THE IMPACT OF STATE MEDICAID REFORM ON VULNERABLE POPULATIONS NEEDING LONG-TERM CARE SERVICES AND SUPPORTS
AN ANALYSIS OF FLORIDA, ILLINOIS, AND NEW JERSEY

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I. INTRODUCTION

The Medicaid Program was created at the same time as Medicare, as part of President Lyndon B. Johnson’s “Great Society.” Its purpose is to provide medical assistance and long-term care services and supports to low-income Americans. Included in this population are the nation’s elderly and individuals with disabilities — a segment of society that seems to be poorer and sicker than the rest of society. This population’s physical and emotional well-being can be dramatically impacted based upon the Medicaid coverage they receive and the manner in which they receive it. States, however, have fiscal responsibility and seek budgetary predictability and, therefore, must weigh those concerns against the need to provide basic health care to their poorest citizens. This struggle has become more apparent during the recent severe economic downturn. States have had to reduce the size of their budgets while still trying to maintain critical services to their citizenry. State Medicaid programs are one of the budgetary areas reviewed by states in their efforts to reduce costs and control growth.

State actions to control Medicaid costs have consequences. The health of the recipients dependent upon Medicaid services can be greatly affected by the way in which costs are reduced and growth is managed. Reducing or eliminating benefits, or changing distribution methods does not assist in cost reduction if the vulnerable populations affected become sicker and ultimately in need of even greater amounts of care.

This article will look at recent legislative actions taken by three states,¹ Florida, Il-

¹ There is no special reason these three states were chosen other than the three authors have actively studied their respective state’s transformation of Medicaid.
linois, and New Jersey, relevant to their Medicaid programs in light of state fiscal crises. It will illustrate the different approaches taken by these states to control the growth of their Medicaid programs and the resulting potential or actual effect those changes have had on their respective elderly and individuals with disabilities populations. Part II will provide a primer on the Medicaid program. Part III will highlight some of the more important changes to Medicaid due to the health care reform passed by Congress and signed by President Obama in 2010 and the impact that will have on state Medicaid budgets. Part IV will provide a national overview of the condition of states’ budgetary and fiscal health. Part V will provide an overview of the types of actions states take to reduce Medicaid budgets and control growth. Part VI will then provide an analysis of specific actions taken in Florida, Illinois, and New Jersey to control Medicaid costs in light of their respective state budgetary concerns, and the impact or potential impact those actions have on the most vulnerable populations.

II. Basics of Medicaid

Medicaid, enacted in 1965 and codified at Title XIX of the Social Security Act, is a means-tested entitlement program that was established to provide medical assistance to low-income individuals and families. Over the years, Congress has expanded Medicaid eligibility to reach more Americans living below or near poverty, and presently covers (as it relates to this article) individuals with diverse physical and mental conditions and disabilities, and the elderly. Medicaid is the single largest health care program in the United States covering in excess of 55 million individuals in 2011. By design, Medicaid operates as a safety net. During economic recessions, more people become eligible due to job loss and resulting loss of health insurance and the program expands thereby increasing its cost to federal and state budgets.

A. The Program

Medicaid, a jointly financed partnership between the federal government and the states, is an optional grant program; though voluntary, all states participate. The federal government provides a framework of minimum standards and provides states flexibility for program design and administration. Each state’s Medicaid program, referred to as its “state plan,” is on file with the Centers for Medicare & Medicaid Services (CMS). The

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5 Kaiser Commn., supra n. 3, at 4.
8 See 42 C.F.R. § 400.203 (2012) (“State plan or the plan means a comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the [Social Security] Act, to administer or super-
state plan identifies the services (both mandatory and optional) that a state has elected to provide and how the state intends to comply with the requirements of the federal Medicaid statutes and regulations. States can change their Medicaid program by several methods, one of which is to make a state plan amendment if the change is something that is allowable under the federal mandates. A state can also seek a waiver to make a program change not otherwise allowable under the program rules. A “Section 1115 waiver” allows states to use funds to test new or existing approaches to financing and delivering services for a segment of the Medicaid population, while “Section 1915 waivers” allow states to mandate enrollment in managed care and provide home and community-based services. States must apply for and obtain CMS approval for waivers to their state plan.

B. Persons Covered

Federal law requires states to cover “mandatory” groups in order to receive federal matching funds. The mandatory groups include (as it relates to this article) aged and disabled individuals who have limited income. Only U.S. citizens and certain categories of lawfully residing immigrants can qualify for Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 barred most lawfully residing immigrants from Medicaid during their first five years in the U.S., except for emergency treatment. Medicaid is a means-tested program, which means that people must meet certain financial criteria to be eligible. Working under broad federal guidelines, states have flexibility to determine their own income and asset tests.

States can expand Medicaid eligibility beyond federal minimum standards to cover additional “optional” groups. Those groups include the elderly and individuals with disabilities with income up to 100 percent of the Federal Poverty Level (FPL), persons residing in nursing facilities with income below 300 percent of the SSI standard, and individuals who are receiving care under home and community-based services waivers but would be otherwise eligible if institutionalized.

Medicaid, the main source of long-term care coverage and financing, covers over 10 million people, including about 6 million elderly, in need of long-term care services and supports (LTCSS). Medicaid covers approximately seven of every 10 nursing home residents, with the program financing more than 40 percent of nursing home spending.

vise the administration of a Medicaid program in accordance with Federal requirements.”).  
11 Waivers and demonstrations detailed under Section 1115 of the Social Security Act are codified at 42 U.S.C. § 1315 (2012).  
12 Waivers and demonstrations detailed under Section 1915 of the Social Security Act are codified at 42 U.S.C. § 1396n (2012).  
13 Donenberg, supra n. 9, at 1506.  
14 See 42 U.S.C. § 1396d(a)(iii) (to be considered “aged,” individuals must be “65 years of age or older”).  
16 Id. at §§ 401, 402.  
17 See 42 U.S.C. § 1396a(a)(10).  
and long-term care spending overall.\textsuperscript{20} Institutional care comprises more than half of all Medicaid long-term care spending, but a growing percentage is attributable to home and community-based services.\textsuperscript{21}

\section*{C. Services Covered}

States must provide enrollees a core set of “mandatory” benefits and certain cost sharing protections in order to participate and receive matching funds.\textsuperscript{22} The mandatory benefits include physician and hospital services, nursing facility services for individuals age 21 or over, and home health services for individuals entitled to nursing facility care.\textsuperscript{23} If an individual is eligible for Medicaid, the state cannot withhold or create waiting lists for those mandatory services. States may also choose to cover “optional” benefits, including those that constitute long-term care services and supports.\textsuperscript{24} For both mandatory and optional benefits, states determine the amount, duration, and scope of covered benefits, subject to the requirement that coverage of the benefit be sufficient to achieve its purpose.\textsuperscript{25}

\section*{D. Financing}

As stated above, Medicaid is a jointly financed partnership between the federal government and participating states. The federal government provides matching dollars for state Medicaid expenditures using the federal medical assistance percentage (FMAP), which is a statutory formula\textsuperscript{26} based on state per capita income. The FMAP therefore varies among the states, with poorer states receiving more federal assistance, and varies from year to year.\textsuperscript{27} In 2011, matching rates ranged from 50 percent (the floor amount) to 75 percent.\textsuperscript{28} Under the American Reinvestment and Recovery Act of 2009 (ARRA), the federal government temporarily increased the matching rate to provide fiscal relief to states dealing with the effects of the economic downturn; the increase was originally through December 2010 but was later extended through June 2011 at a lower level.\textsuperscript{29}

\section*{E. Cost and Enrollment}

In 2008, total federal and state Medicaid spending on services was nearly $339 billion,\textsuperscript{20}

\begin{thebibliography}{9}
\bibitem{20} Based on 2008 Ctrs. for Medicare & Medicaid Servs. (CMS) National Health Accounts Data. See Kaiser Commn., \textit{supra} n. 3, at 4.
\bibitem{21} Kaiser Commn., \textit{supra} n. 3, at 4.
\bibitem{22} See 42 C.F.R. §§ 440.1–440.355.
\bibitem{24} \textit{Id.}
\bibitem{25} See 42 C.F.R. 440, subpt. B.
\bibitem{26} 42 U.S.C. § 1396b (2012).
\bibitem{28} U.S. Dept. of Health and Human Servs., \textit{Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP}, http://aspe.hhs.gov/health/fmap.htm; select “Fiscal Year 2010 Table” and “Fiscal Year 2011 Table” (accessed Mar. 29, 2012).
\end{thebibliography}
of which 34 percent of total spending went toward long-term care. The elderly and people with disabilities made up roughly 25 percent of the Medicaid population, but accounted for about 66 percent of spending; and dual eligibles (low-income individuals who were enrolled in both Medicare and Medicaid) made up 18 percent of the Medicaid population, but accounted for 46 percent of Medicaid spending. The above illustrates that Medicaid spending is skewed; a small group of recipients accounts for a large share of spending.

In the several years before the economic downturn, Medicaid enrollment increased at an average annual rate of 4.2 percent; however, between June 2008 and June 2009 enrollment grew by 3.3 million, or 7.5 percent. Several factors affect Medicaid enrollment: 1) states tend to expand Medicaid eligibility when their economies are strong; 2) in economic recessions, job loss and resulting loss of insurance cause more people to qualify for Medicaid; and 3) ongoing erosion in employer-sponsored insurance contributes to the expanded enrollment.

III. Health Care Reform Impact on Medicaid

As stated before, the Medicaid program has been expanded over time. Each expansion affects states due to potential costs and savings associated with those changes. The landmark health reform legislation, the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act (ACA)), signed by President Barack Obama in March 2010, also has major implications for states’ Medicaid programs.

