[55] Medical home implementation is a lengthy and laborious process for all practices, yet smaller practices may find implementation particularly difficult. Smaller practices have fewer incentives to transform as their patient base is smaller, and certain

50. *Id.* .
51. Merrell & Berenson, *supra* note 30, at 857.
52. *Id.* at 857.
53. Berenson, *supra* note 9, at 1227.
54. Robert L. Phillips Jr. & Andrew W. Bazemore, *Primary Care and why It Matters for U.S. Health System Reform*, 29 HEALTH AFFAIRS 806, 809 (2010).
55. Berenson, *supra* note 9, at 1228.

components of the medical home, such as integrated and coordinated care, are not feasible for such small practices.[56] Additionally, confusion remains regarding the target population for medical homes. While Medicaid expanded their definition of "chronic patients," many smaller practices are unwilling to redesign their practices for the small percentage of patients "eligible" for medical home care.[57]

Time constraints also intimidate practices, as the transformation to a medical home "requires a continuous, unrelenting process of change."[58] Financial distress, staff burnout, and turnover are all hindrances practices face if they attempt to transform their practices too fast.[59] A significant period of time is necessary to adjust any issues which may arise during the transition to a medical home model. The medical home transformation must not occur in incremental steps as the components are interdependent and require a simultaneous transition.[60] Furthermore, a primary care physician must allocate his or her time differently under the medical home model, yet this is impossible until the reimbursement method is dramatically transformed.[61] Proponents of medical homes gloss over the significant implementation costs and time constraints placed on the primary care physicians.

Physicians may question why they should bother to change their practice to the medical home model. Under the fee-for-service method, practitioners are reimbursed, perhaps disproportionately, as this method of payment focuses on personal visits instead of other services that may prove more

56. Berenson, *supra* note 9, at 1226-27.
57. *Id.*
58. Nutting, *supra* note 22, at 255.
59. *Id.* at 256.
60. *Id.* at 255.
61. Lawrence P. Casalino, *Analysis & Commentary A Martian's Prescription for Primary Care: Overhaul the Physician's Workday*, 29 HEALTH AFFAIRS 785, 788 (2010).

helpful to the patient.[62] Thus, this form of reimbursement promotes face-to-face service while neglecting other services that may help the patient but do not fall within the fee-for-service method.[63] Additionally, physicians fear that medical home implementation will merely increase their workload.[64] While the medical home standard preaches collaboration, particularly regarding electronic health records (EHR), between practitioners and hospitals, coordination of the patient's medical care is left to the primary care physician.[65] Specialists also lack any incentive to conform to the medical home model, and primary care physicians have little leverage over other practitioners.[66]

A significant factor in the success of medical homes is the use of EHR in collaboration with a higher level of patient care previously not achieved with paper records.[67] However, current EHR systems are frequently not compatible between hospitals and primary care physicians.[68] The updated NCQA standards emphasize collaboration and EHR, yet provide no regulations for standardization or how well the EHR systems are integrated.[69] Proponents of the standards underestimate the difficulty of merging various EHR programs. Unfortunately, hospitals do not even have centralized EHR, let alone EHR in accord with corresponding physician practices.[70] Under the Health Information Technology for Economic and Clinical Health Acts (HITECH), hospitals and practices that fail to

62. Merrell & Berenson, *supra* note 30, at 853.
63. *Id.*
64. Casalino, *supra* note 61, at 787.
65. Elliot S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1203 (2008).
66. *Id.* at 1204.
67. Berenson, *supra* note 9, at 1224.
68. Joy M. Grossman et al., *Hospital-Physician Portals: The Role of Competition in Driving Clinical Data Exchange*, 25 HEALTH AFFAIRS 1629, 1633 (2006).
69. Fisher, *supra* note 65.
70. Grossman, *supra* note 68.

implement EHR systems face penalties.[71] Such penalties include cuts in Medicaid and Medicare payments.[72] Incentives to avoid penalties encourage health systems to quickly implement EHR.[73] However, per patient costs of EHR are higher for smaller practices, placing these practices at risk for penalties associated with EHR.[74] Health reform heralds EHR as a means to reduce administrative costs in hospitals and practices[75], yet recent studies demonstrate that there is no evidence to support this conclusion.[76] Conversely, computerization may lead to increased administrative costs.[77]

VI. CONCLUSION

At this point, actual implementation of the medical home without further refinements may jeopardize the model's future use within the healthcare system.[78] Significant barriers, including payment reform, must be addressed prior to transitioning primary care practices into medical homes. Current standards promulgated by the NCQA address factors that are easily evaluated, but not the true concerns within primary care. Additionally, the implementation of delivery systems such as collaboration and EHR are greatly emphasized, but are ambiguous and impossible to complete without further standardization.[79] Physicians are unlikely to transition from their steady fee-for-service primary care practices without increased incentives. Moreover, Medicaid's current model reimbursement methods do not encourage this transition, as many pilot programs only provide financial

71. Nancy Ferris, *Health Policy Brief: 'Meaningful Use' of Electronic Health Records*, HEALTH AFFAIRS (Aug. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=24

72. *Id*.

73. *Id*.

74. Berenson, *supra* note 9, at 1226.

75. David U. Himmelstein et al., *Hospital Computing and the Costs and Quality of Care: A National Study*, 123 AM. J. MED. 40, 40 (2010).

76. *Id.* at 44.

77. *Id*.

78. Nutting, *supra* note 22, at 254.

incentives once certain standards are met. Additionally, practices must be made aware of the significant time, effort, and finances involved in transitioning into a medical home model. In sum, medical homes contain the potential to assist in transforming the primary care practice. However, without further regulation, guidance, and financial assistance in both technology development and reimbursement, medical homes will flounder and fail like other healthcare beacons of hope.

79. Stenger, *supra* note 3, at 391.

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Medicaid Managed Long-Term Care: Will it Solve Medicaid's Financial Crisis?

Jenna Steffy·

I. INTRODUCTION

The number of elderly persons in the United States continues to grow as a result of increased life expectancies and the aging baby boomer population.[1] Accordingly, the demand for long-term medical care assistance through Medicaid is certain to rise.[2] Medicaid is the dominant financing system for individuals with long-term medical needs.[3] However, Medicaid programs are bound to abide by their particular state's budget while endeavoring to meet the increased demand for long-term medical services.[4] A Medicaid system that offers managed long-term care for the elderly would help programs maintain a high quality of care as its state incurs more financial responsibility.

This article is a brief introduction to the Medicaid system and how it

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1. PAUL SAUCIER ET AL., THE PAST, PRESENT AND FUTURE OF MANAGED LONG-TERM CARE 2 (2005), *available at* http://aspe.hhs.gov/daltcp/reports/mltc.htm.

2. *Id.*

3. KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM CARE SERVICES AND SUPPORTS (Mar. 2011) [hereinafter KAISER, LONG-TERM CARE SERVICES AND SUPPORTS].

4. *Id.*

addresses managed long-term care for the elderly. Medicaid and managed long-term care programs are extremely complex. This article is intended to give a broad overview of how a managed long-term care program could integrate within the Medicaid system. This article provides a look into the bulk of long-term care expenditures by the Medicaid system, whether a managed care or fee-for-service system is most cost effective, and whether a proposed managed long-term care program should be mandatory or voluntary.

II. OVERVIEW OF MEDICAID

In 1965, the federal government created Medicaid and Medicare to provide health care entitlements to needy individuals.[5] Medicaid is the nation's primary provider of public health care coverage for millions of high-need and low-income Americans.[6] Federal and state governments jointly finance the Medicaid program; states maintain the autonomy to manage their programs while remaining consistent with broad federal guidelines.[7] Because each state has the power to control its Medicaid program, distinction between state programs is widespread.[8]

In order to qualify for Medicaid, candidates must fit into an eligibility group that is required by both federal and state law.[9] Federal law requires that candidates for Medicaid be "categorically needy" individuals.[10] The coverage groups of categorically needy individuals are persons who receive welfare, minors and the parents of minors, persons with disabilities, pregnant women, and the elderly.[11] Individuals that fall within any of the aforementioned coverage groups must also have income or economic

5. Joshua Tenzer, Note, *Reaching the Final Frontiers in Medicaid Managed Care*, 62 N.Y.U. ANN. SURV. AM. L. 329, 338 (2006).
6. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM 1 (Apr. 2010).
7. Tenzer, *supra* note 5, at 342.
8. *Id.*
9. Ctr. for Medicare & Medicaid Serv., https://www.cms.gov/MedicaidGenInfo/ (last visitedSept. 20, 2011).
10. Tenzer, *supra* note 5, at 339.
11. *Id.*

resources that fall below a certain level; the economic resource level that determines Medicaid eligibility may vary from state to state.[12] Aside from the categorically needy, states are permitted to expand their coverage to groups that are "medically needy."[13] A medically needy individual is someone who belongs to a specific coverage group and whose income or economic resources exceed the limit set for the categorically needy.[14] However, a medically needy candidate can become eligible if a certain amount of his or her income and personal resources are spent on medical care.[15] Once a medically needy candidate's expenses on medical care exceed the established state limit, Medicaid will cover any additional expenditure required for the care of that candidate.[16]

Federal law not only mandates the population that is covered by Medicaid, it also determines the services that are afforded to them.[17] Inpatient and outpatient hospital services, physician services and care within nursing facilities are among those covered under the law.[18] Congress's intent in the Medicaid statute was to provide individuals in need with the same standard of medical services received by individuals who have health insurance.[19]

III. WHAT IS MANAGED LONG-TERM CARE?

Among the millions of individuals on Medicaid, a significant portion requires long-term care.[20] Long-term care services include those provided within the community, such as doctor visits and personal care at the home, as well as institutional care, namely hospital and nursing home placement.[21] The aging process often results in decreased mobility and cognitive

12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id.* at 342-43.
18. *Id.* at 343.
19. *Id.* at 339.
20. SAUCIER ET AL, *supra* note 1, at 2.

functioning, as well as the onset of debilitating diseases.[22] This combination of factors creates the need for increased medical services on a more frequent basis.[23] Medicaid managed long-term care seeks to provide a system of care for the elderly to support them within their communities and postpone or prevent the need for institutional placement in hospitals and nursing homes.[24]

IV. ELDERLY LONG-TERM CARE EXPENSES

The average yearly cost to an individual for nursing home stay is $70,000.[25] Medicaid covers approximately fifty percent of nursing home costs.[26] Elderly individuals with income levels and assets that strip them of Medicaid eligibility can quickly become eligible due to the depletion of personal resources from an extended nursing home stay.[27] Consequently, over half of all nursing home residents will become eligible for Medicaid support due to the enormous cost.[28] Services provided by nursing homes include skilled nursing care, rehabilitative therapies, and basic custodial care.[29] Medicaid incurs the cost for approximately half of these services.[30] Managed long-term care, through an organized and coordinated system of assessing the breadth of an individual's medical needs, aims to disrupt nursing home placement by providing care to the elderly within their

21. *Id.*
22. KAISER, LONG-TERM CARE SERVICES AND SUPPORTS, *supra* note 3, at 1.
23. *Id.*
24. RICHARD KRONICK & KAREN LLANOS, CTR. FOR HEALTH CARE STRATEGIES, RATE SETTING FOR MEDICAID MANAGED LONG-TERM SUPPORTS AND SERVICES: BEST PRACTICES AND RECOMMENDATIONS FOR STATES 3 (Mar. 2008).
25. KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID AND THE UNINSURED, PAYING FOR NURSING HOME CARE: ASSET TRANSFER AND QUALIFYING FOR MEDICAID (Jan. 2006) [hereinafter KAISER, NURSING HOME CARE].
26. Thomas Day, *Guide to Long Term Care Planning: About Nursing Homes,* NAT. CARE PLANNING COUNCIL, http://www.longtermcarelink.net/eldercare/nursing_home.htm (last visited Jan. 2, 2012).
27. KAISER, NURSING HOME CARE, *supra* note 25.
28. *Id.*
29. U.S. GEN. ACCOUNTING OFFICE, MEDICAID NURSING HOME PAYMENTS: STATE'S PAYMENT RATES LARGELY UNAFFECTED BY RECENT FISCAL PRESSURES 4-5 (Oct. 2003).
30. *Id.* at 5.

communities.[31]

V. MANAGED LONG-TERM CARE VERSUS FEE-FOR-SERVICE

Services needed by Medicaid beneficiaries range from acute to long-term care.[32] Nearly all beneficiaries that require acute care receive their services through a managed care organization (MCO).[33] Alternatively, nearly all long-term care beneficiaries receive their services on a fee-for-service basis.[34] Managed care differs from the fee-for-service system because the MCO assumes either full or partial financial risk.[35] Under the traditional fee-for-service system, medical providers issue a fee for each service they provide and are reimbursed by the state's Medicaid program.[36] Fee-for-service providers are only responsible for the specific service that they provide.[37] Little incentive exists to perform the most efficient service because under this system, each service provided is reimbursed, resulting in provider profit.[38]

However, under the risk-based approach to managed long-term care, the state's Medicaid program arranges to have a single MCO, also known as a contractor, provide a package of long-term care benefits.[39] The MCO then contracts with medical providers to render medical services to the beneficiaries within their program.[40] When choosing which medical providers to contract with, the MCO may seek providers known to be cost-effective or it may choose to pay providers a capitated per patient fee.[41]

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31. KAISER, LONG-TERM CARE SERVICES AND SUPPORTS, *supra* note 3.
32. *Id.* at 1.
33. PAUL SAUCIER & WENDY FOX-GRAGE, MEDICAID MANAGED LONG-TERM CARE 1 (Nov. 2005).
34. *Id.*
35. NAT'L CONSORTIUM FOR HEALTH SYS. DEV., MEDICAID MANAGED LONG-TERM CARE: BACKGROUND BRIEF 1, *available at* http://www.nchsd.org/libraryfiles/Medicaid General/MMLTC_Brief.pdf.
36. Tenzer, *supra* note 5, at 334.
37. SAUCIER & FOX-GRAGE, *supra* note 33, at 2.
38. Tenzer, *supra* note 5, at 334.
39. SAUCIER & FOX-GRAGE, *supra* note 33, at 1.
40. Tenzer, *supra* note 5, at 336.
41. *Id.*

Medical providers with a capitated per patient fee bear the burden that the cost of each beneficiary's care will not exceed the providers' per capitated fee, impinging upon profit margins.[42] Conversely, if a medical provider does not have a capitated fee, but instead bills the MCO for each service, the MCO bears the financial risk when the cost of care exceeds the pre-set budget per beneficiary.[43] Because the MCO is responsible to pay for services that exceed its budget, it will want to provide services in full consideration of a beneficiary's entire breadth of needs as opposed to spot treating.[44]

In order for a managed long-term care program to survive under this risk-based approach, it is crucial that the amount of enrollees is of a significant size so that the MCO is able to manage the financial risk.[45] The expenditures will vary significantly among long-term care individuals.[46] A significant enrollment size is necessary to manage the risk that some beneficiaries will require more costly care than others.[47] Because the MCO assumes the financial risk, there is a strong incentive to provide quality service, which will curb the need for costly ongoing treatment resulting from inadequate care, to manage costs.[48]

The rationale behind a managed long-term care program, as opposed to fee-for-services, is that the beneficiary will receive a more organized sequence of care and that states will have the ability to hold one entity, the MCO, accountable.[49] In a fee-for-service system, where numerous medical providers deliver a variety of medical services, it is difficult and cumbersome to pinpoint accountability for any adverse consumer or system

42. *Id.*
43. *Id.*
44. SAUCIER & FOX-GRAGE, *supra* note 33, at 2.
45. NAT'L CONSORTIUM FOR HEALTH SYS. DEV., *supra* note 35, at 2.
46. KRONICK & LLANOS, *supra* note 24, at 18.
47. NAT'L CONSORTIUM FOR HEALTH SYS. DEV., *supra* note 35, at 2.
48. *Id.* at 1.
49. SAUCIER & FOX-GRAGE, *supra* note 33, at 3.

outcome.[50] Managed care programs are also appealing to states because paying a fixed amount to the MCO allows the state to stabilize its budget.[51]

VI. SHOULD A MANAGED CARE PROGRAM BE MANDATORY OR VOLUNTARY?

If states opt to provide their Medicaid coverage to the elderly through a managed long-term care program, issues arises whether the managed care program should be mandatory or voluntary.[52] Several factors control a state's decision to implement a mandatory or voluntary program.[53] First, and possibly the most determinative, is whether a state plans to integrate long-term care Medicaid services with acute-care Medicare services.[54] If a MCO has medical and financial responsibility over the services provided to a beneficiary, it makes sense that the beneficiary's entire medical needs should be assessed and managed in conjunction with one another.[55] Medicare programs must be voluntary, and any state seeking to incorporate acute and long-term care under the same MCO must do so under a voluntary program.[56] Second, population size can influence whether a program will be mandatory or voluntary because beneficiary enrollment is crucial for survival.[57] To manage the risk, MCOs must to be able to spread the financial risk over a large number of beneficiaries.[58] Lastly, a state may consider the concerns of beneficiaries and medical providers, who often prefer voluntary programs.[59] Beneficiaries are typically comfortable with the relationship they have established with their current medical provider and fear being forced into a new relationship with a different provider.[60]

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50. *Id.*
51. *Id.*
52. SAUCIER ET AL, *supra* note 1, at 10.
53. *Id.*
54. *Id.*
55. KRONICK & LLANOS, *supra* note 24, at 16.
56. SAUCIER ET AL, *supra* note 1, at 10.
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*

Additionally, many providers find convenience in the ability to bill the state directly for services provided to a Medicaid beneficiary and are discouraged from entering into a new business relationship with a MCO.[61]

VII. STUDYING THE SUCCESS

Comparing the success of managed long-term care programs and the fee-for-service system is an arduous process.[62] To begin, states exercise an enormous amount of control in the design of their program.[63] Therefore, a program in one state may vary greatly from that in another.[64] Furthermore, the implementation of managed long-term care programs into Medicaid programs is relatively new and states are still discovering the repercussions of the integration.[65] Finally, and perhaps the biggest challenge, is determining whether the switch from a fee-for-service system to managed care improved, or at least neutralized, the quality of and access to care, as well as with minimizing the cost.[66] Although it is too early to make a conclusive determination, due to increasing preventative measures taken by MCOs, there has been less reliance on costly emergency room and hospital visits.[67]

VIII. CONCLUSION

The Medicaid system plays a major role in providing medical coverage to elderly individuals within the United States. The struggling economy creates a need for the Medicaid system to find cost effective ways of providing quality care for people who have nowhere else to turn. A managed care system for individuals with long-term medical needs attempts to remove the daunting financial burden imposed solely upon federal and state governments by placing beneficiaries within a managed care

61. *Id.*
62. Tenzer, *supra* note 5, at 351.
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*

organization that can better control the quality and cost of a beneficiary's medical needs.

