

MEDICAID AND NEW FEDERALISM: THE STATE OF INDIANA

Medicaid is a Federal grant-in-aid program which allows states to enter into agreements with the Secretary of Health and Human Services to fund health care services for public assistance recipients and specific categories of low income individuals and families;¹ it is the major government health program which provides medical assistance to poor individuals.

Since the program's inception in 1965 as Title XIX of the Social Security Act, Medicaid expenditures have risen from \$238 million in 1966² to present expenditures of \$32.6 billion.³ The spiraling growth and cost of Medicaid have placed an enormous burden upon both Federal and state budgets. It represents the single most rapidly rising item in most state budgets, and many states have reduced other expenditures to maintain their Medicaid program.⁴

On July 30, 1981, President Reagan told the National Conference of State Legislatures:

"This nation has never fully debated the fact that over the past 40 years federalism — one of the most essential and underlying principles of our Constitution—has nearly disappeared as a guiding force in American politics and government. My administration intends to initiate such a debate. . . ."⁵

Mr. Reagan called for the implementation of New Federalism: a program which would return \$47 billion in Federal programs to state and local government,⁶ while retaining other programs like Medicare. Medicaid would be federalized and over forty categorical grant programs in other areas would be returned to the states for administration.⁷

New Federalism has been shelved for the time being but Federal cutbacks and the spiraling cost of Medicaid have forced states to closely scrutinize their programs.⁸ The response of the state to Federal cutbacks and higher Medicaid program costs raises many of the ques-

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1. Grants to State for Medical Assistance Programs, 42 U.S.C. § 1396 (1976).
 2. *Medicare and Medicaid: Problems, Issues and Alternatives: Hearings Before Senate Committee on Finance*, 91st Cong., 1st Sess. 42 (1970) [hereinafter cited as *Medicare and Medicaid*].
 3. Anders, *Federal Takeover of Medicaid Could Give Boost to Insurers*, Wall St. J., Feb. 1, 1982, at 43, col. 3. The states are paying approximately 40% of this amount.
 4. Demkovich, *For States Squeezed by Medicaid Costs, the Worst Crunch is Still to Come*, NAT'L J., Jan. 10, 1981, at 48.
 5. President Reagan, Address before the National Conference of States Legislatures in Atlanta, Georgia, 17 WEEKLY COMP. PRES. DOC. 833 (Aug. 3, 1981).
 6. President Reagan, State of the Union Address, 18 WEEKLY COMP. PRES. DOC. 80 (Feb. 1, 1982).
 7. Borfield, *New Federalism: The Debate is On*, J. INST. SOCIOECON. STUD. 19 (1982).
 8. The Reagan Administration has suspended its efforts to write legislation transferring welfare and food stamps programs to the states in exchange for a federal assumption of all Medicaid

tions which New Federalism will raise, and an examination of how the state responds to Federal cutbacks may suggest how states will react to the implementation of New Federalism. This paper analyzes how one state, Indiana, has responded to Medicaid cutbacks.

The Medicaid Program: An Overview

In 1965, Congress amended the Social Security Act of 1935 to include grants to states for medical assistance programs.⁹ Unlike Medicare which is available as a matter of right to all retired individuals who paid Social Security taxes,¹⁰ Medicaid stems from public welfare concerns and focuses upon specific low income groups.

The report of the Committee on Ways and Means notes:

"a state [Medicaid] plan to be approved must include provisions for medical assistance for all individuals receiving aid or assistance under state plans approved under Titles I, IV, IX, XIV, and XXI [of the Social Security Act]. The people who are eligible for assistance under these titles are the most needy and it is appropriate for their medical costs to be met. Thus, poor people will have the first call on the resources of the state, and only after these individuals are provided for may states provide medical assistance to the less needy."¹¹

Medicaid is a program of matching funds for state plans approved by the Secretary of Health and Human Services.¹² Federal funds are available contingent upon the state's per capita income and range from 50 to 77.5% of the state program costs. All states as well as the District of Columbia, Puerto Rico, Guam, and the Northern Marianas participate in the program.¹³

Medicaid is a program of "statutory provisions and HEW regulations of labyrinthine complexity."¹⁴ Congress desired to provide states with flexibility in the design and implementation of their programs.¹⁵ Thus state programs differ substantially in eligibility criteria and services provided. Additionally, since the Federal government pays a substantial portion of state Medicaid costs, it subjects state programs to substantial Federal regulation, particularly regarding the curtailment

costs. The transfer is at the heart of President Reagan's new federalism initiative. N.Y. Times, Apr. 7, 1982, at 1, col. 6.

9. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

10. HEALTH CARE FINANCING ADMINISTRATION, HEALTH CARE FINANCING PROGRAM STATISTICS 1 (1980) [hereinafter cited as HCFA STATISTICS].

11. H.R. REP. No. 213, 89th Cong., 1st Sess. 66, reprinted in 1965 U.S. CODE CONG. & AD. NEWS 2017.

12. 42 U.S.C. §1396 (1976). When the author uses the term matching funds, the author refers to federal financial participation in the Medicaid program. Federal expenditures vary with the state's per capita income and currently range from 50% to 77.5% of program medical expenditures. HCFA STATISTICS, *supra* note 10, at 2.