A. New Mandatory Group

Beginning January 1, 2014, states will have to provide Medicaid coverage for almost all individuals under age 65 with incomes (based on modified adjusted gross income) up to 133 percent of FPL without any asset test. Specifically excluded from this new Medicaid eligibility category are individuals who are entitled to or are enrolled in Medicare Part A or

30 Kaiser Commn., supra n. 3, at 22.
31 Id. at 23, 24.
32 Id. at 25.
33 Id.
34 Patient Protection and Affordable Care Act [herinafter PPACA], Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 [hereinafter HCERA], Pub. L. No. 111-152, 124 Stat. 1029 (2010), collectively referred to as the Affordable Care Act (ACA). The constitutionality of 1) the individual mandate and whether it is a tax or a penalty, 2) the mandatory changes for each state’s Medicaid programs to continue receiving federal matching funds, and 3) the entire law, was decided on June 28, 2012, in the case of National Federation of Independent Business, et. al. v. Sebelius, Secretary of Department of Health and Human Services, 132 S.Ct. 2566 (2012), wherein the U.S. Supreme Court upheld the constitutionality of the individual mandate as a tax and a legitimate exercise of Congress’s power to tax. As to Medicaid expansion, the Court held that Congress cannot take away existing Medicaid funding of states that choose not to participate in Medicaid expansion.
36 See PPACA §§ 2001(a), 2002.
Part B, individuals who are over 65, and individuals who are pregnant.\textsuperscript{37} Under the ACA, these newly eligible individuals will not be entitled to standard comprehensive Medicaid benefits; instead, the ACA provisions require that states provide at least a benchmark or benchmark equivalent benefit package to the majority of this newly eligible population.\textsuperscript{38}

**B. Long-Term Care Services and Support**

LTCSS are critical for the elderly and individuals with disabilities. The ACA does not include significant changes to Medicaid’s eligibility rules or methodologies for coverage of LTCSS.\textsuperscript{39} The ACA does, however, deal with the disparity between institutional care and home and community-based services in Medicaid’s delivery of LTCSS coverage, present since Medicaid’s creation, by authorizing new programs and enhancing existing ones designed to help Medicaid recipients access community services.\textsuperscript{40} The features of the ACA’s Medicaid LTCSS provisions include:

1. the authorization of the State Balancing Incentives Payment Program;\textsuperscript{41}
2. a new “Section 1915 waiver” that authorizes states to provide coverage for a comprehensive personal attendant benefit to Medicaid beneficiaries;\textsuperscript{42}
3. extension of the authorization for Money Follows the Person through Fiscal Year (FY) 2016 (additionally, the original eligibility requirement that beneficiaries be institutionalized for at least six months has been reduced to three months);\textsuperscript{43} and
4. expansion of spousal impoverishment protections.\textsuperscript{44}

The ACA requires that spouses of all home and community-based services waiver enrollees receive the spousal impoverishment protections presently only provided to spouses of institutionalized Medicaid beneficiaries.\textsuperscript{45}

**C. ACA Financing**

The ACA provides increased match rates to states to fund the Medicaid expansion to newly eligible Medicaid individuals. Over the next 10 years, it is estimated the federal government will finance approximately 96 percent of the increase in Medicaid costs attributable to the ACA.\textsuperscript{46} The match rates will differ depending on whether a state is deemed to be an expansion state or a non-expansion state.\textsuperscript{47} For years 2014 through 2016, non-expansion states will receive full federal funding, and then the FMAP will drop incrementally from 95 percent in 2017 to 93 percent in 2019.\textsuperscript{48} Expansion states (states that

\textsuperscript{37} See id. at § 2001(a)(1)(C).
\textsuperscript{38} See id. at § 2001(a)(2).
\textsuperscript{39} Gene Coffey, *The Affordable Care Act’s Changes to Medicaid’s Coverage for Long-Term Services and Supports*, 7 NAELA J. 93 (2011).
\textsuperscript{40} Id. at 94.
\textsuperscript{41} See PPACA § 10202.
\textsuperscript{42} See PPACA § 2401, codified at 42 U.S.C. § 1396n(k) (2012).
\textsuperscript{43} See PPACA §§ 2403(a)(1), 2403(b).
\textsuperscript{44} 42 U.S.C. § 1396r-5(h)(1).
\textsuperscript{45} See PPACA § 2404.
\textsuperscript{46} Landers & Leeman, *supra* n. 35, at 151–152.
\textsuperscript{47} See PPACA § 10201(c).
\textsuperscript{48} Landers & Leeman, *supra* n. 35, at 151-152; PPACA §10201(c).
added the newly eligible category prior to the mandated date) will receive lower match rates since these states will have fewer newly eligible individuals to cover.49 Beginning in 2020, all states will receive a 90 percent FMAP.50

As a condition of receiving federal Medicaid funding, the ACA requires (with some limited exceptions) states to maintain eligibility, enrollment, and renewal policies that were in place as of March 23, 2010.51 This Maintenance of Effort (MOE) requirement, which preserves coverage until the broader reforms are in place, remains in effect until January 1, 2014, for adults and until September 30, 2019, for children.52

D. States’ Role and Cost in ACA Implementation

States will take part in implementing some of the major provisions of federal health care reform, such as the expansion of Medicaid coverage. Because of this, states have concerns about the costs that will accompany their actions, especially in light of the fact that state revenues are just beginning to recover from very tough fiscal times.53 Reported fiscal impacts of the ACA on individual state budgets vary widely partly due to differing methodology as to anticipated costs and savings. However, there is some consensus that new enrollment will be the largest new cost and states with the lowest Medicaid eligibility enrollment will have the largest increases in enrollment.54 The most significant source of savings to states will be related to reductions in payments for uncompensated care. However, the actual impact of the ACA on individual states will vary depending on how states choose to implement the new law.55 In contrast to some individual state estimate reports, national estimates show that aggregate savings due to reductions in uncompensated care outweigh new state costs under the ACA, although the level and ability of states to realize these savings may vary.56

Given the fiscal obstacles in funding their Medicaid programs, some states have taken the position that Medicaid expansion costs will be too great and place substantial strains on state budgets for states that had not previously chosen to cover the newly eligibles.57 Though some states emphasize the costs of implementation, other states expect to save money as a result of the increased federal financing and the fact that the newly

49 Id.
50 Id.
51 See PPACA § 2001(b).
52 Id.
54 Id.
55 Id. at iv.
57 Landers & Leeman, supra n. 35, at 155.
eligible individuals are likely to be healthier than traditional Medicaid enrollees and that they will not be receiving full Medicaid benefits.\textsuperscript{58} Also, economists predict the economy and state budgets will improve and the unemployment rate will drop so that the number of income-eligible people to cover may decline by 2014.\textsuperscript{59}

IV. OVERALL STATE FISCAL AND BUDGETARY OUTLOOK

States have been experiencing the effects of the deepest economic downturn since the Great Depression, and as they adopted their budgets for fiscal year 2012, most were still experiencing the continued effects of the economic recession.\textsuperscript{60} Revenue levels were still below pre-recession levels despite some rebounding. Unemployment rates remained high as did demand for Medicaid.\textsuperscript{61} At the start of FY 2012, 42 states faced budget shortfalls and, being legally required to balance their budgets, faced using reserves or rainy day funds, increasing taxes, or cutting spending to reach their goal.\textsuperscript{62} For most states in these economic and political times, spending cuts have prevailed.\textsuperscript{63}

On average, states spend about 20 percent of their general funds on Medicaid, making it the second largest item in most states’ general fund budgets, following spending for education.\textsuperscript{64} State budget pressures to cut Medicaid spending intensify during economic downturns, when state revenues decline just as enrollment in Medicaid and other assistance programs grows.\textsuperscript{65} States will cut spending or sometimes institute hurdles to dampen Medicaid participation in an attempt to control costs.\textsuperscript{66} In FY 2011, total annual state Medicaid spending increased on average by 7.3 percent.\textsuperscript{67}

V. STATE REFORM ACTIONS AVAILABLE TO CONTAIN MEDICAID COSTS

In an effort to contain Medicaid spending, states have used a variety of tactics, which include provider rate freezes or reductions, limitations on benefits and use of co-pays, and increased use of waivers and managed care.\textsuperscript{68} Additionally, states have used the legislative process to curtail or limit the use of Medicaid planning techniques.\textsuperscript{69}

\textsuperscript{58} Leighton Ku, Ready, Set, Plan, Implement: Executing the Expansion of Medicaid, 29 Health Affairs 1173, 1173, 1175 (June 2010).
\textsuperscript{59} Id.
\textsuperscript{61} Id.
\textsuperscript{62} Id. at 23.
\textsuperscript{63} Id.
\textsuperscript{65} Kaiser Commn., supra n. 3, at 28.
\textsuperscript{66} Id. at 13.
\textsuperscript{67} Kaiser Commn., supra n. 60, at 26.
\textsuperscript{68} Id. at 29.
A. Provider Rate Changes

Provider rate changes have an immediate impact on state budgets and many states have either reduced or put a freeze on Medicaid provider payments. Provider rates affect provider participation and access to services for Medicaid beneficiaries, so cutting Medicaid rates can jeopardize provider participation in the program as well as access. If access is affected due to less provider participation then vulnerable populations do not receive needed care services, which includes long-term care.

B. Eligibility/Copays/Limitations

Since Medicaid eligibility standards determine who qualifies for the program, enrollment procedures impact the ease with which individuals can actually access the program and its services. Another cost containment measure available to states is raising or imposing new copayment requirements. To reduce Medicaid spending, states also turn to the elimination of a covered benefit or the application of utilization controls for existing benefits.

