

**THE NEW GOVERNANCE IMPLICATIONS  
OF MEDICAID WAIVERS**

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## **I. INTRODUCTION**

Medicaid is a cooperative program between the federal and state governments, aimed at providing health care to low income Americans. States can choose to participate in the Medicaid program. If they choose to participate, however, they must fulfill the Medicaid mandate, and they must comply with the regulations promulgated by the Center for Medicare and Medicaid Services (CMS). States that participate in the Medicaid program may contract with private and public providers for the provision of health care services that are required by Medicaid, but states retain ultimate responsibility for its administration. Prior to the inception of Medicaid waivers, states had very little authority over coverage determinations, which were made largely by the federal government.

Medicaid is currently facing a crisis. Although Medicaid covered 31.9 million people by 1999, another 44.6 million Americans lacked health insurance coverage during the same period. Moreover, concerns have recently arisen that a centralized Medicaid program administered at the federal level causes inefficiencies, contributing to a widening health care gap and diminishing quality of care.

To address the Medicaid crisis, the federal government has, through waivers, gradually ceded authority over the program's administration to states. Congress acted first by delegating authority to the Secretary of the U.S. Department of Health and Human Services via specific sections of the Social Security Act to grant to states waivers of certain federal Medicaid requirements, such as state-wideness, comparability of

services, and community income and resource rules for the medically needy. The Secretary then solicited waiver applications from state governments interested in experimenting with the administration of Medicaid in their home states. Almost every state responded, resulting in the Secretary's approval of dozens of state waiver programs. These waiver programs have encouraged and incentivized local experimentation with expanding health care coverage, which has arguably improved the quality of care, and enhanced program efficiency. Critics, however, argue that the creation of Medicaid waivers represents the gradual dismantling of the Medicaid entitlement, since the expansion populations served by the specific waiver programs are not presumptively entitled to the services provided. A few of the notable waiver programs in existence today include Wisconsin COP, Massachusetts MassHealth, Wisconsin Badgercare, Florida Medicaid Reform Waiver, and Wisconsin SeniorCare.

Medicaid waivers represent a strikingly new form of governance perhaps best characterized as cooperative federalism. Under the old governance, command-and-control regulatory model, the federal government strictly dictated what services federal Medicaid funds would cover and who would receive them. States were left to address deficiencies in health care coverage using their own funds. Under the emerging Medicaid waiver regulatory model, however, the federal government cedes authority over certain coverage determinations to states in the form of a contractual agreement. The "terms and conditions" of this contract tightly regulate the areas of experimentation and require either budget neutrality or cost-effectiveness. These cost requirements serve as mechanisms for controlling state spending of federal Medicaid funds under the waiver.

While the federal government clearly retains superior bargaining power under the waiver process, the devolution of authority that results from the agreement represents a significant and notable change in the administration of Medicaid. First, the contract allows for a variety of contingencies, including renegotiation, revision, amendment and renewal. Second, it provides states with discretion in experimenting with mechanisms designed to expand health care coverage, improve quality of care, and enhance program efficiency. To date, waiver programs have experimented with a variety of mechanisms, including coverage of preventative care, pooling risk by targeting groups, leveraging market clout, simplification of eligibility requirements, and privatization. Third, the experimental and conditional nature of the waiver process stimulates the cooperative involvement of a wide array of stakeholders, including state and local government, interest groups, corporations and citizens, in addition to the incorporation of transparency promoting measures, such as benchmarking.

Although Medicaid waivers have uncovered numerous tools for expanding health care coverage, increasing quality of care, and enhancing program efficiency, it is not clear that these programs will spread, either horizontally or vertically. Waiver programs do not, in and of themselves, provide any mechanisms for the expansion of successful programs from state to state. In practice, however, states have integrated successful aspects of similarly situated states' waiver programs into their own waiver applications. This may suggest a movement towards the adoption of related best practices amongst geographically and demographically similar states. While this horizontal expansion is a positive side-effect of Medicaid waiver programs, it is unclear whether expansion will occur on a vertical axis.

The waiver program appears to have reached a point where it has fulfilled its purpose of allowing experimentation. In the near future, the federal government may seek to analyze the results of the various waiver experiments, with the possibility of integration of the individual programs on a national basis. However, if the federal government continues to fail in achieving a scaling up, the creation and adoption of Medicaid waivers over the past two decades may be viewed more as a symbolic political scheme than a pursuit of best practices.

## **II. MEDICAID WAIVERS: A Model of Cooperative Federalism**

The Medicaid Act along with the regulations promulgated by CMS provide quite stringent rules that states participating in the Medicaid program must generally follow. Medicaid waivers, however, allow states to apply for a waiver from the federal government that will allow them to stray from these rules and to experiment with new, innovative health care solutions for lower-income people without requiring them to meet all of the mandates of federal Medicaid programs. Some of the requirements that may be waived are: state-wideness, comparability of services, and community income and resource rules for the medically needy.