13. Arizona which has never had a Medicaid program, opted to participate as of October 1, 1982. *Id.*

14. Friedman v. Berger, 547 F.2d 724 (2nd Cir. 1976).

15. States have great flexibility in determining eligibility, services, and the scope of services, within the federal guidelines. Courts have traditionally been very respectful of this flexibility. See, e.g., Dandridge v. Williams, 397 U.S. 471 (1970).

of services.¹⁶

Federal regulations mandate that a state program must provide medical assistance to specific groups of individuals.¹⁷ At a minimum, the state must assist the categorically needy,¹⁸ individuals eligible for cash assistance under AFDC or blind or disabled individuals meeting the income and resource levels for supplemental security income eligibility.¹⁹ Federal regulations also require that state Medicaid programs provide at least certain services to the categorically needy: In and Out-patient hospital service; rural health clinic services; other laboratory and X-ray services; skilled nursing facility services for individuals twenty-one or older; early and periodic screening of diagnosis and treatment; family planning services and supplies; physician services; and home health services.²⁰ States also may offer a comprehensive list of services to both the categorically and the medically needy for which federal funds are available.²¹

States may extend Medicaid to the medically needy,²² individuals who meet all criteria for categorically needy assistance with the exception of income, and who have substantial medical bills.²³ Federal regulations allow states to include a spenddown provision in their Medicaid programs covering individuals who do not meet the categorically needy income levels but whose medical bills effectively reduce their income to the categorically needy threshold.²⁴

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16. States will often attempt to implement cutbacks without following federal notice requirements. The courts respond by enjoining the cutbacks until the notice provisions are properly complied with. *See, e.g.*, *Claus v. Smith*, 519 F.Supp. 829 (N.D. Ind. 1981); *Kimble v. Solomon*, 599 F.2d 599 (4th Cir. 1979); *Becker v. Toia*, 439 F.Supp. 324 (S.D.N.Y. 1977).
17. 42 C.F.R. §§ 435.1-1011 (1979).
18. 42 C.F.R. §§ 435.100-135 (1979).
19. *Id.*
20. 42 C.F.R. § 440.210 (1979).
21. Federal regulations provide that the state may make available a broad range of services: a) inpatient hospital services (other than services in an institution for tuberculosis or mental disease) and rural health clinic services; b) outpatient hospital services; c) other laboratory and X-ray services; d) skilled nursing facility services; e) early and periodic screening, diagnosis and treatment (EPSDT); f) family planning services; g) physician's services; h) medical care or other remedial care recognized by state law furnished by licensed practitioners within the scope of their practice as defined by state law; i) home health care services; j) private duty nursing services; k) clinic services; l) dental services; m) physical therapy, related services; n) prescribed drugs, dentures and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye; o) any other diagnostic, screening, preventive and rehabilitative services; p) inpatient hospital services, skilled nursing facility services and intermediate care facilities for individuals 65 years or older in an institution for tuberculosis or mental diseases; q) intermediate care facility services (other than institutional services for mental disease or tuberculosis) for individuals who are determined . . . to be in need of such care; r) inpatient psychiatric hospital services for individuals under age 21 . . .; s) any other medical care and any other type of remedial care recognized under state law specified by the secretary. 42 U.S.C. § 1396d (1974).
22. 42 C.F.R. §§ 435.300-325 (1979). Financial eligibility for the medically needy varies from program to program, ranging from a high of \$6,552 per year in Hawaii, to a low of \$1,512 per year in Puerto Rico, for a family of four. HCFA STATISTICS, *supra* note 10, at Table 4.2.
23. *Id.* 42 C.F.R. §§ 435.300-325 (1979). *See also* HCFA STATISTICS, *supra* note 10, at 65.
24. State programs often provide Medicaid coverage to other needy groups, such as individuals eligible for a state administered welfare program. However, federal funds are not available to cover these individuals.

Congress recently amended the Social Security Act to allow states substantially more freedom in selecting the services provided to the medically needy.²⁵ The new regulations enable a state to offer services to the medically needy without regard for requirements as to a minimum number of services, or a mix of institutional and non-institutional services. States may offer services to one group of individuals, such as the elderly, without being required to offer comparable services to other groups. The 1981 amendments intend to provide states with flexibility in establishing eligibility criteria and the scope of services provided under the medically needy program.²⁶ This flexibility allows states to attune their medically needy programs to the needs of various population groups.²⁷

Federal regulations also mandate the degree and scope of other non-medical services that must be provided.²⁸ Each service under the state plan must be sufficient in amount, duration, and scope to reasonably achieve its purpose.²⁹ The state Medicaid plan may not deny or reduce services in amount or scope merely because of the diagnosis, type of illness or condition.³⁰

States may implement appropriate limitations, however, based upon criteria of medical necessity or overutilization of medical services.³¹ States often use this provision to limit the number of days of hospitalization for which it will reimburse a recipient. Despite the Federal regulations, differences in the state eligibility requirements and the scope of services offered produce substantial variations among state Medicaid programs.

