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## MEDICAID, MANAGED CARE, AND THE MISSION FOR THE POOR

JOHN V. JACOBI\*

### ABSTRACT

*Medicaid has financed care for the poor for five decades. During that time it has balanced two important missions: providing for the particular health needs of the poor, and mainstreaming care for the poor. These roles have been consistent as all insurance payors—public and private—have shifted away from passively funding fragmented care to actively supporting patient-centered coordinated care. But the health needs of the poor go beyond medical interventions; the health status of the poor depends on the provision of social services to address social determinants of health, including housing, nutrition, and employment training services. Unlike non-poor insureds, Medicaid beneficiaries rely uniquely on third-party support for access to both medical care and social services. This need for a focus on funding for social as well as medical care distinguishes the circumstances of the poor, and argues for a Medicaid focus not on mimicking middle-class health insurance programs, but rather on the particular needs of the poor. These particular needs should be coordinated and funded through Medicaid Accountable Care Organizations and interagency cooperation through Health in All Policies orientations. While it is appropriate from Medicaid programs—including managed care programs—to ease the transition of beneficiaries between Medicaid and commercial insurance, it is more important than ever for Medicaid to have a particular focus on its core mission of serving the most vulnerable. As the Centers for Medicare and Medicaid Services agency turns to the regulation of Medicaid managed care programs, it should leave states sufficient flexibility to encourage innovative programs for the poor, and avoid overvaluing efforts to make Medicaid more like mainstream commercial insurance.*

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\* Dorothea Dix Professor of Health Law & Policy, Seton Hall Law School. Thanks to Leslie Francis and all of the participants in the Medicaid Challenges program, cosponsored by the Law, Medicine and Health Care and Disability Law Sections of American Association of Law Schools' Annual Meeting on January 8, 2016.

## I. INTRODUCTION

The poor have poor health status. The reasons are several: significant barriers to adequate health care;<sup>1</sup> exposure to determinants of ill-health, including insecure housing, environmental insult, underemployment, and inadequate access to wholesome food and recreational facilities;<sup>2</sup> and physical, intellectual, or behavioral disabilities that engender social isolation.<sup>3</sup> Medicaid was created fifty years ago as a vehicle for providing for the health care needs of the “needy poor.”<sup>4</sup> In the years since, up to and including the amendments to Medicaid in the Affordable Care Act (ACA),<sup>5</sup> the program has expanded the services and beneficiaries covered, but it remains a medical insurance program for low-income Americans. Along the way, Medicaid’s performance and social role have been grist for the health policy mill.<sup>6</sup>

The poor continue to be sicker than the general population, and that correlation between socioeconomic status and poor health status is entwined with issues of race.<sup>7</sup> As the population served by Medicaid has expanded, however, and in particular with the implementation of the ACA, regulators and scholars have argued that Medicaid should no longer be a program dedicated to the poor, but instead should evolve beyond the poverty population. This evolution is urged to facilitate the movement of the poor and near-poor from

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1. See Karen E. Lasser et al., *Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey*, 96 AM. J. PUB. HEALTH 1300, 1305 (2006).

2. See Steven A. Schroeder, *We Can Do Better — Improving the Health of the American People*, 357 NEW ENG. J. MED. 1211, 1225-26 (2007).

3. See generally Lisa I. Iezzoni, *Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities*, 30 HEALTH AFF. 1947, 1948 (2011); Kristina W. Hanson et al., *Uncovering the Health Challenges Facing People with Disabilities: The Role of Health Insurance*, 2003 HEALTH AFF. W3-552, 558, 560.

4. See ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* 47, 52 (Transaction Publishers 2003) (1974).

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1201-05, 124 Stat. 1051-1057 (2010). The PPACA, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

6. See, e.g., Timothy Stoltzfus Jost & Sara Rosenbaum, *The Supreme Court and the Future of Medicaid*, 367 NEW ENG. J. MED. 983, 984 (2012); Adam Sonfield, *The Central Role of Medicaid in the Nation’s Family Planning Effort*, 15 GUTTMACHER POL’Y REV. 7, 7 (2012); Jeffrey A. Buck, *Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services*, 54 PSYCHIATRIC SERV. 969, 970 (2003); Paul W. Newacheck et al., *The Role of Medicaid in Ensuring Children’s Access to Care*, 280 [J]AMA, 1789, 1792-93 (1998); Diane Rowland et al., *Medicaid: Health Care for the Poor in the Reagan Era*, 9 ANN. REV. PUB. HEALTH, 427, 428, 438 (1988); STEVENS & STEVENS, *supra* note 4, at 51-52.

7. See Nancy E. Adler & David H. Rehkopf, *U.S. Disparities in Health: Descriptions, Causes, and Mechanisms*, 29 ANN. REV. PUB. HEALTH 235, 246 (2007); Ichiro Kawachi et al., *Health Disparities By Race And Class: Why Both Matter*, 24 HEALTH AFF. 343, 345-47 (2005).

Medicaid to commercial medical insurance, and to permit the formation of a patchwork form of broad social insurance comprising Medicare, Medicaid, and private insurance.<sup>8</sup>

This article argues that the broadening of Medicaid's mission is inconsistent with the needs of the poorest Americans. The needs of the poor are sufficiently different from those of the non-poor, suggesting that Medicaid should continue to focus on a narrower mission. How should Medicaid be configured going forward to maximize its ability to improve the health status of the poor? To make a difference, Medicaid must broaden its methods from those of a medical insurer to a poverty program cognizant of the need to connect the poor to services beyond medical care. Medicaid should take its cue from structural developments in health care financing and delivery to create incentives for patient-centered care. In the Medicaid context, such strategies will require close coordination with social services providers and other community partners, as improving the health of the poor requires attention to health determinants as much as or more than access to remedial medical services.