67. *Id.* at 351-52.

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Between Barack and a Hard Place: The Looming Struggle Facing States Under Obama's Proposed Blended FMAP Rate Changes

Karim Hussein[*]

I. INTRODUCTION

Medicaid is the largest health insurer in the United States in terms of eligible beneficiaries, covering medical services and long-term care for sixty million low-income Americans.[1] The program is funded by a federal matching program, where the federal government matches a portion of state expenditures on Medicaid services, depending on the per-capita income in each individual state.[2] Generally, this Federal Medical Assistance Percentage (FMAP) is a reimbursement to states in the range of 50% to 74.18%.[3]

In recent years, due in part to the economic downturn and states struggling to keep up with Medicaid payments for services, the American Reinvestment and Recovery Act of 2009 (ARRA), provided significant

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1. KAISER FAMILY FOUNDATION, STATE FISCAL CONDITIONS AND MEDICAID (last updated Feb. 2010), http://www.kff.org/medicaid/upload/7580-06.pdf.

2. E. Richard Brown, *Medicare and Medicaid: The Process, Value, and Limits of Health Care Reforms,* 4 J. OF PUB. HEALTH POL'Y 335, 347 (Sep. 1983).

3. Evelyne P. Baumrucker, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, CONGRESSIONAL RESEARCH SERVICE, 1 (Sep. 24, 2010), aging.senate.gov/crs/

funding increases for Medicaid.[4] The ARRA provided state fiscal relief through a temporary increase in the federal share of Medicaid costs in the amount of $87 billion, between October 2008 and December 2010.[5] During this time, all states received a 6.2% increase in their FMAP match rate, with additional increases awarded to states with higher rates of unemployment.[6] This increase was extended by H.R. 1586 (signed into law as P.L. 111-226) through June 2011, and funded with an additional $16 billion from Congress.[7] More precisely, there was a phased-down enhance match: 3.2% from January 1 to March 31, 2011, and 1.2% from April 1 to June 30, 2011.[8]

The temporary increase expired on June 30, 2011 and FMAP was reduced to pre-stimulus levels.[9] As a result, twenty-one states had lower FMAPs than they did in 2008.[10] This comes at a time when states have seen an eighteen percent increase in Medicaid enrollment from June 2007 to December 2010.[11] A provision of The Patient Protection and Affordable Care Act (PPACA) will help states cope with this loss of federal funding for Medicaid by requiring states to increase their Medicaid enrollment to all non-elderly, non-pregnant adults at or below 133% of the Federal Poverty Level (FPL) in 2014.[12] This expansion of the Medicaid program will include an increase of the FMAP reimbursement, beginning with 100% of state costs, to cover the newly eligible from 2014 to 2016, and then tapering

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medicaid6.pdf.

4. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, *at* 1.

5. *Id.* at 2.

6. Amanda Cassidy, *Extra Federal Medicaid Support Ends,* HEALTH POLICY BRIEF (Jul. 14, 2011), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=50.

7. Baumrucker, *supra* note 3, at 1.

8. *Id.* at 8.

9. Cassidy, *supra* note 6, at 2.

10. *Id.* at 2.

11. *Id.* at 1.

12. Baumrucker , *supra* note 3, at 11.

to 90% by 2020.[13]

Under President Barack Obama's proposed plan to change the PPACA provision, a new, blended FMAP rate would be imposed upon each state instead of the PPACA-mandated 100%.[14] This proposed calculation method would replace the various reimbursement rates with a single rate calculated by forecasting the level of enrollment after the implementation of the PPACA.[15] This blended rate would shift the increased costs of covering the "newly eligible" onto states, thereby decreasing federal dollars spent on Medicaid and increasing the burden on states to make up the shortfall.[16]

II. BACKGROUND

Medicaid and Medicare were part of the original movement for social insurance and public assistance following the passage of the Social Security Act of 1935.[17] While national compulsory health insurance was pursued in the 1940s, it was not until the 1960s when the government began actively implementing a system of government-subsidized healthcare.[18] The Kerr-Mills Act of 1960 expanded a previously paltry federal grant program that matched state expenditures on the "medically needy," mainly the elderly

13. *Id.*

14. White House Press Release, *The President's Framework for Shared Prosperity and Shared Fiscal Responsibility,* White House Press Release, 4 (April13, 2011), http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp.

15. *See* Edwin Park & Judith Solomon, *Proposal to Establish Federal Medicaid "Blended Rate" Would Shift Significant Costs to States Would be Hard to Set Fairly and Accurately; Would Likely Force Cuts to Children, People with Disabilities, Seniors, and Health Care Providers* [hereinafter Park & Solomon], CENTER ON BUDGET AND POLICY PRIORITIES, 2 (Jun. 24, 2011), http://www.cbpp.org/cms/index.cfm?fa=view&id=3521 (explaining that calculation of the blended rate would involve the current 100% funding levels with what the government forecasts the expected levels of enrollment will be after implementation of PPACA).

16. Park & Solomon, *supra* note 15, at 4.

17. *See generally* Brown, *supra* note 2 (tracing the history of Medicare and Medicaid though the 1930s to the 1990s and the original purposes for the establishment of social welfare programs).

18. *Id.* at 337, 342.

who needed assistance paying their medical bills.[19]

Medicaid was intended to "pick up the pieces" left behind by the Medicare program.[20]

While Medicare is an entitlement program tied to Social Security, Medicaid was originally a supplemental and need-based system meant to serve the medically needy.[21] In fact, Medicaid has been tied to welfare from its beginnings, since it was originally set in place over existing welfare programs, which were the only state social services systems in existence at the time.[22] In order to encourage poorer states to implement their respective Medicaid programs in the 1960s, the original FMAP reimbursements were as high as eighty-three percent to such states.[23] By 1972, all states except for Arizona had adopted their own Medicaid programs, which did not follow suit until 1982.[24] No major changes were made to the Medicaid program until 1995, when a republican-controlled Congress, aimed at cutting government spending, converted Medicaid to a state-run program funded by federal block grants.[25] Then, in 1997, President Clinton and Congress agreed to establish a more balanced division of authority between the federal government and the states.[26]

More recently, with the downturn of the American economy and high levels of unemployment, Medicaid enrollment levels have increased and will likely continue to grow.[27] Even with stimulus funds and increases in

19. *Id.* at 342.
20. *Id.* at 346.
21. *Id.*
22. John K. Inglegart, *The American Healthcare System –Medicaid,* 340, NEW ENG. J. MED. 403, 403 (Feb, 1999).
23. Brown, *supra* note 2, at 347.
24. *Id*.
25. Inglehart, *supra* note 22, at 405.
26. *Id.*
27. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, RISING UNEMPLOYMENT, MEDICAID AND THE UNINSURED, 1 (Jan. 2009), http://www.kff.org/uninsured/upload/7850.pdf.

FMAP calculations, twenty-nine states are projecting budget shortfalls for fiscal year 2013, which begins July 1, 2012, in the amount of forty-four billion dollars.[28] As previously discussed, President Obama and Congress responded to these budget shortfalls by passing the ARRA and the PPACA, both of which increased FMAP reimbursements to the states. However, these increases were only temporary, and Obama's newest plan calls for reducing federal funding to FMAP calculations, as mandated by the PPACA, at a time when states have not even begun to recover from the recession.[29]

III. THE PROPOSED BLENDED FMAP CHANGES

President Obama's proposed plan would replace the various FMAP matching rates that states have traditionally enjoyed with one, single blended rate.[30] While the President has not yet announced the specific details of how the blended FMAP will be calculated, the Center on Budget Policy and Priorities predicts that it will be calculated through a two-part process.[31]

First, federal officials would need to determine a "current-law" blended matching rate to determine the average FMAP calculation for each state.[32] This would involve consideration of each state's regular FMAP calculation and its higher matching rate for newly eligible individuals under the

28. Elizabeth McNichol, Phil Oliff & Nicholas Johnson, *States Continue to Feel Recession's Impact,* CENTER ON BUDGET AND POLICY PRIORITIES, 1 (Jan. 9, 2012), http://www.cbpp.org/files/9-8-08sfp.pdf.

29. Michael Leachman, Erics Williams & Nicholas Johnson, *Failing to Extend Fiscal Relief to States Will Create New Budget Gaps, Forcing Job Cuts and Job Loss in at Least 34 States More Cuts in Health, Education and Other Areas Could Stall Nation's Economic Recovery,* CENTER ON BUDGET AND POLICY PRIORITIES, 1 (Aug. 13, 2011), http://www.cbpp.org/cms/index.cfm?fa=view&id=3207.

30. Park & Solomon, *supra* note 15, at 1.

31. Park & Solomon, *supra* note 15, at 6.

32. *Id.*

PPACA.[33] Then, federal officials could determine what each state's current federal funding level is under the current mix of matching rates.[34] Second, federal officials would then reduce this "current-law" blended matching rate by a specified percentage in order to reduce the overall federal expenditures on state Medicaid programs.[35] Unfortunately, this would ensure all states receive less funding than they otherwise would in 2014 under the PPACA.[36]

The rate calculation would also include assumptions made by federal officials in determining the projected increases in enrollment.[37] In order to determine the first part of this rate, officials would need to estimate how many newly eligible people are likely to enroll in each state under the PPACA Medicaid expansion.[38] Additionally, officials will need to estimate the current health status of the newly eligible so that they can determine whether costs for covering this group would be higher or lower than those already covered.[39]

IV. INCREASED FINANCIAL PRESSURE ON STATES

As a condition of accepting any Medicaid funds moving forward, the PPACA requires the states to comply with maintenance of effort (MOE) provisions that require them to maintain existing eligibility levels until state exchanges become operational in 2014.[40] However, this is difficult for states to do with high levels of unemployment and increases in Medicaid enrollment.[41] If the new blended FMAP rate is implemented, states will no

33. *Id.*
34. *Id.* at 2.
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id*. at 7.
40. Letter from Department of Health & Human Services to State Medicaid Directors, 1 (Feb 25, 2011), *available at* https://www.cms.gov/smdl/downloads/SMD11001.pdf, [hereinafter *DHHS Letter*].
41. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.

longer have an incentive to increase the number of enrollees because they will not be able to receive the increased levels of reimbursement to cover the newly enrolled. This frustrates the original purpose of the PPACA's extension of Medicaid, since states will no longer be receiving 100% reimbursement for the newly eligible enrollees.[42] Accordingly, some states have already applied for exceptions to the MOE requirements, which allow states an exemption from enrolling certain adults if they have a projected budget deficit.[43]

In the wake of the enhancements to FMAP reimbursement rates that expired in 2011, states have implemented cuts to state programs, including Medicaid.[44] Additionally, outside of Medicaid funding, 2011 state budgets had to account for the dropping off of the ARRA funding that further constricted their budgets and exacerbated gaps in state funding.[45] "Without the ARRA funds and Medicaid eligibility protections, states may face considering severe cuts to Medicaid provider payment rates, benefits and eligibility cuts."[46]

VI. THE WINNERS AND LOSERS OF A BLENDED FMAP CALCULATION

The obvious winner of reduced federal spending on Medicaid is the federal government, while the losers will be spread among providers, states, and the medically needy. The increased pressure on states to make cuts to their respective Medicaid programs is substantial, especially considering the various cuts and reductions in services states have already made. Although most states have begun the road to economic recovery, they are now faced with both dried up ARRA funding[47] and the possibility for reduced federal

42. Park & Solomon, *supra* note 15, at 3.
43. DHHS Letter, *supra* note 40, at 4.
44. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.
45. *Id.*
46. *Id.*
47. THE FISCAL SURVEY OF STATES, NAT'L GOVERNORS ASS'N & NAT'L ASS'N OF ST.

matching funds through this blended FMAP rate. In 2010, during the temporary ARRA increases to FMAP reimbursement, Medicaid accounted for twenty-two percent of total state spending.[48] Now that these funds are being reduced with the expiration of the ARRA, state spending on Medicaid is expected to jump nearly nineteen percent in fiscal year 2012, with federal funds decreasing by thirteen percent.[49] These figures are not taking into account the proposed FMAP changes.

It is not only states that will lose out if the proposed blended FMAP rate goes into effect. Providers too, will feel this tightening of purse strings, as thirty-three states will be reducing already low provider rates, and sixteen states will be freezing rates in fiscal year 2012.[50] This comes at a time when ten states will see their Medicaid enrollment increase by ten percent or more.[51] The medically needy, those who depend on Medicaid as their sole source of health insurance, will feel these reductions in spending too, as twenty-seven states will reduce spending on prescription drug benefits, twenty-one states will require new or higher copayments, and eight states will reduce their coverage of long-term care.[52]

V. CONCLUSION

The President's proposal to blend FMAP calculations state-by-state will only result in less funding to states for their respective Medicaid programs at a time when they are already experiencing budget shortfalls.[53] While the country struggles to recover from the recession, and with the passage of comprehensive health reform, reducing funds for Medicaid at this crucial

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BUDGET OFFICERS, viii (Spring, 2011) [hereinafter FISCAL SURVEY].

48. *Id.* at 51.
49. *Id.*
50. *Id.*
51. *Id.* at 53.
52. *Id.* at 57.
53. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.

time will only be counter-productive and lead to a decrease in coverage and services for Medicaid enrollees across the country.[54]

Health reform was intended to provide coverage to a larger portion of the uninsured by increasing eligibility.[55] Reducing federal payments to states for Medicaid will cause at least thirty-four states to cut jobs and services.[56] Once these cuts are made, states will receive even less federal funding, since their ability to commit funding to their Medicaid programs will be severely hindered. Because their funding commitments will be reduced, and Medicaid is based on the federal match, smaller funding commitments will leave states eligible for lower federal matches, as they will only receive matching federal funds on the dollars they are able to commit.[57]

Medicaid was enacted to provide public assistance for the poor and other low-income individuals who were not receiving adequate medical care, as previously discussed.[58] Unfortunately, President Obama's new plan puts the PPACA-mandated funding levels in jeopardy with the goal of saving federal funds.[59] This will come at great cost to states, providers, and the medically needy in states that depend on Medicaid funding from the federal government.[60] The proposed blended FMAP calculation is flawed, and will only lead to decreases in funding for Medicaid and ultimately, decreases in Medicaid enrollment.

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54. Leachman, *supra* note 29 at 1.

55. Baumrucker, *supra* note 3, at 10.

56. Leachman *supra* note 29 at 2.

57. *See* Robert Helms, *The Medical Commission Report: A Dissent,* AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH HEALTH POLICY OUTLOOK, 3 No. 2, January 2007 (discussing the FMAP reimbursement system and the extreme pressure on states to fund their Medicaid programs to obtain the federal matching dollars, and that the less money states have to commit to their Medicaid programs, the less they will be able to receive as reimbursement).

58. *See generally* Brown, *supra* note 2 (tracing the history of Medicare and Medicaid though the 1930s to the 1990s and the original purposes for the establishment of social welfare programs).