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25. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2171-2172, 95 Stat. 807 (1981). Previously, state plans providing services to the medically needy had to insure that the state program offered the mandatory services for the categorically needy, or any seven of the medical services offered under the Medicaid program. If the state plan opted to cover inpatient hospital services or skilled nursing facility services, physician services for individuals undergoing such treatment had to be included. 42 C.F.R. § 440 (1979).
 26. SENATE COMM. ON FINANCE, SUMMARY OF FINANCE COMMITTEE RECOMMENDATIONS, SOCIAL SECURITY PROVISIONS, S. REP. 139, 97th Cong., 1st Sess. 427, *reprinted in* 1981 U.S. CODE CONG. & AD. NEWS 697-98.
 27. Congress did, however, establish specific restrictions. A state which does offer medically needy services must provide ambulatory services to children and prenatal and delivery service for pregnant women. Where a state provides institutional services to any medically needy group, it must provide ambulatory services for the same. Finally, if the state Medicaid program covers the mentally retarded in intermediate care facilities, it must provide all services required prior to the 1981 amendment to medically needy individuals. *See supra* note 22.
 28. 42 C.F.R. § 431.53 (1979). "Provider" means any individual or entity furnishing Medicaid services under a provider agreement with a Medicaid agency, 42 C.F.R. § 430.1 (1979).
 29. 42 C.F.R. § 440.230 (1979).
 30. *Id.*
 31. The case of *Beal v. Doe*, 432 U.S. 438 (1977), is interesting in this regard. Medicaid recipients brought an action challenging the denial of coverage for non-therapeutic abortions. The Supreme Court noted that nothing in the Medicaid statute suggests that states are required to fund every medical procedure that falls within the delineated categories of medical care. The court noted that states were given broad discretion in determining the extent of medical care, provided that such assistance be "reasonable" and "consistent with the objectives of the Act." *Id.* at 444. *See also* S. DAVIDSON & T. MARMOR, *THE COST OF LIVING LONGER* (1980).

The Medicaid Crisis

When Congress considered implementing the Medicaid program, the Department of Health, Education and Welfare³² estimated that Medicaid would cost the government \$238 million in its first year of operation.³³ Current expenditures are estimated to reach \$32.6 billion.³⁴ This spiraling cost has created the Medicaid crisis.³⁵

Between 1967 and 1976, the Medicaid program grew rapidly. The six states which implemented Medicaid programs in 1967 spent the entire \$238 million allocated to Medicaid by HEW as first year costs.³⁶ President Johnson's 1968 budget allocated \$4.24 billion as the Federal share for forty-eight state Medicaid programs.³⁷ Only 37 states were able to implement Medicaid programs—at a cost exceeding \$3.54 billion.³⁸ The number of recipients doubled from 11.5 million in 1967 to almost 23 million in 1977.³⁹

Since 1977, slow growth and substantial coverage changes have characterized the program.⁴⁰ The number of Medicaid recipients has declined at an annual rate of 3.1% since peaking in 1977. Costs have continued to spiral, nonetheless, from \$16,277,000 in 1977, to \$20,474,000 in 1979.⁴¹ Two factors account for the current Medicaid crisis: increasing coverage of long term institutional care and state fiscal difficulties.

In 1979, 42.3% of Medicaid reimbursements covered nursing home costs and an additional 31.4% covered hospitalization costs.⁴² Nearly three-fourths of the Medicaid budget, therefore, paid for institutional care. Institutional care represents the costliest sector of health care, generally.⁴³ State fiscal difficulties compound the Medicaid crisis. During a recession, states have less revenue available but face an increasing demand upon state welfare services from the seasonally and permanently unemployed. As Medicaid program costs outgrow available state revenues, and as the Federal government reduces matching funds, state budgets become increasingly strained.

32. HEW is now known as the Department of Health and Human Services.

33. See *Medicare and Medicaid*, *supra* note 2, at 42.

34. See Anders, *supra* note 3.

35. An analysis of private sector health costs indicates that the spiraling cost of Medicaid is symptomatic of the health care industry in general. Hospital costs have soared from \$3.9 billion in 1950 to \$76 billion in 1978, an average annual increase of 11.2%. Nursing home expenditures have risen at an annual rate of 17.2%. While the consumer price index rose 87% for all items from 1970-1979, medical care service charges rose 200% over the same period. DEP'T OF HEW, HEALTH, UNITED STATES 181 (1979).

36. *Medicare and Medicaid*, *supra* note 2, at 42.

37. *Id.*

38. *Id.*

39. *Id.*

40. HCFA STATISTICS, *supra* note 10, at Table 2.1.

41. *Id.* In 1978, this figure dropped by 700,000 to 22,197,000, and the following year fell to 21,540,000.

42. *Id.* at Figure 1.1.

43. Roemer, Hopkins & Gartside, *Copayments for Ambulatory Care: Penny-Wise and Pound Foolish*, 13 MEDICAL CARE 457 (1975) [hereinafter cited as Roemer].

Cutbacks on the Federal Level

Since October 1981, the poor and the near poor have lost more than \$10 billion in Federal support.⁴⁴ Many of the cutbacks have been in the area of health care, particularly Medicare and Medicaid. The House-Senate Conference Committee on Medicare and Medicaid agreed to nearly \$14.3 billion in cuts in those programs alone,⁴⁵ most of which impact on lower income individuals.