CMS administers a variety of Medicaid waiver programs. Specific authority for Medicaid waivers is provided within the Social Security Act. Section 1115 and Section 1915(c) waivers are among the most popular and most utilized of the waiver programs. The 1115 waiver was created by Section 1115 of the Social Security Act, and gives the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects which are likely to assist in promoting the objectives of the

Medicaid statute. Examples of 1115 waivers include the Health Care Reform Demonstration Project, which includes Massachusetts MassHealth, Wisconsin Badgercare, and the Florida Medicaid Reform Waiver, and the Pharmacy Plus Demonstration Project, which includes Wisconsin SeniorCare.

Section 1915(c) of the Social Security Act provides specific authority for the Home and Community-Based Services Waiver (HCBS) program. HCBS waivers allow states, using Medicaid funds, to provide services that would traditionally only be covered under Medicaid if provided in an institutional setting to people in their homes and communities. Wisconsin has several HCBS waivers, including the Community Options Program (COP).

The primary benefit of a waiver program is that it allows states the opportunity to experiment with alternative programs, and the freedom to adopt the program that works best for their particular state. In this paper, we will explore several 1115 waiver programs, including Wisconsin Senior Care, MassHealth, BadgerCare and Florida Medicaid Reform Waiver as well as Wisconsin's HCBS waiver known as COP. We will examine the new governance aspects of these programs, and determine whether they appear to be effective models. Finally, we will compare and contrast Wisconsin's programs with the Florida Medicaid Reform Waiver and Massachusetts' MassHealth program.

## **II. MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS**

### **a.) A Gap in the System: Limited Long-Term Care Options**

Americans are not getting any younger. According to the Central Intelligence Agency's World Factbook, 12.4% of the United States' population is currently 65 or older.<sup>1</sup> This may not seem like a large percentage, but according to the United States Census Bureau, by 2025, the elderly population is expected to increase 80%, while the population of working age adults and children is only expected to increase by 15%.<sup>2</sup> Though the United States only had one quarter the size of India's population in 2002, it had more people age 80 or older in that same year.

Until the 1980s, nursing homes were the only option for elderly people in need of assistance with certain activities of daily living or minor medical problems. Nursing homes are expensive, and they are not always necessary. Expense is not the only problem with nursing homes. With the population of the United States aging so quickly, it is unlikely that the currently existing nursing homes are going to have the capacity to meet the needs of this population. In 1999, for example, there were approximately 18,000 nursing homes in the United States, housing about 1.7 million beds.<sup>3</sup> This capacity could accommodate a meager 6% of the number of Americans over the age of 65 in 1999, and that number of aging Americans has since increased.<sup>4</sup>

Medicaid has traditionally reimbursed nursing homes for a large percentage of the cost of housing Medicaid-eligible residents. However, in decades past there were few options available for senior individuals who did not want or need to enter an institutionalized setting, but needed assistance with the tasks of everyday life. Medicaid

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<sup>1</sup> *World Factbook: United States*, <http://www.cia.gov> (October 4, 2005).

<sup>2</sup> Michael Bergman, *Census Bureau Frames US in Global Context; Identifies Aging, Fertility Trends*, <http://www.census.gov/Press-Release/www/2002/cb02cn53.html> (Feb. 6, 2002).

<sup>3</sup> Harold Reubin, *Statistics on Nursing Homes and their Residents*, <http://www.therubins.com/homes/stathome.htm>, (Aug. 8, 2004).

<sup>4</sup> *Id.*

long-term care benefits were limited to home health and personal care services and to institutional facilities, like nursing homes.<sup>5</sup> Medicaid did not reimburse these individuals for, say, the cost of a nurse to come into the home during the day, or an adult day care program. The only option for a thirty-year-old with multiple sclerosis, for instance, was to go into a geriatric nursing home. Thankfully, this changed in the early 1980s.

President Reagan was acutely aware of the rapidly growing aging population, and in 1981 he took a significant step towards providing for that population by addressing the growing problem of finding housing for this population.

#### **b.) Creation of Medicaid Home and Community-Based Services Waiver Program**

President Ronald Reagan created the Home and Community- Based Services Waiver Program (HCBS) in 1981. Signed into law as section 1915(c) of the Social Security Act, this waiver program was created to provide funding to establish and furnish services to elderly and disabled people in their own homes and communities rather than in an institutional setting. Services that may be provided under an HCBS waiver include: homemaker/home health aid services, personal care services, adult day health, habilitation, case management and respite care, among others.<sup>6</sup> This legislation recognized that it is sometimes more cost-effective and better for an individual to allow him or her to seek care in their homes and communities rather than in an institutional setting. HCBS waivers created an option for senior citizens to maintain independence by

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<sup>5</sup> *Home and Community-based Waivers Program; History*, <http://www.cms.hhs.gov/medicaid/1915c/history/asp>, (Sept. 16, 2004).

