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MEDICAID: PAST SUCCESSES AND FUTURE CHALLENGES

Jane Perkins

I. INTRODUCTION

THIS ARTICLE DISCUSSES the Medicaid program. Medicaid uses federal and state government funding to provide health and long-term care coverage for low-income people who meet the program's eligibility requirements. Medicaid makes payments to qualified health care providers, including hospitals, clinics, nursing homes, and doctors in private practice.

Since its enactment as part of the Social Security Act in 1965, Medicaid has been an entitlement program for beneficiaries and states. Individuals who meet Medicaid eligibility requirements have a legal right to have payments made to their providers for the covered services they need. In addition, while state participation in Medicaid is voluntary, all States choose to participate. States have an open-ended entitlement to receive federal matching payments for all state spending on covered services. The federal payments do not come without strings attached, however, as States must implement their Medicaid programs consistent with minimum federal requirements.¹

¹ J.D., M.P.H. Jane Perkins is the Legal Director at the National Health Law Program, working in the Chapel Hill, N.C. office. Preparation of this article was made possible, in part, through a grant from the David and Lucile Packard Foundation and the Nathan Cummings Foundation. The opinions expressed in this article are entirely those of the author.
Medicaid covers one in seven people, more than any other public or private insurer in America, including Medicare.\(^2\) The program is the health care safety net for the poor, the elderly, and people with disabilities.

Medicaid coverage provides crucial protection to the most needy; however, despite its importance, Medicaid faces serious threats. After a period of slow growth, Medicaid spending is expected to increase in the coming years, particularly for people with disabilities and the elderly. These demands could be compounded by recession-driven increases in eligibility. To complicate matters, Medicaid does not have a wealth of political support behind it. Tied at its inception to the receipt of public benefits, the program has never shaken its stigma as a welfare program. Medicaid may become a target of legislative and judicial decisionmakers who are seeking to curb program spending and others who see the Medicaid entitlement as antithetical to their concepts of states’ rights and a reduced federal role.

Part II of this article provides an introduction to the rules of the Medicaid program, and Part III gives an overview of the populations served. Part IV outlines some of the successes that are attributable to the Medicaid program. These range from public health improvements to innovations in delivery of services in home and community-based settings. The last section of the article, Part V, focuses on major challenges that will face the Medicaid program in the next few years. Essentially, budget pressures and political philosophies that favor reducing the role of federal programs and protections will test Medicaid’s continued existence as an entitlement program. However, the entitlement is essential if Medicaid is going to continue to exist as insurance, as opposed to government largess. The entitlement allows beneficiaries to depend on and enforce Medicaid coverage just as individuals who are privately insured can enforce their rights to private insurance coverage. It also allows providers to depend on and enforce their rights to Medicaid payment after services have been provided.

\(^2\) In 1998, Medicaid covered 40.4 million Americans while Medicare covered about 39 million. Medicare spending, however, was $213.6 billion, compared to $169.3 billion in total Medicaid spending. KAISER COMM’N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MEDICAID: A PRIMER 2 (Mar. 2001), http://www.kff.org/content/2001/2248/2248.pdf [hereinafter MEDICAID: A PRIMER].
II. OVERVIEW OF THE MEDICAID PROGRAM RULES

Over its thirty-five year history, Medicaid has been expanded, restricted, and modified—all too often as part of eleventh-hour congressional compromises. Not surprisingly then, Medicaid is complex, confounding, and in the words of one judge, “almost unintelligible to the uninitiated.” Moreover, given the breadth of options available to the States for implementing Medicaid, there is great variation from state to state in terms of administration, eligibility, benefits, delivery systems, and provider payment.

Administration of the Medicaid program at the federal level is the responsibility of the Centers for Medicare and Medicaid Services (CMS), of the United States Department of Health and Human Services. CMS promulgates guidelines and regulations to implement the Medicaid statute and has the authority to withhold or terminate federal funding when a State is not complying with its approved State Medicaid plan.

Federal law requires each State to designate a “single State agency” to administer its Medicaid program. The single state agency cannot delegate its authority for exercising discretion in the administration of the program or for the issuance of policies and rules on program matters. Each State is required to have in

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3 In fact, Medicaid was the product of a last-minute political compromise when the Medicare program was enacted in 1965. For discussion of the background and compromise leading to enactment of Medicaid, see RAND E. ROSENBLAT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 415-21 (1997).

4 Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976) (Friendly, J.).


6 See 42 U.S.C.A. § 1396c (West 1992). The actual withholding of funds has rarely, if ever, been used. CONG. RESEARCH SERV., HOUSE SUBCOMM. ON HEALTH AND THE ENVIRONMENT, 103RD CONG., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) (stating the process has “never yet been carried to the point of actual withholding of funds”); see also, e.g., Arthur C. Logan Mem’l Hosp. v. Toia, 441 F. Supp. 26, 27 (S.D.N.Y. 1977) (holding that upon determination of noncompliance, federal government may withhold payments or negotiate with State but cannot compel compliance).


8 42 C.F.R. § 431.10(e) (2000). For additional discussion of single state agency requirements, see JANE PERKINS & SARAH SOMERS, NAT’L HEALTH LAW PRO-
effect a comprehensive, written state plan for medical assistance
that has been approved by the federal government. The plan
describes who is eligible for Medicaid, what services are cov-
ered, and how the program is administered. In general, the
State's Medicaid plan must conform to all requirements of fed-
eral law and operate statewide.

States must provide that all individuals wishing to apply for
Medicaid can do so without delay and ensure that assistance
will be furnished with reasonable promptness. States must also
establish a Medical Care Advisory Committee, which includes
Medicaid beneficiaries and knowledgeable providers, to advise
the single state agency on policy development and program ad-
ministration and to review marketing materials of Medicaid-
participating managed care organizations.

The federal and state governments, through matching pay-
ments, fund Medicaid services and administration. The federal
matching payments to states for Medicaid covered services can
vary from 50% to 83% of the total expenditures, with poorer per
capita income states receiving higher federal payments. It is
important to note, again, that Medicaid is not a grant of a finite
amount of money to the states each year but rather an open-
ended entitlement to the states of federal matching funding for
their lawful expenditures. In fiscal year 1999, Medicaid was the
single largest source of federal funding to the states, accounting
for nearly 40% of all federal grants-in-aid to the states.

A. Medicaid Eligibility—Fitting into a Category

An individual is not eligible for Medicaid simply because
he or she is poor. Rather, individuals must successfully pass

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10. See 42 U.S.C.A. § 1396a (setting forth many of the requirements States
must meet).
11. See id. § 1396a(a)(1) (providing the state plan be in effect in all political
subdivisions of the State); 42 C.F.R. § 431.50 (2000).
14. See 42 U.S.C. § 1396d(b) (providing the federal medical assistance per-
centage rates). Federal financial participation averaged 57% in 1998. MEDICAID: A
PRIMER, supra note 2, at 1.
15. MEDICAID: A PRIMER, supra note 2, at 6.
through four separate screens before being awarded a Medicaid card.\textsuperscript{16}

First, the individual must fit into a recognized eligibility category. There are currently about sixty Medicaid eligibility categories, some of which are mandatory while others may be offered at state option.\textsuperscript{17} The categories focus on four groups: children and their caretakers, pregnant women, the elderly, and people with disabilities.

For example, States must cover children under age six whose family incomes are below 133\% of the federal poverty level,\textsuperscript{18} and children between ages six and nineteen whose family incomes are below the federal poverty level.\textsuperscript{19} In most states, individuals who are receiving Supplemental Security Income (SSI) on the basis of disability also automatically qualify for Medicaid.\textsuperscript{20} For the most part, mandatory eligibility is characterized by absolute income standards that leave no room for an “over-income” individual to qualify by paying a premium or other cost sharing amount, regardless of their pressing need for health care.