C. Home and Community-Based Services Waivers

States are increasing the use of home and community-based services and LTCSS options as a method to reduce Medicaid costs with the most common action being the adoption of new home and community-based services waivers or expansion of existing waivers (including home and community-based services delivered through “Section 1115 waivers” for research and demonstration projects or through the “Section 1915(i) Home and Community-Based Services State Plan option”). Despite the fact that public demand for such services is high, overall home and community-based services spending represents only 43 percent of long-term care spending. In addition, such services waivers are optional benefits, thereby allowing for waiting lists. As of 2009, the number of individuals nationally on waiting lists for home and community-based services waiver programs totaled over 365,000.

D. Managed Care

In the last 30 years, there has been an increased use of various models of managed care to deliver and finance care for Medicaid enrollees with the purported goals of in-

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71 Kaiser Comm., supra n. 60, at 31.
72 Id. at 70.
73 Kaiser Comm., supra n. 60, at 38.
74 Id. at 44.
76 Kaiser Comm., supra n. 60, at 49.
78 Id.
creasing access to care, improving quality, and reducing costs.\(^79\) States establish a network of providers or contract with health plans and/or providers who agree to accept Medicaid patients and meet certain access to care requirements.\(^80\) The share of Medicaid beneficiaries enrolled in some form of managed care reached 71.7 percent as of June 30, 2009, according to CMS.\(^81\) Many states are expanding managed care to cover more medically complex and vulnerable populations and to serve the millions of adults who will become newly eligible for Medicaid in 2014 as a result of the ACA.\(^82\)

In FY 2011, 17 states expanded managed care service areas, added eligibility groups to managed care, required enrollment into managed care, or implemented new managed long-term care programs.\(^83\) For FY 2012, the changes continued and related to the inclusion of persons with disabilities and dual eligibles and new initiatives for managed long-term care directly affecting the elderly and individuals with disabilities.\(^84\)

Following the Balanced Budget Act of 1997,\(^85\) states can require Medicaid recipients, except for exempt high-need populations, to enroll in managed care and can enroll individuals in managed care on a voluntary basis, as long as certain federal requirements relating to choice of plan and consumer protection are met.\(^86\) States determine the structure of their managed care arrangements, including the extent to which they utilize capitated or noncapitated payment arrangements.\(^87\)

Some states require legislative approval of amendments to a state plan or waivers before a state Medicaid agency can move forward with a change to managed care; others require legislative notice and review of changes.\(^88\) In some states there are specific statutory requirements related to cost sharing amounts and benefits, while others have a general requirement that mandates state legislative approval prior to amendments or program changes having certain financial impact on state expenditures.\(^89\)

E. Limitations on Medicaid Planning

Over the years since the enactment of Medicaid, Congress has made changes that affect the planning ability of individuals to qualify for Medicaid. Part II of the Omnibus Budget Reconciliation Act of 1993\(^90\) (OBRA ’93) made changes to the Medicaid eligibility rules (all amendments were to 42 U.S.C. § 1396 \textit{et seq.}). OBRA ’93 increased the “look back” period, for purposes of calculating improper transfer penalties, from 30

\(^{79}\) Kaiser Commn., \textit{supra} n. 4.

\(^{80}\) Id.

\(^{81}\) Id.

\(^{82}\) Id.

\(^{83}\) Kaiser Commn., \textit{supra} n. 60, at 60.

\(^{84}\) Id.


\(^{87}\) Id.


\(^{89}\) Id.

months to 36 months for outright gifts, and to 60 months for transfers to trusts. OBRA ’93 also affected the availability of trusts for eligibility purposes and recovery from estates of recipients. In 2005, additional significant changes to eligibility rules were put in place through the Deficit Reduction Act of 2005 (DRA ’05). That law, among other things, lengthened the look back period to five years for all transfers and changed the beginning date for a penalty period caused by an uncompensated transfer. DRA ’05 also revised the rules for the treatment of annuities, loans, and promissory notes as part of its effort to reform the asset transfer rules for those seeking long-term care under Medicaid.

Efforts to limit the techniques used to qualify individuals for Medicaid are not only the province of the federal government. In the past, states have also promulgated legislation to restrict Medicaid planning options that some critics view as legal loopholes resulting in increased enrollment and cost to states’ Medicaid programs. Most recently, at least one of the states in this article (Florida) attempted to limit some of the options available by the legal profession in order to assist a person in need of long-term care benefits to qualify for Medicaid.

VI. SELECT STATE MEDICAID REFORM EFFORTS

State Medicaid program reform has been used by state legislatures as a means of dealing with some of the budgetary problems they face due to the recent economic downturn. This section will present recent legislative actions taken by three specific states to contain Medicaid costs: Florida, Illinois, and New Jersey. As will be shown, states have taken different approaches with differing impacts; however, all actions have the potential to negatively affect the respective states’ populations of the elderly and people with disabilities with respect to the availability and affordability of LTCSS.

A. Florida

The 2011 Florida legislative session had many issues on its plate. The main goal for the Florida legislature was to close a $4.5 billion budget shortfall. Medicaid was one of the programs that the legislature targeted in 2011. Since 1996, through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives, the Florida legislature cut $5.2 billion from the State’s Medicaid program.
During the economic downturn, Florida further reduced expenditures through cuts in provider payments, pharmacy cost controls, utilization program changes, and benefit reductions.\textsuperscript{99} The legislature went further in 2011 to control costs with the passage of legislation that, if ultimately approved by CMS, will significantly refigure Florida’s Medicaid program into an almost all-inclusive managed care program. Besides the passage of Medicaid managed care reform, the 2011 legislature also attempted to pass legislation that would have limited the Medicaid planning techniques presently used by individuals, including the elderly and people with disabilities populations, to access Medicaid benefits.

1. A Brief History of Florida’s Medicaid Program

Florida implemented its Medicaid program\textsuperscript{100} on January 1, 1970, and by FY 2007, it had in excess of 2.8 million enrollees.\textsuperscript{101} Enrollment has increased by 42 percent within the last several years, attributed mostly to the state’s economic condition.\textsuperscript{102} Florida’s total Medicaid spending for FY 2009 was $15.088 billion, of which almost 25 percent was


spent on the elderly, and current state and federal expenditures account for 28 percent of Florida’s state budget.

With continued Medicaid spending growth, in 2005, the Florida legislature authorized Medicaid Reform, a pilot managed-care program initiative. Florida’s Agency for Health Care Administration (AHCA) formally submitted an application for a Section 1115 Research and Demonstration Waiver to CMS. The application was approved in October 2005, and, by early December of that year, the Florida legislature had passed legislation authorizing the design and implementation of the reforms described in the waiver application. Beginning in mid-2006, Medicaid beneficiaries were transitioned into managed care organizations in two of Florida’s most geographically and demographically diverse counties: Duval and Broward. Three rural counties, Baker, Clay, and Nassau, were added in the second year of implementation. By 2011, over 290,000 people, about 10 percent of Florida’s statewide Medicaid enrollment, were in the managed-care pilot program. The pilot program, though, did not include persons in nursing homes or other fragile populations needing LTCSS. Since the waiver was scheduled to expire on June 20, 2011, the State of Florida, in June 2010, submitted an application for renewal of that waiver which CMS approved, thereby allowing the pilot program to continue in those five counties through June 30, 2014.

2. Medicaid Managed Care Reform Legislation of 2011

Building upon the pilot program, and in furtherance of controlling Medicaid spending growth and costs, the Florida legislature, in the 2011 legislative session, acted to “dramatically revamp the way the state delivers health care to those on Medicaid.” In hopes of

103 Kaiser Fam. Found., supra n. 101.
104 Fla. Ctr., supra n. 102.
106 Id.
107 Id.
109 Id.
112 Allen, supra n. 96.
saving $1 billion for the state budget, Florida passed legislation replacing its fee-for-service model with a capitated managed care for the almost 3 million Medicaid recipients.\footnote{Id.}

\textit{a. Medicaid Managed Care System Reform}

The 2011 legislation, Enrolled CS/HB 7107 and 7109, seeks to expand the prior Medicaid Reform pilot program statewide and add new populations.\footnote{Fla. Ctr. for Fiscal and Econ. Policy, \textit{Mismanaging Medicaid Managed Care: Senate Proposal Goes Further, Risks Even More Than Problematic Predecessors} 1, http://www.fcfep.org/attachments/20110307--Mismanaging%20Medicaid%20Managed%20Care.pdf (Mar. 2011).} The idea was to create a plan that “changes the state’s relationship with Medicaid and Medicaid health care providers.”\footnote{Allen, supra n. 96.} The proponents of the proposals have asserted several guiding principles to ensure a successful program, which include:

1. improved care and fiscal responsibility;
2. long-term care, home and community-based service options presented contemporaneously with nursing home alternative;
3. transformation of AHCA from a check writing and fraud chasing agency into a contract compliance and monitoring operation;
4. legislative determination of the precise amount of money to be spent on Medicaid each fiscal year; and
5. delivery of Medicaid health benefits that are comparable to health insurance benefits received by Floridians paying the taxes that fund Medicaid.\footnote{Fla. Sen., \textit{Medicaid Reform Presentation} 4, http://www.flsenate.gov/Topics/Medicaid; under Medicaid Reform, select Medicaid Reform Presentation February 15, 2011 (accessed Mar. 25, 2011).}

Two separate components encompass the new Medicaid Managed Care program: the Florida Long-Term Care Managed Care program,\footnote{Fla. Stat. § 409.961 through 409.977.} which is set to be implemented first, and the Florida Managed Medical Assistance program,\footnote{Fla. Stat. § 409.978 through 409.985.} the expansion of the five-county Medicaid pilot program currently operating. AHCA is to use a capitated managed care approach for both medical and long-term care components for most Medicaid beneficiaries\footnote{Laura Summer & Joan Alker, \textit{Proposed Medicaid Long-Term Care Changes Raise Host of Questions about Impact} 2, http://hpi.georgetown.edu/floridamedicaid/pdfs/Proposed%20Changes%20to%20Florida%20Medicaid's%20Long-Term%20Care%20Program.pdf (Jan. 2012).} and will administer the long-term care program in partnership with the Department of Elder Affairs.\footnote{Id.} If approved, Florida will be divided into 11 regions with a competitive procurement process to select long-term care managed care organizations for each region.\footnote{Id. at 3.}