The federal government acted to alleviate the Medicaid crisis in the Omnibus Budget Reconciliation Act of 1981 (Reconciliation Act),⁴⁶ and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).⁴⁷ First, Congress has imposed much of the increasing cost of Medicaid directly upon state budgets. Second, Congress created various incentives and reformed present laws to make Medicaid a more cost-effective program.

In the Omnibus Budget Reconciliation Act of 1981, Congress increased state Medicaid costs by reducing federal funding:⁴⁸ by 3% in fiscal year 1982, 4% in 1983, and 4 1/2% in 1984.⁴⁹ The reduction would be adjusted upward by one percent for each of three contingencies:

- 1) an unemployment rate of at least 150% of the national average;
- 2) currently existing state hospital rate review programs; and
- 3) documented reductions in state Medicaid expenditures which equal one percent of the federal funds available to the state, provided that the reduction is due to third party, fraud and abuse recoveries.⁵⁰

This provision directly imposes the brunt of increasing Medicaid costs upon already heavily burdened state budgets. Since most states find it increasingly difficult to cope with the increasing cost of Medicaid, a shell game begins at the state and local levels to determine who will ultimately bear the costs.⁵¹

44. "Since last October, the poor and near poor in America have lost more than \$10 billion in federal support. Some 661,000 children have lost Medicaid coverage; 900,000 poor youngsters no longer receive free or reduced-price school lunches; 280,000 no longer receive free or reduced-price breakfasts; 150,000 poor working families have lost eligibility for government-supported day care, 200,000 fewer pregnant women, new mothers, infants, and children are getting special federal coupons for milk, juice, and other diet supplements. One million people have been dropped from the food stamp rolls. In addition, 890 school districts have cut back on special education programs." Reich, *Ideologies of Survival*, NEW REPUBLIC, Sept. 27, 1982.

45. K. GLENN, *MEDICINE AND HEALTH PERSPECTIVES* 1 (Aug. 16, 1982).

46. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981).

47. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 131-150, 96 Stat. 367 (1982).

48. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2161, 95 Stat. 803 (1981).

49. *Id.*

50. *Id.* This effectively assists states with high employment in the one instance, but encourages states to be fiscally prudent in the other.

51. It appears very unlikely state and local governments will be able to make up for the loss of federal funds in the immediate future. Certainly, it is even less likely that private contributions from the business community, churches, or the United Way will be large enough to fill the gaps. Many existing agencies, programs, and services are likely to be eliminated. Most

The Tax Equity and Fiscal Responsibility Act of 1982 enormously expanded the ability of a state to impose cost-sharing upon Medicaid recipients.⁵² Under the previous law, a state could impose cost-sharing upon all services received by the *medically* needy, but only upon optional services provided to the *categorically* needy.⁵³ TEFRA allows copayments upon virtually all services to Medicaid recipients.⁵⁴ Copayments reduce state program costs in two respects: by the amount of the copayment, and by a financial disincentive to the recipients' use of services. The TEFRA Conference Committee estimated that copayments could reduce state expenditures by \$45 million in fiscal year 1985.⁵⁵

Both the Reconciliation Act and TEFRA also provide incentives to render state Medicaid programs more effective. By making state Medicaid programs more cost-conscious and cost-effective, the Federal government hopes to reduce or stabilize its Medicaid costs. The Reconciliation Act allows states to waive administrative requirements, such as the recipient's freedom of choice of provider⁵⁶, or statewide uniformity⁵⁷ of programs where the waiver is in the context of specific programs designed to make the state Medicaid program more effective. For example, the state may purchase laboratory or medical services through competitive bidding; limit or suspend a provider whom the state determines has provided more services than necessary; limit or suspend a provider not meeting professionally recognized health standards; or restrict or "lock in" Medicaid recipients who have overutilized services.⁵⁸

other programs will be reduced in size. Eligibility criteria will be tightened for many programs limiting service to only the most needy. Services such as research, demonstration, program evaluation, and training programs will also be severely curtailed. Everywhere there will be intense competition for available funds. NATIONAL CONFERENCE ON SOCIAL WELFARE, THE ROLE OF AMERICAN GOVERNMENT IN AMERICAN SOCIAL WELFARE, 8-9 (1982).

52. Pub. L. No. 97-248, § 131.

53. 42 C.F.R. § 447.53 (1979).

54. There are specific limitations, however. Copayments may not be imposed, inter alia, upon pregnancy services, patients in significant and intermediate care facilities, emergency services and family planning services.

55. See *supra* note 4.

56. Congress imposed the freedom of choice requirement upon state Medicaid programs to insure that Medicaid recipients would receive the same level and quality of care the private patient receives.

57. Federal regulations mandate that a state Medicaid program provide uniform standards of care and levels of service throughout the state. However, waiver of the state uniformity requirement is intended to allow the states to try experimental programs without being required to implement such programs nationwide.

58. The Secretary is given waiver authority to allow states to restrict providers from whom a recipient can obtain services (other than emergency services) so long as: 1) the providers comply with reimbursement, quality and utilization standards under the state plan; 2) the restrictions are consistent with access, quality, and efficient and economic provision of care and services; and 3) the restrictions do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency; implement a case management system or speciality physician services arrangement which restricts the provider through whom recipients can obtain primary care services; share savings of cost-effective medical care with recipients through expanded service coverage; and allow localities to act as central brokers in assisting recipients in selecting among competing health care plans. B.