Some states are experimenting with community-based, patient-centered care in their Medicaid programs.<sup>9</sup> One complicating factor in the success of those experiments is states' continued and increasing reliance on commercial managed care plans as vehicles for payment for Medicaid services. Managed care plans are vitally important to many state Medicaid programs, as many states now rely on commercial managed care plans to perform network formation and claims payment functions.<sup>10</sup> But managed care plans can impede progress toward a Medicaid that addresses the particular needs of the poor. They are an impediment because these commercial plans operate in Medicaid populations largely the same as they do in commercial populations, by focusing on the payment of medical claims with little attention to determinants of health. Such narrow attention to medical care is traditional in commercial health insurance, and may continue to be acceptable today in that market. But such a narrow focus could impede or frustrate attempts to move Medicaid to a broader focus of tackling determinants of health.

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8. See Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31,098, 31,098 (June 1, 2015) [hereinafter Managed Care NPRM]; Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L., & ETHICS 67, 84 (2015).

9. Mary Takach, *Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results*, 30 HEALTH AFF. 1325, 1325 (2011).

10. *Id.* at 1330. See generally Ctrs. for Medicare & Medicaid Servs., *Managed Care State Profiles and State Data Collections*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html> (last visited Apr. 6, 2016) (showing a table of each state's managed care profile).

Part II of this article provides a brief background of the Medicaid program, and argues for a continued focus on the particular needs of the poor. Part III discusses how the particular focus on the poor could look in practice, with discussion of the development of patient-centered care models in general health care delivery and finance, and forward-looking programs in some states that embrace a particular vision of patient-centered care for the poor. Part IV discusses the historical place of commercial managed care plans in Medicaid; the importance of those plans as “back office” managers for Medicaid programs in many states; the danger that these plans can impede the development of new models that target improvement in determinants of health as a means to improve the health status of the poor; and a proposed federal rule for state oversight of commercial Medicaid managed care plans that could, if adopted, impede state innovation in care for the poor.

## II. IS MEDICAID A POVERTY PROGRAM OR A PARTNER IN UNIVERSAL COVERAGE?

Medicaid was enacted in 1965 to substitute third-party medical insurance for the existing patchwork of state systems for the poor.<sup>11</sup> Medicaid’s adoption was animated in part by a desire to shift care for the poor from relatively ungoverned welfare programs to a system in which care was provided through an entitlement-based insurance system in which federal oversight ensured basic programmatic coherence.<sup>12</sup> “[I]n its essential structure, Medicaid resembled not a grant program to clinics and hospitals, but instead a ‘third party payment’ system structured to operate like insurance, paying ‘participating’ health care professionals and institutions for covered services furnished to enrolled persons.”<sup>13</sup> Medicaid enrollees were, prior to the passage of the ACA, both poor and vulnerable: the most medically precarious in society.<sup>14</sup> To be eligible, people were required to be both poor and “categorically eligible,” that is, blind, disabled, elderly, pregnant women, children, or in families with children.<sup>15</sup> These categories comprise high-cost enrollees. A child with disabilities, for example, requires about four times the health expenditures of a child without

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11. See Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the “Equal Access” Provision*, 73 U. CHI. L. REV. 673, 675 (2006).

12. See Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction*, 9 J. HEALTH CARE L. & POL’Y 5, 8-9 (2006). See generally STEVENS & STEVENS, *supra* note 4, at 51-52.

13. Rosenbaum, *supra* note 12, at 9.

14. Sarah Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 127, 127-28 (2011).

15. See 42 U.S.C. § 1396d(a)(i)-(xvii) (2012) (eligibility criteria for traditional Medicaid—that is, those eligible without resorting to Medicaid expansions under the ACA).

disabilities,<sup>16</sup> and people over the age of sixty-five are similarly expensive to cover.<sup>17</sup>

The health vulnerability of people in the Medicaid program goes beyond issues of disability and age. The non-elderly enrollment in Medicaid was over fifty-three percent Black or Hispanic just prior to the implementation of the ACA's Medicaid expansion, although those two groups comprised only about thirty percent of the American population.<sup>18</sup> The long history of race- and ethnicity-based health disparities in American health care strongly suggests that the overrepresentation of people of color in Medicaid will reflect poorer health outcomes in the American health care system<sup>19</sup> regardless of the success or failure of the Medicaid program to connect beneficiaries to medical care. "For example, relative to whites, African Americans and Hispanics are less likely to receive appropriate cardiac medication . . . or to undergo coronary artery bypass surgery, even when the variations in such factors as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account."<sup>20</sup> In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.<sup>21</sup> Regardless of the causes of these effects, they establish that people

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16. See Paul W. Newacheck et al., *Health Services Use and Health Care Expenditures for Children with Disabilities*, 114 PEDIATRICS 79, 81 (2004).

17. See Uwe E. Reinhardt, *Does the Aging of the Population Really Drive the Demand for Health Care?*, 22 HEALTH AFF. 27, 27 (2003) ("Average per capita health spending for Americans age sixty-five and older was more than triple that for Americans . . . (ages 34-44) in 1999.").