Individuals, age 65 years or older, or those age 18 years or older and eligible for Medicaid by reason of a disability, must enroll in the new Long-Term Care Managed Care program if they presently participate in the elder and disabled waiver programs currently in operation, or if they receive nursing facility or hospice services. Individuals currently
enrolled in disease specific or developmental disability long-term care waivers are not required to enroll.\(^{122}\)

As many as 84,000 current Florida long-term care Medicaid beneficiaries, as well as another 27,000 eligible individuals who are on various waiting lists for services, will be affected by the legislation if approved.\(^{123}\) Though the foregoing total represents a small portion of the Medicaid beneficiaries in Florida, they tend to be particularly vulnerable and costly. Moreover, significant growth (127 percent increase) in Florida’s population eligible for long-term care services (those age 65 and older) is expected between 2010 and 2030.\(^{124}\)

Currently, for medical (non-LTCSS) care, Florida Medicaid recipients are enrolled either in Medipass\(^ {125}\) or a managed care plan, such as an HMO.\(^ {126}\) Under the legislation as passed, implementation of statewide expansion of Long-Term Care managed care was to begin July 2012, with recipients being required to be enrolled by December 2013. Managed Medical Assistance implementation was to begin after long-term care implementation.\(^ {127}\) Updated timeline information has enrollment of individuals in the Long-Term Care managed care component starting January 2013, and enrollment in the Medical Assistance component beginning in June 2013.\(^ {128}\)

In addition to the above changes, the 2011 legislation included a provision that would attach a $10 monthly premium for most Medicaid recipients\(^ {129}\) and would authorize charging beneficiaries a $100 copayment for nonemergency use of the emergency room.\(^ {130}\)

Before Florida can implement its new approach to providing services, however, CMS must grant a waiver of existing federal rules. As stated above, CMS already approved the continuation of the pilot waiver program. On August 1, 2011, AHCA submitted to CMS Section 1115 Waiver requests to expand the current pilot program statewide and implement the above referenced copays and premiums.\(^ {131}\) In addition, for authorization of the Long-Term Care Managed Care program, Florida submitted Section 1915(b) and (c)


\(^{123}\) Summer & Alker, _supra_ n. 119, at 1.

\(^{124}\) Id. at 3.

\(^{125}\) MediPass is a form of primary care case management; see Fla. Ctr., _supra_ n. 114, at 2.


\(^{127}\) Summer & Alker, _supra_ n. 119, at 3.


\(^{131}\) See Fla. Agency for Health Care Administration, _Florida Medicaid, Managed Medical Assistance Federal Correspondence and Authorities_, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA; select Federal Correspondence and Authorities tab, then links under Request(s) for Amendment of the 1115 Medicaid Reform Waiver (accessed Mar. 30, 2012).
waivers, relying on a waiver combination approach historically used to provide managed long-term services and supports. The Section 1915 waivers would permit Florida to mandatorily enroll beneficiaries in Medicaid Long-Term Care managed care plans, selectively contract with certain service providers, and provide services in a community-based setting to select groups of individuals who otherwise would require institutional services reimbursable by Medicaid.

b. Plan Flexibility and Treatment of Optional Services

Besides changing the structure of Florida’s Medicaid Program, the 2011 Medicaid Reform legislation gives participating plans much flexibility regarding benefit levels and amounts. The present Florida Medicaid program incorporates as many as 30 optional services, which include such things as dental care for adults, prescription drugs, and hospice care, services generally consumed by Florida’s most vulnerable populations. Under the proposed legislative reform, plans have a requirement to provide benefits that are “sufficient” to meet the needs of “most” enrollees, with the state being the entity that decides if the benefits are in fact sufficient. Different benefit packages allowed could produce increased confusion in plan choice and care access for applicants and recipients. In fact, the above type of flexibility is present in a varied form in Florida’s Medicaid Reform pilot program and the anticipated negative result has already occurred as described below. Additionally, due to a lack of patient data from Florida’s existing Medicaid reform, no assessment has occurred to determine the impact of this amount of plan flexibility on access and quality of care. In a DuPont Fund Report on the five-county pilot programs, researchers found that though most HMOs did not limit benefits, those that did were HMOs that had a large market share.

Not offering certain benefits while maintaining “sufficient” benefits for “most” recipients could have negative effects. Optional Medicaid services are already limited in scope and elimination of a service, such as dental services often necessary to maintain healthy teeth and gums, could have detrimental effects. A lack of access to health care services can lead to increased hospitalizations, decreased quality of life, and higher health care costs over the long-term.
proper nutrition, could prevent an elderly person from obtaining those services altogether if the person has limited resources. Results from the pilot program illustrated that when HMOs did limit benefits, they limited durable medical equipment, home health services, physical and respiratory therapies — the types of services used by Florida’s elderly and persons with disabilities. The end result could be that the Medicaid program expends more intensive medical services at an increased cost to the system overall.

3. Florida’s Budgetary Basis for Medicaid Reform

In its analysis for Medicaid reform, the legislative materials supporting the changes in the Medicaid program noted that Florida’s current system was inefficient, and unsustainable, and that fiscal predictability was necessary. The legislative supporting materials noted that the program had over 2.9 million enrolled recipients and $20.3 billion spending in fiscal year 2010-2011, making it the second largest single program in the state, representing 28 percent of the total FY 2010-11 budget. By FY 2013-2014, the program cost was estimated to be $23.6 billion.

Part of the reason for reform in 2011 was also due to the potential impact of the ACA on the cost of the state’s Medicaid program, despite the fact that Florida has taken the position that the ACA is unconstitutional. The ACA adds a new mandatory population as stated previously in this article. Though raising the federal match rates for the new groups finances the expansion, the additional federal match is time-limited, thereby increasing the cost to the state thereafter. The legislative analysis noted that many of Florida’s uninsured individuals eligible for Medicaid coverage are not enrolled; however, the ACA’s mandate to purchase insurance could result in many eligibles enrolling (who would not have without the mandate), thereby increasing costs.

The legislative analysis supporting the 2011 Medicaid reform identified the costs of federal reform to Florida’s Medicaid program to be significant. Florida is expected to have over 379,000 new enrollees from the expanded federal reform population in 2014, at a cost of $1.5 billion, of which $142 million will be paid by the state, and by 2019, 1.9 million additional enrollees will cost over $7.7 billion, of which $1 billion will be paid by the state. The legislative staff analysis did not quantify the amount of savings, stating only that “[t]he exact savings are indeterminate but are expected to be significant.” Based on the estimated increase in program costs, the 2011 legislature found further reason for the Medicaid changes.

141 Alker & Hoadley, supra n. 110, at 4.
143 Fla. H., supra n. 98, at 1.
144 Id. at 3–4.
146 Fla. H., supra n. 143, at 5.
147 Id.
148 Id. at 5–6.
149 Id. at 38.
4. Questionable Cost Savings

The 2011 Medicaid Managed Care system reform anticipates savings based on studies asserting expenditure reductions of 10 percent per member per month and as much as a 20 percent savings overall.\textsuperscript{150} Supporters of managed care state that HMOs are better able to prevent, reduce, or eliminate systemic fraud and abuse.\textsuperscript{151} Advocates also state that the managed care model can better address healthcare disparities due to its emphasis on primary care, member education, disease and case management, and provider collaboration.\textsuperscript{152}

Managed care in Florida, by way of the pilot program, however, has a record of inadequate performance. In 2010, the University of Florida and Health Foundation of South Florida concluded a study of the Medicaid Reform pilot program.\textsuperscript{153} Per study findings, over 50 percent of surveyed providers rated access to specialists and prescription drugs as either “not working very well” or “not working at all.”\textsuperscript{154} Two-thirds of physicians reported that the supply of specialty care physicians was inadequate to meet Medicaid patient needs.\textsuperscript{155} The Medicaid pilot managed care program suffered from plans entering and exiting the system, had the largest Medicaid fraud in Florida’s history, and after five years there was still no patient encounter data needed to assess the changes in access.\textsuperscript{156} An April 2011, Jesse Ball DuPont Fund Report\textsuperscript{157} concluded that there was insufficient data available to draw conclusions as to whether the pilot program saved any money, and if it had, whether that was due to reduced access or increased efficiency of services.