By contrast, States have the option of covering the medically needy—persons who fit into a federal public benefit program category, such as SSI, but whose income or resources are

\textsuperscript{16} For more in-depth discussion of the Medicaid eligibility rules, see An Advocate’s Guide to Medicaid, supra note 8, at 3.3-3.62.

\textsuperscript{17} See 42 U.S.C.A. § 1396a(a)(10) (indicating both mandatory and optional categories).


\textsuperscript{20} See id. § 1396a(a)(10)(A)(II). To be disabled, a person must have a “medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.” Id. § 1382c(a)(C)(i). SSI was created in 1972 to provide cash assistance to the aged, blind and disabled who have limited income and resources. SSI provides a uniform federal payment, and States have the option to supplement this payment. Eleven States do not provide Medicaid automatically to persons receiving SSI. Under § 1902(f) of the Social Security Act, these States use their 1972 state assistance eligibility rules in determining Medicaid eligibility. See Social Security Amendments Act of 1972, Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381. These States, referred to as “209(b) states” after the provision of the Social Security Act enacting the option, are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.
above the eligibility levels for the benefit program.\textsuperscript{21} Such individuals qualify for Medicaid once their income, minus incurred medical expenses, is less than the State’s medically needy income level.\textsuperscript{22} States have the option to cover a number of other groups, including infants and pregnant women with incomes up to 185% of the federal poverty level,\textsuperscript{23} noninstitutionalized disabled children,\textsuperscript{24} working disabled individuals,\textsuperscript{25} and elderly and disabled persons with incomes below the federal poverty level.\textsuperscript{26}

In addition to fitting within an eligibility group, an individual must meet financial criteria by having limited income and resources.\textsuperscript{27} The individual must have the appropriate immigration status, in most cases United States citizenship.\textsuperscript{28} Finally,

\begin{itemize}
\item \textsuperscript{21} See 42 U.S.C.A § 1396a(a)(10)(C) (indicating that the state plan must include eligibility requirements for medical assistance, scope and duration of assistance and a single standard in determining eligibility). The following jurisdictions have medically needy programs: California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. States electing the 209(b) option, see supra note 20, must have a medically needy program for the aged, blind, and disabled. See 42 U.S.C.A. § 1396a(f) (stating the effective date is determinative of whether a state plan has a duty to provide medical assistance to aged, blind, or disabled individuals). For further discussion, see AN ADVOCATE’S GUIDE TO MEDICAID, supra note 8, at 3.16-3.19.
\item \textsuperscript{22} See 42 U.S.C.A. § 1396a(a)(17). While States have a great deal of flexibility in how they operate their medically needy programs, States choosing this option must include prenatal and delivery services for pregnant women and ambulatory services for children under age eighteen. Id. § 1396a(a)(10)(C)(ii)-(iii).
\item \textsuperscript{23} See id. §§ 1396a(a)(10)(A)(ii)(IX), 1396a(h)(1)(A)-(B).
\item \textsuperscript{24} See id. §§ 1396a(f)(1)(A)-(B), 1396a(h)(2)(A)(i).
\item \textsuperscript{25} See id. § 1396a(a)(10)(A)(ii)(XV). States may impose premiums and cost-sharing requirements on this covered group. See id. at § 1396o(g).
\item \textsuperscript{26} See id. § 1396a(a)(10)(A)(ii)(XIII).
\item \textsuperscript{27} See id. § 1396a(a)(17). For example, possession of a car with an equity value of $1,500, or less at state option, makes an applicant ineligible for Medicaid. See Hazard v. Sullivan, 44 F.3d 399, 405 (6th Cir. 1995) (upholding $1,500 limit on automobile exclusion); Noble v. Shalala, 870 F. Supp. 340, 309 (D. Colo. 1994) (same).
\item \textsuperscript{28} Most immigrants who arrive in the United States lawfully after August 22, 1996 are barred from receiving full-scope Medicaid benefits for at least five years, and Medicaid will only cover treatment of emergency medical conditions for these persons. 8 U.S.C. §§ 1611-15 (2000); see also 42 U.S.C.A. § 1320b-7(d) (West Supp. 2001) (describing citizenship or satisfactory immigration status verification requirement as a condition of an individual’s eligibility for State Medicaid benefits); Id. § 1396(b)(v) (describing how aliens receiving Medicaid benefits must either be permanent residents or aliens who require emergency care and meet other eligibility re-
the person must be a resident of the state where they are applying for Medicaid benefits. 29

Given the strict eligibility requirements, it is not surprising that not all poor people qualify for Medicaid. In 1999, Medicaid covered only 37% of non-elderly Americans with incomes below the federal poverty level. 30

B. Services—Structured to the Covered Populations’ Needs

Under federal law, States must provide coverage for certain services and may choose to cover other types of services when needed by program beneficiaries. States can impose “nominal” co-payments on services, typically prescriptions and physician visits. 31 However, given that Medicaid is serving low-income populations, many beneficiaries and services are exempt from cost sharing, including children and youth, pregnant women, nursing home residents, emergency services, family planning services, and hospice services. 32

Included in the mandatory benefit package that is available to most beneficiaries are: inpatient and outpatient hospital services, 33 physician services, 34 laboratory and x-ray services, 35 family planning services, 36 federally qualified health center services, 37 nurse-midwife services, 38 and pediatric nurse-

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29 42 C.F.R. § 435.403(a) (2000).
31 42 U.S.C.A. § 1396o(a)(3)(b)(3) (West Supp. 2001) (stating that “any deduction, cost sharing, or similar charge imposed under the plan . . . will be nominal in amount”); see 42 C.F.R. § 447.50 (2000).
34 42 U.S.C.A. § 1396d(a)(5)(A); see also 42 C.F.R. § 440.50 (defining term).
35 42 U.S.C.A. § 1396d(a)(5)(C); see also 42 C.F.R. § 440.30 (defining term).
36 42 U.S.C.A. § 1396d(a)(4)(C); see also 42 C.F.R. § 441.20 (2000) (providing the necessary conditions for a recipient to receive family planning services).
38 42 U.S.C.A. § 1396d(a)(17); see also 42 C.F.R. § 440.165 (defining term).
practitioner services.\textsuperscript{39} States must also cover home health services for any individual who is eligible to receive nursing facility services.\textsuperscript{40} As described more fully below, States must also cover Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children and youth under age twenty-one.\textsuperscript{41}

There are twenty-three optional services that States can choose whether to cover for adults,\textsuperscript{42} including prescription drugs,\textsuperscript{43} dental services,\textsuperscript{44} physical and related therapies,\textsuperscript{45} home health services,\textsuperscript{46} intermediate care facility services for the mentally retarded,\textsuperscript{47} and personal care services.\textsuperscript{48} States can also provide transportation as an optional Medicaid service, which includes expenses for transportation and other travel-related expenses necessary to secure medical examinations and treatment for a beneficiary.\textsuperscript{49} If a State chooses to cover an optional service, it must provide the service to all eligible individuals.\textsuperscript{50}

Although Congress listed the mandatory and optional benefits, it did not explicitly define the minimum level of each service to be provided. Rather, the Medicaid Act requires States to establish reasonable standards for determining the extent of medical assistance. "Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose."\textsuperscript{51} For example, while a State can limit coverage of inpatient hospital days to, for example, twenty-one days per year, it should not be