18. Compare U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012 107 (2012), <http://www2.census.gov/library/publications/2011/compendia/statab/131ed/2012-statab.pdf> (53.4% of non-elderly Medicaid recipients in 2009 were either Black or Hispanic), with *QuickFacts: United States*, U.S. CENSUS BUREAU, <http://www.census.gov/quickfacts/table/PST045215/00> (last visited Apr. 6, 2016) (thirty percent of Americans were either Black or Hispanic in 2014).

19. See David R. Williams & Pamela B. Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327-29 (2005) (recounting effects of socioeconomic status, neighborhood conditions, and medical care on health status of African-Americans); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 857 (2012) ("[H]ealth insurance and health care remain racially and ethnically segregated with one health care system serving disproportionately white patients with private insurance and a different 'safety net' system serving minority patients with Medicaid and the uninsured."). See generally BRIAN D. SMEDLEY ET AL., INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (2002) (discussing reasons for racial disparities in health care and strategies for more equitable care).

20. SMEDLEY ET AL., *supra* note 19, at 30.

21. See Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382-84 (2011) (arguing that health status improvements for the poor cannot be achieved simply by increasing access to health care services); Williams & Jackson, *supra* note 19, at 327-40 ("Racial differences in socioeconomic status, neighborhood residential conditions, and medical care are important contributors to racial differences in disease.").

covered by Medicaid are more medically fragile, have more complex health conditions, and are affected by determinants of poor health, independent of their access to health coverage or care.<sup>22</sup>

Health status, then, is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of traditional health services.<sup>23</sup> One recent commentary observed that “[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them.”<sup>24</sup> These “determinants of health” that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.<sup>25</sup> Tackling these determinants is a daunting task. One point of agreement on how to begin to do so is that medical care should no longer be viewed in isolation but should be part of a system that coordinates services and interventions.<sup>26</sup> This coordination requires not only the purposeful interaction of previously separate public services, but also coordination of the funding that flows to and through the providers of those services. The health status of the poor and vulnerable should, then, be addressed by broadening the focus from medical care to health care—sweeping in interventions capable of addressing the shortfalls in social circumstances that comprise a significant barrier to good health.

The ACA significantly expanded Medicaid. Under the ACA as written, states were required to sweep in all persons not previously eligible who have an income at or below 133% of the federal poverty level.<sup>27</sup> The extent to which each state’s Medicaid enrollment would have been affected by this change depended on the prior state-specific eligibility levels, but the estimates for total

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22. See Braveman et al., *supra* note 21, at 382-84; Williams & Jackson, *supra* note 19, at 327-40.

23. See Kelly M. Doran et al., *Housing as Health Care — New York’s Boundary-Crossing Experiment*, 369 NEW ENG. J. MED. 2374, 2374 (2013) (“[E]xperts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest.”).

24. David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012).

25. See Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 284, 284 (2010); Nicole Lurie, *What The Federal Government Can Do About The Nonmedical Determinants of Health*, 21 HEALTH AFF. 94, 94-95 (2002).

26. See Lurie, *supra* note 25, at 104-05.

27. 42 U.S.C. § 1396a(a)(10)(XX) (2012).

increases ranged as high as 21.3 million by 2022.<sup>28</sup> Those predictions had to be adjusted after the Supreme Court rendered the ACA's Medicaid expansion optional at the election of each state.<sup>29</sup> As of this writing, thirty-two states have agreed to expand Medicaid to the income limits of the ACA.<sup>30</sup> There are substantial arguments that at least some of the remaining states will come to some agreement to expand Medicaid in the future.<sup>31</sup>

The ACA's expansion of Medicaid adds populations that are not "categorically eligible"—that is, not elderly, blind, disabled, pregnant, or in a family with children in addition to being poor.<sup>32</sup> This expansion, as enacted, pushed Medicaid from coverage of the "needy poor" to coverage of all low-income Americans.<sup>33</sup> Indeed, that shift was regarded as sufficiently significant to form the basis for Chief Justice Robert's decision that the ACA's Medicaid changes worked such a reformation of the program that Congress's threat to defund states that failed to adopt the expansion exceeded the limits of the conditional spending powers:

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. . . . Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to

28. JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 4 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>.

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

30. *The Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (Mar. 14, 2016), <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>.

31. See, e.g., STAN DORN ET AL., ROBERT WOOD JOHNSON FOUND. & URBAN INST., WHAT IS THE RESULT OF STATES NOT EXPANDING MEDICAID?, 1, 2 (2014), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf414946](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946) (describing financial cost to federal and state governments of states' Medicaid expansion decisions); SHERRY GLIED & STEPHANIE MA, COMMONWEALTH FUND., HOW STATES STAND TO GAIN OR LOSE FEDERAL FUNDS BY OPTING IN OR OUT OF THE MEDICAID EXPANSION 1, 8-10 (2013), [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718\\_Glied\\_how\\_states\\_stand\\_gain Lose\\_Medicaid\\_expansion\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain Lose_Medicaid_expansion_ib_v2.pdf) (describing financial cost to federal and state governments of states' Medicaid expansion decisions); Carter C. Price & Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And \$8.4 Billion Less In Federal Payments*, 32 HEALTH AFF. 1030, 1034 (2013) (describing financial cost to federal and state governments of states' Medicaid expansion decisions); MAIA CRAWFORD & SHANNON M. MCMAHON, CTR. FOR ST. HEALTH CARE STRATEGIES, ALTERNATIVE MEDICAID EXPANSION MODELS: EXPLORING STATE OPTIONS 1, 8 (2014), [http://www.chcs.org/media/Alternative\\_Medicaid\\_Expansion\\_Models\\_Exploring\\_State\\_Options.pdf](http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf) (describing alternative state models for expanding Medicaid).