In addition to the above, opposition to the creation of the mandatory program for the delivery of LTCSS in Medicaid through private proprietary health plans is increasing.\textsuperscript{158} Despite the lack of empirical evidence and increasing opposition, the 2012 Florida legislature continued to advance statewide application of managed care by way of House and Senate Bills seeking approval by CMS of AHCA’s waiver requests.\textsuperscript{159}

The intended goal of cost savings may not be within reach of Florida’s proposed

\textsuperscript{151} Id. at 3.
\textsuperscript{152} Id. at 4.
\textsuperscript{154} Id. at 3.
\textsuperscript{155} Id.
\textsuperscript{156} Fla. Ctr., \textit{ supra} n. 114, at 2.
\textsuperscript{157} Alker & Hoadley, \textit{ supra} n. 110, at 4.
LTC Managed Care Program even if allowed by CMS. Nationally, home and community-based services comprise 36 percent of Medicaid spending for long-term care, whereas in Florida, the percentage is only 21 percent (ranking it 37th in the nation).\footnote{Summer & Alker, supra n. 119, at 7.} The 2011 Managed Care legislation has as a goal the shifting of services from institutional to community-based settings with financial incentives available to managed care organizations that facilitate this transition. Those goals may be difficult to achieve, however, due to the continuation of waitlists for community-based services.\footnote{Id.} There are almost 27,000 people on waitlists for the waiver programs that are slated to be part of the Long-Term Care Managed Care program, and AHCA has indicated that the new program does not provide additional funding or create additional slots for home and community-based services.\footnote{Id.} Therefore, those currently on waitlists will not be eligible to enroll in the Long-Term Care Managed Care program until program funds become available.\footnote{Id.}

Additionally, Florida’s present experience with long-term care managed care does not demonstrate cost savings. Of Florida’s five elderly and disabled waiver programs, the only one using a managed care approach, the Nursing Home Diversion Waiver Program, has costs that are substantially higher than the other programs.\footnote{Off. of Program Policy Analysis & Govt. Accountability, Profile of Florida’s Medicaid Home and Community-Based Services Waivers 1–7, http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1203rpt.pdf (Jan. 2012).} However, the higher frailty level of the participants may be one reason for the cost differential.\footnote{Summer & Alker, supra n. 119, at 9.}

5. 2011 Legislative Attempts to Limit Medicaid Planning Techniques

As part of its efforts to lower Medicaid costs, the 2011 Florida legislative body attempted not only to change Florida’s Medicaid system, but also to alter the planning options available to Florida citizens seeking to qualify for Medicaid. Both the Florida Senate and House of Representatives submitted bills aimed at altering the use of personal services contracts and spousal refusal.\footnote{Fla. Sen. 1356, 22d Legis., 1st Reg. Sess. § 18 (2011); Fla. H. CS/HB 1289, 22d Legis., 1st Reg. Sess. (2011), amending Fla. Stat. § 409.902(2)(b).}

a. Personal Services Contracts

A personal services contract is a written contract between a person needing care and a caregiver, usually a family member, to provide those personal care services, usually for the rest of that person’s life. In consideration for those services, the person generally transfers a lump-sum payment to the caregiver in advance of the services being performed.\footnote{Jerome I. Solkoff & Scott M. Solkoff, Florida Elder Law (2011-2012), West Publishing, § 25.304, at 270.} These contracts can be used as a planning method for elderly persons seeking Medicaid eligibility. The contract is based upon fair market consideration, so the lump-sum payment is not an uncompensated transfer for Medicaid purposes and incurs no penalty pe-
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168 The personal services contract allows for a better quality of care for the elderly person through the remaining days of his or her life and reduced costs to the state due to care given to the elderly person that can defer entrance into a nursing home.169

Despite its intended purpose, critics view Medicaid planning as a way for the wealthy to qualify for Medicaid.170 Identical bills were introduced into the Florida House of Representatives and Senate in the 2011 legislative session seeking to alter the use of personal services contracts as a Medicaid planning tool.171 The target of the bills was an amendment to Florida Statute § 409.902 by the addition of language that imposed restrictions on payments to family caregivers for care provided to an elderly relative. If family caregivers received payment in violation of the proposal, then a sanction in the form of ineligibility for necessary medical coverage would be imposed upon the aging parent.172 The bills died in Committee and were not passed in any form and no similar bill was introduced into the Florida 2012 legislative session.

Restrictions on personal services contacts could result in higher costs and lower level of care for recipients.173 Initially, the validity of personal services contracts has been judicially allowed in Florida.174 Personal services contracts help lessen the financial and emotional toll placed on caregivers. In a survey by Caring.com, more than a third of caregivers have been forced to quit jobs, take early retirement, reduce hours, or take leaves of absence in order to provide care for family members.175 To decrease Medicaid long-term care expenditures, the Florida legislature could increase the funding for home and community-based waiver programs, which help keep seniors requiring institutionalized level of care in their homes or community.

b. Spousal Refusal

The 2011 legislative bills that sought to restrict personal services contracts176 also had provisions that would have placed restrictions on the use of spousal refusal as a Medicaid planning technique. In spousal refusal, a spouse refuses to pay or to make his or her resources available for the long-term care expenses of the other spouse.177 The 2011 proposed bills sought to amend Florida law by requiring the Department of Children

169 Solkoff & Solkoff, supra n. 167, at 3.
170 Id.
171 Fla. Sen. 1356 and Fla. H. CS/HB 1289, supra n. 166.
172 Fla. H. CS/HB 1289, at 2, lines 50-55 and at 3, lines 56-75.
173 The arguments in this article against the limitations on the use of personal services contracts in the State of Florida as referenced in the 2011 legislative bills were taken from a Joint Public Position Statement by the Elder Law Section of the Florida Bar and the Academy of Florida Elder Law Attorneys. In re: S 1356/HB 1289 (Family Member Personal Care Agreements), http://www.afela.org/images/stories/Personal%20Care%20Contract%20Analysis%20With%20The%20Impact%20of%20State%20Medicaid%20Reform.pdf (Mar. 14, 2011).
176 See Solkoff, supra n. 167.
and Families (DCF) to deny eligibility for a Medicaid applicant (the “institutionalized spouse”) if his/her spouse (the “community spouse”) refused to make resources available.\footnote{178} By way of another amendment to Florida Statute § 409.902, the bills would have created restrictions and imposed additional burdens on an institutionalized married person in the event his or her spouse exercised his or her right of spousal refusal.\footnote{179}

The Medicare Catastrophic Coverage Act of 1988 provides that Medicaid eligibility cannot be denied when the community spouse refuses to make his or her resources available for the cost of care of the institutionalized spouse.\footnote{180} Additionally, Florida has abrogated the common law concept of a spouse being obligated to pay for his or her spouse’s necessaries provided by a third party.\footnote{181}

Many older citizens enter into marriages following the death of a spouse.\footnote{182} For some of these marriages, the individuals keep assets separate or enter into pre- or post-nuptial agreements. The proposed legislation would have the result of disregarding these estate plans and would subject these individuals who remarry to the fears of potential financial ruin if their spouse became disabled or began to suffer from a long-term illness.

Like the fate of the personal services contract bills, the 2011 legislature did not pass any laws regarding spousal refusal. Instead of limiting spousal refusal, the State could seek legislative action to improve availability and affordability of long-term care insurance. In 2005, Florida passed legislation\footnote{183} that established a partnership program between Medicaid and long-term care insurers. The program provides incentives for individuals to purchase long-term care insurance by allowing dollar-for-dollar asset protection of the amount of insurance benefits provided if the individual applies for Medicaid, thereby increasing pre-Medicaid levels of payments for care without requiring total impoverishment.\footnote{184}

B. Illinois

1. Illinois Medicaid History

Medicaid was implemented in Illinois in 1967 through the passage of the Public Aid

\footnote{179} Fla. H. CS/HB 1289.
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Code.185 Subsequent to its initial implementation, the Medicaid program in Illinois has grown considerably.186

Over the past decades, the numbers of Medicaid recipients have rapidly grown. In 2006, there were 2,047,038 individuals receiving Medicaid benefits in Illinois, and in 2011 the number increased to 2,743,277; out of that number, 260,228 were disabled adults, 168,943 were seniors, and 636,531 were adults who did not fall into either of those categories.187 In Cook County alone in 2011, there were 134,690 disabled adults and 93,681 seniors receiving Medicaid benefits.188 After January 1, 2014, another 500,000 adults are likely to qualify for Medicaid as a result of the Affordable Care Act.189 The State of Illinois will need to face the problem of handling a much larger caseload while struggling with antiquated computer systems, paper case files, and overcrowded offices. The staff has a very short time in which to modernize its systems.190

2. Budgetary Concerns

Illinois is encountering the same problems as many other states in terms of an increasing number of individuals receiving Medicaid benefits, while facing growing deficits. The State is currently facing $9 billion in unpaid bills, approximately $2 billion of which are Medicaid related.191 The number of persons enrolled in Medicaid has gone from 1.4 million people in 2000 to 2.7 million people at present.192 In addition, Illinois is facing the implementation of three different consent decrees from federal lawsuits involving the Medicaid program.

As it is, Illinois Medicaid reimbursement rates are low compared with Medicare and other states, and the state’s time period for reimbursement is very slow.193 Currently the state pays approximately 50 percent of its Medicaid budget, but after January 1, 2014, the “new” Medicaid will be federally funded.194 The state’s goal is to contain costs by using more efficient service delivery while keeping clients healthy in addition to having a redesigned health care delivery system that is more patient-centered, with a focus on improved health outcomes, enhanced patient access, and patient safety.195 The state is also reexam-

188 Ill. Dept. of Healthcare and Fam. Servs., Number of Persons Enrolled in Cook County, http://www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/Cook.aspx (accessed May 19, 2012). The city of Chicago is in Cook County.
190 Id.
192 Id.
193 Julie Hamos, supra n. 189.
194 See id.
195 Id.
ning payment methodologies for hospitals and nursing homes. Illinois Department of Healthcare and Family Services (HFS) will establish new risk-based funding, incentives, and quality measurements to the provider community. The State is also hoping to build up the home and community-based service infrastructure. The State will also take advantage of federal waivers for populations with complex health and behavioral needs.  

3. Medicaid Reforms

The state of Illinois only recently initiated significant Medicaid reforms. While at the present time only one piece of legislation has been enacted with respect to Medicaid reform, HFS is in the process of formulating other strategies to reduce the Medicaid cost to the state. Governor Quinn is proposing to cut in excess of $2 billion from the state Medicaid budget. He has not yet disclosed the specifics regarding the proposed reductions.