\textsuperscript{39} 42 U.S.C.A. § 1396d(a)(21); see also 42 C.F.R. § 440.166 (defining term).
\textsuperscript{40} 42 U.S.C.A. § 1396a(a)(10)(D) (Supp. 2001); see also 42 C.F.R. § 440.70 (2000) (defining term).
\textsuperscript{41} See 42 U.S.C.A. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
\textsuperscript{42} EPSDT makes these services mandatory for children when needed to correct or ameliorate a physical or mental condition. See infra notes 73-83 and accompanying text.
\textsuperscript{43} 42 U.S.C.A. § 1396d(a)(12); see also 42 C.F.R. § 440.120 (defining term).
\textsuperscript{44} 42 U.S.C.A. § 1396d(a)(10); see also 42 C.F.R. § 440.100 (defining term).
\textsuperscript{45} 42 U.S.C.A. § 1396d(a)(11); see also 42 C.F.R. § 440.110 (defining term).
\textsuperscript{46} 42 U.S.C.A. § 1396d(a)(7); see also 42 C.F.R. § 440.70 (defining term).
\textsuperscript{47} 42 U.S.C.A. § 1396d(a)(15); see also 42 C.F.R. § 483.400 (defining terms).
\textsuperscript{48} 42 U.S.C.A. § 1396d(a)(24); see also 42 C.F.R. § 440.167 (defining term).
\textsuperscript{49} See 42 U.S.C.A. § 1396d(a)(27); 42 C.F.R. § 440.170. Related travel expenses include the cost of transportation for the service recipient, the cost of meals and lodging to and from care, and necessary attendant care. Id. § 440.170(a)(3)(i)-(iii). State Medicaid plans must describe how States will ensure necessary transportation for beneficiaries to and from providers. See 42 U.S.C.A. § 1396a(a)(4)(A); 42 C.F.R. § 431.53(a).
\textsuperscript{51} 42 C.F.R. § 440.230(b).
able to limit these services to one day per year.\textsuperscript{52} States cannot arbitrarily deny or reduce the amount, duration, or scope of services to an otherwise eligible individual solely because of the diagnosis, illness, or condition.\textsuperscript{53} For example, a State should not be able to exclude drugs needed by people because they are suffering from HIV/AIDS.\textsuperscript{54}

States also have substantial flexibility to decide how they will deliver services to Medicaid beneficiaries and how providers will be paid. Traditionally, States have set provider participation rules and paid providers who choose to participate a fee for each service rendered. Over the last fifteen years, however, Medicaid has shifted dramatically toward managed care delivery that emphasizes prepaid or discounted services and utilization controls, such as prior authorization requirements before providers can render services. Over half of all Medicaid beneficiaries were enrolled in managed care by June 1999.\textsuperscript{55} What started with enrollment of children and families has now expanded to include persons with disabilities. In 1998, about one-fourth of Medicaid beneficiaries with disabilities were enrolled in managed care.\textsuperscript{56}

\section*{III. MEDICAID'S DIVERSE PROGRAMS}

Medicaid's array of eligibility and service options is designed to include and meet the needs of the target populations—children, people with disabilities, and the elderly—who cannot afford to purchase insurance themselves and who the commercial insurance marketplace avoids. While it is treated as a single program, Medicaid is really four separate programs, each with populations, services, and expenditures that differ from one another. These four programs are: a long-term care program for the elderly and people with disabling and chronic health needs, a "Medigap" program for elderly and disabled individuals who

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\item \textsuperscript{52} See, e.g., Charleston Mem'\textquoteright m Hosp. \textit{v.} Conrad, 693 F.2d 324 (4th Cir. 1982) (upholding twelve day annual limit on inpatient hospital services because levels of care were sufficient to reasonably achieve their purpose).
\item \textsuperscript{53} 42 C.F.R. \textsection 440.230(c).
\item \textsuperscript{54} See Weaver \textit{v.} Reagan, 886 F.2d 194 (8th Cir. 1989) (holding that Missouri Medicaid may not deny coverage of the drug AZT to AIDS patients who are eligible for Medicaid).
\item \textsuperscript{56} \textit{Id.}
\end{itemize}
cannot afford Medicare cost sharing, a children's health pro-
gram, and a provider support program that helps assure the vi-
ability of the public health infrastructure serving Medicaid and
low-income patients. Each of these programs is described be-
low.

A. The Long-Term Care Program

Medicaid's coverage of long-term care services is a key
difference between Medicaid and other public and private insur-
ers. Medicaid is the largest single purchaser of long-term care
services for the elderly and non-elderly people with disabilities
in the United States. In 1998, Medicaid funded almost half of
the total nursing home expenditures and nearly 40% of total
long-term care expenditures in the United States. Long-term
care services represent 42% of total Medicaid spending. In
eleven states—Connecticut, Indiana, Kansas, Minnesota, Ne-
braska, New Hampshire, North Dakota, Ohio, Pennsylvania,
Wisconsin, and Wyoming—Medicaid spending on long-term
care exceeds spending on acute care services.

Elderly persons and people with a wide range of disabilities
qualify for long-term care services, including individuals with
physical impairments, mental health conditions, cerebral palsy,
cystic fibrosis, Down's syndrome, autism, and HIV/AIDS.
Unlike private health insurance, Medicaid coverage is available
without pre-existing condition exclusions or waiting periods on

57 KAISER COMM’N ON MEDICAID AND THE UNINSURED, KAISER FAMILY
FOUND., LONG-TERM CARE: MEDICAID'S ROLE AND CHALLENGES 8 (Nov. 1999),
http://www.kff.org/content/2000/2172/LongTermCare.pdf. Medicare, the federally
funded and administered program for the elderly and persons with disabilities would
seem a logical choice for the long-term care “program;” however, Medicare coverage
is focused on acute services and long-term care services are limited. Id. For example,
“benefits are limited to people who are homebound, require skilled nursing, physical
therapy or speech therapy on a part-time or intermittent basis and are under the care
of a physician.” Id. at 9. Commercial insurers generally have avoided the long-term
care market and, while coverage is growing, quality policies are often affordable only
to middle and upper income persons who do not qualify for Medicaid. Id. at 10.
58 MEDICAID: A PRIMER, supra note 2, at 2. Between 1990 and 1998, in fact,
spending for home care grew at an average annual rate of 18%, compared to only a
3% growth rate for intermediate care facility services and 12% for acute care ser-
vices. KAISER COMM’N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY
FOUND., MEDICAID’S ROLE IN LONG-TERM CARE (Mar. 2001), http://www.kff.org/
content/2001/2186.pdf [hereinafter MEDICAID: LONG-TERM CARE].
59 MEDICAID: LONG-TERM CARE, supra note 58.
60 MEDICAID: A PRIMER, supra note 2, at 9.
Medicaid coverage. Medicaid is the single largest insurer, public or private, for people under age sixty-five with disabilities, including developmental disabilities. Moreover, almost three-fourths of the projected increase in Federal Medicaid spending from 2001 to 2006 is associated with the provision of health care to disabled and elderly beneficiaries. One in five people with a disability in the United States qualifies for Medicaid. The program is especially important to the 30% of children with chronic disabling conditions who qualify for Medicaid.

The long-term care services provided through Medicaid include institutional care, such as nursing home care and, at state option, intermediate care facility services for the mentally retarded. About 70% of Medicaid long-term care expenditures are for nursing home and other institutional care. Long-term care services also include home and community-based care, such as home health aides, durable medical equipment, prescription drugs, physical and related therapies, and personal care attendants who assist with activities of daily living (e.g., eating, bathing, dressing). Many States have obtained “waivers” from the federal government that allow them to disregard some Medicaid Act requirements and target home and community-based services to limited numbers of Medicaid beneficiaries who would otherwise qualify for institutional care, primarily persons who are developmentally disabled, the frail elderly, and young children born with AIDS-related conditions or drug dependency. From 1990 to 1998, home and community-based spending increased at an annual rate of 18.2% versus an 8.2% rate for spending on nursing home care. During this same period, the number of persons with mental retarda-

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63 Medicaid: Long-Term Care, supra note 58.

64 42 U.S.C.A § 1396n(b) (West Supp. 2001).

