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Key Issues Facing Medicaid After the Affordable Care Act

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**FOREWORD:
KEY ISSUES FACING MEDICAID AFTER THE AFFORDABLE
CARE ACT**

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I. INTRODUCTION

Six years since the enactment of the Affordable Care Act (ACA)¹ and two years after its major coverage provisions took effect, policymakers continue to navigate a range of issues related to implementing the law. This year, the Supreme Court is slated to decide another round of cases involving the contraceptive coverage mandate,² following last term's decision confirming that Marketplace premium subsidies are available in all states.³ Also, legal and policy issues related to the Medicaid program continue to have important implications for health coverage and care. These issues affect ACA implementation because the law uses Medicaid as a foundation for increasing access to affordable coverage; they also affect health care access and quality on a large scale, as the Medicaid program insures nearly seventy million people nationwide.⁴ While some Medicaid issues, such as state decisions about whether to adopt the ACA's coverage expansion, are presently the subject of policy and political debates, others are less often in the news. This essay identifies issues likely to affect Medicaid beneficiaries and other stakeholders

* Associate Director, Kaiser Family Foundation's Commission on Medicaid and the Uninsured. I am grateful for feedback from Julia Paradise, Robin Rudowitz, and Samantha Artiga and for the opportunity to present these remarks at the Medicaid Challenges session co-sponsored by the Section on Law, Medicine and Health Care and Section on Disability Law at the Association of American Law Schools Annual Meeting on January 7, 2016.

1. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).

2. See LAURIE SOBEL & ALINA SALGANICOFF, ROUND 2 ON THE LEGAL CHALLENGES TO CONTRACEPTIVE COVERAGE: ARE NONPROFITS "SUBSTANTIALLY BURDENED" BY THE "ACCOMMODATION"? 4-6 (2015), <http://files.kff.org/attachment/issue-brief-round-2-on-the-legal-challenges-to-contraceptive-coverage-are-nonprofits-substantially-burdened-by-the-accommodation>.

3. Drew Altman, *After King v. Burwell Ruling, Health Law Issues Involve Implementation*, WALL STREET J. (June 25, 2015), <http://blogs.wsj.com/washwire/2015/06/25/after-king-v-burwell-ruling-health-law-issues-involve-implementation/>.

4. JULIA PARADISE, MEDICAID MOVING FORWARD 1 (2015), <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward>.

in the months and years ahead, focusing on matters that affect beneficiary access in four key areas: coverage, care, courts, and community.

II. ACCESS TO COVERAGE

A gap in access to affordable health insurance coverage remains in states that have not adopted the ACA's Medicaid expansion. By its terms, the ACA established Medicaid as the source of affordable health insurance coverage for nearly all adults with low incomes (up to 138% federal poverty level (FPL), or \$16,394 per year for an individual in 2016).⁵ However, the Supreme Court's ruling about the constitutionality of this provision in *National Federation of Independent Business v. Sebelius*,⁶ effectively gives states a choice about whether to expand Medicaid eligibility and, thus, coverage.⁷ As of March 2016, thirty-one states and the District of Columbia (D.C.) have adopted the expansion.⁸ In states that have not expanded Medicaid, there are 2.9 million low-income adults without access to an affordable source of health insurance.⁹ Their income is too low to qualify for Marketplace subsidies, which begin at the federal poverty level, but too high to qualify for Medicaid under these states' low financial eligibility limits for the program.¹⁰ As of January 2016, the median income limit for a parent in a family of three was forty-two percent of the FPL (\$8,438 per year in 2015) in the nineteen non-expansion states, and other non-disabled adults are ineligible regardless of their income level in all of these states, with the exception of Wisconsin.¹¹

5. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The ACA expands coverage to 133% FPL and also provides for an income disregard of five percent FPL, effectively establishing eligibility for the Medicaid expansion group to 138% FPL. 42 U.S.C. § 1396a(e)(14)(I) (2012).

6. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012).

7. *Id.*; see MARYBETH MUSUMECI, A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION 6 (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf>.

8. *Status of State Action on the Medicaid Expansion Decision*, KAISER FAM. FOUND. (Mar. 14, 2016), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

9. RACHEL GARFIELD & ANTHONY DAMICO, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID – AN UPDATE 2 (2016), <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update-2> (adjusted to account for Louisiana's January 2016 decision to adopt the Medicaid expansion, although expanded coverage is not yet effective).

