

**AMERICAN BAR ASSOCIATION
COMMISSION ON LAW AND AGING
SECTION ON HEALTH LAW
SECTION ON INDIVIDUAL RIGHTS & RESPONSIBILITIES
STANDING COMMITTEE ON LEGAL AID AND INDIGENT DEFENDANTS
COMMISSION ON DOMESTIC VIOLENCE
COMMISSION ON HOMELESSNESS AND POVERTY**

REPORT TO THE HOUSE OF DELEGATES

RECOMMENDATION

1 RESOLVED, THAT The ABA recognizes the financial burden of maintaining the Medicaid
2 program and the need for innovation in shaping more effective health care systems, but opposes
3 any structural or financial changes in the Medicaid program that would weaken the current
4 entitlement nature of the program or shared legal obligation that the federal, state, and territorial
5 governments have to provide a comprehensive set of benefits to all individuals who meet
6 eligibility criteria.

7 FURTHER RESOLVED, that the ABA supports Medicaid restructuring that:

- 8 1. Encourages the states and territories to experiment with new and innovative approaches
9 to delivering health and long-term care to economically needy and uninsured populations
10 that do not create unreasonable barriers or burdens on access to care;
- 11 2. Continues the entitlement nature of the program in providing medically necessary health
12 care benefits to historically eligible populations: chronically ill older people, persons with
13 disabilities, children, pregnant women, and families; and ensures that this entitlement will
14 not be undermined by block grants, capped allotments or other funding mechanism;
- 15 3. Recognizes that many middle income Americans have no other option for meeting the
16 catastrophic costs of long-term care other than Medicaid, and that federal, state, and
17 territorial policy must better define and implement a system that permits this population
18 to share fairly in the cost of long-term care without having to become impoverished;
- 19 4. Protects participants' rights to appropriate quality care through strong due process
20 safeguards, including impartial decision-making, internal and external review of
21 decisions, meaningful notice of all major care decisions in language that is easily
22 understood, full access to information, assistance with appeal to an impartial decision
23 maker in a timely manner, and continuation of coverage during the review process;
- 24 5. Ensures that consumers have a meaningful voice in any restructuring process.
- 25 6. Ensures that Medicaid Section 1115 research and demonstration waiver proposals are
26 evaluated predominantly on their potential to expand or improve the quality, delivery,
27 and effectiveness of care with recognition of their potential for budget savings or budget
28 neutrality.

REPORT

I. Background

This recommendation responds to increasing concerns about the functioning and security of the nation's largest health safety-net program, Medicaid. Proposals to restructure the program fundamentally have been proposed largely as a result of state difficulties in weathering the economic downturn since the year 2000, and because of the federal government's desire to achieve long-range deficit reduction. Restructuring may be beneficial and productive if done through principled and thoughtful deliberation. But it will be unfairly burdensome and outright harmful to vulnerable low-income children, families, adults, and elders if done primarily to balance budgets.

The Kaiser Commission on Medicaid and the Uninsured provides a concise overview for understanding the current Medicaid crisis:¹

Our nation's healthcare system relies on Medicaid to finance care for the low-income population and through their care to support providers, private health insurance, the Medicare program and the nation's public health infrastructure. Pressures to reduce the federal deficit may cause policy makers to consider significant changes in the Medicaid program but these changes should be balanced against the role Medicaid plays in the nation's increasingly stressed healthcare system.

Over the last 40 years, Medicaid has evolved to meet the health and long-term care needs for one in ten Americans including people with low-incomes, the working poor and their children, the elderly, and the disabled. Individuals on Medicaid tend to be poorer and sicker than those covered by private insurance. Without Medicaid, many more low-income individuals would be uninsured, adding additional stress to the health care system.

While many argue that Medicaid costs are too high, Medicaid per capita growth has been consistently about half the rate of growth in private insurance premiums. Compared to private health programs, Medicaid also has far lower administrative costs. Both of these factors show that despite program growth, Medicaid is a fairly efficient program. Recent program growth has been fueled by increased enrollment as a result of the economic downturn and not increasing per capita costs.