Additionally, the Reconciliation Act amended the list of services which states must provide to the medically needy.⁵⁹ Under previous law, a state which chose to cover the medically needy had to cover them all, offer the same or similar services to all recipients, and provide as a minimum a combination of institutional and non-institutional services.⁶⁰ The present law allows a state substantially more freedom to determine whom they shall cover and to what extent. States may offer services to one group of individuals, such as the elderly, without offering comparable services to other groups. Essentially, states may attune their medically needy programs to address the specific needs of different population groups.⁶¹

Finally, other provisions in the Reconciliation Act encourage states to seek alternatives to expensive institutional care.⁶² The Secretary of HHS may waive federal requirements and enable a state to cover home or community based care for individuals who might otherwise need institutional care.⁶³ The Act also provides for increased flexibility in the use of Health Maintenance Organizations⁶⁴ and adds increased flexibility to the manner in which states may reimburse hospitals.⁶⁵

THE STATE OF INDIANA

In response to the problem of funding the Medicaid program, Indiana has implemented a variety of new provisions to make Medicaid more cost-effective. Indiana also has imposed the increasing cost of Medicaid upon the recipient through copayments and by tightening eligibility rules.

Cost Control

Indiana's cost control program focuses on the reduction of the unnecessary use of Medicaid services by insuring that Medicaid recipients receive only necessary and appropriate services. Utilization control is one of the best options available to states for reducing Medicaid costs. One commentator for the Urban Institute has noted that

[i]t is not surprising that utilization control is considered a primary element in Medicaid cost containment policy, for it appears to offer some-

SPITZ, STATE GUIDE TO MEDICAID COST CONTAINMENT, App. A 67 (1981).[hereinafter cited as STATE GUIDE]

59. See *supra* note 46, at § 2171.

60. 42 C.F.R. §§ 435.300-325 (1979).

61. Congress did, however, establish specific restrictions. A state which does offer medically needy services must provide ambulatory services to children, and prenatal and delivery services for pregnant women. Where a state provides institutional services for any medically needy group, it must provide ambulatory services for the same. Finally, if the state Medicaid program covers mentally retarded individuals in intermediate care facilities, it must provide all the services required prior to the 1981 amendments to medically needy individuals. Pub. L. No. 97-35, §§ 2171-2172 (1981).

62. *Id.*

63. *Id.*

64. See *supra* note 46, at § 2178.

65. *Id.*

thing for nothing. Unlike benefit limitations or restrictions on eligibility, the client need not suffer any real reduction in program benefits if the control mechanism is properly administered. Likewise, a utilization control need not result in lower levels of remuneration per service to medical providers, at least not for those who meet the program's standards for medical necessity.⁶⁶

Indiana has implemented four programs which effectively control costs: lock-ins; prior authorization; third party liability recovery; and fraud control.

Lock-ins

Under a lock-in program, a recipient is limited to receiving services from a specific doctor or pharmacist.⁶⁷ The Medicaid Management Information Service (MMIS), a federal computer system, enables states to identify the profligate use of Medicaid services by specific individuals.⁶⁸ The state may then contact the individual through the local welfare office to determine the actual need for services. If the need cannot be verified, the state notes this on the recipient's Medicaid card and then allows that individual to receive services only from specific providers.⁶⁹ This lock-in program effectively precludes the recipient from obtaining identical prescriptions from several pharmacists, or going to several physicians with the same problem.⁷⁰ As a result, lock-ins remove the Medicaid recipient's freedom to choose the physician or other provider.⁷¹ The Reconciliation Act expressly allows states to waive the freedom of choice requirement upon finding individual cases of abuse.⁷²

Indiana's lock-in program while new and untested, promises substantial savings to the state. Missouri, for example, has implemented a very effective program⁷³ which saves their Medicaid program approximately \$1.82 million per year.⁷⁴

Prior authorization

Indiana also has acted to control costs through a prior authorization program.⁷⁵ This program requires a Medicaid recipient to receive approval from a medical review team prior to receiving specified medical

66. B. STUART, *Utilization Controls* 29 (The Urban Institute, Medicaid Cost Containment Series, Vol. 3, June, 1977).

67. STATE GUIDE, *supra* note 58, at 22.

68. See generally, D. Chavkin, *An Introduction to the Medicaid Management Information System (MMIS), or Your Friend, The Computer*, 12 CLEARINGHOUSE REV. 99 (1978).

69. 470 INDIANA ADMINISTRATIVE CODE § 5-1-2, reprinted in 5 INDIANA REGISTER, No. 8, at 1699 (Aug. 1, 1982).