The state of Illinois has been researching better ways to manage care under the Medicaid program for several years. In 2004, the Managed Care Task Force was created by the legislature to study the use of managed care organizations such as health maintenance organizations (HMOs). In 2009, the Illinois House and Senate both created Medicaid Reform Committees. In February of 2010, HFS released a Request for Proposal for qualified managed care organizations to enter into risk-based contracts to provide services through an integrated care delivery system for approximately 40,000 adults with disabilities and older adults residing in five counties, including suburban Cook County. The initial phase was to be for all medical programs and the second and third phases would include long-term care.

The goal of the integrated care program is to bring together local primary care physicians, specialists, hospitals, nursing homes, and other providers in which the care is organized around the patient. HFS will make certain that the safeguards are in place by contractually requiring both pay for performance measures as incentives and payment withholds when the Managed Care Organization (MCO) does not have a quality outcome.

While a major goal of moving into a managed care system is the reduction of Medicaid costs, it is unclear as to how effective this move will be for the State. Illinois has an average cost per Medicaid enrollee of $4,129 per year, placing the State in the tenth lowest average cost of any state. Illinois has also kept the Medicaid rates down through reimbursements to providers. For example, doctors in Illinois are paid about 90 percent

196 Id.
199 Id.
200 Id.
201 Id.
of the national average. As Illinois is already paying doctors and providers so little, it is difficult to imagine how an MCO could pay even less. Elderly and disabled patients are the most expensive ones for the State. The average cost for senior citizens is $11,560 and $16,613 for disabled adults.

The Illinois legislature passed a significant piece of Medicaid Reform legislation and it was signed into law on January 2011. The purpose of this Act is to lower Medicaid costs for the state of Illinois. This statute impacts state laws beyond the Public Aid Code.

The State budget law is amended to provide for long-term care rebalancing, which is defined as “removing barriers to community living for people of all ages with disabilities and long-term illnesses by offering individuals using long-term care services a reasonable array of options, in particular adequate choices of community and institutional options to achieve a balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community supports.” In addition, the Governor may designate amounts set aside from institutional services appropriated from the General Revenue Fund or any other state fund that receives funding for long-term care services to be transferred to all state agencies responsible for the administration of community-based long-term care programs, provided that the Director of HFS first certifies that the amounts transferred are necessary for assisting persons in or at risk of being in institutional care to transition to community-based settings.

Perhaps the most significant change in the Act is the mandatory Medicaid managed care programs. The new law requires 50 percent of recipients eligible for comprehensive medical benefits to be enrolled in a care coordination program no later than January 1, 2015. Care coordination is defined as “delivery systems where recipients will receive their care from providers who participate for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, dental services, and rehabilitation and long-term care services.” In order to comply with this provision, the 50 percent will be achieved by enrolling medical assistance enrollees from each medical assistance category, including parents, children, seniors, and disabled adults to the extent that the current Medicaid payment laws would not limit the federal matching funds for recipients in the care coordination programs. Additionally, the services must be more comprehensively defined and more risk assumed than in the department’s primary care case management program as of the effective date of this Act.

203 Id.
204 Id.
205 Id.
210 Id.
211 Id.
212 Id.
The legislation also contains new provisions for managing the recipients of the medical programs. The state agency was given the task to come up with a plan by July 1, 2011, that will include improved systems for verifying initial and continuing eligibility by means of:

1. meeting standards subject to federal and state privacy and confidentiality laws, for timely eligibility verification and enrollment and annual redeterminations of eligibility for means tested programs;
2. receiving and updating data electronically from the Social Security Administration, the U.S. Postal Service, the Illinois Secretary of State, the Illinois Department of Revenue, the Illinois Department of Employment Security, and other governmental entities as appropriate and to the extent allowed by law to verify current and continuing eligibility;
3. meeting federal requirements for timely installation by January 1, 2014 to provide integration with a Health Benefits Exchange pursuant to the Affordable Care Act and the Reconciliation Act in order to ensure the maximum federal financial participation;
4. meeting federal requirements for compliance with architectural standards; and
5. including plans to ensure the coordination with the State of Illinois Framework Project that will expedite and simply access to Illinois Human Services programs, will streamline administration and data sharing, will enhance planning capacity, program evaluation and fraud detection or prevention with access to cross-agency data, and will simplify service reporting for contracted providers.

The new legislation also imposes significant sanctions on individuals who illegally obtain medical assistance. Pursuant to the new law, the Department may seek to recover any and all state and federal monies for which it has improperly and erroneously paid benefits as a result of a fraudulent action and any civil penalties authorized in this section, and in accordance with Section 11-14.5 of the Public Aid Code, the Department may determine the monetary value of benefits improperly and erroneously received. The Department may recover the monies paid for such benefits and interest on that amount at the rate of 5 percent per annum for the period from which payment was made to the date upon which repayment is made to the State. Prior to the recovery of any amount paid for benefits allegedly obtained by fraudulent means, the recipient of such benefits shall be afforded an opportunity for a hearing after reasonable notice. The notice shall include the following information:

1. the time, place, and nature of the hearing;
2. a statement of the legal authority and jurisdiction for the hearing;
3. references to the particular sections of the statutes and rules involved;

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215 Id.
216 Id.
4. at a minimum, a short and plain statement of the matters asserted as well as the consequences of the failure to respond;
5. the amount of the monetary benefits allegedly fraudulently received;
6. a statement that in addition to other penalties provided by law, a civil penalty in an amount not to exceed $2,000 may be imposed for each fraudulent claim for benefits or payments;
7. statement indicating that the recipient may contest the determination by requesting an administrative hearing within 30 days of the mailing of the notice; and
8. the names and addresses of the administrative law judge all parties and all other persons given notice of the hearing.

If a final administrative decision is reached indicating that a repayment is appropriate, the agency will be authorized to place a lien on all property and assets of such person, firm, corporation, etc. until the judgment is satisfied.218

To further the State’s efforts to verify eligibility, the statute also contains new verification requirements regarding income eligibility and residency. At the present time, CMS is blocking these provisions pursuant to a letter from the CMS to the state of Illinois.219

The basis for the bar is that the new requirements violate federal law. The Maintenance of Eligibility (MOE) requirements of Section 2001(b) of the Affordable Care Act state that as a condition of receiving federal payments under Section 1903, states shall not have Medicaid eligibility standards, methodologies, or procedures under the state plan that are more restrictive than those in effect on March 23, 2010.220 In the letter sent to the Illinois Department of Human Services by CMS Director Cindy Mann the new state law requiring more documentation of both income and residency than is required under current Illinois law would be a violation of the MOE provision of the Affordable Care Act.221

The disputed provisions regarding financial eligibility would require verification of one month’s income from all sources during redetermination and the verification will take the form of pay stubs, business income and expense for self-employed persons, letters from employers, and any other valid documentation of income, including data obtained electronically by the department or its designees. If the recipient does not provide this information by the deadline, the recipient will lose his or her coverage.222

The other disputed provision authorizes the department to gain access to information from the Social Security Administration, The Illinois Secretary of State, the Illinois Department of Human Services, the Illinois Department of Revenue, the Illinois Department of Employment Security, and other appropriate entities to gain information appropriate for verifying any factor of eligibility for benefits under the program.223 In conjunction with this new law, the Illinois Vehicle Code was amended by allowing the Secretary of State to disclose information to the Department of Healthcare and Family Services solely

221 Pallasch, supra n. 219.
223 305 Ill. Comp. Stat. 5/11-5.1(b) (Jan. 25, 2011).
for the purpose of verifying Illinois residency when the residency is a requirement for benefits under the Illinois Public Aid Code or other health benefit program administered by HFS.\textsuperscript{224} The two controversial provisions would have called on Medicaid applicants to provide pay stubs for an entire month as opposed to the existing policy of one pay stub, and it would have required cumulative paper evidence of Illinois residence as opposed to the current policy of signing a sworn statement under penalty of perjury. In addition, the current policy allows for electronic monitoring of both income and residency.\textsuperscript{225} At the present time, CMS has denied permission to Illinois to implement these changes by virtue of a June 24, 2011, letter. In that letter, CMS Director Cindy Mann states that the new procedures would constitute a violation of the Maintenance of Eligibility (MOE) requirements in Section 201(b) of the Affordable Care Act, as the new procedures would be more restrictive than those in effect in Illinois on March 23, 2010.\textsuperscript{226} As of February 29, 2012, however, it appears that CMS may have reconsidered and allowed the state to implement the verification procedure regarding residency.\textsuperscript{227}

On February 17, 2012, the State published a proposal for an Illinois Medicare-Medicaid Alignment Initiative for a notice and comment period. This draft proposal seeks to integrate care for dual eligibles under one managed care plan. Dual eligibles represent 25 percent and 46 percent of Medicare and Medicaid spending, respectively, at a national level. However, dual eligible beneficiaries only constitute 16 percent and 18 percent of Medicare and Medicaid enrollment, respectively.\textsuperscript{228} Per Illinois’ new proposal at a state level, full dual eligibles make up 10.3 percent of Medicaid full benefit enrollment as of December 31, 2010, and 30 percent of Medicaid calendar year 2010 net claims-based costs.\textsuperscript{229}

The enrollment in the demonstration project will initially be voluntary and the State is proposing to exclude the Adults With Developmental Disabilities home and community-based waivers from the project at this time.\textsuperscript{230} The covered benefits will include all Medicare and Medicaid covered services including long-term care institutional and community-based services and supports. The overall goal of the State is to create a program that “overcomes barriers to integration and improves upon a coordinated care for dual eligible beneficiaries who often have complex care needs and whose care is typically uncoordinated between Medicare and Medicaid or within either program.”\textsuperscript{231} The program also has a component in which enrollees will chose a medical home with a focus on Federally