In the past, fiscal pressure at the federal level has led to attempts to limit federal Medicaid spending by decreasing matching payments, placing caps on spending or imposing mandatory percentage reductions to the program. Such efforts may

¹ The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Issues in Restructuring Federal Financing* (January 2005). Charts and figures not included.

resurface in the year ahead as policymakers face a growing federal budget deficit. Budget decisions at the federal level that result in reductions in federal support for Medicaid could limit states' capacity to provide health coverage to low-income families, respond to unpredictable situations and support providers at levels that promote accessible and affordable health care.

THE FEDERAL DEFICIT AND THE POTENTIAL IMPACT ON MEDICAID

In January 2001, the Congressional Budget Office (CBO) projected that there would be a surplus in FY 2004 of \$397 billion. However, by 2004, the federal government had a deficit of \$413 billion. Over the next decade, 2005 to 2014, the CBO estimates that the deficit will total \$2.3 trillion. Alternative projections that include the extension of certain tax cuts that are set to expire would increase those deficit projections to \$4.4 trillion over the period.

During the 109th Congress, policymakers will need to make decisions that will shape the size of the federal deficit and tax policy. Entitlement programs, like Medicare and Medicaid, are likely to be targeted to meet the Administration's commitment to cut the federal deficit in half over the next five years and to support tax changes.

Many budget priorities may be determined in March or April as part of the budget resolution which is the "blueprint" that determines federal spending and revenue levels. Later in the year, Congress may consider "reconciliation" bills that determine how to achieve the budget resolution targets. Special rules (such as limited debate time and passage with a majority vote) apply to reconciliation bills in the Senate. A target for Medicaid reductions could be included in the budget resolution and the reconciliation bills would provide more detail on specific program changes.

Medicaid accounted for 8 percent of federal outlays in 2004 (while Medicare accounted for 12 percent and Social Security at 21 percent). Over the next decade Medicaid is expected to increase from 1.5 percent of GDP to 2 percent of GDP, so, while a substantial federal commitment, it is not a dominant contributor to the overall deficit projections.

CURRENT MEDICAID FINANCING STRUCTURE

The current Medicaid financing structure has several key design features that support national healthcare objectives:

States and the federal government share the risk and responsibility for paying for the costs of caring for populations covered by Medicaid; Federal financing is guaranteed to states based on the federal matching percentage (FMAP) and state spending. This gives states capacity to respond to changes in economic conditions, demographics, disasters and epidemics; Guaranteed matching

payments create incentives to invest in health care and discourage reductions in coverage, and State financial obligations act as a constraint on federal spending since states have incentives to control costs. Under the current structure, states with a 50 percent match rate receive an additional \$100 from the federal government for every \$100 they pay for Medicaid, and states with a 70 percent match rate receive \$233 from the federal government for every \$100 that they spend. When states reduce state Medicaid spending, they lose federal revenue.

WHAT IS AT STAKE FOR STATES?

Medicaid is a major source of coverage for low-income individuals but also serves as an engine in state economies supporting millions of private sector jobs. Medicaid is the largest source of federal revenue to states, representing 44 percent of all federal revenue to states.

Under current law, states have a lot of flexibility to design and administer their Medicaid programs. In fact, about two-thirds of all Medicaid spending is for “optional” services or populations. Every state covers some set of optional services or people (like prescription drugs or poor seniors).

States currently can use Medicaid program flexibility to: expand or reduce eligibility, enhance or limit benefits, increase or reduce provider payments, change care patterns or shift costs. However, despite the flexibility in the law, Medicaid covers medically necessary services provided to low-income or very sick individuals and it is hard to use flexibility to limit Medicaid without dealing with consequences such as increases in the uninsured, increases in uncompensated care costs, barriers to access, limited provider participation, or poor quality care.

If federal revenues were limited, states would have to decide whether they should increase their own funds for health care or make cuts to the Medicaid program. Even with fewer federal resources, states might still be held accountable for providing services to medically vulnerable populations like the dual eligibles. About 42 percent of all Medicaid spending for benefits is for elderly and disabled individuals who are dually eligible for Medicare and Medicaid.

Additionally, states that have limited programs with few optional services would have a harder time making program reductions or expanding their programs in the future if federal support were capped based on current funding levels.