70. STATE GUIDE, *supra* note 15, at 29-30.

71. *Id.*

72. See *supra* note 48, at § 2175.

73. *Id.*

74. *Id.*

75. See STATE GUIDE, *supra* note 58, at 28.

services.⁷⁶ The state acts as the final arbiter of medical need by denying payment for services it determines unnecessary.⁷⁷

The prior authorization program can be very effective if properly implemented. It would be administratively impossible for the state to subject every service to review before delivery.⁷⁸ Certain services which are costly or are likely to be overused, however, merit prior authorization by an impartial medical review team. Prior authorization delays delivery of services to the recipient and increases administration and paperwork for the state.⁷⁹ Therefore, prior authorization is most effective for those services for which the state anticipates a high rate of non-confirmation.⁸⁰

Indiana's comprehensive prior authorization program requires prior approval of many overutilized services. Generally physician services, pharmacy services, and in- and out-patient hospital services do not require prior authorization.⁸¹ Indiana provides exceptions to prior authorization, for example, for special surgical procedures where the state anticipates a high rate of non-confirmation by the review board, such as requests for sex change operations, face lifts, reconstructive or plastic surgery, and weight reduction surgery.⁸² Prior authorization is required, also, for many of the optional services Indiana makes available under its Medicaid program, such as dentistry, physical, occupational or speech therapy, audiology, podiatry, optometry, and mental health services.⁸³ All hearing aid purchases and repairs must receive prior approval by the state.⁸⁴

The Medical Review Board determines on a case by case basis whether to allow services based upon criteria of medical reasonableness and necessity.⁸⁵ Prior authorization is not required in an emergency situation.⁸⁶ To reduce the administrative delay of prior authorization, services are deemed authorized if the Department of Public Welfare does not come to a decision within ten days of receipt of all necessary information.⁸⁷ The state regulations grant an appeal for cases denied by the state.⁸⁸

Indiana also uses prior authorization to limit admission to nursing homes.⁸⁹ Institutional care remains the most expensive category of care

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. 470 INDIANA ADMINISTRATIVE CODE §§ 5-6 reprinted in INDIANA REGISTER, No. 1 at 32 (Jan. 1, 1982).

82. *Id.* at §§ 5-6-2(b), reprinted in 5 INDIANA REGISTER, No. 1, at 49 (Jan. 1, 1982).

83. *Id.* at §§ 5-6, reprinted in 5 INDIANA REGISTER, No. 1, at 47 (Jan. 1, 1982).

84. *Id.* at § 5-6-9.

85. *Id.* at § 5-6-1.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.* at §§ 5-6-17.

Medicaid covers, and occupies an increasingly larger share of the state Medicaid dollar. By reducing institutional care costs, a state may substantially reduce its Medicaid bill. Prior authorization of admission to nursing homes limits admission to nursing homes to individuals who are truly in need of institutional care. It reflects a state policy of providing health care in the most appropriate, yet least expensive environment.⁹⁰

Third party liability recovery. Indiana has also implemented an effective third party liability program which recoups Medicaid costs for which third parties are liable.⁹¹ Federal regulations require a state to determine the legal liability of third parties for services provided under the state Medicaid program and to seek reimbursement from them.⁹² Third parties may include insurance companies, other federal and state programs, such as the Veteran's Administration, CHAMPUS, Medicare and private tortfeasors.⁹³ The state's failure to recoup third party costs consequently subsidizes private insurance companies and other public agencies at the state taxpayer's expense.

Indiana prevents the subsidization of insurance companies by prohibiting them from writing policies which limit or exclude payments to Medicaid recipients.⁹⁴ The private insurer, therefore, not the state Medicaid program, bears the cost of the Medicaid recipient's treatment. Where a recipient has received Medicaid services covered under an insurance policy, the insurer must reimburse the state for the services provided.⁹⁵ Indiana law gives the State Department of Public Welfare a lien on behalf of any Medicaid recipient injured, or suffering an illness or disease through the negligence of another individual.⁹⁶ The State Department of Public Welfare has rights of assignment and subrogation of Medicaid recipient claims against third parties.⁹⁷

Third party liability programs control costs not only through utilization control but also through reducing the subsidization of other agencies by the state Medicaid program. Properly managed, such programs can recoup many times their administrative cost. Minnesota implemented a program very similar to Indiana's which recovered nine million dollars with an initial investment of \$263,000.⁹⁸

Fraud control. As of July 1, 1982, Indiana has also implemented an effective fraud control program to prevent abuse in its Medicaid program.⁹⁹ Federal law mandates that states implement fraud control pro-

90. See *supra* note 65.

91. IND. CODE ANN. § 12-1-7-24.6 (Burns Supp. 1982). See also, 470 I.A.C. §§ 5-1-13, reprinted in 5 INDIANA REGISTER, No. 7 (July 1, 1982).

92. 42 C.F.R. § 433.135 (1979).

93. STATE GUIDE, *supra* note 58, at 48.

94. IND. CODE ANN. § 12-1-7-24.4 (Burns Supp. 1982).

95. *Id.* at § 12-1-7-24.2.

96. *Id.* at § 12-1-7-24.6.