<sup>6</sup> *Home and Community-Based Services Program-History*, [www.cms.hhs.gov/medicaid/1915c/history.asp](http://www.cms.hhs.gov/medicaid/1915c/history.asp) (Sept. 16, 2004).

living in their own home, and to maintain ties to family and friends.<sup>7</sup> In many cases, HCBS programs not only provide a better option for certain individuals than nursing homes, they are less expensive.

The HCBS Waiver Program authorizes states to apply for, and upon approval from the Secretary of Health and Human Services, provide services to meet the needs of the elderly, persons with physical disabilities, developmental disabilities, mental retardation, or mental illness.<sup>8</sup> Alternatively, the HCBS waiver program gives states the option of creating target waiver programs to serve individuals with a specific illness or condition, such as AIDS, or traumatic brain injury.<sup>9</sup>

Since 1982, every state in the nation, with the exception of Arizona, and the District of Columbia has taken part in the Home and Community-Based Services Waiver Program.<sup>10</sup> States commonly administer multiple HCBS waivers concurrently and often seek to modify them on a regular basis. Wisconsin, for example, has won approval for six separate HCBS waiver proposals, and twenty-four modifications. Meanwhile, Wisconsin has withdrawn modifications on five separate occasions and has five proposals currently pending before the Department of Health & Human Services.<sup>11</sup>

### **c.) Wisconsin-COP: Creating Long Term Care Alternatives**

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<sup>7</sup> *Id.*

<sup>8</sup> *Home and Community-based Waivers Program; Design*, <http://www.cms.hhs.gov/medicaid/1915c/design.asp>, (Sept. 16, 2004). Note though that it is the state-funded COP program that provides services for the mentally ill and mentally retarded population; the federal government does not provide funding via the COP Waiver for this population.

<sup>9</sup> *Id.*

<sup>10</sup> Home and Community-Based Services Summary Report, [www.cms.hhs.gov/medicaid/services/regular.pdf](http://www.cms.hhs.gov/medicaid/services/regular.pdf) (Sept. 16, 2004).

<sup>11</sup> *Id.*

Wisconsin established its Community Options Program, known as COP-W, in 1982, the same year that the federal HCBS waiver was signed into law.<sup>12</sup> Wisconsin's Department of Health and Family Services (DHFS) administers the COP program, in cooperation with the federal government, Wisconsin counties and contractors. According to Irene Anderson, the Services Supervisor at the Bureau of Long Term Support, COP was created to fill gaps in Medicaid coverage.<sup>13</sup> In this spirit, the COP program subsidizes certain expenses of elderly and disabled citizens to enable them to live in their own homes or communities, rather than in institutional settings. Prior to the advent of HCBS waivers in 1982, Medicaid did not cover personal care services, and short of paying relatives for care or living with relatives, there were very few options for an elderly or disabled person other than entering a nursing home.<sup>14</sup> Since 1982, however, the federal government has provided federal matching funds for those services using HCBS waivers.<sup>15</sup>

Wisconsin applied for and received an HCBS waiver in 1986 to obtain federal funding for COP.<sup>16</sup> Today COP serves elderly and/or those with a physical disability, regardless of age or type of disability, who need the same level of physical health care as would be provided in an institutional setting.<sup>17</sup>

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<sup>12</sup> Telephone Interview with Irene Anderson, Social Services Supervisor, Bureau of Long Term Support, Madison, Wis. (October 20, 2005).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Waiver Program Start-up and Funding History*, [www://dhfs.wisconsin.gov](http://www://dhfs.wisconsin.gov).

<sup>16</sup> Wisconsin now operates two COP programs. The original community options program, which has been referred to as COP, is still state-run and state-funded. Wisconsin has maintained this program in order to work outside of the constraints of the federal system. COP enables Wisconsin to fulfill needs for groups that the federal government does not cover, for instant, mentally disabled. Wisconsin also operates the Community Options Waiver Program, which will be referred to as COP-W. COP-W is the focus of this section.

<sup>17</sup> Remember, the state COP program serves a broader class of people, including people with developmental or mental disabilities.

Wisconsin delegates responsibility for running individual COP programs to counties, which then contract with private organizations to run the programs.<sup>18</sup> Irene Anderson indicated that the recently appointed leadership of the Center for Medicare and Medicaid Services offices in Chicago and Baltimore seem to be opposed to counties running COP-W programs. Irene indicated that, although “so far, it’s been ok,” she believes CMS lacks familiarity with the needs of rural states like Wisconsin, where county and local run programs may be more appropriate.<sup>19</sup> Currently, both the state and federally funded COP is still administered at the county level, with the state conducting reviews twice yearly, and with federal oversight of the COP program upon reapplication.