59. Park & Solomon *supra* note 13 at 2.

60. *Id.*

ANNALS OF HEALTH LAW
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The Repeal of PPACA's Maintenance of Eligibility Requirement: An Unhealthy Outcome

Emily Lowe[*]

I. INTRODUCTION

Throughout the current economic recession, incomes have declined, unemployment has increased, and, as a result, many individuals have lost their employer-sponsored health coverage.[1] This has led to increased enrollment and spending for government-funded health programs.[2] In 2008, the number of uninsured children in the United States was at the lowest level since 1987.[3] State revenues have since declined, however, making it difficult for states to afford the increase in spending this has produced.[4] Adding to states' responsibilities, the Patient Protection and Affordable Care Act (PPACA) was passed on March 23, 2010, which requires, inter alia, that states maintain eligibility and enrollment standards known as maintenance of eligibility provisions (MOE) in order to continue to receive federal Medicaid funds.[5]

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1. KAISER COMM'N ON MEDICAID AND THE UNINSURED, STATE FISCAL CONDITIONS AND MEDICAID, 1 (October 2010), *available at* http://www.kff.org/medicaid/upload/7580-07.pdf.
2. *Id.*
3. KATHLEEN SEBELIUS, HEALTH & HUMAN SERVICES, CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT: ONE YEAR LATER CONNECTING KIDS TO COVERAGE 7 (2011), http://www.insurekidsnow.gov/chip/chipra_anniversary_report.pdf.
4. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 1, at 1.
5. *Id.*

Under the PPACA, "states cannot impose eligibility and enrollment policies that are more restrictive than those in place at the time the [law] was enacted."[6] In this era of cuts to Medicaid and Children's Heath Insurance Program (CHIP) eligibility, the MOE has been a leading factor in keeping children enrolled throughout the recession.[7] In fact, according to the Congressional Budget Office (CBO), by 2019, sixteen million additional individuals will be insured under Medicaid and CHIP then would have been without the requirements.[8] However, some governors assert, among other critiques, that the MOE puts an unreasonable strain on already tight state budgets, leading them to cut other essential public welfare programs.[9] This article weighs arguments from both the critics and supporters of the PPACA's MOE requirements and analyzes the potential impact of its repeal.

II. A BRIEF INTRODUCTION TO CHILDREN'S HEALTH INSURANCE PROGRAM

Written by the late Senator Edward Kennedy, CHIP was created with the intention that tobacco products would be taxed to help finance health care coverage for children.[10] Today, CHIP provides low-cost health insurance coverage to children whose families earn too much to qualify for Medicaid coverage yet cannot afford to purchase private health insurance.[11] Since CHIP was first implemented, over five million uninsured children have

6. KAISER COMM'N ON MEDICAID AND THE UNINSURED, UNDERSTANDING THE MEDICAID AND CHIP MAINTENANCE OF ELIGIBILITY REQUIREMENTS 1 (2011), http://www.kff.org/healthreform/upload/8061.pdf.

7. *See id.* and accompanying text (noting that MOE maintains CHIP coverage).

8. Dennis M. Barry, Charles A. Luband & Holley Thames Lutz, *The Impact of Healthcare Reform Legislation on Medicare, Medicaid and CHIP*, 2d HEALTH L. PRAC. GUIDE, Ch. 3 (2010).

9. *US Federal Government's One-Sized-Fit-All Medicaid Program Does Not Work for. . .*, BIGGOVCARE.COM (Jan. 8, 2011), http://biggovcare.com/government-health-news/us-federal-governments-one-size-fit-all-medicaid-program-does-not-work-for.

10. Susan Milligan, *Clinton Role in Health Program Disputed*, BOSTON GLOBE, Mar. 14, 2008, http://www.boston.com/news/nation/articles/2008/03/14/clinton_role_in_health_program_disputed/?page=full.

11. Texas Department of Insurance, *Texas Health Options – Health Insurance Information for a Parent or Guardian,* (Jan. 16, 2012, 2:46 PM) http://www.Texashealthoptions.com/cp/children.html.

been covered by the program.[12]

The program was reauthorized on February 4, 2009, when President Barack Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA).[13] The reauthorization provided additional funding to renew CHIP and to help make CHIP and Medicaid coverage available to more children.[14] In 2009 alone, nearly 2.6 million previously-uninsured children received insurance coverage through CHIP.[15] States have accomplished this by creating online registration processes along with other streamlined enrollment procedures.[16] The spike in CHIP enrollment illustrates the success of CHIPRA, for a key goal of the Act was to make it easier for low-income families to enroll in the program.[17]

III. AFFORDABLE CARE ACT AND CHIP MAINTENANCE OF ENROLLMENT

The PPACA was designed to address states' attempts to cut Medicaid costs by tightening eligibility requirements and reducing services.[18] Since insurance companies do not always provide coverage when patients are in need, a major goal of the PPACA was, "to put American consumers back in charge of their health coverage. . ."[19] The PPACA improves the health care system by expanding coverage to include more children.[20] For instance,

12. *National Chip Policy*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 4, 2011, 7:06 AM) https://www.cms.gov/nationalchippolicy/.

13. SEBELIUS, *supra* note 3, at 4.

14. *Id.*

15 *Id.* at 1.

16. KAISER COMM'N ON MEDICAID AND THE UNINSURED, ONLINE APPLICATIONS FOR MEDICAID AND/OR CHIP: AN OVERVIEW OF CURRENT CAPABILITIES AND OPPORTUNITIES FOR IMPROVEMENT, 1 (June 2011), *available at* http://www.cbpp.org/files/6-27-11health.pdf.

17. *See* SEBELIUS, *supra* note 3, at 4 (stating that one of CHIP's goals is to incentivize enrollment for children).

18. CTR. FOR CHILDREN & FAMILIES, HOLDING THE LINE ON MEDICAID AND CHIP: KEY QUESTIONS AND ANSWERS ABOUT HEALTH CARE REFORM'S MAINTENANCE-OF-EFFORT REQUIREMENTS 1 (2010), *available at* http://ccf.georgetown.edu/index/holding-the-line-on-medicaid-and-chip.

19. *Fact Sheet The Affordable Care Act's New Patient's Bill of Rights*, HEALTHREFORM.GOV (June 22, 2010), http://www.healthreform.gov/newsroom/newpatients_bill_of_rights.html.

20. Farra Bracht, *The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Program*, Legislative Analyst's Office, May 13, 2010, http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.aspx.

job-based and new individual health plans are no longer allowed to deny coverage for children based on a pre-existing disability or condition.[21]

Moreover, the PPACA helps reduce variations in eligibility between states.[22] Even though it is not a requirement for states to participate in Medicaid, all fifty do.[23] However, state involvement varies greatly.[24] In 2014, when the Medicaid expansion takes full effect, the extreme variations that are present between states will be eliminated to a great extent because of the uniformity inherent in the PPACA's requirements, including state benefit exchanges.[25]

The PPACA requires states to offer an American Health Benefit Exchange through which individuals can purchase coverage, with reduced payments for individuals and families with income between 133% and 400% of the federal poverty level.[26] Until these state exchanges become fully operational, the PPACA requires states to maintain existing income eligibility levels.[27] The CHIP MOE, for example, requires maintenance of CHIP "eligibility standards, methodologies and procedures" as a condition of continued Medicaid funding, with certain exceptions.[28] The MOE requirement for adults is expected to last through January 1, 2014 and is extend through September 30, 2019 for children.[29]

There is an exception for states that are experiencing a current or

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21. *Families with Children and the Affordable Care Act*, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/08/families.html (last visited Sept. 25, 2011).

22. JULIETTE FORSTENZER ESPINOSA, RESEARCH INSIGHTS: REIMAGING FEDERAL AND STATE ROLES FOR HEALTH REFORM UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, ACADEMY HEALTH 2 (Feb. 3, 2010).

23. *Id.*

24. *Id.* at 2.

25. *Id.* at 4.

26. *America's Agenda Recommendations in the Patient Protection and Affordable Care Act: Building Blocks for a Cost-Effective, High Quality Health System*, AMERICA'S AGENDA, http://www.americasagenda.org/Campaigns/Federal-Campaigns/Proposals-in-the-PPACA.aspx (last visited Sept. 29, 2011).

27. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 6, at 5.

28. CTR. FOR MEDICARE & MEDICAID SERVS., THE AFFORDABLE CARE ACT MAINTENANCE OF EFFORT (MOE)-QUESTIONS & ANSWERS, (2011), *available at* http://www.cms.gov/smdl/downloads/SMD11001.pdf.

29. CTR. FOR CHILDREN & FAMILIES, *supra* note 18, at 2.

projected budget deficit.[30] If the state can verify the deficit they may qualify for an exemption for non-pregnant,[31] non-disabled adults above 133% of the federal poverty line (FPL) through 2014.[32] However, if non-exempt states do not comply with either the Medicaid or CHIP MOE requirements, their federal Medicaid funds will be at risk; the state could lose all Medicaid funding.[33] Given such a high penalty, states are encouraged to come into compliance with the PPACA's MOE requirement in order to maintain state funding.

IV. CRITICS OF MOE

There has been widespread criticism concerning the MOE requirements, especially among politicians.[34] In a letter to Congress, nine Republican governors, past and present, call the maintenance requirements "unconscionable" because, as they put it, they force states to cut critical programs, "in order to fund a 'one-size-fits-all' approach to Medicaid."[35] With the economy in recession, unemployment rising, and the number of eligible Medicaid recipients increasing, coupled with the fact that the average allocation to Medicaid is twenty percent of an entire state's budget, it is no surprise that the budget deficits are at the forefront of the political scene.[36] Texas Governor Rick Perry agrees, stating that it "imposes unnecessary financial burdens on already strapped state budgets. . ."[37] Critics highlight this concern, noting that the new law fails to address how states are supposed to manage these new, increased costs for either existing

30. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 1, at 5.
31. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 6, at 1.
32. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 1, at 5.
33. *See id.* and accompanying text (noting that states may lose all Medicaid funds).
34. *Id.*
35. Jocelyn Guyer, *States Should Seek a Balanced Approach to Maintaining Medicaid* (Jan. 7, 2011, 6:06 PM), http://theccfblog.org/2011/01/states-should-seek-a-balanced-approach-to-maintaining-medicaid.html.
36. FORSTENZER ESPINOSA, *supra note 22, at 3.*
37. *US Federal Government's One-Sized-Fit-All Medicaid Program Does Not Work for. . .*, *supra* note 9.

or newly eligible Medicaid recipients.[38]

The PPACA's MOE requirement has faced backlash concerning the requirement's interference with states' control.[39] Absent federal involvement, Medicaid and CHIP implementation varies greatly among the states.[40] However, passage of the PPACA and implementation of its requirements, including the MOE, limit states' flexibility in creating new policy or procedure around Medicaid or CHIP.[41]

In addition to budget and constitutional violation concerns, critics claim that the requirement also interferes with states' ability to reduce fraud and waste, including improper payments within the federal health care programs.[42] Whatever their reasons, critics of the MOE provision have a common goal: to see the MOE requirement repealed.[43] According to the Kaiser Commission, a repeal of the requirements would allow states to roll back eligibility standards and impose more restrictive enrollment procedures.[44] Then, many states could tighten enrollment procedures, "resulting in reductions in caseload in a less visible way than cutting eligibility levels."[45]

V. SUPPORTERS OF MOE

Despite critic pushback, supporters contend that the MOE requirements have been extremely beneficial throughout this economic recession.[46] In her January 2011 article, Jocelyn Guyer, executive director at Georgetown's Center for Children and Families, emphasized that the requirements have been extremely effective in stabilizing coverage for children in families

38. ESPINOSA, *supra* note 22, at 2–3.
39. *Id.* at 1
40. *Id.* at 2.
41. *Id.*
42. SARAH LUECK, CTR. ON BUDGET & POL'Y PRIORITIES, MAINTENANCE-OF-EFFORT REQUIREMENT DOES NOT STOP STATES FROM FIGHTING FRAUD 1 (June 6, 2011), *available at* http://www.cbpp.org/files/6-6-11health.pdf .
43. Guyer, *supra* note 35.
44. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 6, at 2.
45. *Id.*
46. Guyer, *supra* note 35.

without job-related insurance.[47] For example, in June of 2010, Arizona planned to completely eliminate its CHIP program.[48] This would have left approximately 47,000 children without insurance.[49] Because of the MOE requirements, however, enrollment in CHIP for underprivileged children has to date remained consistent.[50]

The increased standardization between states' eligibility for Medicaid and CHIP has also been a point supporters emphasize.[51] Additionally, experts speaking at a panel discussion on the health care reform in February 2010, explained that "increases in state spending" under PPACA will be "small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted."[52] While this may not eliminate all of the critics' apprehensions, it should ease the common concern regarding already-stretched state budgets.[53]

Despite the belief of some that the MOE standards impede states' efforts to reduce fraud, waste and abuse, supporters claim that is far from the truth.[54] As stated in recent testimony, "the MOE does *not* affect any of the tools and initiatives that states. . . [or the federal government] . . . use to combat fraud and abuse. . ."[55] They argue that, "[i]n fact, anti-fraud activities have increased since the MOE was enacted as part of the Affordable Care Act."[56] In particular, additional tools to assist these problem areas have been provided by the PPACA to the Centers for

47. *Id.*
48. *Id.*
49. *Id.*
50. JUDITH SOLOMON, CTR. ON BUDGET & POL'Y PRIORITIES, REPEALING HEALTH REFORM'S MAINTENANCE OF EFFORT PROVISION COULD CAUSE MILLIONS OF CHILDREN, PARENTS, SENIORS, AND PEOPLE WITH DISABILITIES TO LOSE COVERAGE 3 (February 24, 2011), *available at* http://www.cbpp.org/files/2-10-11health.pdf.
51. ESPINOSA, *supra* note 22, at 2.
52. *Id.* at 3.
53. Kathryn Nix, *Wyden-Brown Won't Give States the Flexibility they need to Reform Health Care* (Feb. 14, 2011), THE FOUNDARY, http://blog.heritage.org/2011/02/14/wyden-brown-won%e2%80%99t-give-states-the-flexibility-they-need-to-reform-health-care/.
54. LUECK, supra note 42, at 1.
55. *Id.*
56. *Id.* at 2.

Medicare and Medicaid Services (CMS).[57] For instance, the PPACA includes heightened requirements for screening payments for providers and suppliers, along with oversight controls such as payment caps.[58] Kimberly Brandt, Director of Program Integrity Group, explained that these additional requirements will allow states to focus their resources on addressing the areas of greatest concern, not vice versa.[59] Moreover, it is not the actions of underprivileged patients, but the health care provider's actions that lead to fraud and abuse in Medicaid.[60] Additionally, the MOE does not affect efforts to identify and remedy Medicaid payment errors that do not involve fraud or abuse.[61]

Policy-makers expect that, when fully implemented, ninety-five percent of Americans will be covered, primary care services will have expanded, and cost-cutting programs and procedures will have been created.[62] Predictions aside, supporters disapprove of a repeal because it would make it more difficult for eligible individuals to obtain and maintain health coverage.[63]

VI. IMPACT OF REPEAL

Currently, H.R. 1683, the State Flexibility Act, is under consideration by Congress.[64] The bill, if passed, would repeal the MOE requirements in the PPACA, and according to the CBO, would reduce federal deficits by an estimated $2.1 billion over the next nine years.[65] "In 2016, CBO estimates that half of the states would end their CHIP programs. . ." and enrollment in

57. Kimberly Brandt, Dir., Program Integrity Grp., Reducing Fraud, Waste and Abuse in Medicare, Testimony Before the Committee on Ways and Means (April 19, 2011), http://www.hhs.gov/asl/testify/2010/06/t20100615a.html.
58. *Id.*
59. *Id.*
60. Lueck, *supra* note 42, at 1.
61. *Id.*
62. ESPINOSA, *supra* note 22, at 5.
63. SOLOMON, *supra* note 50, at 5.
64. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 6, at 2.
65. *Id.*

employer-based coverage would increase.[66] Moreover, compared to CHIP, enrollees would be required to pay a larger share of the cost for insurance through the exchanges.[67]

However, the true impact of legislation would be that many low-income children would lose their Medicaid coverage and have no source of insurance.[68] Currently, MOE provisions ensure eligibility standards and their application and renewal procedures do not get altered.[69] However, if the MOE requirements were to be repealed, states would be able to tighten their enrollment procedures by requiring extra paperwork and adopting other procedural barriers.[70] Unfortunately, this would cause many families to lose insurance coverage.[71] For example, in 2003, Washington state began requiring families to reapply every six months (rather than once every year) to maintain their children's Medicaid eligibility.[72] The state also began requiring families to provide pay stubs to verify family income, instead of using state earnings databases.[73] According to the Center on Budget and Policy Priorities, consequently, over the following two years, over 30,000 of Washington's children lost coverage.[74] Then in January 2005 when "the state restored its previous 12-month eligibility period[,] 30,000 children gained coverage by the end of the year."[75] Likewise, roughly 1.4 million adults and children lost coverage in the current recession because thirty-four states cut back Medicaid and CHIP eligibility in the early 2000s.[76]

Finally, "if states curtail [CHIP] eligibility now, they will [likely] have to increase their Medicaid budgets by much greater amounts when the

66. *Id.*
67. *Id.*
68. LUECK, *supra* note 42, at 1.
69. SOLOMON, *supra* note 50, at 6.
70. *Id.* at 5–6.
71. LUECK, *supra* note 42, at 1, 3.
72. SOLOMON, *supra* note 50, at 6.
73. *Id.*
74. *Id.*
75. *Id.*

Medicaid expansion takes effect in 2014, because they will have to add back the beneficiaries they dropped. . .".[77] States would then be responsible for an average of forty-three percent of those costs.[78] This evidence illustrates the devastating effect an MOE repeal could have on the state budget, in addition to low-income families and their children.