97. *Id.*

98. STATE GUIDE, *supra* note 58, at 48.

99. IND. CODE ANN. § 4-6-10-1 (BURNS SUPP. 1982).

grams "to investigate and prosecute all aspects of the provision of medical assistance [Medicaid] and the activities of providers of such assistance under the state plan."¹⁰⁰

Various studies demonstrate that there is little direct incentive to states to implement fraud control units because these units are expensive and yield a poor return on the money invested in them. A recent General Accounting Office study of seven state fraud control units found that these units recovered less than fifty cents per dollar invested in them.¹⁰¹ However, fraud control units have a clear deterrent effect which cannot be measured in terms of dollars.¹⁰²

To enhance the deterrent effect, states should enact clearly defined civil and criminal penalties against fraudulent Medicaid recipients and providers. Providers of Medicaid services are particularly susceptible to deterrence under traditional theories.¹⁰³ Indiana recently strengthened laws which provide strong penalties against Medicaid providers who abuse the Medicaid program. These sanctions include: denial of payment for services rendered during a specific period, rejection of a prospective provider's application for assistance, removal of a provider's certificate to participate in the Medicaid program, assessment of interest charges accruing from the date of overpayment, and fines against the provider not exceeding three times the amount of the overpayment.¹⁰⁴ The state may deny payment to providers under a variety of circumstances including when the Department of Public Welfare finds that the service claims were not in fact provided, were not medically reasonable and necessary, or were otherwise fraudulently obtained.¹⁰⁵ Overpayments may be deducted from subsequent payments to that provider.¹⁰⁶

Fraud control serves as a very effective deterrent where the State Department of Public Welfare has sufficient authority to pursue and penalize fraud. Fraud control reduces program costs by punishing individuals who wrongfully exploit the program, not by reducing services to individuals in need.

Copayments

Indiana took a second step to combat the spiraling cost of Medicaid by reducing the level of services provided under its Medicaid program. Initially, Indiana implemented copayments—the requirement that Medicaid recipients pay a portion of the cost of their medical services.¹⁰⁷ Federal law mandates that copayments be nominal and, at the

100. 42 C.F.R. § 455-12 (1979).

101. STATE GUIDE, *supra* note 58, at 30.

102. *Id.*

103. W. LAFAVE & A. SCOTT, HANDBOOK ON CRIMINAL LAW 23 (1972).

104. IND. CODE ANN. § 12-1-7-15.3 (Burns Supp. 1982).

105. *Id.* at § 12-1-7-15.7.

106. *Id.* at § 12-1-7-15.9.

107. *See generally*, 42 C.F.R. § 447.50 (1979).

time Indiana implemented its Medicaid program, copayments could only be imposed upon non-mandatory services available to the categorically needy.¹⁰⁸ Indiana imposed the maximum copayment allowable under the Federal regulations.¹⁰⁹

Indiana's copayment program was enjoined on procedural grounds, however, in a lawsuit filed by the Legal Services Corporation. In *Claus v. Smith*,¹¹⁰ the district court for the Northern District of Indiana found that the copayment plan as implemented by the state of Indiana violated both federal and state notice requirements. Although Indiana has subsequently complied with the Federal and state requirements, the state has taken no action to reinstate copayments.

The Tax Equity and Fiscal Responsibility Act broadened the scope of copayments which states may implement.¹¹¹ States may now impose nominal copayments on all Medicaid recipients including the categorically needy. Congress specifically exempted from the copayment requirement, however, services furnished to individuals under eighteen years of age, pregnancy and prenatal services, some institutional care services and emergency services.¹¹² Indiana has not yet indicated whether they intend to implement a copayment pursuant to the new federal regulations.

Copayments, while deceptively attractive, provide an ineffective solution for states burdened with rising Medicaid costs.¹¹³ Indiana hoped the copayment program would reduce costs in two respects: first, the copayment the recipient pays reduces the cost the state has to bear; and second, copayments impose a financial disincentive upon the recipient, thus deterring the use of medical services.¹¹⁴ The amount of money the state hopes to save through the copayment itself is minor. By deterring the use of medical services by the recipient, however, the state hopes to substantially reduce Medicaid costs.

Unfortunately, copayments, do not deter the overutilization of medical services. Physicians, not consumers, determine the need for most medical services.¹¹⁵ Imposing copayments on physician ordered services does not deter the overutilization of services: it deters the necessary use of services. Copayments apply equally to necessary as well as unnecessary services.¹¹⁶

108. 42 C.F.R. § 447.53 (1979).

109. 42 C.F.R. § 447.54(2), (3) (1979).

110. 519 F. Supp. 820 (N.D. Ind. 1980). The State of Indiana specifically did not comply with 42 C.F.R. § 447-205 (1979), 42 C.F.R. §§ 431.206, .210, .220 (1979), as well as IND. CODE ANN. § 4-22-2-4 (1981).

111. See *supra* note 47, at § 131.

112. *Id.* at § 1916(A)(B)(C)(D).

113. See generally Note, *Medicaid Copayments, A Bitter Pill for the Poor*, 10 J. LEGIS. 213 (1982).

114. See generally STATE GUIDE, *supra* note 58, at 25.

115. NAT. COMM. ON SOCIAL SECURITY, SOCIAL SECURITY IN AMERICA'S FUTURE 291 (1981). Physician decisions on behalf of patients were responsible for \$154 billion in medical expenditures as of 1980.

116. Roemer, *supra* note 43, at 458.

Second, two major studies suggest that copayments ultimately cost a state more than they save.¹¹⁷ While copayments may initially reduce state expenditures for ambulatory care, ultimately, non-ambulatory care costs increase. Dr. Milton Roemer who conducted a study on the effect of copayments on utilization levels, notes:

These findings suggest that the effects of copayment requirements for ambulatory services (and prescriptions) in a medical care program for low-income families were to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to drug prescriptions. Easy access to and use of general ambulatory doctors' services are widely considered to have preventative value, by permitting prompt diagnosis and treatment of an illness before it becomes more serious.