32. See 42 U.S.C. § 1396a(a)(10)(A)(i).

33. *Id.*



meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.<sup>34</sup>

This decision had the effect of authorizing Medicaid's expansion, but permitting the states to adopt or reject the expansion (and the federal funds that go with it) at their option.<sup>35</sup> Most states have opted into the expansion program, some in slightly unorthodox ways, and some remaining states appear inclined to accept the expansion option in the future.<sup>36</sup>

The expansion highlights a central paradox in Medicaid. Medicaid is a program for the poor.<sup>37</sup> The poor have substantial health status deficits rooted in the social determinants of health, which deficits are not generally shared by those outside of poverty.<sup>38</sup> These observations support a view that Medicaid should differ from other forms of public and private health insurance, which are more likely to fulfill their missions through an exclusive focus on medical care; the non-poor are likely to live in settings free from many of the most destructive social deficits experienced by the poor, and by definition possess resources to remedy non-medical impediments to health in ways not possible for the poor. And yet, it has been a central feature of Medicaid since its inception to provide beneficiaries with coverage that is *not* particular to the poor. Rather, this goal has been cast as affording beneficiaries "mainstream" health coverage.<sup>39</sup> The tension between a vision of Medicaid as a component of a comprehensively universal coverage system and one focused on the particular and distinct needs of the poor and vulnerable raises issues beyond

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34. Nat'l Fed'n of Indep. Bus. V. Sebelius, 132 S. Ct. at 2566, 2605-06 (2012).

35. *Id.* at 2707. The Chief Justice explained the creation of an optional Medicaid II in terms of the Court's remedial powers:

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding . . . . In light of the Court's holding, the Secretary cannot apply [her enforcement powers] to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion. \* \* \* That fully remedies the constitutional violation we have identified.

*Id.*

36. See KAISER FAM. FOUND., *supra* note 30.

37. See *supra* text accompanying notes 11-17.

38. See *supra* text accompanying notes 18-25.

39. Huberfeld, *supra* note 8, at 82-83; Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL., POL'Y & L. 821, 825-26 (2003); John K. Iglehart, *The American Health System: Medicaid*, 328 NEW ENG. J. MED. 896, 899 (1993).

the scope of this article.<sup>40</sup> It is, at any rate, not clear that a choice must be made, as Medicaid has long been a complex program serving as a vehicle to advance many goals.<sup>41</sup> Suffice it to say that Medicaid, whether it focuses on remediating the inferior health status of the poor and vulnerable or expands to fill a coverage gap for the near-poor and the middle class, must address the basic barriers to the improvement of the health status of the former group.

### III. ADDRESSING BARRIERS TO GOOD HEALTH: ADOPTING NEW MODELS OF CARE

#### A. *From Fragmented to Patient-Centered Care*

It is widely recognized that the fragmented nature of health care delivery—the failure of health care providers to communicate and coordinate the care they severally provide to patients—is one of the barriers to quality improvement in health care.<sup>42</sup> The focus on coordinated, rather than fragmented care arises in part due to the increase in the incidence of and significance of chronic conditions. The number of Americans living with chronic conditions is large and growing. A recent study estimated that 43.8% of civilian, non-institutionalized persons had one or more chronic illnesses.<sup>43</sup> The Institute of Medicine has estimated that about 100 million Americans had a chronic illness as of the late 1990s (about forty-four million of whom had more than one), with the number expected to rise to 134 million by 2020.<sup>44</sup> Chronic conditions are on the rise in part due to the aging of the population and in part because acute illnesses are more susceptible to treatment, thereby extending life but leaving the patient with ongoing care needs.<sup>45</sup>

The high incidence of chronic conditions has a significant effect on Medicaid. “More than 9 million people qualify for Medicaid based on a disability, and many of these individuals have particularly complex needs – almost one-half of them suffer from mental illness and 45% are diagnosed with

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40. *But see generally* John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL’Y, L., & ETHICS, 89, 98-99 (2015) [hereinafter Jacobi, *Multiple Medicaid Missions*]. An eloquent analysis of this issue by two leading Medicaid analysts a decade ago argued strongly for a move away from a focus on the poor and toward coverage of “working-class and middle-class families.” Grogan & Patashnik, *supra* note 39, at 822, 854-55.

41. *See generally* Iglehart, *supra* note 39.

42. *See generally* THE FRAGMENTATION OF U.S. HEALTH CARE (Einer Elhauge ed., 2010).

43. Katherine Anne Paez et al., *Rising Out-Of-Pocket Spending for Chronic Conditions: A Ten-Year Trend*, 28 HEALTH AFF. 15, 17 (2009).

44. COMM’N ON QUALITY OF HEALTH CARE IN AM. INST. MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 27 (2001).

45. *See* ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 28, 29 (2005).

three or more chronic conditions.”<sup>46</sup> As is true among the chronically ill more generally, those on Medicaid often suffer from the failure of caregivers to coordinate their various services.<sup>47</sup> As one clinical researcher investigating the care for people with chronic conditions has described the problem,

Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, . . . treatment can become a series of medical interventions that target only the disease and ignore the ill person.<sup>48</sup>

Such fragmentation can endanger patients with chronic illnesses through lost opportunities for appropriate care and conflicting treatments that can do more harm than good.<sup>49</sup>

Even before the enactment of the ACA, some states were experimenting with coordinated care models for Medicaid enrollees with chronic illnesses.<sup>50</sup> These programs were models for the ACA’s “health home” provisions.<sup>51</sup> Under the ACA, states may, at their option, add services for home care for people with chronic illnesses.<sup>52</sup> The services contemplated by the health home provisions for the chronically ill are calculated to knit together care in a patient-centered way, and include “comprehensive case management; care coordination and health promotion; comprehensive transitional care . . . ; patient and family support; and referral to community and social support services.”<sup>53</sup>

These and other clinical innovations are intended to bring medical care into an era of chronic illness for Medicaid beneficiaries. They move from

46. MIKE NARDONE ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS 1, 4 (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8340.pdf>.