In 2003, COP and COP-W cared for almost 7000 elderly people in Wisconsin.<sup>20</sup> In 2001, the state and federal government spent \$180,902,789 on COP and COP-W.<sup>21</sup> Because COP is funded with a “sum certain” rather than “sum sufficient” appropriation, however, there is a very long waiting list for COP services.

### **III. MEDICAID HEALTH CARE REFORM DEMONSTRATION PROJECT**

#### **a.) A National Crisis: The Diminishing Access to and Increasing Cost of Health Care**

Access to health care has been a major and growing concern nationally over the past decade. By 2002, the number of Americans not covered by health insurance grew to 44.6 million.<sup>22</sup> Much larger numbers of Americans lack health insurance for at least short periods of time. The primary reason for the rise in uninsured persons has been a decline

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<sup>18</sup> Interview with Irene Anderson, *supra* note 12.

<sup>19</sup> *Id.*

<sup>20</sup> *Report to the Legislature: Community Options Program Waiver*, 7. Department of Health and Family Services, Division of Disability and Elder Services, Bureau of Aging and Long Term Care Resources (2003).

<sup>21</sup> *Medicaid Waivers Manual, Exec. Summary.*

<sup>22</sup> Barry R. Furrow et. al., *The Law of Health Care Organization and Finance*, Thomson West, 5<sup>th</sup> Edition, 2004, p. 123.

in the proportion of the population covered by employment-related coverage from 70% in the 1970s to 61.3% in 2002. Meanwhile, a Medicare report indicates that health care costs will continue to rise at a rate of approximately 7% per year.<sup>23</sup> Should this data be borne out, the nation is looking at a doubling in costs over the next 10 years.

Between 2001 and 2002, various states, in cooperation with the federal government, increased public insurance coverage for at-risk groups from 25.3 percent to 25.7 percent of the population, mainly through Medicaid expansion.<sup>24</sup> Medicaid expansion was greatly facilitated by the Health Care Reform Demonstration Project, which provides Medicaid waivers to states under Section 1115 of the Social Security Act. Examples of 1115 waivers to be discussed are the Health Care Reform Demonstration Project, which includes Massachusetts MassHealth, Wisconsin Badgercare, and Florida Medicaid Reform Waiver, as well as the Pharmacy Plus Demonstration Project, which includes Wisconsin SeniorCare.

#### **b.) Creation of the Medicaid Health Care Reform Demonstration Project**

Section 1115 of the Social Security Act empowers the Secretary of the U.S. Department of Health & Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objective of (the Medicaid statute).<sup>25</sup> By the mid-1990s, the Secretary, acting pursuant to this authority, established the Medicaid Health Care Reform Demonstration Project, which allows approved states to develop innovations in outreach

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<sup>23</sup> John Carroll, "Can Managed Care Programs Rein in Medicaid's Runaway Budgets?" *Managed Care Magazine* (April, 2005).

<sup>24</sup> Furrow, *supra* note 22, 123.

<sup>25</sup> Section 1115 of the Social Security Act.

and enrollment, eligibility requirements, access, benefits, quality assurance, payment, safety net providers, and special needs populations.<sup>26</sup>

The Health Care Reform Demonstration Project is grounded in a few fundamental concepts.<sup>27</sup> The first consists of experimentation in the area of eligibility. States have implemented their Medicaid expansions through raising the income level for eligibility or adopting innovative methods to encourage Medicaid enrollment, such as simplifying the eligibility process or removing the asset tests traditionally required for Medicaid enrollment. The second concept involves payment. That is, States may provide beneficiaries with health insurance coverage directly, or may pay part or all of the beneficiary's private health insurance premiums. Moreover, the waiver program must be budget neutral, meaning the federal government will not pay more under the waiver program than under traditional Medicaid. Third, the Health Care Reform Demonstration Project promotes high quality health care services for Medicaid beneficiaries through the collection and analysis of utilization and encounter data. In other words, states are encouraged to monitor the quality of health care services delivered to beneficiaries and utilize these data, in collaboration with health plans, to improve the quality of care.

On October 1, 1982, Arizona became the first state in the nation to be awarded a waiver under the Health Care Reform Demonstration Project, followed by 25 subsequent states and the District of Columbia.<sup>28</sup> Seven states currently have proposals pending before the U.S. Department of Health & Human Services. Examples of significant

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<sup>26</sup> Joyce Jordan et. al., "Innovations in Section 1115 Demonstrations: Extended Eligibility to Medicaid Managed Care Programmes," *Health Care Financing Review*, Winter 2000.