10. *Id.* at 1.

11. TRICIA BROOKS ET AL., THE KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES AS OF JANUARY 2016: FINDINGS FROM A 50-STATE SURVEY 9 (2016). This report, which refers to twenty states that have not expanded Medicaid, was prepared prior to Louisiana's January 2016 decision to expand Medicaid under the ACA, making it the thirty-second state (including D.C.) to do so. See *Status of State Action on the Medicaid Expansion Decision*, *supra* note 8.

A. *What to Watch*

While most states adopting the ACA's Medicaid expansion have done so according to the terms set out in the law, a limited number of states have sought waivers to expand coverage and access the associated enhanced federal matching funds according to terms that differ from federal law.¹² It is likely that additional states will seek to adopt the Medicaid expansion through waivers, and states that implemented the expansion consistent with the ACA provisions may seek to alter the terms through waivers. While rejecting certain state requests, such as requiring beneficiaries to work, the Centers for Medicare and Medicaid Services (CMS) has granted states additional flexibility in a number of areas, permitting them to use Medicaid funds to purchase private Marketplace coverage,¹³ to impose premiums on beneficiaries above the poverty level, and to eliminate the otherwise required non-emergency medical transportation benefit.¹⁴ In addition to assessing the impact of the expansion on Medicaid enrollment and spending, and on the uninsured rate and state fiscal indicators such as revenues and employment, it will be important to understand the experience of states implementing the expansion through waivers. How states manage the complexity and costs of administering waiver provisions, how well beneficiaries understand program features and are able to access care, and how CMS responds to future waiver requests all will be important points of further inquiry.

III. ACCESS TO CARE

CMS recently finalized regulations that, for the first time, govern how states should monitor access to care under Medicaid.¹⁵ Under federal law, provider payments for Medicaid-covered services must be "consistent with efficiency, economy and quality of care" and "sufficient to enlist enough providers so that care and services are available . . . at least to the extent . . . [as] to the general population in the geographic area."¹⁶ CMS's new regulations implementing the "equal access" provision requires states to develop monitoring plans and conduct regular access reviews for certain

12. MARYBETH MUSUMECI & ROBIN RUDOWITZ, THE ACA AND MEDICAID EXPANSION WAIVERS 4 (2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

13. JOCELYN GUYER ET AL., A LOOK AT THE PRIVATE OPTION IN ARKANSAS 4 (2015), <http://files.kff.org/attachment/issue-brief-a-look-at-the-private-option-in-arkansas>.

14. *See generally* MUSUMECI & RUDOWITZ, *supra* note 12, at 7, 10.

15. *See generally* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576 (Nov. 2, 2015) (to be codified at 42 C.F.R. pt. 447).

16. 42 U.S.C. § 1396a(a)(30)(A) (2012).

services and whenever Medicaid payment rates are reduced or restructured.¹⁷ Within this federal framework, states retain substantial flexibility to set and adjust Medicaid provider payment rates.

A. *What to Watch*

CMS's new equal access regulations have the potential to affect Medicaid payment rates and provider participation in the program as well as beneficiary access to care, health outcomes, and care quality. Along with the final regulations, CMS also issued a request for information that could lead to a set of core access to care measures and national standards or thresholds.¹⁸ Notably, CMS determined that its new equal access regulations apply only in the fee-for-service arena and not in the Medicaid managed care environment.¹⁹ Medicaid managed care plans serve substantial shares of beneficiaries,²⁰ and it remains to be seen whether the expected final Medicaid managed care regulations will adequately address access to care issues in that system.

IV. ACCESS TO COURTS

In the aftermath of the Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center*, which removed providers' ability to challenge state payment rates in federal court under the Supremacy Clause,²¹ enforcement of Medicaid's equal access provision will fall solely to CMS. Historically, private parties challenging the adequacy of Medicaid payment rates have sought relief from the courts, although the Medicaid Act does not specifically authorize private parties to sue to enforce its provisions.²² The *Armstrong* Court found that Congress explicitly provided for the United States Department of Health and Human Services Secretary's withholding of federal funds as the remedy for a state's failure to comply with federal Medicaid law, and that enforcement

17. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67,602-04.