47. See KANE ET AL., *supra* note 45, at 49.

48. *Id.* at 50-51.

49. *Id.* at 50.

50. See MARY TAKACH & JASON BUXBAUM, COMMONWEALTH FUND, CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS 7 (2013), [www.commonwealthfund.org/publications/fund-reports/2013/may/care-management](http://www.commonwealthfund.org/publications/fund-reports/2013/may/care-management); see also Mary Takach, *About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations*, 31 HEALTH AFF. 2432, 2432 (2012); KELLY DEVERS ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, INNOVATIVE MEDICAID INITIATIVES TO IMPROVE SERVICE DELIVERY AND QUALITY OF CARE: A LOOK AT FIVE STATE INITIATIVES 1 (2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8224.pdf>.

51. 42 U.S.C. § 1396w-4 (2012).

52. *Id.* § 1396w-4(a). For purposes of this provision, “people with chronic conditions” include enrollees with two chronic conditions, one chronic condition and at risk of another, or one “serious and persistent mental health condition.” *Id.* at § 1396w-4(h)(1)(A)(ii).

53. *Id.* § 1396w-4(h)(4)(B).

fragmentation, in which discrete conditions are treated in isolation toward integration, in which the entire person is the subject of care, and the range of medical conditions affecting that person are within the contemplation of a care team coordinating care to serve the patient's goals. So far so good; the next section describes how innovative Medicaid programming moves beyond a sole focus on medical care to recognize the importance of social services and other components of a broader health care strategy.

### B. *From Medical Care to Health Care*

There has long been controversy over whether access to Medicaid improves the health outcomes or health status of low-income people. It is clear that people with Medicaid coverage receive more routine care, are more likely to have a regular source of care, and are less likely to go without health services when such services are recommended.<sup>54</sup> One could infer that access to health care would improve health outcomes; studies that have sought evidence for such an effect have produced mostly mixed results,<sup>55</sup> although some have asserted findings of positive correlations between Medicaid coverage and improved mortality rates.<sup>56</sup>

Difficulty in producing robust evidence that access to Medicaid coverage improves health status should not be surprising. Health status is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of

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54. See JULIA PARADISE & RACHEL GARFIELD, KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT IS MEDICAID'S IMPACT ON ACCESS TO CARE, HEALTH OUTCOMES, AND QUALITY OF CARE? 6 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf>; Sharon K. Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39, 54-55 (2005); Teresa A. Coughlin et al., *Assessing Access To Care Under Medicaid: Evidence For The Nation And Thirteen States*, 24 HEALTH AFF. 1073, 1081 (2005); Marc L. Berk & Claudia L. Schur, *Access To Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169, 170 (1998).

55. One outcomes study of Medicaid expansion produced little positive evidence of health benefits for those obtaining Medicaid coverage:

Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups — persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups) — showed similar results.

Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1716 (2013).

56. See Benjamin D. Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025, 1028 (2012).

traditional health services.<sup>57</sup> One recent commentary observed that “[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them.”<sup>58</sup> These “determinants of health” that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.<sup>59</sup> Tackling these determinants is a daunting task. One point of agreement on how to begin to do so is that medical care should no longer be viewed in isolation but should be part of a system that coordinates services and interventions.<sup>60</sup> This coordination requires not only the purposeful interaction of previously separate public services, but also coordination of the funding that flows to and through the providers of those services.<sup>61</sup> There are various ways to reconfigure the provision of care so as to integrate medical and social services. With the coordination of *medical* care, the goal is to facilitate the communication of patient information across medical disciplines to facilitate appropriate care.<sup>62</sup> With coordination of more broadly construed *health* care, the goal is to facilitate the communication of patient information across medical, social service, and other resources in order to facilitate the provision of goods and services that will improve recipients’ health status. This broader health coordination can take place in the context of one organization—an Accountable Care Organization (ACO)—or in the context of a coordinated set of medical and social service partners—Health in All Policies (HiAP) networks.

ACOs consist of various health care providers and organizations that collaborate by agreement to coordinate care of a population to improve quality and reduce cost.<sup>63</sup> They can be thought of as expansion of the spirit and structure of health homes<sup>64</sup> on a larger scale, moving beyond primary and secondary medical care to encompass a wide range of services. The ACA

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57. See Doran et al., *supra* note 23, at 2374 (“[E]xperts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest.”).

58. Asch & Volpp, *supra* note 24, at 888.

59. Bamba et al., *supra* note 25, at 284; Lurie, *supra* note 25, at 95.

60. See Lurie, *supra* note 25, at 95.

61. *Id.* at 105 (“Donald Berwick’s often-quoted adage, ‘The system is perfectly designed to achieve exactly the results it gets. If you don’t like the results, change the system,’ applies not only to health systems, but also to the ‘stovepiped’ way in which policy and budget development often occurs.”).

62. See *supra* text accompanying notes 50-53.

63. Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982 (2010).