<sup>27</sup> *Id.*

<sup>28</sup> "1115 Waiver Research and Demonstration Projects: List of Comprehensive Health Care Demonstrations," [www.cms.hhs.gov/medicaid/1115/statesum.pdf](http://www.cms.hhs.gov/medicaid/1115/statesum.pdf).

Health Care Reform Demonstration Project waivers include Massachusetts MassHealth, Wisconsin Badgercare, and Florida Medicaid Reform Waiver.

**c.) Massachusetts MassHealth: Revolutionizing Medicaid Expansion**

On April 24, 1995, the Secretary of Health & Human Services approved the creation of Massachusetts' MassHealth program, making it the seventh Health Care Reform Demonstration Project waiver in the nation.<sup>29</sup> Massachusetts implemented the program in 1997. The federal government pays half of the cost of MassHealth, while the state pays the rest.<sup>30</sup> The main purpose of the program is to complement Massachusetts' current Medicaid program and fill a gaps in health care coverage. In this spirit, MassHealth provides health insurance for children, adults with or without children, adults working for small employers, unemployed individuals, pregnant women, disabled individuals, elderly people on small incomes, women with breast or cervical cancer, and people in need of long-term care.

MassHealth is composed of five essential elements. First, it significantly expanded Medicaid eligibility.<sup>31</sup> The state restructured its Medicaid eligibility system to utilize one income level for the family rather than distinct income levels based on the age of children in the family and to require less documentation for enrollment. Moreover, MassHealth provides coverage to targeted key groups within the uninsured population, including low-income children, families and the disabled, low-income long-term

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<sup>29</sup> "1115 Waiver Research and Demonstration Projects: List of Comprehensive Health Care Demonstrations," [www.cms.hhs.gov/medicaid/1115/statesum.pdf](http://www.cms.hhs.gov/medicaid/1115/statesum.pdf).

<sup>30</sup> "MassHealth: What is MassHealth," [www.massresources.org](http://www.massresources.org).

<sup>31</sup> Joyce Jordan et. al.

unemployed, and low-income unemployed.<sup>32</sup> Second, Massachusetts simplified the Medicaid eligibility process by eliminating the asset test, streamlining the application process, and providing substantial outreach and marketing activities, particularly in foreign languages.<sup>33</sup> Third, MassHealth supported the development of two Medicaid managed care plans comprised of traditional safety net providers, which have traditionally focused on serving the indigent and medically needy, and provided technical assistance and support to these plans to enable them to participate in MassHealth.<sup>34</sup> Fourth, MassHealth included an insurance partnership program that provided premium assistance to lower-wage workers to help them purchase employer-sponsored coverage for themselves and their families.<sup>35</sup> Finally, MassHealth supports quality improvement activities for its Medicaid managed care plans in negotiation with participating plans and conducts performance reviews semi-annually to assess plan progress towards the specified goals.<sup>36</sup> Previous quality improvement goals have included care of persons with disabilities, well-child care visits, access to behavioral services, childhood and adolescent immunizations, breast and cervical cancer screenings, and eye exams for persons with disabilities.

Massachusetts believed that by expanding Medicaid eligibility, it could reduce both the number of uninsured as well as the cost of caring for the uninsured and get federal payment for several existing state-funded health programs for low income residents.<sup>37</sup> Moreover, there are many advantages to covering the uninsured through

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<sup>32</sup> Nation's Health, May/June 95, Vol. 25 Issue 5, p. 9.

<sup>33</sup> Sharon K. Long and Stephen Zuckerman, "MassHealth Succeeds in Expanding Coverage for Adults," Health Policy Center of the Urban Institute, Excellus Health Plan, Inc., Washington, DC (Fall 2004).

<sup>34</sup> Joyce Jordan et. al.

<sup>35</sup> Long and Zuckerman.

<sup>36</sup> Joyce Jordan et. al.

<sup>37</sup> [http://www.massmedicaid.org/pdfs/MassHealth\\_Waiver.pdf](http://www.massmedicaid.org/pdfs/MassHealth_Waiver.pdf).

Medicaid rather than through the state's Uncompensated Care Pool. For example, MassHealth members have access to a broader range of services, care can be purchased and managed more effectively, and the federal government reimburses half the cost. Massachusetts projected that the cost of uncompensated care would decrease and new federal funds would be generated on existing state programs, more than covering the cost of expanding Medicaid. The waiver also proposed that the majority of MassHealth members would be enrolled in managed care programs, emphasizing comprehensive, coordinated and preventive care to improve quality and reduce cost.