VII. CONCLUSION

With a repeal of PPACA's MOE provisions and in an effort to reduce state spending, states could scale back Medicaid and CHIP eligibility or tighten enrollment procedures.[79] While this might put less pressure on state budgets, as found by the Kaiser Foundation on Medicaid and the Uninsured, "it would also result in a loss of federal matching funds and more uninsured [children] prior to the implementation of the coverage expansions under [the PPACA] in 2014."[80] CBO estimates that those who lose CHIP or Medicare eligibility based on the H.R. 1683 would not lose coverage because they would enroll in employment-sponsored health care.[81] However, these estimates seem to forget our current economic climate and its effect on health care coverage. Until we can be confident that few will lose coverage and that money will in fact be saved, repealing an effective health insurance system would be irresponsible, if not completely devastating on the health and safety of our nation's children.

76. *Id.* at 8.
77. *Id.* at 9.
78. *Id.*
79. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 6, at 2.
80. *Id.*
81. *Id.*

ANNALS OF HEALTH LAW
Advance Directive

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Access to Medicaid for the Mentally Ill: PPACA's Effect on Payment of Mental Health Services

*Logan Parker**

I. INTRODUCTION

The prevalence of mental illness in our country causes more disability than any other class of illness.[1] "One in four Americans experience a mental disorder at one point in their lives. . ."[2] "The most serious of these conditions affect 10.6 million people," with twice as many Americans living with schizophrenia than with HIV/AIDS.[3] Additionally, Americans suffering from a mental disorder are significantly more likely to be uninsured.[4] Therefore, those who suffer from a mental illness may find it difficult to find and pay for the services they need.

However, Medicaid can help alleviate some of the stress associated with paying for mental health services. Medicaid is the nation's largest health

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1. NATIONAL ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES 2009: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS, http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459. (last visited August 30, 2011) [hereinafter NAMI].

2. *Id.* at ix.

3. *Id.*

4. Rachel Garfield et al., *The Impact of National Health Care Reform on Adults with Severe Mental Disorders*, 168 AM. J. PSYCHIATRY 486, 490 (2011).

insurance program that aids millions of low-income individuals.[5] In recent years, Medicaid has become the largest payer in the mental health system.[6] Treatment of mental illnesses can be expensive, even with government sponsored heath care coverage like Medicaid. Today, that is even more the case.

With the effects of the recent economic recession still lingering, newspaper and Internet headlines continue to report nationwide budget cuts to health services. In 2009, the National Alliance on Mental Illnesses (NAMI) took aim at the problems of the American healthcare system in its annual report, *Grading the States*.[7] The United States mental health system, as a whole, received a dismal grade of "D," which publishers attributed to the growing need for financial assistance by the influx of new mental health sufferers into the system.[8] However, hope is on the horizon for these individuals. In the years to come, the issues concerning payment of mental health services may finally be solved. The Patient Protection and Affordable Care Act (PPACA) has several beneficial provisions, including mental health coverage under Medicaid expansion that is set to greatly increase service and funding for those suffering from mental illness.[9] The PPACA, once fully implemented in 2019, is expected to lead to an additional 2.3 million new users of mental health services.[10] Thus, uninsured individuals with mental conditions are likely to gain coverage under Medicaid expansion.

The focus of this article will be to provide an overview of Medicaid. Next, it will explain the provisions of the PPACA that authorize the expansion of Medicaid coverage to many uninsured Americans living with

5. Diane Rowland et al., *Accomplishments and Challenges in Medicaid Mental Health*, 22 HEALTH AFF. 73, 74 (2003).
6. *See* NAMI, *supra* note 1, at 6.
7. *Id.* at 18.
8. *Id.* at 54.
9. Rachel Garfield et al., *Health Reform and the Scope of benefits for Mental Health and Substance Use Disorder Services*, 61 PSYCHIATRIC SERVS. 1081, 1081 (2010).
10. Garfield, *supra* note 4, at 490.

mental illness. Additionally, this article will discuss the effects of Medicaid reform on mental health coverage and analyze whether the reform will improve access to Medicaid for the mentally ill.

II. MEDICAID OVERVIEW

Medicaid was enacted in 1965 under the Social Security Amendments.[11] It is now the primary program for providing comprehensive and affordable health care coverage to over sixty million low-income individuals,[12] paying up to sixty-five cents for every dollar of care provided.[13] Medicaid is also the largest source of financing for nursing home and community-based long-term care, and it provides essential funding as a "safety net" upon which many Americans rely.[14] It also provides coverage for children, maternity matters, and nearly nine million low-income Medicare beneficiaries, commonly referred to as "dual eligibles."[15]

Furthermore, Medicaid also covers a broader range of behavioral health services than Medicare or private insurance.[16] The program is a lifeline for people suffering from mental illness, and since its enactment it has paid part of or all of the costs of care associated with individuals suffering from mental illness.[17] This includes prescription medications.[18] Medicaid does not, however, reimburse patients for treatment in state Institutions for Mental Disease (IMD).[19]

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11. *Overview Medicaid Management Information Systems* (2011), CTR. FOR MEDICARE & MEDICAID SERVS. (Sept. 9, 2011, 10:21 AM), http://www.cms.gov/mmis.

12. THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID MATTERS: UNDERSTANDING MEDICAID'S ROLE IN OUR HEALTH CARE SYSTEM (2011), available at http://www.kff.org /medicaid/upload/8165.pdf [hereinafter KAISER, MEDICAID].

13. David C. Main & Melissa M. Starry, *The Effect of Health Care Reform on Hospitals: A Summary Overview* (2010), PILLSBURY LIFE SCIENCES & HEALTH CARE, 4 [hereinafter Main & Starry].

14. KAISER, MEDICAID, *supra* note 12, at 1.

15. *Id.*

16. Garfield, *supra* note 9, at 1082.

17. Joanmarie Davoli, *No Room at the Inn. How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. OF L. & MED. 160, 163 (2003).

18. Garfield, *supra* note 9, at 1082. (In 2007, among individuals who were treated for mental illnesses, 84% received pharmacotherapy.).

19. *See* MEDICAID DISCRIMINATION AGAINST PEOPLE WITH SEVERE MENTAL ILLNESS,

Currently, Medicaid is experiencing difficulties such as the high costs of some medications[20] and states budget cuts that specifically target mental health services.[21] For example, the state of Illinois stopped automatically prescribing seventeen brand name psychotropic drugs to individuals on Medicaid in order to save costs.[22] The changes are meant to trim $90 million annually from the $14 billion Medicaid budget of Illinois, which accounts for nearly a quarter of the state spending.[23] Likewise, the state of Utah shifted money away from services for the uninsured, specifically decreasing the funding to mentally ill citizens by forty percent.[24] In Arizona, lawmakers have slashed $65 million from mental health services since 2008.[25] According to the National Association of State Mental Health Program Directors, at least $2.1 billion has been collectively cut from state mental health budgets in the last three fiscal years alone.[26]

With continued budget cuts taking place, it is hard to imagine any meaningful improvement in NAMI's evaluation of the condition of America's mental health care system.[27] However, the PPACA may help to solve many of the issues related to uninsured individuals and payment of mental health services.

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http://treatmentadvocacycenter.org/resources/473?task=view (last visited August 30, 2011).

20. *See* Garfield*, supra* note 9*,* at 1082 ("Approximately a quarter of currently uninsured adults. . . experience serious. . . psychological distress. . .; and over 6% of uninsured adults show indications of having a serious mental illness. Similarly, more than a quarter uninsured youths report a past-year major depressive episode."); *see also* Rowland, *supra* note 5, at 73.

21. *See, e.g.*, John Keilman, *Illinois Limits Psychiatric Drugs for Medicaid Patients*, CHI. TRIB., Sept. 7, 2011 at 1, *available at* http://www.chicagotribune.com/news/local/ct-met-mediciad-drugs-20110907,0155283.story.

22. *Id.*

23. *Id.*

24. Julia Lyon, *Deep Budget Cuts Coming for Utah's Mentally Ill*, THE SALT LAKE TRIB., Aug. 27, 2001 at 1, *available at* http://www.sltrib.com/sltrib/news/52420332-78/medicaid-health-mental-ill.html.csp.

25. Betty Ann Bowser & Lea Winerman, *State Budget Cuts Slash Mental Health Funding*, PBS NEWS HOUR (Jan. 17, 2011, 1:37 PM), http://www.pbs.org/newshour/rundown/2011/01/state-budget-cuts-slash-mental-health-funding.html.

26. Marc Lacey et al., *States' Budget Crises Cut Deeply Into Financing for Mental Health Programs*, N.Y.TIMES, Jan. 20, 2011 at 1, http://www.nytimes.com/2011/01/21/us21mental.html?_r=1.

27. NAMI, *supra* note 1, at 54.

III. PPACA REVISIONS

On March 23, 2010, President Barack Obama signed the PPACA into law.[28] A number of the key financing reforms to expand Medicaid will not be implemented until January 1, 2014.[29] However, a few provisions are already in effect, and others will be phased in over the next several years, until the law is fully implemented in 2019.[30]

PPACA makes sweeping changes to the U.S. health care system.[31] The law requires the creation of health insurance exchanges to provide individuals and small employers with access to insurance.[32] Additionally, the PPACA increases access to health insurance coverage by extending funding to the Children's Health Insurance Program (CHIP), and subsidizing private insurance premiums and cost-sharing for certain lower-income individuals enrolled in exchange plans.[33] It also includes several changes to the regulation of insurance, such as the extension of dependent coverage through age twenty-six, which aims to increase availability and affordability of coverage.[34] It will likely solve many of the states' issues with funding services, because the federal government will pay 100% of the cost for newly eligible individuals from 2014 through 2016.[35] That percentage will gradually reduce after 2017.[36] Finally, the PPACA expands Medicaid and makes coverage available to individuals with incomes up to 133% of the federal poverty level.[37] This amounts to approximately $14,404 for individuals and $29,327 for a family of four,[38] regardless of

28. THE HENRY J. KAISER FAMILY FOUNDATION, FOCUS ON HEALTH REFORM: SUMMARY OF NEW HEALTH REFORM LAW 1 (2010). [hereinafter KAISER, SUMMARY]
29. *Id.* at 2.
30. *See generally*, THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL 2 (2010).
31. *See* Main & Starry, *supra* note 13, at 1.
32. *See* KAISER, SUMMARY, *supra* note 27, at 1-2.
33. *Id.*
34. Garfield, *supra* note 9, at 1081.
35. KAISER, SUMMARY, *supra* note 27, at 1-2.
36. *Id.*
37. ACA § 2001(a) (to be codified at 42 U.S.C.§ 1396(a)).
38. THE HENRY J. KAISER FAMILY FOUNDATION, EXPANDING MEDICAID: COVERAGE FOR

traditional eligibility categories like health status, pre-existing conditions, and family composition.[39]

Coverage of mental health services is further extended through the inclusion of behavioral health treatment and prescription drugs under "Essential Health Benefits."[40] States will now be allowed to enroll mentally ill citizens in "benchmark" plans.[41] Federal law defines "benchmark" coverage "as that equal to the Federal Employees Blue Cross/Blue Shield preferred provider organization plan. . ."[42] For example, the newly covered individuals with mental illnesses will have the same "coverage available to state employees, coverage offered by the health maintenance organization with the state's largest commercially enrolled population, or other coverage approved by the U.S. Secretary of Health and Human Services."[43] "Benchmark equivalent" coverage includes basic specified services and has an aggregate actuarial value.[44]

In addition, the PPACA specifies that federal parity requirements apply under "benchmark equivalent" coverage.[45] The federal parity requirements established by the Mental Health Parity of 2008[46] essentially puts mental health treatment on par with other types of medical care.[47] This includes such factors as deductibles, copayments, coverage, and doctor visits.[48]

LOW INCOME ADULTS UNDER HEALTH REFORM 1 (2010), *available at* http://www.kfff.org/healthreform/upload/8052.pdf.

39. ACA §2705(a) (to be codified at 42 U.S.C. §300gg-4).

40. PPACA mandates "Essential health benefits" coverage. "Essential health benefits" includes items and services within at least 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. ACA § 1302(b) (to be codified at 42 U.S.C. § 18022).

41. Garfield, *supra* note 9, at 1084.

42. *Id.*

43. *Id.*

44. Aggregate actuarial value refers to a position where two or more conditions or plans have the same current value. *Id.*

45. *Id.*

46. *Id.* at 1083.

47. ACA § 1302(c)(6) (to be codified at 42 U.S.C. § 1396(a)).

48. ACA §1302 (to be codified at 42 U.S.C. § 18022).

Therefore, mental health must be provided with the same coverage as someone treated for diabetes, cancer, or heart disease.

The PPACA also targets insurance companies by creating a mandate that they cover mental health disorders.[49] In essence, the PPACA requires insurance companies to cover mental health services as a necessity. For example, at the state level the PPACA will stimulate coverage by "allowing states to seek service and training grants for psychiatric emergencies, child and adolescent conditions, and postpartum depression and psychosis."[50]

Mental health advocates believe health reform will be a huge victory for persons with mental health issues, and policymakers anticipate that when fully implemented in 2019, "[the] PPACA will reduce the number of uninsured by 32 million at a net cost of $778 billion over 10 years."[51] More specifically, 3.7 million individuals with severe mental disorders will gain coverage once reform is fully implemented, most of them under Medicaid.[52] However, only time will tell if the PPACA is successful at meeting its goals; in this case, reducing the amount of uninsured suffering from mental illness while improving the quality of services they receive.

IV. EFFECTS OF REFORM ON MENTAL HEALTH COVERAGE

The PPACA will expand and improve services for persons with mental illness. However, the problematic issues that remain are a point of debate. "First, the PPACA largely relies on states to implement key provisions even as they experience fiscal crises that threaten mental health services."[53] Even after reform is fully implemented in 2019, behavioral health coverage will continue to vary by coverage source because different rules are in place

49. Neil Krishan Aggarwal et al., *Is Health Care a Right or a Commodity? Implementing Mental Health Reform in a Recession*, 61 PSYCHIATRIC SERVS. 1144, 1144 (2010).
50. *Id.*
51. Garfield, *supra* note 4, at 486.
52. *Id.* at 490.
53. Aggarwal, *supra* note 48, at 1144.

for existing and new coverage sources.[54] Additionally, the PPACA does not stipulate that states cannot cut services after reform is implemented.[55] Therefore, mental health coverage may fluctuate because it is ultimately up to the states to enact reform. This may be attributed, in part, to recent state budget cuts in mental health services.

Although the PPACA guarantees access for the newly covered individuals under benchmark plans, it does not substantially change mental health services for current Medicaid recipients.[56] Newly eligible Medicaid beneficiaries with serious mental disorders may require additional services because the "benchmark equivalent" only covers basic services.[57] Ultimately, access for newly eligible individuals with serious mental illness will depend on state coverage decisions and final regulations on benchmark coverage under the PPACA.

Regardless of the issues concerning payment and coverage of mental health services, the PPACA is a stepping-stone in the right direction. NAMI believes that the PPACA will help by expanding mental health service coverage through state-based private health exchanges and extending the Medicaid poverty level.[58] Moreover, health reform provides an unprecedented opportunity for millions of individuals with behavioral health needs to gain insurance coverage for crucial services, such as psychosocial counseling and prescription drugs. It is estimated that Medicaid will cover 24.5% of the population with a mental illness when reform is fully implemented, compared to 12.8% currently.[59] Those suffering from mental illness will particularly benefit, as nearly one-third (31.2%) of currently uninsured individuals with severe mental disorders

54. Garfield, *supra* note 9, at 1083-4 ("Policy makers estimate that approximately 40% of currently uninsured individuals will remain uninsured").

55. *Id.* at 1084.

56. *Id.* at 1083-4.

57. *Id.* at 1084.

58. *See* Laura Usher, *Will Heath Care Reform Help Those Most at Risk? A Unique Perspective from the NAMI Crisis Intervention Team (CIT) Action Center*, NAMI BLOG (Nov. 23, 2010), http://blog.nami.org/2010/11/will-health-care-reform-help-those-most.html.

59. Garfield, *supra* note 4, at 489.

will be covered under the Medicaid expansion, compared to only 21.8% of other low-income individuals without severe mental illness.[60] Despite the shortfalls of mental health coverage under the PPACA and Medicaid Expansion, the legislation will ultimately help alleviate access issues for those with mental illness.

V. CONCLUSION

The PPACA will go a long way in improving the way of our nation's mental health system is perceived by organizations like NAMI. Reform is needed in the mental health system as the vast majority of people with mental illness continue to need care, but lack the coverage to seek that care. One must not assume that the PPACA was meant to be the final solution to all of the problems plaguing the mental heath system. Additional work must continue to be done to further provide mental health services to those who need it the most. Policy makers will need to develop strategies to ensure adequate coverage of mental health services. The PPACA may not be the final solution to cover uninsured mental illness sufferers, but it is a legitimate and honest attempt that will aid a significant portion of the population.