Finally, health care payments are extremely hard to predict due to new technology, changes in practice patterns, and economic downturns. The State Children’s Health Insurance Program (SCHIP), a capped entitlement to states, highlights the difficulty projecting spending needs and appropriately targeting funds to where they are needed most. Under SCHIP, the federal spending allotments exceeded spending in the early years of the program and now many states are expecting funding shortfalls in SCHIP over the next few years.

WHAT IS AT STAKE FOR PROVIDERS?

Medicaid accounts for one of every six dollars of health care spending and nearly one in every two long-term care dollars. Medicaid is also the country's major payer for mental health services, HIV/AIDS care, care for children with special needs and births. Like private health insurance, Medicaid purchases services from hospitals, physicians and other providers in the private healthcare market place. To even a greater extent than the private market, Medicaid enrolls many beneficiaries in managed care plans that have contracts with private providers. Medicaid is unlike Veteran's Affairs that operates its own health care facilities.

Many public hospitals, children's hospitals, rural providers and community health centers rely heavily on Medicaid revenue.

Most providers already receive Medicaid payments that are lower than the cost of providing care to program beneficiaries. Most providers can shift these costs to other payers, but providers that rely more heavily on Medicaid cannot shift costs as easily as other providers. Many of these same providers also rely on Disproportionate Share Hospital (DSH) payments. These payments help hospitals that serve a disproportionate share of low-income or uninsured patients. Federal DSH payments are already capped.

Medicaid is the largest payer for long-term care (both institutional and community-based) and public mental health services. Because Medicaid represents such a large share of revenues for these provider types, they would be at a higher risk if federal Medicaid financing were reduced or capped.

In recent years, states have experienced sharp declines in state revenues and large budget shortfalls. In response to this fiscal stress, states implemented a number of efforts to control Medicaid costs. All 50 states and the District of Columbia have imposed some restrictions on provider payments over the last four years. Physicians, inpatient and outpatient payments were the most likely to be frozen or cut over the period

Limiting federal Medicaid resources would place additional pressures on providers, resulting in fewer providers able to serve Medicaid and uninsured patients. Increasing the differential between Medicaid and private insurance payments would result in less access for beneficiaries and could hamper needed efforts to improve quality of care.

WHAT IS AT STAKE FOR BENEFICIARIES?

Medicaid is the dominant source of insurance coverage for many groups of individuals including the poor and near poor, children (especially Hispanic and African American children), and the elderly and people with disabilities

(especially individuals in nursing homes and those living with HIV/AIDS). All of these groups would be at a high risk for either losing coverage or access to essential benefits if federal Medicaid financing were restricted.

Medicaid currently serves as a safety net for many individuals, especially children, who fall into poverty or lose their private health insurance. Without Medicaid, many more individuals would have become uninsured as a result of the recent economic downturn. From 2000 to 2003 the number of low-income children who are uninsured declined by 90,000 despite increases in poverty and declines in private health insurance.

Additionally, Medicaid serves many elderly and people with disabilities who are among the poorest and sickest people in the country, including many who are also eligible for Medicare. These “dual” eligibles are sicker and need more services than other Medicare beneficiaries.

Each state provides Medicaid coverage to some “optional” populations or provides beneficiaries with some “optional” services. People with disabilities such as autism, schizophrenia, HIV/AIDS, cerebral palsy, Down’s Syndrome and Parkinson’s disease who would not be able to receive private health coverage are disproportionately represented among the “optional” people and services covered by Medicaid. Medicaid plays a special role for individuals with mental health needs, accounting for about one-half of all public mental health funds.

Individuals with Medicaid have access to health care services and outcomes comparable to the privately insured. Recent program waivers provide states with additional flexibility to modestly expand eligibility but also to impose eligibility caps, reduce benefits or increase premiums and cost sharing. Recent 1115 waivers have tended to focus mostly on the cost-cutting approaches with very limited expansions. For home and community based waiver services, capped enrollment has resulting in long waiting lists of up to several years for services. This experience of waivers is a strong indicator of how states may behave to help alleviate state budget pressures if given additional flexibility without guaranteed federal financing.