By 2002, MassHealth provided health coverage for 1 million Massachusetts residents.<sup>38</sup> In other words, one in four children and one in six residents overall received their medical insurance through MassHealth. Moreover, Massachusetts had a 3 percent uninsured rate for children and a 6 percent uninsured rate for adults at that time. National averages were 12 percent and 16 percent, respectively.

#### **d.) Wisconsin Badgercare: A Progressive Approach to Medicaid Expansion**

On January 22, 1999, the Secretary of Health & Human Services approved the creation of Wisconsin's \$158.4 million Badgercare program as part of the federal Health Care Reform Demonstration Project.<sup>39</sup> Wisconsin implemented the program later that year. The waiver allowed the state to utilize grant money that would otherwise have lapsed. The purpose of Badgercare was to expand medical benefits to low-income working families with income below 185% of the Federal Poverty Level (FPL) in order

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<sup>38</sup> "Don't Dismantle State's Outstanding Health Care Coverage," Worcester Telegram & Gazette, November 21, 2002, p. A23.

<sup>39</sup> "1115 Waiver Research and Demonstration Projects: List of Comprehensive Health Care Demonstrations," [www.cms.hhs.gov/medicaid/1115/statesum.pdf](http://www.cms.hhs.gov/medicaid/1115/statesum.pdf).

to increase insurance coverage among Medicaid eligible children<sup>40</sup>. Since Badgercare's inception, 114,883 Wisconsin children have enrolled in Medicaid, one of the highest percentages in the nation for children<sup>41</sup>. Badgercare has, thus far, been a huge success in increasing enrollment; while Wisconsin estimated that 25,000 parents would sign up for Badgercare in its first years, over 45,000 parents signed up for the benefit in actuality<sup>42</sup>.

Badgercare benefits are identical to Medicaid benefits. This package was chosen for two reasons: first, because the state wanted to offer a comprehensive package of services and found only a marginal benefit in adopting the reduced benefit package allowed under federal law, and second, because adopting the Medicaid model made the administration of BadgerCare much easier. By integrating the programs, the state avoided having to make changes in its computer-based Medicaid Management. This provides that, no matter where the funding is coming from, families can go to a common care provider, lessening confusion and hassle.<sup>43</sup>

As an experiment, Badgercare has demonstrated that a family-based insurance model definitely encourages enrollment. Badgercare faces some serious issues, among them competition for resources, budget issues, and concern with crowding out. It is currently questionable whether Wisconsin will be able to continue to provide the high level and scope of care available under Badgercare in the current financial environment.

A major issue facing Badgercare is that of future funding. Since the economic downturn of 2001, Wisconsin's financial situation has been weakened. This, combined with the rapidly rising cost of healthcare, has created a large budget gap in projected costs

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<sup>40</sup> Badgercare Website, <http://www.dhfs.state.wi.us/badgercare/>.

<sup>41</sup> Id.

<sup>42</sup> "The Origins and Implementation of BadgerCare", Coimbra Sirica, The Milbank Memorial Fund, January, 2001, <http://www.milbank.org/010123badgercare.html>.

<sup>43</sup> Id.

for the Badgercare program over the next two years. Enrollment in Badgercare continues to rise, and according to the Milwaukee Journal-Sentinel, the program faces a budget gap of approximately \$650 million dollars in the coming two years.<sup>44</sup> Enrollment is expected to continue its upward trend because of the shift in Wisconsin's job market. Wisconsin employees are increasingly in retail and sales, jobs which often do not provide health insurance, as opposed to the former emphasis on manufacturing, in which employers traditionally provide health coverage.<sup>45</sup>

Interconnected with the financial issues is the concern that Badgercare will be hindered by crowding out. Crowding out occurs when low wage employers drop health insurance coverage knowing that their employees will then be eligible for the state program and unfairly shifting the burden for insuring their employees to the taxpayer. This has been a concern from the inception of Badgercare. At the 4,500-member Wisconsin Manufacturers and Commerce (Wisconsin's equivalent of a state chamber of commerce), Eric Borgerding, director of legislative relations, said that his organization is concerned about the possibility that some companies could gain an unfair advantage by sending their employees to BadgerCare for insurance coverage.<sup>46</sup>

Mr. Borgerding's concerns have been borne out to a certain extent. As of April, 2005, the ten employers with the greatest number of employees on Badgercare accounted for 2,919 enrollees at a cost to Wisconsin of about \$6.4 million dollars per year.<sup>47</sup> Wal-Mart accounts for 40% of those enrollees. According to Robert Kraig, political director for Service Employees International Union Wisconsin State Council, "(Employers) are

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<sup>44</sup> Stacy Forester, "Big Companies Fill BadgerCare Rolls," *Milwaukee Journal-Sentinel*, May 24, 2005.