65 Medicaid: Long-Term Care, supra note 58.
tion/developmental disability who received services through waiver programs increased by more than 200,000 persons.\textsuperscript{66}

While States’ application processes for long-term care services may differ somewhat, there are some special rules that all States must apply. State Medicaid agencies must apply special eligibility rules to individuals who are entering a nursing home and who have a spouse living at home. These rules allow couples to protect some of their income and resources for the at-home spouse, thus allowing the institutionalized spouse to qualify for Medicaid sooner and preventing the at-home spouse from becoming impoverished by the institutionalized spouse’s ongoing nursing home bills.\textsuperscript{67}

B. The Medicare Supplemental Insurance Program

Medicaid is also a financial support program for Medicare beneficiaries who cannot afford to pay the program’s cost sharing amounts. To understand this Medicaid program, a brief explanation of Medicare is needed.

Medicare is a federally funded health insurance program for people sixty-five years of age and older and some disabled persons. Eligibility is not means-tested, so Medicare beneficiaries are not required to have limited income and resources as with Medicaid. Medicare coverage emphasizes services for acute, rather than long-term care. For example, outpatient prescription drugs are not a covered benefit. Medicare hospital insurance, called Part A, helps pay for inpatient hospital services, skilled nursing and home health services following a hospital stay, and hospice care. Medicare medical insurance, called Part B, helps pay for doctors’ services, outpatient hospital care, ambulance services, medical equipment, and prosthetic devices. Medicare requires beneficiaries to share in the cost of their health care. For example, in 2001, a patient must pay a $792 deductible before Medicare will begin covering a hospital stay and a $100 annual deductible and $50 monthly premium for Part B medical insurance.\textsuperscript{68} Those who can afford to do so often purchase supplemental “Medigap” insurance from a private in-

\textsuperscript{66} DAVIS ET AL., supra note 61.
\textsuperscript{67} See 42 U.S.C.A. § 1396r-5.
surer to fill the gaps created by Medicare’s cost sharing requirements and limited services.

Not everyone can afford Medigap insurance. The Medicaid supplemental insurance “program” fills this gap for many Medicare beneficiaries. Legislation passed in 1988 required States participating in the Medicaid program to begin paying the Medicare premiums and cost-sharing amount for certain low-income Medicare beneficiaries with incomes below the federal poverty level. Over the years, supplemental coverage has been broadened to include additional groups, for example to cover Medicare Part B premiums for Medicare beneficiaries with incomes between 100% and 120% of the federal poverty level.

The Medicaid supplemental insurance program has become a critical benefit to many Medicare beneficiaries. By 1997, over half of Medicare beneficiaries with incomes below the federal poverty level relied on Medicaid for supplemental health insurance coverage of Medicare benefits. In 1997, Medicaid paid the Part B premiums for six million low-income elderly and disabled Medicaid beneficiaries, about 14% of the total Medicare population.

C. The Children’s Health Program

One of the Medicaid program’s primary beneficiary groups is children under age twenty-one. In 1998, Medicaid covered one-fourth of the children in America. Over 50% of Medicaid beneficiaries were children and youth—about twenty-one million children. Another 21% of program beneficiaries (over eight million people) were adult caretakers with children. Even though children and their caretakers represent about three-fifths of the Medicaid population, they account for only 25% of program spending.

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69 See 42 U.S.C.A. § 1396d(p).
70 See id. § 1396a(a)(10)(E)(ii).
72 MEDICAID: A PRIMER, supra note 2, at 2.
73 Id. at 1.
74 Id.
75 MEDICAID AT A GLANCE, supra note 55. In 1998, Medicaid spending averaged $1,225 per child, compared to $11,235 for each elderly beneficiary and $9,558 for each disabled beneficiary. MEDICAID: A PRIMER supra note 2, at 5.
As noted above, all children under age six with family incomes below 133% of the federal poverty level qualify for Medicaid, and all children between the ages of six and eighteen with family incomes below the federal poverty level qualify. States have the option to extend Medicaid to higher income children, for example all children with family incomes below 200 percent of the federal poverty level.

Children who qualify for Medicaid are eligible to receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT covers four separate, periodic screening services—medical, vision, hearing, and dental—and includes immunizations, lead blood tests, and health education. The treatment component of EPSDT must include any necessary health care, treatment, and other measures—if included in the Medicaid Act as a mandatory or optional service—when needed to "correct or ameliorate" physical and mental illnesses and conditions, whether or not such services are covered for adults in the State’s Medicaid program. EPSDT also includes outreach requirements to make sure children and families know about the program and appointment scheduling and transportation assistance, if needed.

EPSDT coverage is significant for its recognition that low-income children suffer disproportionately from illness and disabling conditions and that children's health and developmental needs differ from those of adults. President Johnson summed up the goal of the EPSDT program when introducing the legislation as a 1967 amendment to the Medicaid Act:

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77 See id. §§ 1396a(a)(10)(A)(i)(VII), 1396a(j)(1)(D).
78 See id. §§ 1396a(r)(2), 1396u-1(b)(2)(C) (stating that less restrictive income and resource methodologies than used under the state plan are permissible under Medicaid); 42 C.F.R. § 435.601 (2000); 42 C.F.R. § 435.1007 (2001) (promulgated by 66 Fed. Reg. 2316 (Jan. 11, 2001) (final rule), but noting that effectiveness was delayed until May 11, 2001 by 66 Fed. Reg. 14343 (Mar. 12, 2001)). For additional discussion, see AN ADVOCATE’S GUIDE TO MEDICAID, supra note 8, at 3.19.
80 See id. §§ 1396a(a)(43), 1396d(r)(5).
81 Id. § 1396d(r)(5).
82 See id. § 1396a(a)(43); 42 C.F.R. §§ 441.50-.62 (2000). The regulations pre-date the most recent statutory amendments and thus do not reflect the statutory changes. For more information about EPSDT, see AN ADVOCATE’S GUIDE TO MEDICAID, supra note 8, at 4.4-4.5, 4.16-4.19.
The problem is to discover, as early as possible, the ills that handicap our children. There must be a continuing follow-up and treatment so that handicaps do not go neglected.

We must enlarge our efforts to give proper eye care to a needy child. We must provide help to straighten a poor youngster's crippled limb before he becomes permanently disabled. We must stop tuberculosis in its first stages, before it causes serious harm.\(^{83}\)

D. The Provider Support Program

Medicaid’s fourth “program” acts as a major financial support system for a wide range of health care providers who serve low-income people and people with disabilities. Medicaid is a “vendor payment program,” meaning that payments are made directly to health care providers, not patients. Large numbers of private health care providers—individual practitioners, physician group practices, proprietary nursing homes, community hospitals, and public hospitals—participate in Medicaid. In 1998, over 5,000 community hospitals, 15,000 nursing homes, 7,000 group homes and institutions for the mentally retarded, 700 community health centers, and 585 managed health care plans participated in Medicaid.\(^{84}\)

Some providers are more dependent on Medicaid than others—nursing homes, community health centers, and disproportionate share hospitals (DSHs) that serve a disproportionate number of Medicaid and other low-income people. For example, Medicaid covers 33% of patients using community health centers and more than 35% of patients using public hospitals.\(^{85}\)

Payments to DSHs have been particularly significant. These payments, first authorized by Congress in 1981, are in addition to the payment that the hospital receives from Medicaid when it provides services to a Medicaid beneficiary. States have flexibility to decide which hospitals qualify. In the past, States and hospitals have used definitional and funding schemes to maximize federal DSH payments. Federal contributions to

\(^{83}\) 113 CONG. REC. 2883 (Feb. 8, 1967).
\(^{84}\) MEDICAID: A PRIMER, supra, note 2, at 2.
\(^{85}\) Id.
these activities were curbed in the early 1990s, when Congress began imposing ceilings on Medicaid DSH payments.\textsuperscript{86} Nevertheless, DSH spending has grown disproportionately to the point where, in 1998, payments to DSHs represented fully 8% of total Medicaid spending.\textsuperscript{87} In 1998, Connecticut, Missouri, and South Carolina paid more total dollars to DSHs than on children’s services; in Louisiana, payments to DSHs topped spending on children and the elderly.\textsuperscript{88}