60. *Id.*

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Waiting Five Years for Healthcare: How Restricting Immigrants' Access to Medicaid Harms All

Karla Guerrero·

I. INTRODUCTION

Healthcare has historically been afforded to both citizens and non-citizens alike.[1] However, the dwindling economic resources of the federal and state governments, coupled with the influx of immigration in the United States (U.S.), has led to larger numbers of uninsured immigrant populations.[2] The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) curtailed immigrant eligibility for most federal benefits, such as Medicaid.[3] In order to justify the limitations imposed on immigrants, Congress reasoned that the federal government has a duty to regulate immigration so that immigrants rely on their own capabilities instead of public benefits.[4] Because states receive federal

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1. *See* KIMBERLEY CHIN ET AL., HOW HAVE STATES RESPONDED TO THE ELIGIBILITY RESTRICTIONS ON LEGAL IMMIGRANTS IN MEDICAID AND SCHIP? 1 (2002), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13988.

2. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS 2 (2006) [hereinafter MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS], *available at* http://www.kff.org/medicaid/upload/7492.pdf.

3. *Id.* at 1.

4. *See* 8 U.S.C. § 1601(2)(A) (stating that the PRWORA's immigrant restrictions are

funding for programs like Medicaid, the PRWORA extended these immigrant restrictions to individual states.[5] Individual states can extend Medicaid coverage to most legal immigrants if they entered the U.S. before the passage of the PRWORA.[6] However, if they entered the U.S. after the passage of the PRWORA, states are not permitted to use federal money to provide Medicaid coverage to these immigrants for their first five years in the country (the five-year bar).[7] In light of these restrictions, several states have undertaken initiatives to provide state-funded replacement programs to some or all legal immigrants during the Medicaid ineligibility period.[8]

First, this article will cover the basics of Medicaid, including the eligibility requirements that have been reformed to limit immigrants' access to coverage. The second part of this article will discuss how some states have chosen to reject the five-year bar and permit eligible legal immigrants to immediately apply for Medicaid or some alternative healthcare program, given that they meet certain other eligibility requirements.[9] Lastly, this article will discuss the impact the five-year bar has on states, legal immigrants, the healthcare system, and healthcare funding.

II. AN OVERVIEW OF MEDICAID

A. Medicaid for Citizens

Medicaid was enacted by Congress under Title XIX of the Social Security Act of 1965.[10] The Medicaid program was intended as a partnership between federal and state governments that granted states the option to provide a more comprehensive healthcare program for low-

important for fostering self-sufficiency, and that immigrants "within the Nation's borders [cannot] depend on public resources to meet their needs"); *see also id.* § 1601(2)(B) (stating that a priority of the PRWORA is to ensure that "the availability of public benefits not constitute an incentive for immigration to the United States").

5. *See* 8 U.S.C. § 1621(a).
6. CHIN ET AL., *supra* note 1.
7. *Id.*
8. *Id.*
9. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 1.
10. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO THE CONGRESS ON

income individuals who were unable to afford the costs of needed medical services.[11] Today, Medicaid is a significant component of our healthcare system, covering sixty-eight million people.[12] Income is the predominant factor in determining Medicaid eligibility; Medicaid has provided coverage to "low-income children, their parents, pregnant women, individuals with disabilities, and individuals age 65 and older."[13] Under the program, the federal government covers between fifty percent and seventy-six percent of the total state costs for Medicaid,[14] thereby incentivizing the states to comply with federal guidelines and provide healthcare coverage to income-eligible citizens.[15]

The federal government also mandates that each state's Medicaid program cover certain benefits in order to receive matching federal funding for the program.[16] If states do not comply with the federally mandated provisions and services set forth under Medicaid, the federal government will deny funding to the state.[17] However, states may supplement the federally mandated coverage by relaxing eligibility requirements or by extending coverage to additional types of medical services as their budgets see fit.[18] As a result, the Medicaid program does not provide consistent services across the country.[19] Hence, the range and quality of services that an individual receives, as well as his or her eligibility status, depends principally on his or her state of residence.[20]

MEDICAID AND CHIP 27 (2011).

11. *Id.*

12. *Id.*

13. *Id.*

14. *Extra Federal Medicaid Support Ends. A Temporary Increase During 2009-11 in Federal Medicaid Funding to the States Has Expired. A Crunch Looms*, HEALTH POL'Y BRIEF 1 (2011), http://www.rwjf.org/files/research/65908.pdf.

15. *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 10, at 37-38.

16. 42 U.S.C. § 1396d(a) (enumerating mandatory benefits that states must provide to their residents).

17. *See* 42 U.S.C. § 1396c.

18. *Id.* at § 1396d(a) (permitting states to provide optional services beyond the minimum federal requirements).

19. *See* Jon Donenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance With Federal Availability Requirements*, 117 YALE L.J. 1498, 1504-05 (2008).

20. *See* David M. Herszenhorn, *Medicaid Expansion Poses Test for Some Democrats*,

B. Separate Medicaid Provisions for Immigrants

Title IV of the PRWORA severely reduced immigrants' eligibility for Medicaid.[21] Under the PRWORA, qualified immigrants are ineligible to receive Medicaid assistance for their first five years of their legal resident status if they entered the U.S. on or after August 22, 1996.[22] Prior to the passage of the PRWORA, legal immigrants were able to receive Medicaid benefits using the same eligibility criteria as citizens.[23] Congress justified the change in treatment in §1601 of the PRWORA by explaining that "aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates," and that "[c]urrent eligibility rules . . . have proved wholly incapable of assuring that individual aliens not burden the public benefits system."[24] For purposes of the PRWORA, qualified citizens includes lawful permanent residents, refugees, asylees, persons granted withholding of deportation, persons granted conditional entry, and immigrants who have been battered or subject to extreme cruelty in the U.S. and who otherwise satisfy certain federal requirements, or the parents of such immigrants.[25] However, some legal immigrants, such as refugees, other humanitarian immigrants, and active duty members or veterans, are exempt from the five-year bar.[26] Additionally, the Deficient Reduction Act of 2005 requires all individuals applying for Medicaid to show proof of citizenship in order to determine Medicaid eligibility.[27]

Additionally, the PRWORA allowed states to limit the eligibility of legal

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N.Y. TIMES PRESCRIPTIONS BLOG (Sept. 14, 2009, 12:27 PM) http://prescriptions.blogs.nytimes.com/ (search "Medicaid Expansion Poses Test for Some Democrats"; then follow "Medicaid Expansion Poses Test for Some Democrats" hyperlink) (showing that eligibility criteria for Medicaid services vary significantly from state to state. In Alabama, for example, the maximum qualifying household income is 12% of the federal poverty level, whereas in Minnesota, it is 275% of the federal poverty level).

21. *See* 8 U.S.C. §§ 1601, 1611-1613, 1621-1622, 1641 (2006).
22. *See* 8 U.S.C. § 1613(a).
23. CHIN ET AL., *supra* note 1.
24. 8 U.S.C. § 1601(3), (4).
25. CHIN ET AL., *supra* note 1, at 4-5.
26. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 1.

immigrants to solely state-funded benefits programs.[28] Consequently, the PRWORA placed the burden of deciding immigrant eligibility for state-funded benefits on state legislatures.[29] In the years immediately following the PRWORA's enactment, states promulgated regulations for their Medicaid programs that conformed to the guidelines of the PRWORA.[30] Some states enacted affirmative legislation that created supplemental health insurance programs for certain categories of immigrants, although in some cases the scope of services available to eligible immigrants were made less inclusive than the pre-PRWORA federal Medicaid provisions.[31] Still, in the midst of any economic instability, state-subsidized programs for legal immigrants have been cut from state budgets.[32]

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[33] The PPACA expands Medicaid eligibility by requiring states to provide Medicaid to any individual or family whose annual income is at or below 133% of the federal poverty level.[34] However, Congress declined to repeal many of the immigrant restrictions enacted in the PRWORA, such as the five-year bar for legal immigrants.[35] Therefore, state-funded healthcare programs

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27. *Id.* at 2.

28. 8 U.S.C. § 1622(a) (". . .a State is authorized to determine the eligibility for any State public benefits of an alien who is a qualified alien. . .").

29. *See id.* § 1622(a).

30. *See* SHAWN FREMSTAD & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED,COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS' ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 18 (2004), *available at* http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf.

31. *See id.* at ii, 18. (Massachusetts, Rhode Island, Florida, and Washington, D.C. cover all income-eligible children regardless of immigration status; thirteen states provide prenatal care regardless of immigration status.); *Id.* at 17.

32. *See id.* at 18.

33. *See* KAISER COMM'N ON HEALTHCARE & THE UNINSURED, FOCUS ON HEALTH REFORM: SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2010), *available at* http://www.kff.org/healthreform/upload /8023-R.pdf.

34. *Id.*

35. *See* NAT'L IMMIGRATION LAW CTR., HOW ARE IMMIGRANTS INCLUDED IN HEALTHCARE REFORM? 1 (2010), *available at* http://www.nilc.org/immspbs/health

continue to provide the only source of health insurance for legal immigrants.[36]

III. UNDERTAKING TO EXPAND MEDICAID TO LEGAL IMMIGRANTS

Although legislation has made it increasingly difficult for legal immigrants to qualify for Medicaid benefits, non-citizens do not remain entirely exempt from ever obtaining coverage.[37] States may enact measures to expand coverage of Medicaid through Medicaid-like replacement programs for uninsured immigrants without a five-year waiting period, if the state can finance the program entirely on state funds.[38] For example, "[t]he Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides states with an opportunity to provide affordable health coverage with federal funding to 'lawfully residing' immigrant children and pregnant women through the Medicaid and Children's Health Insurance Program (CHIP)."[39] This regulation allows individual states the flexibility to provide coverage to pregnant women, children, or both.[40] States may also choose to extend coverage to Medicaid and/or CHIP if the individuals in question are legally residing immigrants of that state.[41] "CHIPRA officially lifts [the] bar for children and pregnant women, although all other legal immigrants are still ineligible for Medicaid and CHIP during their first five years in the country."[42] This new option only affects legally residing

/immigrant-inclusion-in-HR3590-2010-04-19.pdf (noting that legal immigrants may purchase insurance through exchanges, but remain ineligible for Medicaid under previous restrictions).

36. *See id.*

37. KAISER COMM'N ON MEDICAID & THE UNINSURED, SUMMARY: FIVE BASIC FACTS ON IMMIGRANTS AND THEIR HEALTH CARE 6 (2008) [hereinafter FIVE BASIC FACTS], *available at* http://www.kff.org/medicaid/upload/7761.pdf.

38. CHIN ET AL., *supra* note 1, at 6.

39. NAT'L IMMIGRATION LAW CTR., FACTS ABOUT FEDERAL FUNDING FOR STATES TO PROVIDE HEALTH COVERAGE TO IMMIGRANT CHILDREN AND PREGNANT WOMEN 1 (2010), *available at* http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA-facts-2010-08-06.pdf.

40. JENNIFER SULLIVAN, EXPANDING COVERAGE FOR RECENT IMMIGRANTS: CHIPRA GIVES STATES NEW OPTIONS 1 (2010), *available at* http://www.familiesusa.org/assets/pdfs/chipra/Immigrant-Coverage.pdf.

41. *Id.*

42. *Id.*

immigrants, while illegally residing immigrants are still ineligible from ever enrolling in Medicaid.[43] States that choose to take advantage of CHIPRA receive federal matching funds for the services they provide to pregnant women and children.[44]

In total, forty-two states receive federal funding to provide coverage to legal immigrants who entered this country on or after August 22, 1996, after the immigrant has been in the U.S. for a minimum of five years.[45] Twenty-two states have elected to offer a state-funded program for immigrants during the five-year bar.[46] In addition to the extension of Medicaid services offered to legal immigrant pregnant women and children, legal and illegal immigrants are eligible to receive Emergency Medicaid as long as they meet certain eligibility requirements.[47] Emergency Medicaid covers the costs of emergency medical treatment through the Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, which requires hospitals to treat individuals facing medical emergencies regardless of their ability to pay, their immigration status, or whether the hospital could receive reimbursement for services that went beyond simply stabilizing the patient's medical emergency.[48]

IV. LIMITING LEGAL IMMIGRANTS' ACCESS TO MEDICAID IS DETRIMENTAL

The five-year bar affects immigrants' at the most inopportune time.[49] Upon arriving into the U.S., immigrants are statistically the least likely to have employer provided coverage[50] and tend to earn less than citizens or

43. *Id.*
44. *Id.* at 4.
45. CHIN ET AL., *supra* note 1, at 9.
46. *Id.*
47. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 2.
48. *See* 42 U.S.C. § 1395dd(a), (b)(1) (2006); *see also* FIVE BASIC FACTS, *supra* note 37.
49. *See* NAT'L IMMIGRATION LAW CTR., IMPROVING IMMIGRANT ACCESS TO AFFORDABLE HEALTH COVERAGE: ANALYSIS OF THE MASSACHUSETTS HEALTH CARE SYSTEM AS A MODEL 2 (2009) [hereinafter IMPROVING IMMIGRANT ACCESS], *available at* http://www.nilc.org /immspbs/health/MA-health-reform-2009-05-26.pdf.
50. *Id.*

immigrants that have been in the country for longer periods of time.[51] Only California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, Pennsylvania, Rhode Island, Virginia, and Washington allow all legal immigrants access to Medicaid benefits before the five-year bar.[52] However, as previously stated, some states eliminate the five-year bar of legal immigrants towards pregnant women and children under CHIPRA.[53] Both immigrants and natural born citizens suffer when state-funded health care programs restrict access to legal immigrants from an economic as well as a social policy perspective.

Barring healthcare coverage to residents that are permanently residing in the U.S. shifts expenditures from cost-controlled preventive care to expensive emergency room treatment.[54] The EMTALA mandates that all hospitals treat patients with an emergency medical condition, regardless of their ability to pay or citizenship status.[55] Therefore, legal immigrants without access to preventive care, such as Medicaid, will still be treated at emergency rooms but at a significantly higher cost.[56] As a result, immigrant restrictions in state healthcare programs, which have been enacted to reduce costs, actually increase the costs absorbed by states and hospitals in treating legal immigrants.[57] Treating illnesses with preventive care reduces future costs and are the most economical way to maximize better health.[58] According to the Executive Director of the Kaiser Family

51. *See* FIVE BASIC FACTS, *supra* note 37, at 4.

52. USLEGAL, INC., STATE-BY-STATE GUIDE TO GOVERNMENT BENEFITS FOR IMMIGRANTS (2010), http://immigration.uslegal.com/eligibility/state-by-state-guide-to government-benefits-for-immigrants/.

53. SULLIVAN, *supra* note 40, at 1.

54. NAT'L IMMIGRATION LAW CTR., COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS: A SOUND STRATEGY FOR FISCAL AND PUBLIC HEALTH 1 (2004) [hereinafter COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS], http://www.nilc.org/immspbs/health/Issue_Briefs /comphealthcare_0404.pdf.

55. *See* 42 U.S.C. § 1395dd(a) (2006).

56. *See* COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54 (arguing that denying immigrants preventive care and relying on emergency room treatment is the least cost-effective strategy).

57. *See id.*

58. IMMIGRATION POLICY CTR., INCLUDING LEGAL IMMIGRANTS IN HEALTHCARE REFORM, JUST WHAT THE DOCTOR ORDERED 2 (2009), *available at* http://www.immigration

Foundation's Commission on Medicaid and the Uninsured, restricting healthcare means that "we are already paying a substantial amount to care for a large uninsured population without any guarantee of coverage," and, "we pay for care in the least efficient way possible— after people get sick and need emergency or hospital care."[59] Imposing a five-year bar on legal immigrants is economically damaging because legal immigrants are "citizens in waiting," and many will naturalize.[60] Even if legal immigrants do not naturalize, they become eligible for federal health programs after five years[61] and will delay treatment for potentially serious conditions while they are uninsured, ultimately leading to care that is more expensive and less effective after the five-year bar.[62]

From a social policy perspective, restricting legal immigrants' healthcare access decreases participation in government programs that are vital to the public interest. Also, many immigrants live in "mixed households," containing both citizens and noncitizens.[63] Particularly common are households containing noncitizen adults and citizen children, and these children are adversely affected by their parents lack of access to medical care.[64] Noncitizen parents are also less likely to enroll their citizen children, who are fully eligible for all government healthcare programs, out of fear and confusion over potential immigration consequences for utilization of public benefits.[65]

Furthermore, legal immigrants pay taxes just as natural born citizens, and it does not make sense to exclude them from a state and federally funded healthcare program, such as Medicaid, for any amount of time when their

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policy.org/sites/default/files/docs/Including_Legal_Immigrants_in_Health_Care_Reform.pdf.

59. COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54, at 2.

60. IMMIGRATION POLICY CTR., *supra* note 58, at 1 (citing statistic that between 2006 and 2008, over two million legal permanent residents became U.S. citizens).

61. *See* 8 U.S.C. § 1613(a) (2006) (stating that legal permanent residents are eligible for benefits five years after becoming qualified aliens).

62. COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54, at 1-2.

63. IMMIGRATION POLICY CTR., *supra* note 58, at 1.

64. *Id.*

tax dollars are being used to fund the program.[66] In addition, immigrants are just as likely as citizens to have at least one full-time worker in the family, but they tend to have lower rates of employer-sponsored insurance or have jobs that do not offer health insurance.[67] These limitations, coupled with the federal restrictions on Medicaid eligibility, severely reduce immigrants' public health coverage.[68] These immigrants are legally residing within our borders, pay taxes and work the same as citizens, which suggests that the five-year bar is an arbitrary restriction that simply allows states to discriminate against lawfully residing immigrants.[69]

V. CONCLUSION

For the first five years following an immigrants' entrance into the U.S., state-funded healthcare programs remain the only option for legal immigrants who cannot afford the high cost of private health insurance. By providing cost-effective preventive care to legal immigrants, states both respect the rights of these "citizens in waiting" and reduce the large deficits created by the EMTALA mandate. As more states scramble to make additional cuts in their social welfare programs, they must be mindful of the legal and policy ramifications resulting from any potential exclusion of legal immigrants.

65. *Id.*
66. *Id.*
67. FIVE BASIC FACTS, *supra* note 37, at 4.
68. *Id.*
69. *See* IMPROVING IMMIGRANT ACCESS, *supra* note 49, at 2.

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A Comparison of Plans: Ohio and Arizona Medicaid Reform

Nikhil Bafna·

I. INTRODUCTION

For over a decade, Medicare and Medicaid have been extensively debated in the American political scene. Specifically, much of the discussion has focused on ways to extend coverage to the maximum number of Americans in the most economically viable way. Lately, Medicaid has been a particularly important topic of discussion nationwide, especially since state and federal governments have less funding to appropriate for publicly funded programs. With the passage of the Patient Protection and Affordable Care Act (PPACA), referred to in the pejorative sense as "Obamacare,"[1] states have created different solutions for how to reform their Medicare and Medicaid systems. In particular, Ohio and Arizona have implemented interesting approaches to reform the administration of Medicaid in their respective states.

In short, Medicaid is a national health program that focuses on helping

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1. Marilyn Serafini, *Does the Patient Protection and Affordable Care Act Need Title Reform?*, THE WASH. POST Dec. 26, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/12/26/AR2010122602374.html.

low-income individuals or families obtain access to health care.[2] It also helps individuals with disabilities to gain access to health care.[3] Medicaid is both a federal and state program, giving states flexibility to participate.[4] The Centers for Medicare and Medicaid Services (CMS) sets guidelines for the states to follow.[5] This article discusses the Medicaid reform plans of both Ohio and Arizona and demonstrates how Ohio's plan focuses more on administrative and structural changes, while Arizona's plan focuses on cutting spending.

II. OHIO

In Ohio, Medicaid is administered by numerous state and local agencies, whose administrative authority derives from the Ohio Department of Job and Family Services (ODJFS).[6] Furthermore, more than 2.3 million Ohioans are enrolled in Medicaid.[7] According to Greg Moody, Director Ohio's Office of Health Transformation (OHT), if the current system remains unchanged, then Medicaid spending will increase by 30% over the next three years.[8] It has already increased more than 16% over the past two years.[9] In January 2011, Governor John Kasich established the OHT to increase efficiency and economy within Ohio's Medicaid program, and all of Ohio's state and local agencies administering Medicaid will now report to the newly created office.[10]

Governor Kasich is trying to tackle Medicaid reform through initiatives

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2. CENTERS FOR MEDICAID & MEDICARE SERVICES, https://www.cms.gov/MedicaidGen Info (last visited Sept. 20, 2011).
3. *Id.*
4. *Id.*
5. HEALTH POLICY INST. OF OHIO, OHIO MEDICAID BASICS 2011 1 (2011) [hereinafter OHIO MEDICAID BASICS].
6. *Id.*
7. *Id.*
8. Reginald Fields, *Medicaid Reforms Are a Key Piece of Gov. John Kasich's Budget Proposal*, THE PLAIN DEALER, Mar. 15, 2011, http://www.cleveland.com/open/index .ssf/2011/03/medicaid_reforms_are_a_key_pie.html, [hereinafter Fields, *Medicaid Reforms*].
9. Sarah Jane Tribble, *Ohio Aims to Transform Medicaid Coordination, Accountability are Key Components*, THE PLAIN DEALER, Apr. 10, 2011, at B1, [hereinafter Tribble, *Transform*].
10. OHIO MEDICAID BASICS, *supra* note 5.

such as coordinating services, implementing principals espoused by the federal health reform act, and giving elderly and disabled patients greater options to live at home instead of in a nursing facility.[11] While the federal government is currently paying for the expanded coverage, the burden will soon shift to the states, many of which are already low on funding.[12]

To understand Ohio's Medicaid reform plan, it is important to understand a few basics of the current state of the program. Of the 2.3 million Ohioans covered by Medicaid, about 79.9% of those are covered families and children (CFC) while the remaining 20.1% are patients who are aged, blind, or have disabilities (ABD).[13]

The expenditures between the CFCs and ABDs are not proportional. ABDs account for 67.5% of Medicaid expenditures, while CFCs account for only 32.5%.[14] The CFC group consists of parents, pregnant women, and children up to nineteen years of age.[15] The ABDs consist of elderly patients sixty-five years and older, the blind, and also individuals with disabilities.[16] The general category of individuals with disabilities also consists of children who have severe disabilities.[17] Eligibility for Medicaid assistance depends on whether a patient falls into the CFC or ABD group, both of which are stratified.[18] The CFCs are separated such that children nineteen years of age and under are considered separately from pregnant women, who are then considered separately from parents.[19] Similarly, the ABD group is stratified such that workers with disabilities are separated from the non-working disabled, who are separated from the elderly, who in turn are

11. Tribble, *Transform*, *supra* note 9.
12. Phillip Klein, *The Legal Case Against Obamacare's Medicaid Expansion*, The Washington Examiner, June 9, 2011, http://washingtonexaminer.com/blogs/beltway-confidential/2011/06/constitutionality-obamacares-medicaid-expansion-0.
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*

separated from those who are institutionalized.[20] Each category has different eligibility requirements for Medicaid based on a percentage of the Federal Poverty Level (FPL).[21]

The PPACA has forbidden states from taking this approach and has mandated that they maintain their current adult eligibility standards until January 1, 2014, as well as their current child eligibility standards until September 30, 2019.[22] Further, states may not make it more difficult for people to enroll in Medicaid.[23] Failure to comply could result in states' loss of federal funds.[24] In Ohio's case, failure to comply could mean loss of federal funding for the state's single largest expense, a consequence that would be very damaging to the state.[25] Due to this mandated expansion, independent organizations and the state government estimate that between 667,000 and 936,000 more people will enroll in Medicaid in 2014.[26]

Ohio's situation underscores the importance of the need to reform how Medicaid is administered in the state, and that is exactly what Governor Kasich has set out to accomplish in Ohio. In addition to reorganizing the Ohio Medicaid system by centralizing it under the OHT, Kasich's plan seeks to coordinate care for those enrolled in both Medicare and Medicaid.[27] This means that health homes will be promoted by calling for

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20. OHIO MEDICAID BASICS, *supra* note 5.

21. *Id.* (FPL guidelines were set in 2009 and were in effect until August of 2011. FPL for this period was $10,400. For Children and Pregnant Women, the limit for Medicaid eligibility was 200% FPL; for parents 90% FPL; for Workers with Disailities 250% FPL; Non-workers with Disabilities and Seniors 65 and older 64% FPL; and the institutionalized have an income less than the cost of care, so it is assumed that the state would cover all of their costs).

22. THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE MEDICAID & CHIP MAINT. OF ELIGIBILITY REQUIREMENTS 1 (2011) [hereinafter REQUIREMENTS].

23. GEORGETOWN HEALTH POLICY INST. CTR. FOR CHILDREN & FAMILIES, CTR. ON BUDGET & POLICY PRIORITIES, HOLDING THE LINE ON MEDICAID & CHIP: KEY QUESTIONS AND ANSWERS ABOUT HEALTH CARE REFORM'S MAINT.-OF-EFFORT REQUIREMENTS 1 (2010) [hereinafter HOLDING THE LINE].

24. REQUIREMENTS, *supra* note 22, at 1.

25. Fields, *Medicaid Reforms, supra* note 8.

26. OHIO MEDICAID BASICS, *supra* note 5.

27. *Id*.

greater coordination of physical and mental medical care.[28] It would also reduce administrative costs by combining departments to eliminate duplicative billing.[29] Instead of separate entities operating independently, their operations would become coordinated, thus resulting in diminished administrative confusion.

Additionally, the Ohio plan calls for payment reform for medical treatment under Medicaid.[30] Currently, the system allows for reimbursement to caregivers for treatments given to patients who suffer from hospital-acquired infections.[31] Under the new plan, Medicaid would refuse to pay hospitals and other caregivers for such treatment under the theory that because such illnesses are preventable, the state should not be burdened.[32] Furthermore, the plan calls for cutting about 15% in administrative funding for aging agencies, such as nursing homes, while also increasing the number of people who can obtain waivers that allow them to live at home instead of in nursing homes.[33] Governor Kasich's hope is that by giving the elderly the option to live at home, the cost of care will be reduced.[34] Further, the option would reduce the administrative costs incurred by nursing home facilities.[35]

The plan also intends to integrate physical and behavioral care in such a way that it has centralized administration, thereby alleviating the financial burden of caring for those with physical and behavioral needs.[36] The Ohio Department of Jobs and Family Services manages the physical healthcare for Ohioans with mental illnesses.[37] The Department of Mental Health and Alcohol and Drug Addiction Services independently administers the

28. *Id.*
29. Tribble, *Transform*, *supra* note 9.
30. *Id.*
31. Tribble, *Transform, supra* note 9.
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.*
36. OHIO MEDICAID BASICS, *supra* note 5.
37. *Id.*

behavioral health services for Ohioans with mental illnesses.[38] The plan would achieve this integration and reduce the cost of administration by shifting the financial burden to the state from the localities.[39] Of course, this also implies that localities would have to cut their spending on the care of the behaviorally and mentally disabled, which may include the reduction of community counseling and psychiatric treatment.[40] The reform also sets out a plan to unify the long-term care budget by combining the Medicaid funds with that of ODJFS in order to create a single long-term care budget.[41]

Ultimately, Governor Kasich's Medicaid reform plan asserts that it will save Ohio $1.4 billion in spending, "without reducing eligibility for the 2.1 million low-income children, families, older adults, and Ohioans with disabilities."[42] Not including the projected new enrollees, estimates indicate that Ohio's Medicaid spending will increase by $2 billion in 2013.[43] However, the new enrollees from 2014 to 2016 will be fully covered by the federal government and subject to gradual payment decreases in subsequent years, which would help the state save money.[44] However, Jennifer Tolbert, an expert at the Kaiser Family Foundation, estimates that the PPACA is expected to save about $1.1 trillion in the long term, while costing approximately $940 million, leaving the federal government with a surplus.[45]

Not all Ohioans are optimistic about the new healthcare plan.[46] Parts of the plan, such as cuts in funding to nursing homes, will result in fewer jobs

38. *Id.*
39. *Id.*
40. Tribble, *Transform*, *supra* note 9.
41. OHIO MEDICAID BASICS, *supra* note 5.
42. Aaron Marshall, *Gov. John Kasich Says His 'Jobs Budget' is the Most Reform-Minded in Ohio History*, THE PLAIN DEALER, Mar. 15, 2011, http://www.Cleveland.com /open/index.ssf/2011/03/gov_john_kasich_says_his_jobs.html.
43. Diane Suchetka, *Health Care Reform Will Move Millions More to Medicaid*, THE PLAIN DEALER, June 21, 2011, http://www.cleveland.com/consumer-health/index.ssf/2011 /06/health_care_reform_will_move_millions_more_people_to_medicaid.html.
44. *Id.*
45. *Id.*

throughout the state.[47] According to Peter Van Runkle, Executive Director of the Ohio Health Care Association, the Medicaid reforms will cut about 7,000 jobs in the nursing home sector alone.[48] Others say that healthcare providers can be more efficient about the way they offer care to their patients.[49]

III. ARIZONA

Arizona's Medicaid reform plan differs greatly from Ohio's plan. Under Governor Jan Brewer's reform plan, there are not only cutbacks, but also pure eliminations in order to control Medicaid spending.[50] Much like Ohio's system of classifying users of Medicaid, Arizona Medicaid recipients are divided into either the ABD or the CFC-like categories.[51] There is no CFC category as such. Instead there are separate categories for Children, Families and Women.[52] However, the Arizona system is more stratified than Ohio's because they also have a category for young adults aged nineteen to twenty-one.[53] Additionally, the coverage provided for women is only stratified into three areas, namely pregnant women, family planning services for women, and women in need of breast and/or cervical treatment.[54]

Furthermore, there is a category that falls under the CFC that is not included in Ohio's administrative setup – coverage for non-ABD adults under the age of sixty-five.[55] The ABD category covers precisely those in its namesake – the aged, blind or disabled.[56] To qualify for the ABD

46. Tribble, *Transform, supra* note 9.
47. *Id.*
48. *Id*.
49. *Id.*
50. *See generally* MRP, *infra* note 59.
51. *See generally* DIVISION OF MEMBER SERVICES, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH INSURANCE (2010) [hereinafter HEALTH INSURANCE].
52. *See generally* HEALTH INSURANCE.
53. *Id.* at 8.
54. *Id.* at 11.
55. *Id.* at 15.
56. *Id.*

category in Arizona, one must be sixty-five or older, or disabled, or blind.[57], Like Ohio, some disabled children may fall into this category.[58]

The Arizona plan calls for several outright eliminations in order to reduce state spending on Medicaid.[59] The reform plan is divided into five categories: Eligibility Reform, Personal Responsibility, Benefit Reform, Long-Term Reform, and an "Other" category.[60]

The Eligibility Reform category includes five major eliminations that will restrict eligibility of those seeking Medicaid coverage.[61] The first, effective July 1, 2011, is the elimination of enrollment of childless adults.[62] Although it allows childless adults who have been enrolled as of June 30, 2011 to continue their coverage, no new childless adults may enroll under this category for Medicaid benefits.[63] Furthermore, those childless adults who lose Medicaid benefits will not be permitted to re-enroll.[64] The apparent goal is to completely eliminate individuals enrolling under the childless adult category.

The next major elimination is the removal of the "spend down" program.[65] Previously, this program extended Medicaid coverage to those Arizonans who bore medical expenses that lowered their income to below forty percent of the FPL and who would not have originally qualified for Medicaid coverage.[66] On May 1, 2011, the program was frozen and was totally shut down on October 1, 2011.[67] The next elimination is that of the Medicaid coverage offered to patients earning between seventy-five percent and one hundred percent of the FPL, which took effect on October 1,

57. *Id.* at 17.
58. OHIO MEDICAID BASICS, *supra* note 5.
59. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, STATE OF ARIZONA PROPOSED MEDICAID REFORM PLAN (2011) [hereinafter MRP], *available at azgovernor.gov/dms/Upload/PR_031511_AHCCCSSummary.pdf.*
60. *Id.*
61. *Id.* at 1-2.
62. *Id.* at 1
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*

2011.[68]

Since Arizona is also home to a large number of aliens, residents and illegal aliens, the plan proposes to cut Medicaid funding of Federal Emergency Services (federal approval pending) to non-qualified aliens.[69] The plan also calls for childless adults and parents to have their eligibility evaluated every six months, rather than every year.[70]

The Personal Responsibility category includes three changes.[71] The state proposes to expand mandatory co-payments for parents and children, along with penalizing patients for missing scheduled appointments.[72].

The Benefit Reform category contains two measures that limit how much patients can recover from Medicaid.[73] The first would limit Medicaid coverage of inpatient care to twenty-five days.[74] The second reform would completely eliminate Medicaid coverage of non-emergency transportation, such as non-emergency transportation to the doctor for appointments.[75] In actuality, the transportation reform only seeks to eliminate coverage in urban areas Phoenix and Tucson, while imposing co-payment rates on non-emergency transport in rural areas.[76]

In the Long-Term Reforms section, the Arizona plan seeks to integrate care of physically and behaviorally ill patients, similar to Ohio's plan.[77] Like Ohio's plan[78], it also proposes to pay for quality of care, not quantity

67. *Id.*
68. *Id.* at 2.
69. Id. at 2; *see generally* CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, WHO IS A QUALIFIED ALIEN? (discussing what constitutes a qualified alien), *available at* https://www.cms.gov/MedicaidEligibility/downloads/alien1.pdf.
70. MRP, *supra* note 59, at 2.
71. *Id.* at 3.
72. *Id.*
73. *Id.* at 3-4.
74. *Id.* at 3.
75. *Id.* at 4.
76. *Id.*
77. *Id.* at 5.
78. Tribble, *Transform*, *supra* note 9.

of care.[79] By implementing this principle, the plan appears to create an incentive for healthcare providers to ensure the patient actually benefits from the received care. However, an interesting addition to the Long-Term Reform is the proposed financial penalties on patients seeking Medicaid coverage who engage in unhealthy habits such as smoking and obesity.[80] From this, the state hopes to put some responsibility on the patients to live a healthier lifestyle, thereby reducing the amount of Medicaid dollars spent on illnesses created by their own poor lifestyle choices.