<sup>45</sup> Coimbra Sirica, "The Origins and Implementation of BadgerCare," The Milbank Memorial Fund, <http://www.milbank.org/010123badgercare.html> (January, 2001).

<sup>46</sup> *Id.*

<sup>47</sup> Forester, *supra* note 44.

now building business models around paying employees as little as possible, providing few benefits and expecting taxpayers to pick up the tab.”<sup>48</sup>

**e.) Florida Medicaid Reform Project: Medicaid Expansion Via Privatization**

On October 19, 2005, the Secretary of Health & Human Services approved the Florida Medicaid Reform Waiver as part of the federal Health Care Reform Demonstration Project.<sup>49</sup> When implemented, the Florida Medicaid Reform Waiver will distribute Medicaid funds through a defined contribution to a plan of the enrollee’s choice. This represents a significant privatization of the Medicaid system. By design, enrollees would be empowered to choose to put their premium contribution to HMOs, employer sponsored insurance, Community Provider Service Networks, or other organized provider networks.<sup>50</sup> Florida hopes the waiver will help control costs in a Medicaid system that covers 2.2 million people and cost the state \$14 billion in 2004.<sup>51</sup> Medicaid expenditures currently account for 26% of Florida’s total annual budget.<sup>52</sup>

The Florida Medicaid Reform Waiver will begin in Broward and Duval counties, which boast a combined population of 2.57 million.<sup>53</sup> Within one year of implementation, the program will be expanded to 17% of Florida’s population with the addition of Baker, Clay, and Nassau counties.<sup>54</sup> The state Legislature will dictate expansion thereafter.

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<sup>48</sup> *Id.*

<sup>49</sup> John Carroll, “Can Managed Care Programs Rein in Medicaid’s Runaway Budgets?” *Managed Care Magazine* (April, 2005).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> U.S. Census Bureau Website, <http://quickfacts.census.gov/qfd/states/12/12089.html>.

<sup>54</sup> *Id.*

Each person enrolled in the Medicaid Reform program will have a calculated, risk-adjusted maximum benefit per year. According to Alan Levine, secretary of the Florida Agency for Health Care Administration, the state's data indicates that no more than 5% of the enrollees will reach or exceed their pre-established limits.<sup>55</sup> If this occurs, the Medicaid recipient will be responsible for costs beyond the limit.

Of course, this program will create a great variance in coverage and plans. To protect the enrollees, Florida says it will enact a "rigorous qualification process in which they must demonstrate, among other things, an appropriate network of providers, and adequate managed care and disease management programs."<sup>56</sup> The plan further provides that outcomes will be transparent and that the Florida Agency for Health Care Administration will have the power to impose sanctions if they find that providers are limiting access unfairly.<sup>57</sup>

Governor Jeb Bush supports this voucher system, explaining "We want to empower the people in the Medicaid program to control their own health care, to choose their own coverage, their doctors, and their treatments."<sup>58</sup> The biggest problem with choosing coverage may come from confusion about benefits. Under the waiver, managed care organizations would not be required to provide some services, such as dialysis, hospice care, and dental and vision coverage.

Patient advocates are concerned about the outcome of this waiver. Bob Sharpe, CEO of the Florida Council for Community Mental Health, worries that "The proposal

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<sup>55</sup> John Carroll, "Can Managed Care Programs Rein in Medicaid's Runaway Budgets?" *Managed Care Magazine* (April, 2005).

<sup>56</sup> Florida Department of Health Care, "Florida Medicaid Reform Questions and Answers", [http://www.fdhc.state.fl.us/Medicaid/medicaid\\_reform/waiver/pdfs/florida\\_medicaid\\_reform\\_question\\_answers.pdf](http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/florida_medicaid_reform_question_answers.pdf).

<sup>57</sup> Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver, <http://www.cms.hhs.gov/medicaid/1115/FIProposal.pdf>.

<sup>58</sup> *Id.*

would eliminate or substantially diminish the entitlement nature of the Medicaid program.” Advocates fear that the program puts too much power into the hands of the free market and that the regulation of Medicaid will increasingly fall on private entities rather than the state.

#### **IV. MEDICAID PHARMACY PLUS DEMONSTRATION PROJECT**

##### **a.) A National Dilemma: Escalating Prescription Drug Costs**

The issue of prescription drugs has been at the top of the nation’s political agenda since the 1990s when prescription drug costs began to escalate seemingly beyond control.<sup>59</sup> According to one report, pharmaceutical spending is growing twice as fast as spending for any other service.<sup>60</sup> Rising prescription drug prices pose a particularly serious threat to seniors, who consume the majority of the nation’s prescription drugs. In 1999, for example, Medicare beneficiaries reportedly filled an average of thirty prescriptions each.<sup>61</sup> While many had prescription drug coverage through retiree plans, Medicaid, individual Medigap policies, and Medicare managed care plans, about thirty-eight percent had no coverage at all.