64. See *supra* text accompanying notes 50-53.

authorizes the creation and financing of ACOs in Medicare, encouraging independent health entities to band together to provide comprehensively coordinated care through contractual arrangements, in order that they might achieve the quality-improvement gains of long-standing integrated care delivery systems.<sup>65</sup> In order to provide a funding stream for these new organizations, the ACA provides for a system by which the ACO, and thereby its constituent parts, could share with Medicare in the savings gained by coordinating the care of the Medicare recipients served.<sup>66</sup>

The ACA created no cognate structure for Medicaid. Some states have created ACO-like experimental efforts built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.<sup>67</sup> Like their Medicare counterparts, these Medicaid ACOs are premised on their ability to manage the health care they deliver to their patients, their ability to constrain health expenditures, and their ability to improve the health status of Medicaid recipients.<sup>68</sup> To improve the health status of poor and vulnerable Medicaid recipients, Medicaid ACOs must be mindful of the extent to which these recipients' health statuses are dependent not on medical intervention but on improving their access to the social goods and services that impede their ability to thrive.<sup>69</sup> One such experimental structure has been dubbed a "totally accountable care organization" (TACO).<sup>70</sup> TACOs avowedly go beyond medical care, and sweep in such social services as housing, substance use disorder treatment, and reentry programming for ex-offenders.<sup>71</sup> The reimbursement of Medicaid ACOs, including TACOs, varies

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65. See 24 U.S.C. § 1395jjj (2012).

66. *Id.*; see also Paul B. Ginsburg, *Spending to Save — ACOs and the Medicare Shared Savings Program*, 364 NEW ENG. J. MED. 2085, 2085-86 (2011).

67. See John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L.J. 357, 374-76 (2013-2014) [hereinafter Jacobi, *Medicaid Evolution*]; see, e.g., Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care in New Jersey*, 16 POPULATION HEALTH MGMT. S-12 (2013); TRICIA MCGINNIS & DAVID MARC SMALL, CTR. FOR HEALTH CARE STRATEGIES, ACCOUNTABLE CARE ORGANIZATIONS IN MEDICAID: EMERGING PRACTICES TO GUIDE PROGRAM DESIGN 5-8 (2012), [http://www.chcs.org/media/Creating\\_ACOs\\_in\\_Medicaid.pdf](http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf).

68. See MCGINNIS & SMALL, *supra* note 67, at 2-5.

69. See *supra* text accompanying notes 58-61 (discussing determinants of health for poverty populations).

70. See Jacobi, *Multiple Medicaid Missions*, *supra* note 40, at 107.

71. *Id.* at 107-08; see Jennifer DeCubellis & Leon Evans, *Investing In The Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), <http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier/>; Stephen Somers & Tricia McGinnis, *Broadening the ACA Story: A Totally Accountable Care Organization*, HEALTH AFF. BLOG (Jan. 23, 2014), <http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization/>.

from state to state, but is often patterned on the gain-sharing method of compensating Medicare ACOs.<sup>72</sup>

Medicaid ACOs require the coordination of several providers and institutions to create a functioning entity capable of both achieving the coordinated provision of services and distributing the shared savings resulting from their joint efforts. HiAP networks are an alternative to the ACO construct; like ACOs, HiAP networks provide a means of achieving the coordination of health and social services in order to improve the health status of the poor and vulnerable.<sup>73</sup>

HiAP calls for broad social policies across all public sectors that take into account determinants of health.<sup>74</sup> HiAP is not an organization or corporate entity, as are ACOs. Instead, HiAP is a set of governing principles by which agencies responsible for health and social services, such as housing, job-training, and food availability, coordinate according to common principles to keep the goal of improving health status at the forefront of the operation of the agencies.<sup>75</sup> HiAP's governing philosophy has been described in the following terms:

The main principle behind the slogan 'Health in All Policies' is really very simple: Health is greatly influenced by lifestyles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly, decisions influencing people's health do not concern only health services or 'health policies', but decisions in many different policy areas have their influence on these health determinants.<sup>76</sup>

Both Medicaid ACOs and HiAP networks, then, are designed to permit organizations connected to the community in which people on Medicaid live to organize and coordinate services in the interest of improving the community's health status. The steps to be taken by these entities are likely to be specific to the needs and context of the people they serve and their communities. In order to succeed, they must have support in the state in which they operate, and the flexibility to respond to the needs of those they serve. The next part addresses the question of how their efforts could be supported.

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72. See DeCubellis & Evans, *supra* note 71.

73. See Jacobi, *Multiple Medicaid Missions*, *supra* note 40, at 101-03.

74. See Jason Corburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URB. HEALTH 623, 624-25 (2014).

75. See Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1819-20 (2011).

76. Pekka Puska, *Health in all policies*, 17 EUR. J. PUB. HEALTH 328, 328 (2007).

#### IV. FINANCING INTEGRATED HEALTH CARE: COMMUNITY POWER OR MANAGED CARE

In its early years, Medicaid payment followed the model of the insurance programs on which it was based, and paid a fee-for-service rate for care provided.<sup>77</sup> Most providers participated voluntarily in the program, and it was necessary for Medicaid to keep its payments at a level acceptable to those providers.<sup>78</sup> Over time, many states failed to live up to this bargain, and fewer providers in those states therefore were willing to treat Medicaid beneficiaries.<sup>79</sup> Medicaid experimented with managed care contracting during the 1980s.<sup>80</sup> By the 1990s, states increased their reliance on managed care in an effort both to increase the quality of care (managed care plans could, it was thought, act as a quality-assurance subcontractor), and to improve beneficiary access (states had let provider rates slip, and, it was thought, managed care plans could act as efficient bargaining agents with providers).<sup>81</sup> As Medicaid continues to grow,<sup>82</sup> states are increasingly relying on managed care, even for the most fragile of the Medicaid population including people with disabilities, the elderly, and the institutionalized.<sup>83</sup>

There is little evidence that states and beneficiaries have received the hoped-for benefits from Medicaid managed care. The evidence that states have saved money, as compared to fee-for-service Medicaid is lacking. Although there are a few studies to the contrary, most studies “agree that [Medicaid managed care] initiatives are either cost neutral or could actually end up costing more than traditional fee-for-service programs.”<sup>84</sup> Managed care has had mixed results also in improving access to care.<sup>85</sup> There is little evidence—and few studies searching for such evidence—that the quality of care provided

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77. See Jacobi, *Medicaid Evolution*, *supra* note 67, at 362.