18. See generally Medicaid Program; Request for Information (RFI)—Data Metrics and Alternative Processes for Access to Care in the Medicaid Program, 80 Fed. Reg. 67,377 (Nov. 2, 2015).

19. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67,582 (observing that "While Medicaid access to services under managed care arrangements is an important issue, that issue is addressed through reviews of network sufficiency and managed care quality review processes. As a result, we are not addressing access to care under managed care arrangements in this rulemaking effort.").

20. *Share of Medicaid Population Covered under Different Delivery Systems*, KAISER FAM. FOUND. (July 1, 2015), <http://kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/>.

21. *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1382-83 (2015).

22. *Id.* at 1386.

of the equal access provision is complex and better suited to CMS's expertise than the Court's.²³

A. *What to Watch*

Now that its efforts will not be augmented by private lawsuits, CMS will need financial and administrative resources to adequately oversee and enforce the equal access provision in the myriad of circumstances in which states adjust provider payment rates. It also remains to be seen whether the remedy available to CMS— withholding federal Medicaid funds²⁴—will be effective at redressing equal access violations or prove to exacerbate provider payment issues and further harm beneficiary access. CMS lacks the power of courts to grant injunctive relief, ordering states to act in compliance with federal law. It is also unclear whether *Armstrong's* reasoning might be applied in future cases to affect private parties' ability to enforce other provisions of federal law, further limiting beneficiaries' and providers' access to the courts when they allege violations of federal rights.

V. ACCESS TO COMMUNITY

Medicaid continues to play a vital role in helping states meet their obligations under *Olmstead v. L.C.* to serve people with disabilities in the community instead of institutions.²⁵ Although the community integration mandate arises under the Americans with Disabilities Act (ADA), not Medicaid law,²⁶ Medicaid finances over half of all spending for long-term services and supports (LTSS) nationally.²⁷ Since the Supreme Court's 1999 decision in *Olmstead*, which found that the unjustified institutionalization of people with disabilities is illegal discrimination under the ADA,²⁸ states have made substantial progress in devoting a greater share of Medicaid LTSS funds

23. *Id.* at 1386-87.

24. 42 U.S.C. § 1396c (2012).

25. *See, e.g.*, MARYBETH MUSUMECI & ERICA L. REAVES, MEDICAID BENEFICIARIES WHO NEED HOME AND COMMUNITY-BASED SERVICES: SUPPORTING INDEPENDENT LIVING AND COMMUNITY INTEGRATION 2-3 (2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8568-medicaid-beneficiaries-who-need-home-and-community-based-services.pdf>.

26. *See* MARYBETH MUSUMECI & HENRY CLAYPOOL, OLMSTEAD'S ROLE IN COMMUNITY INTEGRATION FOR PEOPLE WITH DISABILITIES UNDER MEDICAID: 15 YEARS AFTER THE SUPREME COURT'S OLMSTEAD DECISION 1, 2 (2014), <http://files.kff.org/attachment/issue-brief-olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision> [hereinafter OLMSTEAD'S ROLE].

27. ERICA L. REAVES & MARYBETH MUSUMECI, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER 3 (2015), <http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer>.

28. *Olmstead v. L.C.*, 527 U.S. 581, 600, 607 (1999).

to care provided in the community instead of institutions.²⁹ Continued progress in this area remains important as access to home and community-based services varies among states and beneficiary populations, and nearly 600,000 people nationally were waiting to receive Medicaid home and community-based waiver services as of 2014.³⁰

A. *What to Watch*

While the U.S. Department of Justice Office for Civil Rights and private parties pursue individual cases seeking to further community integration under the ADA,³¹ a number of current Medicaid policy issues will have an impact in this area. These include implementation of new regulations from the U.S. Department of Labor (DOL) establishing wage and overtime protections for home care workers,³² CMS's regulations defining community-based settings for purposes of Medicaid funding,³³ and forthcoming final Medicaid managed

29. See, e.g., MARYBETH MUSUMECI, REBALANCING IN CAPITATED MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS PROGRAMS: KEY ISSUES FROM A ROUNDTABLE DISCUSSION ON MEASURING PERFORMANCE 5, 8-9 (2015), <http://files.kff.org/attachment/issue-brief-rebalancing-in-capitated-medicare-managed-long-term-services-and-supports-programs-key-issues-from-a-roundtable-discussion-on-measuring-performance>.