IV. MEDICAID’S SUCCESSES—CRITICAL TO BENEFICIARIES, STATES, AND PROVIDERS

Medicaid has achieved a remarkable number of significant successes that, unfortunately, often go unacknowledged. For over three decades, Medicaid has offered insurance coverage to millions of people who would otherwise be uninsured because they cannot afford to pay for private insurance, their employers do not offer insurance, or their chronic health conditions have deemed them uninsurable by the commercial marketplace. Currently, Medicaid covers 26.1% of the elderly,\textsuperscript{89} 40.1% of all children,\textsuperscript{90} and 20% of persons with disabilities in America. Medicaid coverage has improved access to needed health care and the health status of its enrollees. When compared with the uninsured, people on Medicaid are better able to get needed medical care, medications, and mental health care.\textsuperscript{91} Children with insurance are more likely to receive routine screening examinations for conditions such as asthma, recurring ear infections, and sore throats; uninsured children are 70% more likely not to receive care for such problems.\textsuperscript{92} Medicaid coverage also reduces expensive and avoidable hospital admissions, for condi-

\textsuperscript{86} See 42 U.S.C.A. §§ 1396a(a)(13)(A), 1396r-4(f) (describing the DSH payment requirements and new restrictions on federal payments).

\textsuperscript{87} MEDICAID: A PRIMER, supra note 2, at 5.

\textsuperscript{88} Id. at 8.

\textsuperscript{89} HOFFMAN \& POHL, supra note 30, at 18 tbl.4.

\textsuperscript{90} Id. at 19 tbl.5. The enrollment of children and their caretakers has declined in recent years. See CATHERINE HOFFMAN & ALAN SCHLOBOHM, HENRY J. KAISER FAMILY FOUN., UNINSURED IN AMERICA: A CHART BOOK 6-7 (2d ed. Mar. 2000), available at http://www.kff.org/content/archive/1407/Uninsured in America.pdf. Many of those losing AFDC remained eligible for Medicaid. See supra note 30 and accompanying text.

\textsuperscript{91} See HOFFMAN \& SCHLOBOHM, supra note 90, at 67; see also, e.g., INST. OF MED., COVERAGE MATTERS: INSURANCE AND HEALTH CARE 19-33 (2001) (discussing how individuals who lack health insurance are less likely to receive health services).

\textsuperscript{92} HOFFMAN \& SCHLOBOHM, supra note 90, at 70.
tions such as diabetes and malignant hypertension. By contrast, the loss of Medicaid decreases access to care. One study found no differences in access among Medicaid beneficiaries studied in 1995; however, those persons who lost Medicaid between 1995 and 1997 were "far more likely" to experience problems getting health care than persons whose Medicaid coverage continued.93

Medicaid's positive influences go beyond lowering the ranks of the uninsured, however. The program has improved and protected public health. For example, Medicaid has helped the United States provide near-universal protection against debilitating, communicable childhood diseases. In 1993, the Medicaid Act was amended and the Vaccine for Children program enacted.94 This program has made free vaccines available to children under age eighteen who are on Medicaid, of Native American descent, or who are uninsured for immunization coverage.95 Since 1993, childhood immunization rates have reached all-time highs, with 90% or more of children receiving critical doses of recommended vaccines by age two. In addition, reported levels of disease have fallen to at or near all time lows.96 Medicaid has also played a major role in reducing infant mortality rates through a series of expansions during the 1980s to enroll infants and children for ambulatory care services and pregnant women for prenatal care services.97 Medicaid's coverage

93 Id. at 62. The number of uninsured Americans dropped for the second straight year in 2000 to 38.7 million. Robert Pear, Number of Uninsured Drops for 2nd Year, N.Y. TIMES, Sept. 28, 2001, at A20.
95 Id. § 1396s(b).
97 See 42 U.S.C.A. § 1396a(a)(10). Since 1990, the infant mortality rate has "declined dramatically" from 8.9 deaths per 1000 live births in 1990 to 7.2 deaths per
rules have also been targeted to allow States to address such public health concerns as HIV/AIDS and tuberculosis.\textsuperscript{98} Women can now enroll in Medicaid to obtain treatment for breast and cervical cancer.\textsuperscript{99}

Medicaid has provided essential services for people with disabilities that are not generally available through private health insurance coverage. Private health insurance, rooted in the workplace, was not designed to cover people with chronic, disabling conditions. Thus, the benefit packages offered by private insurers are geared toward acute care services and "rehabilitation," that return the insured to their previous level of functioning. By contrast, the benefits package offered by Medicaid includes coverage of long-term care services and services which help maximize functioning, such as home health services, durable medical equipment, prosthetic devices, and personal care attendant services.

Though not exclusively designed for working individuals, Medicaid coverage has also created work incentives. For example, thirty-five states and the District of Columbia have chosen to offer medically needy programs that allow individuals to spend down their excess income and become eligible for Medicaid, thus eliminating arbitrary income cut-offs that would discourage individuals from working.\textsuperscript{100} Since 1999 States also have been able to continue Medicaid coverage of people with disabilities who return to work. Without Medicaid, these individuals would risk losing health insurance coverage and experience long waiting periods for private insurance through their workplace.\textsuperscript{101}

\textsuperscript{98} See \textit{42 U.S.C.A. §§ 1396a(a)(10)(A)(ii)(XII), 1396a(z)} (authorizing coverage of tuberculosis-related services); \textit{Id. § 1396n(e)} (providing that a Medicaid program can include medical assistance to children infected with AIDS or dependent upon cocaine, heroin, or phencyclidine).


\textsuperscript{100} See supra notes 21-22 and accompanying text.

Medicaid has ensured beneficiaries a basic level of consumer protection in their receipt of covered services. The Medicaid Act requires participating nursing homes to provide services and activities to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" and to meet a set of basic consumer protections, called requirements of participation. Among other things, nursing homes must make initial and ongoing assessments of each resident's well-being and, thereafter, develop and maintain a written plan of care, employ properly trained and licensed nurse aides, allow residents to make free choices, and limit the use of restraints. Medicaid also requires prior notice before services are denied, reduced or terminated and an opportunity to be heard by an impartial decisionmaker when claims for assistance are denied or not acted on promptly. This requirement provides beneficiaries with a basic level of protection concerning eligibility and service determinations. These protections are particularly important when there are discounted or capped rates to health plans and providers. These situations can create a financial incentive to provide reduced services to needy individuals. The basic consumer protection of notice and opportunity to be heard serves as a counter-balance to this financial incentive.

Finally, Medicaid programs have been innovators in the development of home and community-based care programs for people with disabilities, particularly the frail elderly and developmentally disabled. For instance, one optional Medicaid service, called Program for All-Inclusive Care for the Elderly (PACE), allows States to integrate the financing and delivery of

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102 42 U.S.C.A. § 1396r(b)(2).
103 See id. § 1396r.
104 See id. § 1396a(a)(3); 42 C.F.R. § 431.200 (2000).
acute and long-term care services for frail elderly persons and, in most instances, offer them services through a single service portal of entry. Oregon has elected this option. In addition, since receiving the first Medicaid home and community-based care waiver in the early 1980s, Oregon has developed a range of alternative living arrangements, including foster care homes and assisted living facilities, to offer the most progressive senior and disabled services system in the country, while its long-term care costs are the tenth lowest. In addition to introducing administrative and financing efficiencies, these Medicaid innovations have enabled program beneficiaries to live and interact in independent community settings with and near their families.

V. MEDICAID’S CHALLENGES

Despite its unquestionable successes, Medicaid faces serious challenges. Of particular concern is whether Medicaid will remain an entitlement program. There will undoubtedly be disagreement over Medicaid’s future role because the program involves diverse players who often have competing interests but unequal bargaining power—such as federal policy makers, state governors, judges, managed care companies, nursing homes, community clinics, hospitals, private practitioners, and beneficiaries. In this debate, it will be critical to examine the entitlement status of Medicaid openly and fully in order to understand its implications. Otherwise, the perhaps unintended consequences of losing the entitlement—through, for example, federal grants of unchecked flexibility to states or novel opinions from the judiciary—will not be appreciated until it is too late.