78. See *id.* at 359.

79. *Id.* at 366-69.

80. MICHAEL SPARER, ROBERT WOOD JOHNSON FOUND., *MEDICAID MANAGED CARE: COSTS, ACCESS, AND QUALITY OF CARE* 3 (2012); Robert E. Hurley & Stephen A. Somers, *Medicaid And Managed Care: A Lasting Relationship?*, 22 *HEALTH AFF.* 77, 78-79 (2003).

81. See Hurley & Somers, *supra* note 80, at 79-81.

82. As of December 2015, 71,777,758 people were enrolled in Medicaid. *State Health Facts: Total Monthly Medicaid and CHIP Enrollment*, KAISER FAM. FOUND. (Dec. 2015), <http://kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/> (reporting a running total of enrollees); see also TRICIA BROOKS ET AL., 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 5* (2016), <http://files.kff.org/attachment/report-medicare-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>.

83. See SPARER, *supra* note 80, at 4.

84. *Id.* at 11 (citing studies).

85. *Id.* at 15-16.



through Medicaid managed care plans is superior to that provided through fee-for-service Medicaid.<sup>86</sup>

There is no reduction in states' reliance on managed care for their Medicaid programs,<sup>87</sup> notwithstanding the lack of support for the cost, access, or quality rationales for the use of managed care plans. Several reasons are given for states' continued allegiance to managed care. One reason is that many states "seem to believe that the conversion of Medicaid to managed care has been a step in the right direction to gain more control and accountability from the health care marketplace where beneficiaries are seeking services."<sup>88</sup> This optimism seems divorced from the evidence that managed care has likely not delivered the value states were hoping to realize.

An alternative explanation for states' continued and growing interest in Medicaid managed care is a version of path dependence: now that states have transferred (or outsourced) much of the network formation and claims analysis functions to managed care plans, they realize that reversing course would require them to carve these functions back into state government—in an era in which growing the size of government payrolls is not a popular move. As two researchers described this phenomenon over a decade ago, "states that have invested heavily in developing systems, infrastructure, expertise, and more balanced and constructive relationships with plans and providers are reluctant to relinquish this progress."<sup>89</sup> It appears, notwithstanding states' commitment to managed care, that there are severe limitations in managed care plans' ability to demonstrate improvement on their record as to cost-savings,<sup>90</sup> access,<sup>91</sup> or quality.<sup>92</sup> Nevertheless, states press on, and at least one researcher credits that "stick-to-itiveness" as prudent and proper:

Medicaid officials have no choice but to continue efforts to better manage the care of the high-cost beneficiary. This is both an economic and a political imperative. The hope is that the states can act as effective policy laboratories, trying and testing different managed care strategies, looking and learning from each other, researching and evaluating what works, what doesn't, and why. As

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86. *Id.* at 19-20.

87. *Id.* at 4.

88. Hurley & Somers, *supra* note 80, at 86.

89. *Id.*

90. See SPARER, *supra* note 80, at 12 ("Health plans have relatively little ability to themselves change the health delivery systems for the poor, especially if there are multiple plans contracting with multiple providers.").

91. *Id.* at 16 ("The health delivery system for the poor is entrenched and decentralized, and health plans generally lack the leverage to ensure systemwide changes.").

92. *Id.* at 20 ("Health outcomes are produced by a complex combination of factors, including various social determinants (such as education, housing and culture), making it hard to identify the impact of any particular intervention (such as Medicaid managed care).").

this national effort proceeds, the need for rigorous research and evaluations could not be more important.<sup>93</sup>

It is certainly important that states consider “what works, what doesn’t, and why,” but it is not clear that the only thing that can help with cost, access, and quality for the poor and vulnerable in Medicaid is managed care.

There is an alternative that states should try in designing their Medicaid plans. Historically, risk in health care was a simple thing. Health plans (including managed care plans) accepted risk of higher than expected cost in return for payment, and providers accepted no risk, but only payment for services rendered.<sup>94</sup> As is described above, Medicaid ACOs and like constructs are in development or operational in several states.<sup>95</sup> Those models depend on the shift of risk to provider associations, both as a means for financing their efforts and as an incentive for their maintaining necessary care with appropriate quality. The shift to providers as risk-bearers is well underway in the private sector;<sup>96</sup> there is no reason for Medicaid to remain aloof. States may find that, unlike managed care plans, Medicaid ACOs have the “ability to themselves change the health delivery systems for the poor,”<sup>97</sup> and, as associations of essential providers in their community, to exercise “leverage to ensure systemwide changes” for the benefit of Medicaid recipients.<sup>98</sup>

Some states are indeed moving forward with experiments in community-based Medicaid ACOs.<sup>99</sup> In order to foster the growth of this new and promising type of community-based care organization, state Medicaid agencies must be free to provide them with appropriate funding. In states with most or all of their Medicaid beneficiaries enrolled in managed care plans, it may be necessary for the state Medicaid agency to direct the managed care plans to participate in gain-sharing plans or other forms of funding for Medicaid ACOs.