\textsuperscript{224} 625 Ill. Comp. Stat. 5/2-123(h) (Jan. 1, 2012).
\textsuperscript{226} Id.
\textsuperscript{230} Id.
\textsuperscript{231} Id. at 5.
Qualified Health Centers, Community Mental Health Centers, Primary Care Physician (PCP)-centered medical groups and private practice PCP offices. The medical homes will "coordinate care across the spectrum of the healthcare system with a particular emphasis on managing transitions between level of care and coordination between physical and behavioral health." 232

The program plans will also be required to provide care coordination services to make sure that the medical homes are linked to other providers and services. 233 Finally, the plans will need to have the technology to assist with the care coordination process. 234 Within 90 days of enrollment in a plan, the plan should complete a health risk and behavioral health screening in order to identify needs for care management and to develop care plans. For those individuals identified to need care management, a multidisciplinary care team will assist the individual. 235 The care coordinators will lead the multidisciplinary teams and work with the enrollee to develop and maintain the care plan and coordinate critical information sharing between the care team and the enrollee. 236

On June 1, 2012, Illinois Gov. Pat Quinn signed into law five pieces of legislation designed to save the state of Illinois Medicaid system from the brink of collapse and make it sustainable for the future by reaching the goal of $2.7 billion in Medicaid savings. 237 The most significant Medicaid reform legislation is the Save Medicaid Access and Resources Together Act, or the SMART Act. 238 This Act not only drastically cuts Medicaid funding, including eliminating several optional Medicaid covered services, 239 it also significantly changes the state’s Medicaid laws. 240

One of the most significant changes is the elimination of pooled trusts for individuals age 65 and older except under certain conditions. 241 Under the new law, “any funding by or on behalf of the person to the trust shall be treated as a transfer of assets for less than fair market value unless the person is a ward of a county public guardian or the State guardian pursuant to Section 13-5 of the Probate Act of 1975 or Section 30 of the Guardianship and Advocacy Act and lives in the community, or the person is a ward of a county public guardian or the State guardian pursuant to Section 13-5 or the Probate Act of 1975 or Section 30 of the Guardianship and Advocacy Act and a court has found that any expenditures from the trust will maintain or enhance the person’s quality of life." 242

232 Id. at 11.
233 Id.
234 Id. at 12.
235 Id.
236 Id.
239 Id.
240 Id.
241 305 Ill. Comp. Stat. 5/3-1.2 (July 1, 2012).
242 Id.
Another change concerns an increase in the minimum determination of need (DON) score necessary for a person to qualify for home and community-based services, as well as skilled nursing facilities (SNFs) and supportive living facilities (SLFs). The minimum score will be increased from 29 to 37 pending approval by CMS. If CMS approves this change, many elderly persons could be deprived of placements in SNFs, SLFs, and/or home services.

The SMART Act also changes the law with regards to spousal refusal. Under the new law, “If an institutionalized spouse or community spouse refuses to … provide [the Department of Healthcare and Family Services (HFS)] the total value of assets, including income and resources, to the extent either the institutionalized spouse or community spouse has ownership interest in them …, such refusal may result in the institutionalized spouse being denied eligibility and continuing to remain ineligible for [long-term care] based on failure to cooperate.” The new law goes on to state that “The Department may seek support for an institutionalized spouse, who has assigned his or her right of support from his or her spouse to the State, from the resources and income available to the community spouse.” The law also specifies that actions may be brought in state court to establish support orders or the Department may establish administrative support orders.

An additional change made by the SMART Act is that farmland property and equipment are no longer exempt from determining a person’s eligibility for Medicaid. Farmland property and equipment will be treated the same as any other income-producing property and equipment.

Under the new law, if a farm has a net return in excess of 6 percent and an equity value of more than $6,000, the farmland property and equipment would need to be sold before a person could qualify for Medicaid. As a practical matter, it is virtually impossible for an elderly farmer to borrow funds to pay for long-term care, because the income from the farm may not cover the mortgage payments. If the farmer were forced to sell the farm, in addition to removing the community spouse’s source of income, it also would likely result in capital gains taxes.

The SMART Act also impacts the issue of exempt homestead property. Pursuant to the new law, homes held in a trust, even an individual’s personal revocable trust, no longer will be considered homestead property for Medicaid purposes. In the emergency rules that were issued, an exception is made if the long-term care resident’s spouse, minor child, or disabled child resides in the home.

The new law does not set a time limit for the transfer of the real estate into a trust or the creation of a trust. It also does not take into account the fact that many trusts are

243 Id. at 5/5-5.
244 Id. at 5/504(b)(i-iv).
245 Ill. Admin. Code tit. 89, pt. 120.379(j).
246 Id. at pt. 120.379(k)(1).
247 Id. at pt. 120.379(k)(2).
248 305 Ill. Comp. Stat. 5/3-1.2 (July 1, 2012).
249 Id.
250 Id.
251 Id.
252 Ill. Admin. Code tit. 89, pt. 120.381(a)(1)(C).
created for reasons other than Medicaid planning. The law’s impact on persons residing in their homes who are seeking to receive services from the Community Care Program (CCP), a Medicaid waiver program in Illinois, is unclear.\textsuperscript{253} Arguably, under the CCP, if the beneficiary of the trust is unable to convey the home out of the trust due to incapacity, the home no longer will be exempt and the beneficiary may be forced into nursing care much sooner than necessary.

The SMART Act also imposes limits on prescriptions for individuals with pharmaceutical coverage under Medicaid.\textsuperscript{254} Medicaid recipients will not be allowed to receive more than four prescriptions including three brand name prescriptions in a 30-day period unless approval is received for all prescriptions in excess of the four-prescription limit.\textsuperscript{255} The following categories of drugs are excluded from this requirement: immunosuppressant drugs, oncolytic drugs, and antiretroviral drugs.\textsuperscript{256}

When this article was written, no permanent administrative rules had been filed by HFS. Although HFS has promulgated emergency administrative rules, the rules are subject to being suspended by the Illinois Joint Commission on Administrative Rulemaking, a bipartisan committee composed of members from the state Senate and state House of Representatives.\textsuperscript{257}

4. Potential Negative Impact on Vulnerable Populations

Because Medicaid reform is relatively new in Illinois, it is too soon to evaluate its impact on the various populations. The new programs and laws certainly could create potential barriers for seniors and adults with disabilities.

One of the major barriers is access to information about providers participating in managed care plans. Participants in the initial group of Medicaid recipients placed in one of the two managed care plans, were not given any written materials that list providers. To locate providers, recipients likely will need Internet access and phone service, which they may not have.

Another barrier is that fewer providers may participate in the managed care plans than are currently participating in the Medicaid program. Fewer hospitals are participating in the managed care plans than are currently participating in Medicaid. In Chicago, for example, none of the top teaching and research hospitals are in either plan.

In addition to managed care problems, the additional documentation required to qualify for and maintain Medicaid coverage may be an onerous burden on an applicant. The elderly and persons with disabilities may be adversely impacted by the new laws.

The SMART Act will have a negative impact on vulnerable populations. In addition to the Act’s dramatic cuts in Medicaid-covered services, its elimination of pooled trusts for most individuals age 65 and older will exacerbate these cuts.

\textsuperscript{253} Id. pt. 240.815.
\textsuperscript{254} 305 Ill. Comp. Stat. 5/5-5.12(j) (July 1, 2012).
\textsuperscript{255} Id.
\textsuperscript{256} Id.
\textsuperscript{257} Ill. Admin. Code tit. 89, pt. 100.900.
C. New Jersey

New Jersey faces a much larger budget shortfall than Florida, $10.5 billion for fiscal year 2012. And here as well, lawmakers are eyeing Medicaid to close the deficit. However, Medicaid expenditures in New Jersey are substantially less than in Florida. New Jersey’s total Medicaid spending for FY 2010 was $10.22 billion. Still, Governor Christie is hoping that a bold and controversial proposal to reform the state’s Medicaid system will result in savings of $300 million. The question for advocates is how it will impact New Jersey’s most vulnerable citizens.

1. History of Medicaid in New Jersey

New Jersey serves nearly 1.3 million Medicaid beneficiaries. Historically, New Jersey has provided comparatively generous benefits. Going beyond the federally mandated services, the state offers many optional services (including dental, durable medical equipment, and vision) and covers additional eligibility groups such as low-income parents of eligible children.

However, in the long-term care arena, coverage has been both inadequate and inefficient. This is despite the fact that the State spent $3.5 billion on long-term care in 2010. The program for home and community-based long-term care services has been particularly problematic. An income cap limits the program to those individuals with incomes below $2,094 in 2012. Limited slots for assisted living and beneficiary budget caps have restricted the usefulness of this program, forcing many beneficiaries to require substantially more costly care in a nursing home. Perhaps, this is why New Jersey spends approximately 70 percent of its Medicaid long-term care dollars on nursing home care, compared to 41 percent nationally.