A. Budget Pressure and the Call for Flexibility

Over the next few years, Medicaid will face political challenges and budgetary pressures at the state and federal levels. Such challenges have arisen before. In past sessions, Congress has considered making Medicaid a capped annual allocation to the states, known as a “block grant.” Future Congresses will re-

106 See 42 U.S.C.A. §§ 1396d(a)(26), 1396u-4; see also Herbert Semmel, Access to Home Health Care Through Medicare and Medicaid: The Program of All-Inclusive Care for the Elderly, 34 CLEARINGHOUSE REV.: J. OF POVERTY L. & POL’Y 311 (2000) (describing the PACE program); Coordination, Choice, and Value in Long-Term Care, 7 STATES OF HEALTH (Community Catalyst, Boston, MA), May 1997, at 3-4 (same) [hereinafter Coordination, Choice, and Value].

107 See Coordination, Choice, and Value, supra note 106, at 2-3.
examine the program, and even though it is a relatively small portion of the total federal budget (about 7%), Medicaid may be a prime budget-cutting target when matched against larger, but more politically popular entitlement programs, such as Social Security, Medicare, and military and civilian retirement programs.

What will be different in this round of debate is the increased pressure Medicaid will experience at the state level. Medicaid is already a significant portion of total state spending, representing, on average, 15% of state general fund expenditures. Many States are now dealing with balanced budget requirements and the effects of tax cuts, and Medicaid will not escape scrutiny. Almost half the States cited higher-than-expected Medicaid spending or Medicaid shortfalls as an important legislative issue for their upcoming legislation sessions.

The National Governor's Association has included increased Medicaid flexibility as a key national health policy position in 2001. To complicate matters, Medicaid spending is expected to increase over the next five years. Nearly three-quarters of this spending will be tied to utilization of and inflation in the price of health services for the elderly and disabled, with current beneficiaries accounting for the majority of the total increase. However, enrollment of newly-eligible disabled beneficiaries is also expected to outpace that of other groups and account for about one-fifth of the total increase in spending!

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108 Medicaid: A Primer, supra note 2, at 1.
109 Id.
110 See Matthew Mosk, Maryland Racks Up $150 Million Medicaid Debt, Wash. Post, Oct. 2, 2001, at B1 (noting several States experiencing shortfalls in Medicaid funding, including California, Maryland, Massachusetts, Michigan, North Carolina, and Vermont, and the cutbacks that may result).
111 Ku & Guyer, supra note 62, at 3. Over the next decade, the Congressional Budget Office projects that the state share of Medicaid spending will increase significantly, from $88 billion to $202 billion. Cong. Budget Office, An Analysis of the President's Budgetary Proposals for Fiscal Year 2001 (Apr. 2000), http://www.cbo.gov/showdoc.cfm?index=1908&sequence=3&from=1.
112 See Nat'l Governor's Ass'n, Policy Position Detail: Medicaid Policy HR-16 (2001), http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION?D_533,00.html.
113 Ku & Guyer, supra note 62, at 4. Spending related to additional beneficiaries will average only 1.7% per year. Id.
114 Id. at 2.
state) of covering a person with a disability to increase from $10,600 in fiscal year 2001 to $15,600 in fiscal year 2006; the cost of covering an elderly person to rise from $11,900 to $17,100; and the cost of covering a child to increase from $1,400 to $2,000.\textsuperscript{115}

Increases in the use and price of outpatient prescription drugs will also be a major source of Medicaid spending—particularly for the elderly and disabled. Drug spending is expected to rise about 70\% faster than overall Medicaid spending between 2001 and 2006.\textsuperscript{116}

While States will be faced with increasing spending demands, Congress has recently restricted a funding scheme that has allowed a number of States to obtain significant federal matching payments from Medicaid without making an actual matching expenditure from state funds. One example occurs where the State calculates the maximum amounts that can be paid to public hospitals, claims federal matching dollars based on these maximized rates, and then requires the hospitals to transfer large portions of the excessive payments back to the state government. These funds become part of the general state revenue and can be used for any purposes, including tax cuts and other actions unassociated with Medicaid.\textsuperscript{117} The Congressional Budget Office labeled these arrangements the “most notable factor” causing Federal Medicaid spending to increase in recent years.\textsuperscript{118} In 2000, Congress passed legislation to restrict use of these sorts of funding arrangements.\textsuperscript{119} In the coming years, States that have been using these schemes will be forced to come up with other sources of funding or curtail spending.

\textsuperscript{115} \textit{Id.} at 6.
\textsuperscript{116} \textit{Id.} at 5.
\textsuperscript{117} \textit{See} Letter from Timothy M. Westmoreland, Director, Health Care Fin. Admin., to State Medicaid Director (July 26, 2000), \url{http://www.hcfa.gov/medicaid/smd72600.htm} (explaining how state procedures directing county and municipal facilities to transfer excessive Federal Medicaid funds back to state government has lead to federal action).
Notably, spending increases will not be attributable to two commonly argued reasons. First, critics point to the cost of implementing federal mandates as a cause of the increase in Medicaid spending. However, the last major mandate was the 1990 expansion of Medicaid to older children and youth. Second, there are complaints about the costs associated with covering children and parents. In fact, recent spending for these two groups is quite small—just two-tenths of one percent.

With increasing demands expected on the health care delivery system from a population that is aging and increasingly disabled, the question becomes, what can be done to assure needed care while also keeping spending in check? The Bush administration has announced the Health Insurance Flexibility and Accountability Initiative (HIFA), a program to increase States’ flexibility to operate their Medicaid programs by waiving provisions of the Federal Medicaid Act. The HIFA proposal ostensibly is designed to grant States rapid approval of requests that have as their goal coverage of currently uninsured populations in the state whose incomes are below 200% of the federal poverty level—for the most part, childless adults and near-poor children. To accomplish this, however, a State cannot increase the amount of federal money currently spent on or allocated to the State for its Medicaid program. To meet this requirement for “budget neutrality,” the States will be given unprecedented ability to reduce coverage of optional eligibility groups, alter the benefit package for currently-covered optional eligibility groups and for the expansion group, and to impose increased cost-sharing on these groups.

This latter aspect of the proposal raises numerous concerns. First, flexibility already has failed as the magic bullet. Over the past decade, state flexibility already has been greatly enhanced, through the use of waivers, to allow mandatory managed care and other cost containment initiatives. However, as discussed above, Medicaid spending is, nevertheless, projected to in-

120 See NAT’L GOVERNOR’S ASS’N, supra note 112, at §16.1 (calling for reduction in “federal statutory and regulatory micro-management that has typified the program in the last decade”).
121 Ku & Guyer, supra note 62, at 8.
crease. Other factors beyond the control of state and federal policy makers are at the root of the spending increases—the aging of the population, increases in the number of people who are disabled, and health care price inflation.

Second, to the extent they result in cutbacks to maintain budget neutrality, the HIFA waivers will have the greatest impact on the elderly and disabled who are heavily dependent on Medicaid’s optional service and eligibility categories and who would face bleak prospects for obtaining needed services through the private insurance market. Almost half of all Medicaid spending is for optional eligibility populations and services, and most of this spending is attributable to the elderly and disabled. Significantly, the optional home-based services used by the elderly and people with disabilities have allowed them to move from unnecessarily restrictive institutional placements to more independent community settings.