A recent publication of a proposed rule<sup>100</sup> by the Secretary of the United States Department of Health and Human Services has called into question the ability of states to enjoy sufficient flexibility to facilitate the growth of Medicaid ACOs. The proposed rule revises the requirements for states’

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93. *Id.* at 23.

94. Franklin J. Rooks, *Is This a Fair Way to Pay Doctors?*, PHYSICIANS NEWS (Dec. 5, 2013), <https://physiciansnews.com/2013/12/05/is-this-a-fair-way-to-pay-doctors/>.

95. *See supra* text accompanying notes 63-73.

96. *See* Laurence F. McMahon & Vineet Chopra, *Health Care Cost and Value: The Way Forward*, 307 [J]AMA 671, 691 (2012); Zirui Song et al., *The ‘Alternative Quality Contract,’ Based On Global Budget, Lowered Medical Spending And Improved Quality*, 31 HEALTH AFF. 1885, 1885 (2012).

97. *See* SPARER, *supra* note 80, at 12.

98. *Id.* at 16.

99. *See supra* text accompanying notes 67-72.

100. Medicaid and Children’s Health Insurance Program (CHIP) Programs, 42 C.F.R. §§ 431, 433, 438 (2015). *See generally* Managed Care NPRM, *supra* note 8.

contracts with Medicaid managed care companies.<sup>101</sup> In particular, it would limit the ability of such a contract to “implement value-based purchasing models for provider reimbursement”<sup>102</sup> or “participate in a multi-payer delivery system reform”<sup>103</sup> unless the contract demonstrates that the arrangement:

- (A) Must make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms of performance, to all public and private providers providing services under the contract related to the reform or improvement initiative;
- (B) Must use a common set of performance measures across all of the payers and providers;
- (C) May not set the amount or frequency of the expenditures; and
- (D) Does not allow the State to recoup any unspent funds allocated for these arrangements from the [managed care plan].<sup>104</sup>

This rule, if adopted, would limit states’ ability to engage in pilot programs for Medicaid ACOs, and would sharply limit states’ ability to direct managed care plans’ participation in any ACO pilot. The reason for this proposed restriction on states’ ability to experiment with alternatives to traditional Medicaid managed care systems is described in terms the paradox, described above, of framing Medicaid as a program devoted to the particular needs of the poor and vulnerable as opposed to one attempting to mainstream beneficiaries.<sup>105</sup> Medicaid ACOs construe Medicaid as the former, directed as they are to incorporating social services and other non-medical care into the package of services to which poor Medicaid beneficiaries are entitled.<sup>106</sup> But the Secretary’s explanation of the proposed rule comes down squarely in favor of a mainstreaming effort:

[W]e believe that adopting standards for Medicaid managed care that parallel or align with those in the private health care and [Medicare Advantage] context . . . will benefit Medicaid programs and enrollees, both because those minimum standards would provide an appropriate level of protection for enrollees and because alignment would ease the administrative burden on issuers and regulators . . . [W]e believe enrollees will experience smoother transitions and have fewer disruptions to care when they transition among sources of health care coverage.<sup>107</sup>

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101. Managed Care NPRM, *supra* note 8, at 30,198.

102. *Id.* at 31,259 (§ 438.6(c)(1)(i)).

103. *Id.* (§ 438.6(c)(1)(ii)).

104. *Id.* (§ 438.6(c)(2)(ii)(A)-(D)).

105. *See supra* text accompanying notes 11-12.

106. *See supra* text accompanying notes 67-73.

107. Managed Care NPRM, *supra* note 8, at 31,101.

Facilitating the ease of movement from Medicaid to commercial insurance is a worthy goal. The Secretary should not, however, impede states should they be interested in branching out from traditional Medicaid managed care to facilitate the development of an alternative care delivery and finance model. Permitting states to direct Medicaid-participating managed care plans to take reasonable steps to support experimental Medicaid ACO programs is appropriate for the health of the Medicaid program, and for the health of Medicaid beneficiaries.

## V. CONCLUSION

Medicaid was created to address the needs of the poorest and most vulnerable Americans. Those beneficiaries had poor health status in 1965, and they have poor health status today. Even more than most Americans, their health status is more dependent on social circumstances in their environment than on access to medical care. Medicaid's mission has grown, particularly as the ACA's dramatic expansions take effect. Medicaid has been chosen as a vehicle for expansion of medical insurance to the working-class and middle-class that has been increasingly poorly served by commercial coverage.

As Medicaid moves to serve its new beneficiaries, it must keep faith with its original mission—to raise the health status of the poor and vulnerable, addressing the particular barriers to good health that impede their ability to flourish. These populations increasingly have been served over recent decades by commercial managed care plans contracting with state Medicaid agencies. It is far from clear that managed care plans have reached the social determinants of health that are critical to moving the health status of the poor. New forms of health care delivery and finance, including Medicaid ACOs, stand ready to be tested. They are designed to integrate social and medical services to target the needs of the poor. States could facilitate their growth by requiring managed care plans to contract with them, a requirement that could be made more difficult by a proposed federal rule governing Medicaid managed care.

The first fifty years of Medicaid were dedicated to improving access to medical insurance to the poor. The future should be about improving access to health care—including medical care and the social services needed to improve the poor population's health status.