Without the current Medicaid financing structure, many individuals could lose their entitlement to health insurance coverage. Most would find it difficult to get affordable or adequate coverage to meet their needs in the private market. Most notably, long-term care benefits are typically not included in private health insurance plans. Clinics and other providers would face additional stress and without the resources to serve an increased number of uninsured.

OUTLOOK FOR THE YEAR AHEAD

During the upcoming budget debate, it is critical to weigh the implications of cuts in federal funding and fundamental changes in Medicaid at a time when there is

no clear alternative to the program and the role it plays in the healthcare system. While some may argue funding for Medicaid needs to be constrained, others argue that Medicaid is currently under-funded to meet the responsibilities expected of the program.²

II. Current Federal Developments

Federal budget developments since January 2005 have reinforced concerns about large-scale Medicaid program cuts. The President's budget included \$60 billion in spending reductions over ten years to be achieved as follows:

- Roughly one-third of the proposed reductions would be achieved by tightening the rules for calculating state expenditures (Inter-governmental transfers) that are matched by the federal government
- Savings of \$15 billion by using the average sales price (ASP) in place of often inaccurate average wholesale price (AWP) for Medicaid drug purchasing.
- Proposed reductions to federal funding for case management, projected to save the Medicaid program \$12 billion over ten years.
- Capping of state administrative costs for a projected saving of \$6 billion.
- Providing more flexibility to states to adjust benefits in exchange for capped funding to the states.
- Finally, proposed savings of \$4.5 billion by increasing penalties for transfers of assets prior to seeking long-term care eligibility.

The President's budget also proposed \$16.5 billion in program improvements, including the "New Freedom Initiative," a demonstration project to move disabled individuals from institutions into the community.

Differing House and Senate budget resolutions represented polar opposite approaches. The House version called for reductions in mandatory programs – Medicaid and State Children's Health Insurance Program (SCHIP) – totaling \$15.1 billion to \$20 billion over the next five years. (Note: The Congress uses 5-year budget projections, while the President's uses 10-year.) The House cut significantly exceed the savings the CBO estimates would be achieved under the President's budget. The Senate, in lieu of cutting Medicaid, adopted the Smith-Bingaman amendment to create a Bipartisan Medicaid Commission to consider and recommend appropriate reforms to the Medicaid program. The Commission would be charged with "reviewing and making recommendations within one year with respect to the long-term goals, populations served, financial sustainability, interaction with Medicare and safety-net providers, quality of care provided, and such other matters relating to the effective operation of the Medicaid program as the Commission deems appropriate."³ Regardless of which budget approach prevails, significant changes to the Medicaid program will be on the table.

² The full report can be found on the Kaiser Family Foundation web page at: <http://www.kff.org/medicaid/7236.cfm>.

³ Fact Sheet on Bipartisan Commission on Medicaid, published at 151 Cong. Rec. S1213 (Feb. 9, 2005).

III. Current State Developments

According to another analysis by the Kaiser Commission, FY 2005 marks the fourth consecutive year of Medicaid cost containment action for most states, and the fifth year for some. Every state has taken and is continuing to take significant steps to contain Medicaid costs, including reducing or restricting eligibility, reducing benefits, increasing co-payments, and reducing or freezing provider payments.⁴ During 2005, we are seeing cost-cutting efforts step up to a new level, as well as serious efforts to change Medicaid from an entitlement program to a capped benefit defined primarily by the individual states. The following examples illustrate the trend:

TennCare

Gov. Phil Bredesen (D) on January 10 announced that he will eliminate coverage for 323,000 adults enrolled in TennCare (the state's Medicaid program) in an effort to reduce costs by about \$1.7 billion annually. Adults expected to lose coverage generally have annual incomes that are too high to qualify for traditional Medicaid. In addition, the governor called for restrictions on coverage for about 396,000 adult beneficiaries who would remain in the program. None of the 612,000 children in TennCare would lose coverage or be subject to coverage changes. TennCare, which was launched in 1994 to expand traditional Medicaid benefits, provides health care coverage to 1.3 million low-income, uninsured and disabled Tennessee residents—about 22 percent of the state's population. If the plan is approved by the joint legislature, TennCare Oversight Committee, Tennessee Justice Center, and CMS, the changes could be implemented by early 2006.⁵