Third, a HIFA initiative that cuts optional service and eligibility groups would be the expedient, but shortsighted, choice. As noted, each HIFA proposal will extend health coverage to currently uninsured persons, primarily childless, nondisabled adults and near-poor children. While the goal of reducing the ranks of the uninsured is certainly laudable, it will come at the expense of the elderly and disabled. It will, in effect, replace high need, high cost groups with relatively low need, low cost individuals. The elderly and disabled persons affected by the cuts in optional eligibility and services that may be needed to provide budget neutrality will almost certainly themselves become uninsured and underinsured because it is unlikely they will have access to either affordable commercial insurance products or products that meet their health care needs.

Fourth, the HIFA initiative could undermine Medicaid’s existence as an entitlement program. Caps on enrollment are allowed; therefore, for the populations affected by the cap,

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123 Medicaid: A Primer, supra note 2, at 6.
124 The HIFA initiative comes at an interesting time, on the heels of renewed efforts by people with disabilities and disability advocates to improve the availability of home and community-based services following the Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999). Olmstead holds the Americans with Disabilities Act to prohibit States in their public programs from unnecessarily institutionalizing persons with disabilities. Among other things, Olmstead found a need for States to have a “comprehensive, effectively working plan” for placing qualified individuals in less restrictive settings and waiting lists that move at a “reasonable pace.” Id. at 605-06.
Medicaid will not be an open-ended entitlement. Moreover, States will be allowed to expand coverage to uninsured groups through Medicaid or another program, the State Children's Health Insurance Program (SCHIP). SCHIP currently allows States to expand coverage to uninsured near-poor children by expanding the Medicaid program or by establishing a separate program, typically with more limited benefits and, according to Congress, minus the legal entitlement for beneficiaries. By implementing their HIPA waiver through a separate program, States can seek to avoid providing beneficiaries with a legally enforceable right to the covered benefits.

An alternative approach has been suggested by Rosenbaum and Rousseau, who call for thoughtful modernizing of the Medicaid program without sacrificing the entitlement that provides beneficiaries and providers with legally enforceable insurance protections. Among others things, they suggest placing a greater responsibility for financing the program at the federal level; restructuring eligibility to, for example, allow the near-poor to qualify through flexible cost-sharing; simplifying administration using, for example, annual enrollment periods and enrollment sites away from welfare offices; separating the benefit package into acute and long-term components to allow for stable managed care purchasing; and federalizing payment policies for certain safety net providers.

B. Medicaid Enforcement in the Courts

The legislative and administrative policy negotiations surrounding the Medicaid program will take place in the public

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125 See 42 U.S.C.A § 1397aa(a) (West Supp. 2001). For additional overview to the rules governing SCHIP, see AN ADVOCATE’S GUIDE TO MEDICAID, supra note 8, at 3.11-3.12.

126 Presumably, States will be able to maintain budget neutrality of an SCHIP expansion by cutting optional Medicaid eligibility and services, a process that would end the insurance entitlement for the current beneficiaries who are affected by the cuts. For discussion of other concerns, see Edwin Park & Leighton Ku, CTR. ON BUDGET AND POL’Y PRIORITIES, ADMINISTRATION MEDICAID AND SCHIP WAIVER POLICY ENCOURAGES STATES TO SCALE BACK BENEFITS SIGNIFICANTLY AND INCREASE COST-SHARING FOR LOW-INCOME BENEFICIARIES (Aug. 2001), http://www.cbpp.org/8-15-01health.htm (discussing the potential impact of increased cost-sharing and the lack of a requirement that States reinvest savings from reduced benefits in expanded coverage).


128 See id. at 43-49.
arena. By contrast, there are complex activities underway in the federal judiciary that are garnering scant public attention but that could have an enormous effect on the rights of poor people and people with disabilities, particularly those enrolled in the Medicaid program. In this judicial setting, the questions are not related to Medicaid costs and who should be covered, but instead focus on whether Medicaid is an enforceable legal right. In other words, courts are determining whether beneficiaries have an individual private right of action when eligibility and services are not provided as required by the Federal Medicaid Act.

The Medicaid Act was created as an entitlement program, setting forth the eligibility prerequisites that, if met by the individual, would result in receipt of needed services.129 The Act provides an opportunity for an individual to obtain administrative review when a claim for assistance is denied or not acted upon with reasonable promptness.130 Notably, however, this review by state administrative law judges has significant limitations. It typically does not assess violations of federal law nor does it necessarily provide a right of appeal to a court of law. In addition, the Medicaid Act provides for the Federal Medicaid oversight agency to withdraw federal funding if a State is not complying with the approved State Medicaid plan; however, as noted above, this is a harsh remedy that has rarely, if ever, been followed through to its conclusion. For the entitlement to have meaning, the individually insured person needs a legally enforceable right to the benefits provided by federal law.

While the Medicaid Act does not expressly provide for such a private right of action, the courts have long recognized that a civil rights statute, 42 U.S.C. § 1983, expressly authorizes private enforcement. Section 1983 provides an express cause of

129 See 42 U.S.C.A. § 1396a (West Supp. 2001); see also Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives. State Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services ...."). Congress has always treated Medicaid as an entitlement program, applying the budgetary rules that govern entitlement programs. See, e.g., 2 U.S.C. § 900 (2000) (governing budget enforcement).

130 See 42 U.S.C.A. § 1936a(a)(3); 42 C.F.R. § 431.200 (2000) (requiring State Medicaid plans to provide a fair hearing for denial or delay in assistance). These provisions implement Goldberg v. Kelly, 397 U.S. 254 (1970), which found a constitutional due process right to meaningful notice and an opportunity to be heard prior to the termination of welfare benefits.
action to an individual against a person who, under color of state law, deprives the individual of rights, privileges, or immunities secured by the Constitution and federal laws. Section 1983 is presumed to provide a private right of action to redress violations of federal statutes unless "the statute [does] not create enforceable rights, privileges, or immunities within the meaning of § 1983," or "Congress has foreclosed such enforcement of the statute in the enactment itself." Whether the right in question can be enforced under § 1983 depends on three factors: (1) Is the plaintiff an intended beneficiary of the statute; (2) are the plaintiff's asserted interests not so 'vague and amorphous' as to be beyond the competency of the judiciary to enforce; and (3) does the provision impose binding obligations on the State?

Notably, States have not been able to avoid private actions to enforce the Medicaid Act by claiming sovereign immunity. Although the Eleventh Amendment has long been interpreted to preclude a citizen of a state from suing his or her own state, the 100-year-old Ex parte Young exception has prevented state officials who are violating federal law from benefiting from the cloak of immunity. Specifically, Ex parte Young held that a state official, who acts in violation of federal law, acts without the State's authority because the State cannot authorize him to violate federal law. The official, therefore, is "stripped of his official or representative character and is subjected in his person"

131 Wright v. City of Roanoke Redevelopment and Hous. Auth., 479 U.S. 418, 423 (1987). In Wilder v. Virginia Hospital Ass'n, 496 U.S. 498, 522 (1990), the Supreme Court held that Medicaid does not include a sufficiently comprehensive remedial scheme to preclude enforcement of the Medicaid Act under § 1983.

132 Wilder, 496 U.S. at 509-510; see Wright, 479 U.S. at 431-32 (holding that the benefits Congress intended to confer on tenants are sufficiently definite and specific as to be enforceable under § 1983).

133 See Hans v. Louisiana, 134 U.S. 1, 11 (1890) (stating "[t]he language of the [Eleventh] Amendment is that 'the judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another State or by citizens or subjects of any foreign state'); see also Green v. Mansour, 474 U.S. 64, 68 (1985) ("[T]he availability of prospective relief of the sort awarded in Ex parte Young gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law."). Indeed, the principle that government officials can be sued for injunctive relief, can be traced to English law. See, e.g., Louis L. Jaffe, Suits Against Governments and Officers: Sovereign Immunity, 77 Harv. L. Rev. 1, 9 (1963) (discussing the 13th century principle that the King's officers could be sued).

to the consequences of his individual conduct." Accordingly, a suit to force a state official’s compliance with federal law in the future is not a suit against the State itself, and “[t]he state has no power to impart to him any immunity from responsibility to the supreme authority of the United States.”