Within the Other category, the plan proposes to "[c]ut reimbursement rate[s] for health providers by 5%," in addition to modifying reimbursement of Medicare liabilities.[81]

Overall, the proposed plan for Medicaid reform in Arizona could result in saving the state over 400 million dollars in Medicaid expenses alone.[82]

Most of the cuts and expansions seem to be well received. However, in April of 2011, the Arizona Hospital and Healthcare Association (AzHHA) sent a letter to the United States Secretary of the Department of Health and Human Services opposing certain cuts to healthcare providers.[83] The AzHHA's letter, among other things, emphasized that Governor Brewer's plan would cause hospitals to lose a total of $1.3 billion.[84]

Additionally, the elimination of Medicaid coverage for childless adults was contested and brought to court.[85] In August 2011, Maricopa County Superior Court Judge Mark Brain allowed the Medicaid cuts to childless adults to be implemented, rejecting the petitioners' argument that the cuts

79. MRP, *supra* note 59, at 5.
80. *Id.*
81. *Id.* at 4.
82. *Id.* at 1-5. (totaling all the projected savings from each of the cuts and expansions within the reform plan).
83. *See generally* Letter from Laurie Liles, President and CEO, Arizona Hospital and Healthcare Association, to The Honorable Kathleen Sebelius, Secretary, United States Department of Health and Human Services (Apr. 8, 2011).
84. *Id.* (arguing in the letter to the Secretary of the US Dept. of HHS that the present cuts in addition to cuts from 2008 would total up to losses of $1.3 billion).
85. Mary K. Reinhart, *Judge Allows Cuts to Arizona's Medicaid Program*, THE ARIZ. REPUBLIC, Aug. 11, 2011,http://www.azcentral.com/news/election/azelections/articles/2011

violated Arizona state law.[86] Attorneys for Brewer and the AHCCCS argued that the judicial branch had "no business telling the Legislature how to appropriate state funds."[87] Their main argument was that there was not enough money to keep Arizona's Medicaid system operating as it had before the reform.[88]

In addition to the cuts previously mentioned, Governor Brewer's plan also eliminates financing of certain transplant operations that are normally covered by Arizona's Medicaid.[89] Such transplants include heart, liver, lung, pancreas and bone marrow procedures.[90] Arizona has also elected to eliminate a large number of non-federally required treatment provisions in order to cut as much spending as possible.[91] Such cuts include, but are not limited to, "emergency dental procedures, insulin pumps and orthotics."[92]

IV. CONCLUSION

Ohio and Arizona's reform plans seem to be in contrast with one another. Ohio has reorganized the state's Medicaid system into a more streamlined system under the OHT and is trying to maintain coverage to as many people as possible while eliminating unnecessary spending. On the other hand, Arizona's plan focuses more on budget cuts and restrictions on eligibility than on administrative reorganization.

Ultimately, while Arizona's plan certainly reduces excess spending in many areas, it cuts several life-saving procedures as well. In comparison to Ohio's Medicaid reform plan, which reorganizes the administrative structure of the state Medicaid system and makes long-term changes,

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/08/10/20110810arizona-medicaid-cuts-judge-allows.html.

86. *Id.*

87. *Id*.

88. *Id.*

89. Marc Lacey, *Arizona Cuts Financing for Transplant Patients*, THE N.Y. TIMES, Dec. 2, 2010, http://www.nytimes.com/2010/12/03/us/03transplant.html?_r=1&hpw=&page wanted=1.

90. Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, THE N.Y. TIMES, Dec. 4, 2010, http://www.nytimes.com/2010/12/05/us/05transplant.html?ref=politics.

91. *Id.*

92. *Id*.

Arizona's plan is purely aimed at cutting costs wherever it can for short-term benefits. It fails to provide a long-term solution to effectively administer Medicaid to an increased population.

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How Illinois Medicaid Reform Could Affect You

Daniel Shore·

I. INTRODUCTION

Medicaid is the primary financier for medical and health-related services for the indigent and disabled in America.[1] In Illinois alone, more than 2.8 million people are enrolled in Medicaid.[2] To put that into perspective, one out of every five Illinois residents is on Medicaid, one out of every three children in Illinois is on Medicaid, and one out of every two births in Illinois are paid for by Medicaid.[3] These statistics make Illinois the fifth largest Medicaid program in the country.[4] The sheer size of the Medicaid program in Illinois understandably results in one of the largest Medicaid budgets in the country. Thus, in 2009, Illinois's total Medicaid

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1. Barbara S. Klees et al., *Brief Summaries of Medicare & Medicaid*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, 22 (Nov. 12, 2010), https://www.cms.gov /MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2010.pdf.

2. Monifa Thomas, *How Illinois' Medicaid Reforms Could Affect You*, CHI. SUN-TIMES, Feb. 14, 2011, http://www.suntimes.com/lifestyles/health/3810934-423/how-illinoismedicaid -reforms-could-affect-you.html.

3. Benjamin Yount, *Feds Halt Ill. Medicaid Reform*, ILL. STATEHOUSE NEWS (July 18, 2011), http://illinois.statehousenewsonline.com/6610/feds-halt-illinois-medicaid-reform/(last visited Sept. 22, 2011).

4. THE HENRY J. KAISER FAMILY FOUND., Kaiser State Health Facts, *Total Medicaid Enrollment Fiscal Year 2007, http://www.statehealthfacts.org/comparetablejsp?ind=198& cat=4&sub=52&yr=23&typ=1&sort=a*.

expenditures were the seventh highest in the country.[5] However, the amount of money that Illinois spends on Medicaid has increased dramatically over the past few years. According to Illinois State Representative Patti Bellock, who helped write the recent Medicaid reform package (House Bill 5420), Illinois spent about $7 billion on Medicaid in 2006.[6] In 2011, however, Illinois is projected to spend $15 billion.[7] Illinois's total annual spending budget is $33.4 billion, which means that nearly half of every dollar the Illinois government expects to spend this year will be on Medicaid.[8]

The majority of Illinois taxpayers are able to provide their own health insurance without the state's assistance.[9] Unfortunately, nearly fifty percent of Illinois tax dollars are spent on a program that in no way benefits these taxpayers.[10] According to the Patient Protection and Affordable Care Act (PPACA), by the year 2014, all states will be required to provide Medicaid to individuals whose income is less than 133% of the Federal Poverty Level (currently $29,300 for a family of four).[11] Raising taxes is not necessarily the answer, but achieving efficiencies may be. Thus, on January 25, 2011, Governor Quinn signed House Bill 5420, which he believes will save the state $624 million to $774 million over the next five years, while delivering better services to those that need them.[12] However, there are many negative consequences to this reform plan that will affect all Illinois residents.

This article will examine the four major reforms being implemented by House Bill 5420 and its impact on both Medicaid and non-Medicaid

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5. *Id.*
6. Yount, *supra* note 3.
7. Yount, *supra* note 3.
8. *Id.*
9. *See id.*
10. *See id.*
11. ILL. HEALTH REFORM IMPLEMENTATION COUNCIL, *Affordable Care Act Implications for Ill.*, 2 (Nov. 16, 2010), http://www2.illinois.gov/healthcarereform/Documents/IL-HRIC%20Presentation%20111610.pdf.
12. Ill. *Gov.* News Network, Gov. *Quinn Signs Landmarks Medicaid Reform Legislation*, (Jan. 25, 2011), http://illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=9183.

recipients. Part I of this article provides a brief overview of the importance of Medicaid in Illinois and introduces Governor Quinn's reform plan, which he believes will reduce Illinois's excessive Medicaid spending. Part II will explore Illinois's plan to increase the number of participants in the Medicaid managed care program and how this could negatively affect most Illinois residents. Part III will examine the plan's effect on the children whose benefits may be cut under House Bill 5420. Part IV will discuss how Illinois's reduced reliance on nursing homes will improve living conditions for elderly and disabled individuals while saving the state money. Part V will explain why the federal government rejected Illinois's requirement that Medicaid recipients provide proof of their income and residency and the serious implications this presents for House Bill 5420.

II. THE PROBLEM WITH MANAGED CARE

Governor Quinn projects that moving fifty percent of Illinois Medicaid recipients to managed care by 2015, as mandated by House Bill 5420, will reduce Medicaid costs while providing better health care services.[13] Currently, only eight percent of Illinois Medicaid recipients are enrolled in managed care, which is far below the national average of forty-six percent.[14] Governor Quinn is correct to expect a reduction in Medicaid costs from this plan. The savings will come from shifting the Illinois Medicaid program from a fee-for-service system to a capitation system, or one where the state pays insurance companies a set rate per year for each patient.[15] However, Governor Quinn may be incorrect to expect managed care insurers to provide better health care services to Medicaid recipients.[16] In fact, health care quality may decline for some individuals and force them

13. Christine Vestal, *Crushed by Medicaid Costs*, STATELINE (Feb. 4, 2011), http://www.stateline.org/live/details/story?contentId=547640.

14. *Id.*

15. *See id.*

16. *See* Judith Graham, *Ill. Medicaid's Managed Care Effort Stumbles*, CHI. TRIB. (Aug. 26, 2011), http://articles.chicagotribune.com/2011-08-26/health/ct-met-medicaid-managed care-20110826_1_care-and-lower-costs-care-doctor-hmo-style.

to find medical treatment through alternative sources.[17] This would have negative implications for Medicaid and non-Medicaid recipients, such as hospital emergency room overcrowding.[18]

The state believes that shifting Medicaid recipients to managed care will improve health care because insurance companies will now bear the financial burden.[19] As a result, insurance companies will have financial incentive to carefully coordinate patient care to reduce avoidable hospitalizations and deteriorating of chronic conditions.[20] Essentially, the state's hope is that the managed care plans "will prevent costly hospitalizations by connecting people with teams of doctors, social workers and case managers, improving access to preventive services such as mammograms, and teaching them how to manage chronic conditions such as diabetes."[21] Thus, it is fair to assume that managed care is a viable solution to improving health care services. The vast majority of managed care plans in other states cover only children and pregnant women because they are generally healthy and inexpensive to cover.[22] However, Illinois plans to provide managed care to adults with disabilities and seniors who require long-term care as well.[23] As Bellock stated, these people will finally have a "medical home."[24]

Unfortunately, finding a "medical home" is not as simple as it sounds, especially for disabled adults and senior citizens.[25] The disabled and senior populations make up only twenty percent of the Medicaid population in

17. *See id.*
18. *See* U.S. GEN. ACCOUNTING OFFICE, *Emergency Care: EMTALA Implementation and Enforcement Issues*, 2, (June 2001), http://www.emtala.com/062001.pdf. Medicaid recipients who are unable to make timely appointments with their personal physicians will be forced to visit the emergency room for nonemergency services. This will cause hospital overcrowding.
19. *See* Vestal, *supra* note 13.
20. *See id.*
21. Graham, *supra* note 1616.
22. *See* Vestal, *supra* note 13.
23. *See id.*
24. Diane S.W. Lee, *Ill. Embraces Medicaid Reform*, ILL. STATEHOUSE NEWS, Jan. 25, 2011, http://illinois.statehousenewsonline.com/5005/illinois-embraces-medicaid-reform/.
25. *See* Graham, *supra* note 16.

Illinois, but their services account for seventy cents of every Medicaid dollar spent.[26] Moreover, managed care has a history of difficult administrative requirements and restricted reimbursements.[27] As a result, several hospitals in Illinois have been resistant to making the change.[28] Thus, managed care recipients may be faced with the difficult decision of either traveling a long distance to find a doctor who is willing to accept managed care or visiting a hospital and attempting to receive emergency treatment.[29] Furthermore, those recipients who are lucky enough to find a personal physician in their area often have difficulty obtaining timely appointments, which then leads to overcrowding of hospitals.[30] Overcrowding in hospitals affects patients through inefficiency, the spread of infection, longer hospital stays, and scarcity of rooms. [31] Additionally, overcrowding can cause doctors and nurses to become overly stressed, which can affect the quality of patient care.[32]

It is likely that managed care will begin to cause hospital overcrowding in Illinois in the very near future.[33] A pilot program, which enrolled about 40,000 disabled adult and elderly Medicaid recipients into two private HMO-style plans, is already presenting problems.[34] Many of these disabled adults and elderly individuals are already having difficulty finding new doctors, and as the managed care initiative progresses, hundreds of

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26. Adam Doster, *Finding Waste in Medicaid: Easier Said Than Done*, PROGRESS ILL., Dec. 16, 2010, http://www.progressillinois.com/posts/content/2010/12/16/finding-waste-medicaid-easier-said-done.

27. *See* Graham, *supra* note 16.

28. *Id.*

29. *See id.*; *see also* U.S. GEN. ACCOUNTING OFFICE, *supra* note 18 at 2.

30. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 18 at 2.

31. *See* UOPX Writer Network, *How Does Overcrowding Impact Hospitals?*, U. OF PHX. (Aug. 22, 2010), https://www.phoenix.edu/colleges_divisions/nursing/articles/2010/08/how-does-overcrowding-impact-hospitals.html.

32. *Id.*

33. *See* Herald News, *Area Doctors and Hospitals Snub Medicaid Managed Care Program*, CHI. SUN-TIMES (August 27, 2011, 12:04 PM), http://heraldnews.suntimes.com/news/7295665-418/area-doctors-and-hospitals-snub-medicaid-managed-care-program.html. Most prominent Illinois hospitals have refused to accept Medicaid's managed care program. As a result, it is likely that overcrowding will occur in the hospitals that do accept the managed care program.

34. *See id.*; *see also* Graham, *supra* note 16.

thousands of individuals on Medicaid will be forced to seek treatment within managed care's restricted network of doctors.[35] Many doctors and the majority of prominent hospitals, such as Northwestern Memorial Hospital, Rush University Medical Center, the University of Chicago Medical Center, Children's Memorial Hospital, and Loyola University Health System, have already refused to join the program.[36]

Although these hospitals have refused to join managed care panels, the Emergency Medical Treatment and Labor Act (EMTALA) requires them to provide initial screenings to any person who comes to the emergency department, regardless of the individual's ability to pay.[37] While the hospital only has to treat that individual when the initial screening shows that they have an emergency condition, the threat of being sued for violating EMTALA and potentially losing the ability to practice medicine may sometimes cause doctors to broaden their conception of "emergency medical condition."[38] Overall, the plan to shift fifty percent of Medicaid recipients to managed care will save the state money and simplifies the system, but it may reduce access to those who need it most and cause harm to non-Medicaid recipients.

III. THE IMPACT ON CHILDREN

Illinois is known as a national leader in providing quality health insurance to children in need.[39] Children are, in essence, the centerpieces of the Medicaid reform plan because they make up 1.6 million of the 2.8 million people enrolled.[40] All Kids is Illinois's medical program for

35. *See* Graham, *supra* note 16.
36. *See id.*; Herald News, *supra* note 33.
37. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 18, at 1.
38. *See id.*; *See also EMTALA*, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, http://www.acep.org/content.aspx?LinkIdentifier=id&id=25936&fid=1754&Mo=No&acepTitle=EMTALA (last visited Sept. 26, 2011).
39. Andrea Kovach, *Progress Made with Illinois Medicaid Reforms but Policy Concerns Remain*, THE SHRIVER BRIEF (Jan. 26, 2011), http://www.theshriverbrief.org/2011/01/articles/health-care-reform-1/progress-made-with-illinois-medicaid-reforms-but-policy-concerns-remain.
40. Lee, *supra* note 24; State of Ill. Department of Healthcare and Family Services,

qualifying children who need health insurance coverage.[41] Since July, eligibility for All Kids has been capped at 300% of the federal poverty level, reversing an expansion under former Governor Rod Blagojevich in 2006.[42] The federal poverty level varies depending on the size of an individual's family.[43] A family of four is considered within 300% of the federal poverty level if their total yearly income is under $66,150.[44] This change will cause about 3,100 children to lose their health insurance.[45] Although 3,100 children out of 1.6 million is less than two percent, it still may be too many in some people's eyes.

However, these children will not have much trouble finding new health insurance. Under the PPACA, children now have access to affordable private insurance that they did not originally have under All Kids.[46] Among these affordable insurance options is the modified All Kids, which will still provide health insurance for a fee to those children who are not eligible for the free program.[47] The cost of this insurance will be in relation to the family's income for those who are ineligible for free coverage.[48]

Health insurance is also more available to children due to the PPACA.[49] Insurance companies are now prohibited from denying coverage to children with pre-existing medical conditions.[50] Thus, children being cut from All Kids and those who simply had difficulty finding health insurance due to their medical conditions no longer need to worry. Furthermore, children are

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About All Kids, ALL KIDS, http://www.allkids.com/hfs8269.html (last visited Sept. 25, 2011).

41. State of Ill. Department of Healthcare and Family Services, *Answers to Your Questions about All Kids*, ALL KIDS 2, http://www.allkids.com/assets/hfs8269.pdf.

42. Thomas, *supra* note 2.

43. *See* State of Ill. Department of Healthcare and Family Services, *supra* note 40.

44. Kovach, *supra* note 39.

45. Thomas, *supra* note 2.

46. *Id.*

47. *See* State of Ill. Department of Healthcare and Family Services, *All Kids Income Standards & Cost Sharing Chart*, ALL KIDS, http://www.allkids.com/income.html (last visited Sept. 25, 2011).