State Waivers Aimed at Cutting Expenditures

Three states (CT, MA, MN) have Medicaid Sec. 1115 waivers (research and demonstration waivers) pending before CMS that would significantly curtail and penalize many forms of Medicaid planning that legal counselors currently use to help couples avoid spousal impoverishment when they face the catastrophic costs of long-term care or to help individuals retain enough assets to cover the substantial needs not covered by Medicaid. These waivers seek to do nothing but cut back on eligibility. For example, all the waiver requests seek to extend the “look-back” period for transfers of assets as far as six years, and all would postpone the beginning of the penalty period for transfers to the date of application, rather than the date of transfer.⁶ Additionally, wide ranging restrictions on dispositions of property are included in some of these waiver proposals. For example, the Minnesota waiver would significantly increase the length of transfer of asset penalties; restrict statutorily permitted transfers of the homestead; limit transfers between spouses; limit transfers to trusts for disabled persons; and permit the invalidation of trusts if the state does not approve of its

⁴ The Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions* (January 2004), available at: <http://www.kff.org/medicaid/7001.cfm>.

⁵ Source: Washington Post (18 Jan 2005). See <http://www.washingtonpost.com/wp-dyn/articles/A16471-2005Jan17.html>

⁶ See <http://www.cms.hhs.gov/medicaid/1115/ct1115mtar.asp> (Connecticut's waiver proposal); <http://www.cms.hhs.gov/medicaid/1115/matoa.asp> (Massachusetts' proposal); and <http://www.cms.hhs.gov/medicaid/1115/mnatl.asp> (Minnesota's proposal).

purpose. Several other states have considered or are considering submitting similar waiver requests, including New York,⁷ Montana,⁸ New Hampshire,⁹ North Dakota,¹⁰ and Virginia.¹¹

State “Super Waivers”

Several states are developing so-called “super waivers” for submission to CMS that would fundamentally rewrite their Medicaid programs using the waiver process, rather than wait for Congressional action. None of these had been formally submitted to CMS as of the time of this writing, but all states in the development process have had active discussions with CMS on these proposals as they develop. Florida, California, and New Hampshire have been in the forefront of conducting statewide hearings to gather input for such a waiver. The following characteristics are common to these waivers:

- Seek to expand, at least superficially, coverage within existing resources.
- Move Medicaid toward a private insurance model.
- Permit expenditures not otherwise allowed by federal law.
- Seek broad flexibility to adopt eligibility, benefit package, enrollment caps, or cost sharing rules that do not meet federal requirements.
- Promise budget neutrality (a federal requirement for these waivers)
- Accept a global cap on federal contribution, determined by a base year.
- Put the state at risk for costs rising above cap.
- Seek some level of public input as part of the development process.

The Florida waiver proposal is illustrative. Florida released a description of its plan on January 11, 2005. The proposal would transform the state’s Medicaid program into a competitive private market model in which he claims that participants would be “empowered to make choices and be rewarded for responsible behavior.” The benefit framework would consist of three components defined not by what services are covered but by explicit expenditure thresholds:¹²

- **Basic Care.** All Medicaid participants will receive a risk-adjusted premium amount with which they can buy into a managed care plan or purchase some other insurance plan that must at least cover all the mandatory services under federal rules.
- **Enhanced Benefits.** A portion of the premium amount give to participants will be allocated to a flexible spending account, but how much gets allocated depends on the exercise of personal responsibility and participation with established health practices. The participant can then use these funds to purchase additional services not covered by the basic plan, or to purchase employment-based insurance after Medicaid eligibility expires.
- **Catastrophic Coverage.** This is the coverage that essentially targets long-term care needs. It is triggered when expenses exceed a certain (as yet unspecified) dollar amount. Then all medically necessary services will be covered up to some as yet-

⁷ The governor’s budget bill for 2005. See www.nysba.org/elderlawreport.

⁸ See 2005 Montana House Bill No. 117, 59th Regular Session.

⁹ 2005 New Hampshire House Bill No. 691.

¹⁰ 2005 North Dakota House Bill No. 1249.

¹¹ 2005 Virginia House Bill No. 2601; 2004 Virginia House Bill No. 1215.