30. TERENCE NG ET AL., MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAMS: 2012 DATA UPDATE 3 (2015), <http://files.kff.org/attachment/report-medicare-home-and-community-based-services-programs-2012-data-update>.

31. See OLMSTEAD'S ROLE, *supra* 26, at 1, 2, 5.

32. *Information on the Final Rule: Application of the Fair Labor Standards Act to Domestic Service*, U.S. DEP'T LAB., <http://www.dol.gov/whd/homecare/finalrule.htm> (last visited Apr. 8, 2016). While the new rules were to be effective in January 2015, they have not yet been enforced and were challenged in litigation. *Home Care Ass'n of Am. v. Weil*, 799 F.3d 1084, 1094-95, 1097 (D.C. Cir. 2015). In August 2015, the D.C. Circuit Court of Appeals upheld the regulations. *Id.* DOL has revised its time-limited non-enforcement policy, with no actions to enforce the new rules until thirty days after the D.C. Circuit Court's decision becomes final, and discretion in enforcement actions considering good faith efforts to comply with the new rule through December 2015. *We Count on Home Care, Time-Limited Non-Enforcement Policy*, U.S. DEP'T LAB., http://www.dol.gov/whd/homecare/non-enforcement_policy.htm (last visited Apr. 8, 2016); Informational Bulletin from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., 1 (July 3, 2014), <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/CIB-07-03-2014.pdf>; Letter from Vanita Gupta, Acting Assistant Attorney Gen., Civil Rights Div., Dep't of Justice, & Jocelyn Samuels, Dir., Office for Civil Rights, Dep't of Health & Human Servs., to Colleague, 1-2 (Dec. 15, 2014), http://www.ada.gov/olmstead/documents/doj_hhs_letter.pdf. See generally *Application of the Fair Labor Standards Act to Domestic Service; Announcement of 30-Day Period of Non-Enforcement*, 80 Fed. Reg. 55,029 (Sept. 14, 2015) (to be codified at 29 C.F.R. pt. 552).

33. See generally *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services*, 79 Fed. Reg. 2948 (Jan. 16, 2014).

care rules, which include provisions regarding managed LTSS.³⁴ In addition, states continue to adopt new Medicaid options, established by the ACA, to offer community-based services,³⁵ though it remains to be seen what impact the expiration of two time-limited grant programs that helped states transition beneficiaries from institutions to the community³⁶ and expand access to HCBS³⁷ will be.

VI. LOOKING AHEAD

Prior to the ACA, Medicaid was already playing a substantial role in providing for the health and long-term care needs of millions of people with low incomes. The ACA's amendments to the program, along with state initiatives targeted at delivery system and payment reforms, reflect Medicaid's continuing evolution to meet these needs. As the federal government and states gain more experience with the ACA, policymakers will continue to develop, assess, and revise policies to implement best practices and ensure that the program remains responsive to the people it serves. Developments that affect beneficiary access to coverage, care, courts, and community are important areas to watch in the months and years ahead.

34. JULIA PARADISE & MARYBETH MUSUMECI, PROPOSED RULE ON MEDICAID MANAGED CARE: A SUMMARY OF MAJOR PROVISIONS 2, 3, 6, 7 (2015), <http://files.kff.org/attachment/issue-brief-proposed-rule-on-medicare-managed-care-a-summary-of-major-provisions>.

35. VERNON SMITH ET AL., MEDICAID REFORMS TO EXPAND COVERAGE, CONTROL COSTS AND IMPROVE CARE: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2015 AND 2016 43 (2015), <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>.

36. MaryBeth Musumeci & Molly O'Malley Watts, *Lessons Learned from Eight Years of Supporting Institutional to Community Transitions Through Medicaid's Money Follows the Person Demonstration*, KAISER FAM. FOUND. (Oct. 16, 2015), <http://kff.org/medicare/perspective/lessons-learned-from-eight-years-of-supporting-institutional-to-community-transitions-through-medicaids-money-follows-the-person-demonstration/>.

37. MOLLY O'MALLEY WATTS ET AL., MEDICAID BALANCING INCENTIVE PROGRAM: A SURVEY OF PARTICIPATING STATES 11 (2015), <http://files.kff.org/attachment/report-medicare-balancing-incentive-program-a-survey-of-participating-states>.