Recently, these traditional paths of enforcement have been challenged, based on an expansive reading of state sovereignty that affects enforcement of not just Medicaid but all legislation enacted by Congress pursuant to its Spending Clause authority. A federal district court case, *Westside Mothers v. Haveman,* sets forth the reasoning behind this effort to limit enforcement. In the case, a group of Medicaid-eligible children filed suit against Michigan State Medicaid officials whom they claimed were failing to implement mandatory obligations placed on them in the Federal Medicaid Act, particularly the requirements for Early and Periodic Screening, Diagnosis, and Treatment. The plaintiffs sought to enforce the provisions pursuant to § 1983 in an *Ex parte Young* action.

District Judge Robert Cleland acknowledged that the suit’s objective was “commendable” but held that the court could not provide any relief. In a detailed opinion, Judge Cleland found that Spending Clause legislation, such as Medicaid, is not “the supreme law of the land” within the meaning of the Supremacy Clause; thus, Spending Clause enactments cannot preempt inconsistent state policies. Central to the court’s reasoning was the ability of the State to decide whether to participate in the federal program. This volitional aspect, according to the court, meant that Medicaid was merely a contract between the federal government and the participating state.

135 *Id.* at 160.
137 *See U.S. Const. art. I, § 8, cl. 1. Numerous programs have been created pursuant to the Spending Clause, including public housing, food support, transportation, and disabilities education programs. These programs “are a pervasive feature of modern American governance, and they play an especially pivotal role in the lives of Americans who face limited opportunities and access to the levers of power.” Brief *Amici Curiae* of the Catholic Charities et al. at 1, *Westside Mothers v. Havemen,* 133 F. Supp. 2d 549 (E.D. Mich. 2001) (No. 01-1494).
139 *Id.* at 552.
140 *See U.S. Const. art. VI, § 2.
141 *Westside Mothers,* 133 F. Supp. 2d at 561-62.
142 *Id.* at 558. The court relied, in particular, on language from *Pennhurst State School and Hospital v. Halderman,* 451 U.S. 1, 17 (1981) (stating "legislation
From here, *Westside Mothers* reached a number of conclusions, each providing a basis to bar private enforcement. First, if private actions to enforce Spending Clause legislation are to be allowed against the State, they must be a clear part of the contract; mere participation in the program does not trigger a waiver.\(^{143}\)

Second, *Ex parte Young* does not apply, and therefore the Eleventh Amendment bars the suit. *Ex parte Young* is not available because Spending Clause enactments, lacking supremacy, cannot preempt inconsistent state policies or discretionary actions by state administrators in their official capacity.\(^{144}\) The Court also found *Ex parte Young* inapplicable because the Medicaid Act already included a remedial scheme—the provision that allows the Secretary of Health and Human Services to terminate federal funding in offending states.\(^{145}\)

Third, the district court held that *Westside Mothers* did not have a cause of action under \(\S\) 1983 because Medicaid is not a right secured by federal law but rather a contract between the State and federal government.\(^{146}\) Analyzing the case as a third party beneficiary claim based on the contract, Judge Cleland found that third party beneficiaries could not enforce contracts against States in 1871, when \(\S\) 1983 was enacted, and the Con-
gress that enacted § 1983 could not then have intended to authorize such suits.\footnote{Id. at 576; Contra \textit{Will v. Michigan Dep't of State Police}, 491 U.S. 58, 71 n.10 (1989) (Brennan, J., dissenting) (stating "'official-capacity actions for prospective relief are not treated as actions against the State.' This distinction is 'commonplace in sovereign immunity doctrine,' and would not have been foreign to the 19th-century Congress that enacted § 1983") (citations omitted).}


If it is to be upheld, \textit{Westside Mothers} will have to be reconciled with numerous United States Supreme Court and lower court cases recognizing that Spending Clause enactments do preempt inconsistent state action by operation of the Supremacy Clause\footnote{Six amici curiae briefs have been filed asking the Sixth Circuit to reverse the district court decision. These briefs were filed by the United States Department of Justice, the City of Detroit, a number of health care provider associations (including the American Academy of Pediatrics, the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the National Association of Community Health Centers), over seventy law professors, community-based groups (including Catholic Charities USA, American Association of Retired Persons, National Mental Health Association, the ARC of the United States, National Alliance for the Mentally Ill, and Older Women's League of Michigan), and a group of United States Congressmen. Two briefs have been filed asking the Sixth Circuit to uphold the decision. These were filed by Governor John Engler and the Michigan Municipal League and the Texas Justice Foundation (a non-profit foundation to litigate and educate in cases involving private property rights, limited government and free enterprise).} and with numerous Supreme Court cases that allow
individuals to bring *Ex parte Young* actions to enforce spending clause enactments through § 1983.151

Moreover, *Westside Mothers* must be faulted for treating all Spending Clause programs alike and thus failing to examine the true nature of Medicaid. Medicaid is, in fact, quite different from most other Spending Clause programs. Medicaid guarantees open-ended funding to states for the services used by individuals who fit within an eligibility category. By contrast, many Spending Clause programs offer States only a

151 See Wilder v. Va. Hosp. Ass’n, 496 U.S. 498 (1990) (permitting health care providers to challenge the adoption of reimbursement rates); Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103 (1989) (stating the existence of a § 1983 remedy for violations of federal statutory or constitutional law provided that such statute creates obligations, which are specific enough for judiciary enforcement); Wright v. City of Roanoke Redevelopment and Hous. Auth., 479 U.S. 418 (1987) (finding that nothing in the Housing Act or the Brooke Amendment evidences congressional intent to preclude § 1983 claims against respondent); Maine v. Thiboutot, 448 U.S. 1, 4 (1980) (permitting beneficiaries to challenge Human Service’s denial of welfare benefits); Edelman v. Jordan, 415 U.S. 651 (1974) (recognizing that *Ex parte Young* is no bar to enjoining state officials from failing to process application within federal limits); Rosado v. Wyman, 397 U.S. 397 (1970) (indicating that § 402(a)(23) of the Social Security Act invalidated any state program that decreases the standard of need unless the State proves it no longer constituted part of the reality of welfare recipients); see also 42 U.S.C.A. § 1320a-2 (West Supp. 2001) (re-establishing private rights of action to enforce the Social Security Act as they existed prior to *Suter v. Artist M.*, 503 U.S. 347 (1992)).
fixed amount of funding to engage in specified activities, with no entitlements after the funding runs out. In contrast to other Spending Clause enactments, Medicaid places detailed obligations on a range of entities—States receiving federal payments, health care providers receiving payments from States, and beneficiaries participating in the program as patients. The Medicaid entitlement is what allows all participants in this intertwined health care delivery system to be able to rely on each other and thus participate. It is what makes Medicaid insurance.

VI. CONCLUSION

Over its thirty-five year history, Medicaid has developed into a significant protection for the health of millions of individuals who fit within its eligibility categories—the elderly, people with disabilities, pregnant women, and children and their caretakers. The health care providers who serve Medicaid patients have come to depend on the program’s provider payments. States are heavily reliant on the program’s open-ended entitlement to federal funding.

Over the next five years, Medicaid will face significant pressures. Due to factors largely outside of policy makers’ control—the aging of our society and increased numbers of disabled people—Medicaid spending is expected to increase. At the same time, there is political pressure from some policy makers and members of the judiciary who see beneficiary “entitlement” as a dirty Medicaid word (and who react particularly to the entitlement's association with lawsuits to enforce federal requirements). However, decisionmakers who take aim at the Medicaid entitlement should think twice. Indeed, the entitlement brings with it the legal right to enforce the statutory requirements that are placed on the states. However, the entitlement is what makes Medicaid an insurance program—the key factor that allows an individual to know that coverage will be there when health care is needed and a health care provider to know that payments will be made when services are delivered.