259 Id.
263 For more information on specific programs, see N.J. Dept. of Human Servs., Div. of Med. Assistance and Health Servs., http://www.state.nj.us/humanservices/dmahs/clients/medicaid (accessed July 4, 2012). See, e.g., http://www.state.nj.us/humanservices/dmahs/clients/medicaid/families/index.html. N.J. Admin. Code 10 includes the program manuals for all covered services (ch. 50 through 68) as well as the eligibility criteria and application rules (ch. 70 and 71) (2012).
2. Medicaid Planning Limitations

Prior to the current comprehensive waiver application discussed below, the state had attempted to limit its Medicaid long-term care budget by being one of the most restrictive environments for Medicaid planning in the country. Strategies such as gift and return, caregiver agreements, promissory notes, and annuities have either been completely eliminated or their use drastically narrowed in New Jersey.267

While there has been some case law and administrative case decisions to support these limitations, many have occurred by fiat, without regulation or legislation.268 The lack of legislative reform is highlighted by the fact that it was not until October 2011 that the Administrative Code was updated to reflect the Deficit Reduction Act of 2005 (DRA ’05); however, the State informally implemented the more restrictive DRA ’05 provisions within days of its passage in 2006.269

3. Comprehensive Waiver

Until 1995, Medicaid services in New Jersey were offered by health care providers that participated in Medicaid and billed Medicaid directly for their services. In 1995, New Jersey contracted with MCOs to provide services to all Medicaid recipients except beneficiaries who are residing in nursing facilities or community-based waiver programs, dual eligibles, and children supervised by New Jersey’s Division of Youth and Family Services.270 Last year, in an attempt to control Medicaid spending and thereby address the state budget deficit, the State proposed expanding managed care across all Medicaid segments as part of a major restructuring of its Medicaid program.271

New Jersey submitted a Medicaid comprehensive waiver application to the federal government in October 2011. The waiver has three major components: 1) expansion of managed care to all Medicaid recipients, 2) consolidation of the various Medicaid programs into one unified and streamlined system, and 3) increased flexibility in such areas as scope and duration of services and copayments.272 The waiver request was designed to result in potential cost savings of $300 million.273 Of that, $107 million would have come

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268 See e.g. N.J. Dept. of Human Servs., Div. of Med. Assistance and Health Servs., Medicaid Communication 10-06, http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2010/10-06_Clarification_of_Medicaid_Communication_10-02_Return_of_Transferred_Assets-Resources.pdf (July 19, 2010), which requires that all assets be returned (instead of partial returns) before a penalty period can be adjusted, thereby eliminating gift and return planning.

269 The proposed amendments to the regulations were issued at 43 N.J. Register 804(a) (April 4, 2011).

270 N.J. Dept. of Human Servs., supra n. 264.

271 Id. It should be noted that Medicaid expenditures are being targeted despite the fact that Medicaid per enrollee spending rose a mere 1.9% from 2004 to 2009.

272 N.J. Dept. of Human Servs., supra n. 264.

from federal reimbursement of state expenses associated with a federal error related to Social Security disability determinations. This request has already been denied by the Department of Health and Human Services, although it is likely that there will be some accommodation offered to all states on the issue. It is anticipated that the waiver will be approved shortly; however, individual provisions are still being negotiated with CMS.

Currently, there are over 30,000 New Jersey nursing home and assisted living residents on Medicaid. The State seeks to require all of these beneficiaries to enroll in one of the four managed care companies that contract with the State by July 2012. This deadline is likely to be moved back as MCOs must first show that they have adequate services, which means contracting with facilities throughout the State. Residents will be required to use in-network doctors as well. The waiver does not address the substantial issue of what happens to beneficiaries who are currently residing at a facility that does not contract with an MCO or using other out-of-network providers. Noting that 80 percent of nursing home revenue comes from Medicare and Medicaid, industry representatives warn that many facilities may be forced to close, while others may choose to abandon the Medicaid system altogether. Both of which will result in capacity issues and fewer choices for consumers.

Individuals who are dually eligible for Medicare and Medicaid will also be shifted to managed care. However, since federal law requires Medicare beneficiaries be given freedom of choice, the State has proposed incentivizing use of managed care by limiting Medicaid cost-sharing to providers who are in the patient’s Medicaid MCO’s network. In practice, this means that most dual eligibles will no longer be able to choose their own providers.

One of the primary goals of the comprehensive waiver is to reduce the need for institutional long-term care by expanding the use of home and community-based services, thereby saving costs. In 2009, New Jersey ranked 49th in the United States in use of home and community-based services. The State has proposed mandating MCO’s coordinate care and provide increased social support to allow more individuals to remain in their homes.

A number of other important changes will allow for the increased use of home and community-based services. Under current law, an income cap prevents many individuals

274 Livio, supra n. 261.
275 Id.
277 N.J. Dept. of Human Servs., supra n. 264.
278 Id. at 87.
280 N.J. Dept. of Human Servs., supra n. 264.
283 Fitzgerald, supra n. 245.
284 N.J. Dept. of Human Servs., supra n. 264.
from receiving home and community-based services.285 The waiver program will implement a medically needy program for home care programs whereby beneficiary excess income would be applied to the MCO capitation premium.286 In addition, the budget limit for each beneficiary receiving long-term care services in the community, which is currently $2,841 per month, will be raised to the nursing facility cost, and in certain cases, higher amounts for a transition period up to six months.287 Obviously, this increase in funding will allow individuals with greater needs to pay for the care they need to remain in the community. The State also plans to expand its community transition program to assist individuals who could safely be transitioned from facilities to home care.288 The waiver also allows individuals who do not quite meet the long-term care criteria but are considered “at risk” to receive home and community-based services as well. Finally, retroactive eligibility (for prior quarter coverage) will be added for community long-term care, while being eliminated for some of the traditional Medicaid categories.289

The waiver also seeks federal approval for a number of coordinated care demonstration programs including Medicaid Accountable Care Organizations, as envisioned under the Affordable Care Act.290 This follows legislation passed by the New Jersey Senate in August 2011 for development of a Medicaid Accountable Care Organization demonstration program.291

While the shift to community-based and coordinated care is praiseworthy, one major cause for concern exists. The waiver sacrifices beneficiary freedom of choice in the quest for cost savings. The State seeks authority for MCOs to make placement decisions based on cost, including mandating placement in nursing homes or at home for home and community-based services, without regard for beneficiary or family choice.292 This could result in families being forced to endure difficult living situations in some cases, while other beneficiaries who wish to remain at home would not be permitted to do so. Furthermore, the State requests authority to move beneficiaries between MCOs and providers without the consent of the beneficiary.293 The State also would have authority to disenroll an individual from self-directed home and community-based services.294 Moreover, since case management would be performed by the managed care companies, care planning will likely be as much a function of profits as quality care. It seems clear that the State believes that financial concerns trump the individual’s right to be involved in their own care planning decisions.

Another major component of the comprehensive waiver is the integration of the cur-

286 N.J. Dept. of Human Servs., supra n. 264, at 27.
287 Id. at 88.
288 Id.
289 Id. at 24.
290 Id. at 76; see also N.J. Dept. of Human Servs., supra n. 273.
292 N.J. Dept. of Human Servs., supra n. 264, at 88.
293 Id. at 88–89.
294 Id. at 90.
rent Medicaid programs. New Jersey currently operates nine different waiver programs in addition to “traditional” Medicaid, which encompasses several other eligibility groups under its state plan. 295 The comprehensive waiver proposes to consolidate virtually all services and populations under one waiver. 296 In theory, this would be very beneficial as the current system is quite confusing and the hand-off between agencies and departments can cause additional delays. The State has also proposed an electronic system to automate eligibility decisions and allow sharing of information between workers and across programs. 297 This will not only reduce costs for staffing, storage, and copying, but is designed to eliminate the inconsistencies between counties that are currently rampant. This, along with a new procedure for simultaneous processing of financial and clinical eligibility, will in theory expedite eligibility determinations substantially. Of course, experience tells us that reality does not always match the promise of government reform. Moreover, having experienced the delays and confusion in the roll out of prior waiver programs, it is hard to imagine how these seismic changes will be implemented all at once, especially with current staffing shortages in the Medicaid agency.

Perhaps the most troubling portion of the comprehensive waiver, though, is New Jersey’s request for an expedited process for future CMS approvals. The State has proposed a tiered approach, which would provide it with flexibility to make certain changes in its programs without seeking prior CMS approval. 298 The State specifically requests flexibility in amount, scope, and duration of benefits. 299 It also seeks authorization to charge copayments to provide incentives and disincentives for certain behavior, such as enrollment in certain types of specialty plans or for perceived misuse of emergency room visits. 300 The fear is that this provision will provide the means by which the State can whittle away at rights and services for the most vulnerable patients without public awareness or the opportunity for public comment.

Advocates have already had some impact in shaping the waiver. Initially, the Comprehensive Waiver application included a proposal to freeze enrollment for one optional category, non-disabled adults, essentially eliminating coverage for families with yearly income over $6,000 (for a family of four). 301 After widespread criticism from the public and advocates, the State removed this proposal. 302 However, the waiver application notes that it is restoring coverage subject to availability of funding and includes a request for expanded federal funding to allow this program to continue. 303

If approved, the Comprehensive Waiver will fundamentally alter the delivery of

296 Id.; see also N.J. Dept. of Human Servs., supra n. 273.
297 Id. at 27–28.
298 Id. at 13–14.
299 Id. at 34.
300 Id. at 58.
302 N.J. Dept. of Human Servs., supra n. 264, at 15.
303 Id.
services to Medicaid beneficiaries in New Jersey. The stated goal of the demonstration program is to improve service delivery and quality of care while controlling costs. Many positive aspects of the waiver exist, which will no doubt improve the lives of many beneficiaries. However, it remains to be seen what reduction in services, accessibility and freedom of choice the most vulnerable populations will suffer in order to improve the state’s bottom line.

VII. CONCLUSION

States have been looking at ways to control their budgetary growth while also implementing cost predictability for programs that provide services for their citizenry. The recent economic downturn has caused that concern to take a more prominent role. The recession left states strapped with significant budgetary shortfalls and, as shown from this article, states are still struggling to recover. Reforms to state Medicaid programs became a focus, as illustrated by the states in this article, as a way to achieve cost control and budgetary predictability. Reforms have taken various forms from reduction of provider payments to changes in the type or amount of services offered to improvements in delivery systems and technology. Reform by way of implementation of managed care was or is attempting to be implemented in the three states analyzed. Medicaid reform will definitely bring change and the elderly and individuals with disabilities will be affected as a result. This article shows that reform for the sake of saving the state money could have negative effects for those vulnerable populations. Whether the actions taken by states to save costs in their Medicaid programs, as illustrated in this article, will in fact cause harm to the health and welfare of the elderly and individuals with disabilities in many instances remains to be seen.