48. *See id.*

49. Public Health Service Act, 42 U.S.C. § 300gg-3 (2010). A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

now able to remain on their parents' health policy until the age of twenty-six.[51] Overall, the only negative consequence that the Medicaid reform plan will have on children is that 3,100 of them will lose their health insurance.[52] Fortunately, due to the combination of the reform plan's other policies and the PPACA, children will be able to find coverage at an affordable cost.

IV. BETTER LIVING CONDITIONS FOR THE DISABLED AND ELDERLY

Integrating disabled and elderly individuals from state-run institutions, such as nursing homes, into community housing was a major component of this Medicaid reform plan.[53] As stated above, the disabled and elderly account for seventy percent of Medicaid expenses in Illinois.[54] Community housing developments are small, family scale facilities that are cheaper to administer and more comfortable for those who want greater autonomy.[55] Essentially, community housing consists of subsidized apartments that allow residents to function independently.[56]

There is no doubt that Illinois needs to improve on living conditions and economic efficiency for disabled and elderly individuals. Illinois is currently ranked forty-ninth in the nation for adults treated in community housing.[57] Not only will redirecting state funds from public institutions to private community living institutions save the state money, it will also help improve the horrible living situations in which many of these individuals find themselves. According to an investigation conducted by the Chicago Tribune in 2009, some of the nursing homes that the elderly are forced to live in are "grim, profit making institutions that provide little therapy or

50. *Id.*
51. *Affordable Care Act Implications for Illinois*, *supra* note 11, at 4.
52. *See* Thomas, *supra* note 2.
53. *See* Thomas, *supra* note 2; *See also* Adam Doster, *Breaking Barriers for Illinois' Disabled*, PROGRESS ILL. (Nov. 16, 2010, 3:14 PM), http://www.progressillinois.com/posts /content/2010/11/16/breaking-barriers-disabled.
54. Doster, *supra* note 26.
55. *See id.*
56. *See* David Jackson, *Settlement Eases Reliance on Nursing Homes to House Adults with Disabilities*, CHI TRIB. (Aug. 30, 2011), http://articles.chicagotribune.com/2011-08-30/news/ct-met-nursing-homes-20110830_1_nursing-homes-disabilities-access-living.

discharge planning."[58] In some of the most troubled facilities, numerous cases of sexual assault, violence, and drug abuse were found.[59] An increase in community housing will improve this situation, while saving the state money.

Although the governor's plan was to increase the amount of community housing, the legislature did not specify many details about spending, number of housing units, or any timetable.[60] Ironically, Governor Quinn no longer has to specify these details for Cook County because United States District Judge Joan Humphrey Lefkow has specified this information for him.[61] A class action lawsuit, filed by approximately 20,000 Medicaid-eligible Cook County residents living in nursing facilities, recently reached a settlement that will require Governor Quinn to begin the transitional process.[62] The state of Illinois will be required to spend $10 million in the first thirty months of implementation to ensure that over 1,000 nursing home residents will be able to move into community housing.[63] Additionally, the state will be required to develop a plan to transition other nursing facility residents into community housing in the near future.[64]

One might question where the $10 million and the future community housing development money will come from. Governor Quinn claims that the new agreement will not cost taxpayers any money because the state will recoup Medicaid dollars as it offers community housing to former nursing facility residents.[65] Furthermore, the court agreement requires that the new housing plan be implemented in a manner that costs the state no more than

57. Doster, *supra* note 26.
58. Jackson, *supra* note 56.
59. *Id.*
60. *See* Thomas, *supra* note 2.
61. *See* Kate Dries et al., *Settlement Improves Living Opportunities for Disabled Chicagoans*, WBEZ 91.5 (Aug. 30, 2011), http://www.wbez.org/story/settlement-improves-living-opportunities-disabled-chicagoans-91260#
62. *See id.*, *See also Colbert v. Quinn Fact Sheet*, AMERICAN CIVIL LIBERTIES UNION OF ILL., http://www.aclu-il.org/wp-content/uploads/2011/08/Fact-Sheet-Colbert-8-11.pdf (last visited Sept. 26, 2011).
63. Dries, *supra* note 61; *Colbert v. Quinn Fact Sheet*, *supra* note 62.
64. *See Colbert v. Quinn Fact Sheet, supra* note 62.

its current use of nursing homes.[66] According to officials under Governor Quinn, community housing in other states has proved to be less costly to taxpayers than nursing facilities, so it is unlikely that this will result in a tax increase.[67]

V. ELIGIBILITY VERIFICATION REQUIREMENT NOT LEGAL

Preventing Medicaid fraud was a key component of Governor Quinn's Medicaid reform plan.[68] Currently, all one must do to prove Medicaid eligibility is provide a single pay stub, which could be a pay stub from one day or one week, regardless of whether it is artificially low compared to the income one actually earns.[69] Additionally, to prove Illinois residency, all one must do is write down an address.[70] As a result, people who earn more than the Medicaid threshold or who do not even live in Illinois are fraudulently collecting Medicaid funds.[71] The state government recognized this problem, and the Medicaid reform plan provided a solution.[72] The strategy was to create a civil remedy to prevent Medicaid fraud by requiring applicants to provide proof of Illinois residency and documentation of income made for an entire month.[73] Those who are found to have provided false information will incur a financial penalty of up to $2,000 per fraudulent claim and will repay the state five percent per annum on the value of benefits fraudulently received.[74] Medicaid would be provided only to those in need, and those who fraudulently take advantage of taxpayers'

65. Jackson, *supra* note 56.
66. *Id.*
67. *Id.*
68. *See* Ryan Long, *Feds Say No to Quinn on Tightening Medicaid Proof*, CHI. TRIB. (Jul. 19, 2011), http://www.chicagotribune.com/news/politics/clout/chi-feds-say-no-to-quinn-on-tightening-medicaid-proof-20110719,0,6804492.story.
69. *Id.*
70. *Id.*
71. *See* Avik Roy, *"Ridiculous" Obama Administration Blocks Modest Medicaid Reforms in Illinois*, FORBES (Aug. 27, 201, 12:34 PM), http://www.forbes.com/sites/aroy/2011/08/27/ridiculous-obama-administration-blocks-modest-medicaid-reforms-in-illinois/.
72. *Id.*
73. *See id.*
74. Kovach, *supra* note 39.

money would be severely punished.[75] The simplicity of this plan will likely be a positive factor in its implementation, as the risk of complications is lower.

However, in July, the federal government informed Illinois that it cannot ask Medicaid recipients to prove how much they earn or where they live.[76] The federal government's reason for denial was because states are not allowed to enforce additional procedures that are more restrictive than they were on March 23, 2010, the day President Obama signed the PPACA.[77] There is a major flaw in this reasoning. One of the main objectives of the PPACA is to ensure that Medicaid coverage is provided to citizens with the greatest need.[78] Illinois has also made this a main objective, and its policy requiring eligibility verification helps ensure that only those with the greatest need receive Medicaid coverage.[79] However, the federal government believes that a policy which requires individuals to provide verification that they qualify for Medicaid is an additional restrictive procedure, even though it will likely prevent fraud.[80] "[T]his is what enrages people," said Illinois Senate Minority Leader Christine Radogno, "If all we want to do is find out if people are actually eligible for the services, and the federal government is telling us we can't do that, that's absolutely ridiculous."[81]

Due to the federal government's denial of Illinois's Medicaid eligibility requirements, it is probable that the state will have more citizens enrolled in Medicaid than originally anticipated. Aside from the negative implications discussed above, the amount of money the state estimated it would save will likely need to be adjusted. It is unfortunate that the federal government

75. *See* Roy, *supra* note 71.
76. *Id.*
77. Long, *supra* note 68.
78. *See Medicaid Cost-Savings Opportunities*, U.S. DEPT. OF HEALTH AND HUMAN SERV. (Feb. 3, 2011), http://www.hhs.gov/news/press/2011pres/02/20110203tech.html.
79. *See* Roy, *supra* note 71.
80. *Id.*
81. Long, *supra* note 68.

denied this policy because it could have devastating effects on Illinois's Medicaid reform plan. According to Bellock, stopping fraud is the first step Illinois must take to successfully implement this reform plan and contain the skyrocketing costs of Medicaid.[82] Unfortunately, it appears that Illinois will have to take different measures to complete this first step.

VI. CONCLUSION

Illinois's Medicaid reform plan is a major step in helping to solve the recent explosion of Medicaid spending. Additionally, difficulties for children are kept to a minimum, while elderly and disabled adults living in nursing homes can expect to have their living situations improved.[83] However, there will likely be negative implications for both Medicaid and non-Medicaid recipients. Medicaid recipients are already beginning to experience difficulties such as finding a doctor who accepts managed care.[84] The potential hospital overcrowding that may occur as a result of Illinois's Medicaid reform plan will also have serious negative consequences for all individuals in Illinois.[85] Additionally, it is possible that the federal government's non-allowance of Illinois to request eligibility verification could cause Medicaid fraud to increase.[86] As a result, the state's estimated savings of $624 million to $774 million over the next five years may need to be adjusted.[87] Although the Medicaid reform plan is an improvement, Illinois lawmakers must continue the complex task of finding ways to improve Medicaid while remaining compliant with federal regulations.

82. Yount, *supra* note 3.
83. *See* Thomas, *supra* note 2; *see also* Jackson, *supra* note 56.
84. *See* Graham, *supra* note 16.
85. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 18 at 2.
86. *See* Long, *supra* note 68.
87. *See* Ill. *Gov.* News Network, Gov., *supra* note 12.

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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.[1] 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.[2] 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.[3] This paper suggests that making Medicaid a completely

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1. VICTORIA WACHINO, ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS i-ii (2004), *available at* http://www.kff.org/medicaid/upload/Financing-the-Medicaid-Program-The-Many-Roles-of-Federal-and-State-Matching-Funds-Policy-Brief.pdf.

2. ANDY SCHNEIDER ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE MEDICAID RESOURCE BOOK 130 (2002), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14266.

3. *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. (forthcoming 2011) (manuscript at 27), *available at* http://works.bepress.com/nicole_huberfeld/7/; *see also* John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, *in* 111 FEDERALISM AND HEALTH POL'Y 111-17 (John Holahan et al. eds., 2003).

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.[4] The federal government then reimburses a portion of these costs pursuant to the Federal Medical Assistance Percentage (FMAP).[5] 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.[6] In addition to matching the states' expenditures for medical services, states also receive Federal Medicaid matching funds for the costs of administering their programs.[7] 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.[8] There are approximately fifty-one separate and distinct Medicaid programs, one in each state and the District of Columbia.[9] Each of these programs has unique administrative rules and guidelines, and the federal government assists in funding all of them.[10]

In addition to the states' role in administering their respective Medicaid programs, the federal government has its own administrative functions.[11] The Centers for Medicare and Medicaid Services (CMS) in the Department

4. SOC. SEC. ADMIN. OFFICE OF RESEARCH, EVALUATION AND STATISTICS, SSA PUBL'N NO. 13-11758, SOC. SEC. PROGRAMS IN THE UNITED STATES 61 (1997), *available at* http://www.ssa.gov/policy/docs/progdesc/sspus/sspus.pdf.

5. EVELYNE P. BAUMRUCKER, CONG. RESEARCH SERV., RL32950, MEDICAID: THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 1 (2010), *available at* http://aging.senate.gov/crs/medicaid6.pdf.

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.[12]

It is interesting to note that the cost of administering the current Medicaid program is roughly $18.2 billion.[13] That figure is more than twice the total administrative cost of Medicare ($7 billion).[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.[15]

If Medicaid was fully federalized, countless administrative functions could be eliminated.[16] For instance, there would no longer need to be multiple levels of fraud prosecution or quality assurance.[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.[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.[19] Moreover, providers and beneficiaries would be better served working with one administrative branch and one standardized set of payment policies.[20]

III. INEQUALITY IN CARE

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

11. *Id.* at 135-36.
12. *Id.* at 131, 133.
13. Huberfeld, *supra* note 3, at 26.
14. *Id.*
15. *Id.*
16. *Id.* at 26-27.
17. *Id.*
18. *Id.*
19. *Id.* at 27.

inequalities with respect to medical services provided to beneficiaries.[21] While certain states, like Massachusetts and New York, have generally offered generous benefits,[22] other states, such as Mississippi, have traditionally offered significantly less.[23] These discrepancies exist notwithstanding efforts by the federal government to offer higher matching rates to poorer states.[24]

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.[25] While it is true that the federalization of Medicaid could actually lessen quality of care for Medicaid in some states,[26] 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.[27] In other words, states that currently offer generous benefits could continue to do so.[28]

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.[29] In fact, in 2008, Medicaid's reimbursement level to health care providers nationwide was only seventy-two percent of that for Medicare.[30] Thus, it is not surprising that many providers will not

20. *Id.* at 26-27.
21. Marilyn Moon, *Making Medicaid a National Program: Medicare as a Model*, *in* 325 FEDERALISM AND HEALTH POL'Y 327-28 (John Holahan et al. eds., 2003).
22. *Id.* at 328.
23. *Id.*
24. *Id.*
25. *Id.* at 335.
26. *Id.*
27. *Id.* at 326.
28. *Id.*
29. *See* GREG ANRIG, NEW AMERICA FOUNDATION, THE NEXT PRIORITY FOR HEALTH CARE: FEDERALIZE MEDICAID 6-7 (2010), *available at* http://www.newamerica.net/sites /newamerica.net/files/policydocs/Anrig_Final.pdf.
30. *Id.* at 7.

even accept Medicaid patients because of its low reimbursement rates.[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.[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.[33] This would encourage providers to accept Medicaid patients and ultimately result in greater access to quality care.[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.[35] States tend to "expand Medicaid when the economy is strong, adding benefits . . . and advertising the availability of Medicaid coverage."[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.[37] States often deal with these economic downtowns by limiting eligibility and decreasing benefits offered.[38]

The Patient Protection and Affordable Care Act (PPACA) expands eligibility to all people up to 133% of the federal poverty level.[39] Moreover, the American Recovery and Reinvestment Act of 2009 (ARRA)

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31. *Id.* at 6.
32. *Id.*
33. *Id.* at 8.
34. *See id.*
35. Huberfeld, *supra* note 3, at 29.
36. *Id.*
37. *Id.;* THE HASTINGS CENTER, HEALTH CARE COST MONITOR, TIME TO FEDERALIZE MEDICAID 1 (2011), *available at* http://healthcarecostmonitor.thehastingscenter.org/peterubel/time-to-federalize-medicaid/; *see generally* Moon, *supra* note 21, at 329.
38. *See id*. at 1.
39. *Id.*

and additional funding that the states have received during the recent recession have temporarily prohibited states from weakening their eligibility criteria.[40] Thus, states are no longer able to trim their budgets by adjusting Medicaid eligibility requirements.[41] As a result, "states are scrambling to identify services they can trim from their Medicaid budgets."[42] "Some states . . . are cutting dental coverage for Medicaid enrollees."[43] Some have also cut hospice care, transplant services, and even basic services, such as annual physicals.[44]

Other states have responded to economic downturns by cutting provider payments.[45] "In fiscal 2010, 39 states either cut Medicaid provider rates or froze payments to hospitals and/or nursing homes."[46] Cutting payments to providers has a detrimental effect on Medicaid beneficiaries in terms of the treatment options available to them.[47] 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."[48]

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.[49] Although the federal government is certainly not immune to economic fluctuations, it is better equipped to handle downturns than are the states.[50] Most states "must maintain balanced budgets pursuant to provisions in [their] state constitutions."[51] In fact, Vermont is the only

40. Huberfeld, *supra* note 3, at 30.
41. THE HASTINGS CENTER, *supra* note 37, at 1.
42. *Id.*
43. *Id.*
44. *Id.*; Huberfeld, *supra* note 3, at 29-30.
45. ANRIG, s*upra* 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.
51. Huberfeld, *supra* note 3, at 30.

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 forces[56], 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 costs[59], 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.
53. Huberfeld, *supra* note 3, at 30.
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.[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.[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.[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.[65] However, "[i]n practice, the results of states as laboratories for innovation are mixed."[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.[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.[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.[69] However, healthcare is national in nature, and the practice of medicine generally recognizes uniform standards.[70] Physicians "are not trained within a state to practice only within that state's borders."[71]

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62. *Id.*
63. *See* ROBERT HURLEY & STEPHEN ZUCKERMAN, URBAN INSTITUTE, ASSESSING THE NEW FEDERALISM 18-19 (2002).
64. FERC v. Mississippi, 456 U.S. 742, 788-89 (1982) (O'Connor, J., concurring and dissenting), *quoted in* Huberfeld, *supra* note 3, at 19.
65. HURLEY & ZUCKERMAN, *supra* note 63, at 18-19.
66. Moon, *supra* note 21, at 333.
67. *Id.*
68. *See* Moon, *supra* note 21, at 331-32.
69. *Id.* at 331.
70. *Id.*
71. *Id.*

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.[72]

V. CONCLUSION

The dual federal-state nature of Medicaid has resulted in an inefficient system with significant state-to-state disparities in medical care.[73] 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.[74] 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.

72. U.S. Med. Licensing Examination, *About USMLE*, U.S. MED. LICENSING EXAMINATION, http://www.usmle.org/about/.

73. *See generally* Holahan, *supra* note 3, at 111-17; SCHNEIDER, *supra* note 2, at 111-43.

74. *See* Huberfeld, *supra* note 3, at 29-30.