¹² The Florida proposal: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

unspecified benefit amount. What other eligibility requirements will be imposed for this benefit are not described. For example, the state could conceivably propose rewriting the Medicaid spousal impoverishment rules to make them more draconian.

Other “super waivers” in development include:

- A California proposal expands managed care to all counties of the state, modifies the benefit package to more closely resemble employer based plans, institutes premium payments for certain enrollees, and makes certain administrative changes intended to improve efficiency.¹³
- A New Hampshire “GraniteCare Plan” to modernize the state’s Medicaid program proposes to:
 - Rebalance Long-Term Care System toward less restrictive and less expensive levels of care.
 - Reduce the reliance on public funds, by among other things, changing the eligibility process extending the “look back” period.
 - Shift the focus of the current system from one where care is largely not managed to a comprehensive and integrated care management approach.
 - Institute the nation’s first Health Services Accounts for populations for whom the State provides services on an optional basis.¹⁴
- Vermont’s governor has proposed a “plan to save Medicaid” that has several major components:
 - A proposed new relationship with the federal government called “global commitment” that entails a funding cap under a negotiated growth rate.
 - Implementation of a chronic care initiative known as the “Vermont Blueprint for Health.”
 - Program restraints and modifications, including increasing the “look-back” period on transfers of assets from three to five years.
 - Premium increases, reductions in provider payments, and expansion of employer-sponsored coverage.
 - Malpractice insurance revision, and dedicating additional revenue to health access.¹⁵

A March 2005 report by the Kaiser Commission on Medicaid and the Uninsured found that 17 states have had comprehensive Section 1115 waivers approved since January 2001. In reviewing these waivers, the report raised troubling concerns about beneficiary protections:

Many recently approved waivers have eliminated some beneficiary protections or left unclear which beneficiary protections continue to apply under the waiver. In other waivers, the status of key beneficiary protection rules is unclear. Tennessee’s pending waiver amendment would significantly alter procedural protections otherwise guaranteed to Medicaid beneficiaries. In some cases, notice and grievance and appeal rights would

¹³ See <http://www.medi-calredesign.org/>.

¹⁴ See <http://www.dhhs.nh.gov/DHHS/OCOM/GraniteCare/default.htm>.

¹⁵ See <http://www.vermont.gov/governor/priorities/priorities.html> and click on link to “The Plan for Saving the Vermont Medicaid System.”

be curtailed. These types of policies take on added significance when states also create more complicated rules and eligibility categories, which can increase the likelihood of error.¹⁶

The report went on to conclude that cost-cutting was a driving force behind many waivers:

States are making significant programmatic changes through Section 1115 waivers. Much of this recent round of waiver activity has focused on limiting spending by curtailing coverage, limiting benefits, and increasing costs imposed on beneficiaries, although some recent waivers have enabled people to gain coverage or retain coverage that may otherwise have been lost due to budget pressures. These changes have had adverse impacts on coverage, people's ability to receive needed care, and pressures faced by providers and the waivers' limits on federal funding may create new fiscal pressures for states over time. They have also further increased program variability within and across states.¹⁷

IV. ABA Policy and Challenges

The ABA over the years has adopted various policies dealing with aspects of Medicaid and the prospect of devolution of federal programs to the states. A "devolution" policy adopted in February 1997 focuses primarily on: issues of notice and clear communications; maintenance of procedural due process, appeal rights, and quality assurance; and public participation in plan design.

A substantive Medicaid coverage policy adopted by the ABA in February 1990 calls for "the expansion of the Medicaid program to provide coverage for all children and all pregnant women with family incomes less than 200 percent of the federal poverty level." At that same time, the House of Delegates also adopted a resolution for universal access to health care, which was reaffirmed and revised in February 1994. At the time these policies were adopted, we were not faced with the possibility of a wholesale restructuring of the Medicaid program. The existing policies of the ABA do not provide a sufficient platform for the kind of action and participation necessary for ABA entities to ensure that the rights and needs of vulnerable populations are served when both the federal government and the states undertake fundamental restructuring of the Medicaid program. The emerging Medicaid upheaval (i.e., "reform") may substantially curtail existing access to health and long-term care services for financially vulnerable elders, children, persons with disabilities, and families.