When such ambulatory services are inhibited, it would seem that a price is paid—namely, a rise in the relative rate of hospitalization. It is likely that this elevated hospitalization rate is due to the postponement of ambulatory care, so that when the patient is finally driven to seek assistance, his case is more advanced and requires inpatient care.¹¹⁸

Dr. Roemer suggests that copayment ultimately increases a state Medicaid bill by deterring preventive care and care for an illness at an early stage.¹¹⁹ Copayments deter recipients from seeking care until their illnesses advance and require more expensive and extensive care. "Copayments," Roemer states, "are penny-wise and pound-foolish."¹²⁰

Copayments impact more seriously upon the elderly, the chronically ill and those with large families—those individuals who are likely to need a large amount of medical assistance and with little or no discretionary income. While copayments may be nominal to middle-class individuals, they impose a severe financial burden upon Medicaid recipients, particularly where the recipient needs a variety of services.¹²¹ In *Claus*, one of the plaintiffs with minimal resources needed so many services that she had a monthly copayment bill of \$45.50.¹²²

Indiana also has cut back on Medicaid spending by freezing eligibility levels so as to exclude many Medicaid recipients who receive Supplemental Security Income (S.S.I.).¹²³ S.S.I. recipients receive an-

117. See generally M. ROEMER, L. HELMS, H. NEWHOUSE, C. PHELPS, *COPAYMENTS AND DEMAND FOR MEDICAL CARE: THE CALIFORNIA EXPERIENCE* (1978). There is a recent Rand Corporation study which suggests that copayments reduce medical utilization without a concomitant increase in institutional or non-ambulatory care costs. However, only 5% of the study's participants were Medicaid recipients and the study focused mainly on cost sharing in a lower middle-class environment.

118. Roemer, *supra* note 43, at 464-65.

119. *Id.*

120. *Id.* at 457.

121. Telephone interview with Gerald Riley, Director of the State of Washington Medical Assistance Program (Aug. 19, 1982).

122. *Claus v. Smith*, 519 F.Supp. 820 (N.D. Ind. 1981).

123. Telephone interview with Greg French, Director of the Older Adult Impact Program, and Attorney for the Legal Services Program of Northern Indiana (Oct. 22, 1982).

nual cost of living increases. Indiana has frozen their Medicaid eligibility levels, precluding many S.S.I. recipients from eligibility for Indiana Medicaid benefits in Indiana.¹²⁴

To alleviate the hardship these freezes create, federal regulations mandate that S.S.I. recipients be allowed to "spend down" from their present income level until they reach Indiana eligibility levels, and thus qualify for Medicaid.¹²⁵ If an S.S.I. recipient's income is five dollars above the Indiana eligibility levels, the recipient is eligible for Medicaid when he has incurred five dollars worth of medical bills paid from his own pocket.

Requiring Medicaid recipients to spend their cost-of-living increase to be eligible for Medicaid subsidizes the state Medicaid program at the expense of the S.S.I. recipient. Imposing the increasing cost of Medicaid upon the Medicaid recipient is a poor policy choice because it imposes the cost of medical services upon individuals with no discretionary income. These are also the individuals who can least afford the increased costs. S.S.I. recipients must now choose between food, rent and other necessary services, or medical care.¹²⁶

Additionally, causing recipients to delay or go without necessary health care not a sound fiscal policy.¹²⁷ Many illnesses may be cured quickly and inexpensively if treated early. Delaying health care until it may only be provided in a more expensive environment in the long run will increase Medicaid costs. The human cost in terms of pain and suffering cannot be estimated.

LOCAL LEVEL

Cutbacks on the Federal and state level ultimately appear at the local level. Localities, however, do not have the revenue-raising capabilities of the state and federal governments. States should not adopt a policy which may lead to a shift of the financial burden of public health programs from the state to counties and cities.¹²⁸

The immediate effect of shifting health costs to the local level programs is twofold: Medicaid recipients make greater demands upon the local level, thus stretching an already tight local budget even tighter,¹²⁹ and, moreover, to the extent that the locality is unwilling or unable to fund Medicaid services for local recipients, such individuals must go without needed health care.¹³⁰ When states reduce their Medicaid program, the ultimate loser is the recipient who must often choose between food and housing, or medical services. Localities are simply incapable

124. *Id.*

125. 42 C.F.R. § 435.731 (1979).

126. Telephone Interview, *supra* note 123.

127. *See generally* Roemer, *supra* note 43.

128. *Id.*

129. *Id.*

130. Telephone interview, *supra* note 123.

of responding to the additional burden of funding indigent health care.¹³¹

CONCLUSION

Federal cutbacks and spiraling health costs have made Indiana's Medicaid program leaner and more cost-effective. The state is diligently working to remove abuse and overuse from the program, and provide services at the most appropriate and least expensive level. Services are available to recipients who need them; they are not available to recipients who overutilize services. Unfortunately, Indiana's response to the Medicaid crisis imposes the increasing cost of Medicaid upon the recipients. Often these individuals have little or no discretionary income with which to pay medical bills and, hence, must choose among food, rent, other necessary services, and health care.

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131. *Id.*

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