The proposed policy has two parts. The first part asserts a fundamental principle that should remain intact under any version of reform—that is, the entitlement nature of the program and the shared obligation of both the federal and state/territorial governments to provide comprehensive benefits to all individuals who meet eligibility criteria.

¹⁶ Samantha Artiga & Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* 18 (Kaiser Commission on Medicaid and the Uninsured, March 2005). Available at: <http://www.kff.org/medicaid/7286.cfm>.

¹⁷ *Id.*

The second part of the recommendation enumerates six principles or characteristics that the ABA supports in any reform proposal. The principles address:

1. Support for new and innovative approaches to delivering health and long-term care to economically needy and uninsured populations that do not create unreasonable barriers or burdens on access to care;

Medicaid has always provided a great deal of flexibility to states in structuring the delivery of services within broad federal standards, as well as through §1115 research and demonstration waivers. State interest in creative and innovative restructuring of services has never been greater. This interest can be a very positive force if implemented in a way that does not create barriers or burdens on access to care by those who are most vulnerable.

2. Maintenance of the entitlement nature of the program in providing medically necessary health care benefits to historically eligible populations.

These populations include chronically ill older people, persons with disabilities, children, pregnant women, and families. This principle also asserts that block grants, capped allotments or other different funding mechanism, if tried, must not have the effect of undermining this entitlement.

3. Recognition that many middle income Americans have no other option for meeting the catastrophic costs of long-term care other than Medicaid, and that federal and state policy must better define and implement a system that permits this population to share fairly in the cost of long-term care without having to become impoverished.

Over the years, the Congress has enacted provisions in Medicaid to balance the welfare entitlement focus of the Medicaid program with the reality that middle-income Americans have few other options for long-term care. The spousal impoverishment rules, the transfer of asset rules, and the home exemption are all examples of provisions that seek to balance the needs of individuals and families with that of fiscal responsibility. Unless and until public policy creates other realistic options for coverage of long-term care for middle income persons, there is no other safety net for the catastrophic costs of long-term care.

4. Protection of participants' rights to appropriate quality care through strong due process safeguards, including impartial decision-making, internal and external review of decisions, meaningful notice of all major care decisions in language that is easily understood, full access to information, assistance with appeal to an impartial decision maker in a timely manner, and continuation of coverage during the review process.

This principle addresses due process elements broadly and is not intended to be exclusive or complete in detail. It echoes and reaffirms existing ABA policy on public benefits.

5. Assurance that consumers will have a meaningful voice in any restructuring process.

Much of the discussion around restructuring has occurred in the context of so-called “super waivers” discussed above. The federal government, through CMS, requires public input in the waiver process but does not define either the nature or extent of public input required. Consequently, the process often varies from virtual secrecy to fairly substantial process. A meaningful process would give the public sufficient advance notice of possible restructuring early in the process, as well as later, after specific proposals have been crafted. Opportunities to comment ideally would be sufficiently varied in approach (e.g., town meetings, hearings, written comment) as well as extended in time to maximize input from as broad an audience as possible.

6. Ensures that Medicaid Section 1115 research and demonstration waiver proposals are evaluated predominantly on their potential to expand or improve the quality, delivery, and effectiveness of care, but with recognition of their potential for budget savings or budget neutrality.

As described above, some waiver proposals have been targeted primarily at budget cutting. While cost efficiency is an important goal in research, the criteria for approving waived research and demonstration proposals legitimately distinguishes between meaningful improvements in Medicaid and merely saving dollars.

During the policy dialog ahead, it is not the position of the ABA to tell the federal, state, or territorial governments how much they should spend. But it is an unavoidable responsibility of the ABA to be a critical participant in weighing the implications of cuts in federal funding and fundamental changes in Medicaid, especially at a time when there is no clear alternative to the program. The consequences of such changes are literally a matter of life and death for many of the 52 million people who rely on Medicaid for medical and long-term care, including children and many of the sickest and poorest in our nation. Their well-being and right of access to health care are at stake.

Respectfully submitted,

Kristin Booth Glen
Chair, Commission on Law and Aging
August, 2005.