By 2003, dozens of drug manufacturers and state governments began offering stopgap relief in many forms, resulting in at least 240 programs, covering nearly 800 drugs, to help people of various ages and income levels get the medications they need.<sup>62</sup>

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<sup>59</sup> Barry R. Furrow et. al., *The Law of Health Care Organization and Finance*, Thomson West, 5<sup>th</sup> Edition, 2004, p. 367.

<sup>60</sup> “Don’t Dismantle State’s Outstanding Health Care Coverage,” *Worcester Telegram & Gazette, Inc.*, November 21, 2002, Page A23.

<sup>61</sup> Furrow, *supra* note 57, 367.

<sup>62</sup> “New Tools Can Help Patients Reduce Cost of Medications,” *Wall Street Journal*, January 21, 2003, Section D, Page 2, Column 1.

In 2002, Wisconsin adopted SeniorCare, which is one of the most prominent of these programs, as a federally-approved Pharmacy Plus Demonstration Project.

### **b.) Creation of the Medicaid Pharmacy Plus Demonstration Project**

In 2001, then-Secretary Tommy Thompson established the Pharmacy Plus Demonstration Project (Pharmacy Plus), which allows approved states to provide prescription and over-the-counter drug coverage to a range of individuals including Medicare beneficiaries and/or people with disabilities who are not eligible for full Medicaid benefits and with incomes below 200 percent of the Federal Poverty Level (FPL).<sup>63</sup>

Pharmacy Plus is grounded in two basic concepts. First, Pharmacy Plus demonstration projects are engineered to reduce the costs a State incurs for State plan eligible groups through lesser service utilization, reduced period of Medicaid eligibility, and more effective pharmacy benefit management.<sup>64</sup> The expenditures saved are then available to pay for the new demonstration population. In addition, the costs of the pharmacy expansion are offset theoretically by subsequent reduced expenditures in the state's Medicaid population.

On January 28, 2002, SeniorCare Illinois became the first Pharmacy Plus project program in the nation, followed later that year by Wisconsin, South Carolina and Florida.<sup>65</sup> No other states have reached agreements since that year, although Rhode

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<sup>63</sup> Pharmacy Plus: Technical Guidance and Fact Sheet, [www.cms.hhs.gov/medicaid/1115/RXFACTSHEET41202.pdf](http://www.cms.hhs.gov/medicaid/1115/RXFACTSHEET41202.pdf).

<sup>64</sup> Pharmacy Plus: Technical Guidance and Fact Sheet, [www.cms.hhs.gov/medicaid/1115/RXFACTSHEET41202.pdf](http://www.cms.hhs.gov/medicaid/1115/RXFACTSHEET41202.pdf).

<sup>65</sup> Pharmacy Plus Demonstrations Program: Pharmacy Waivers Under 1115 Authority, [www.cms.hhs.gov/medicaid/1115/pharmplusstatus.asp](http://www.cms.hhs.gov/medicaid/1115/pharmplusstatus.asp).

Island, North Carolina, New Jersey, Michigan, Maine, Indiana, Connecticut and Arkansas currently have proposals pending before the U.S. Department of Health & Human Services.

**c.) Wisconsin SeniorCare: Prescription Drug Savings Via Medicaid Expansion**

On July 1, 2002, Secretary Thompson approved the creation of Wisconsin's \$78 million-a-year SeniorCare program as a Pharmacy Plus Demonstration Project,<sup>66</sup> making it the largest Pharmacy Plus project in the nation.<sup>67</sup> The Wisconsin Department of Health & Family Services (DHFS) administers SeniorCare under a state-federal cooperative agreement, in which Wisconsin pays approximately \$38 million a year or 48% of the total cost), but gets approximately \$41 million or 52% of the total cost in federal Medicaid funds.<sup>68</sup> The main purpose of the program is to complement Wisconsin's current Medicaid prescription drug program and fill a gap in prescription drug coverage for the state's low-income elderly population.<sup>69</sup> In this spirit, SeniorCare currently provides a prescription drug benefit to eligible state residents aged 65 and over, with incomes at or below 200 percent of the FPL.<sup>70</sup>

Wisconsin's SeniorCare program provides prescription drug coverage to 90,000 Wisconsin seniors.<sup>71</sup> Debate over whether to discontinue SeniorCare after implementation of Medicare Part D has spurred numerous assessments detailing the merits of SeniorCare. One report estimated that SeniorCare could save Wisconsin senior

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<sup>66</sup> Wisconsin SeniorCare Approval Letter, [www.cms.hhs.gov/medicaid/1115/wiappv.pdf](http://www.cms.hhs.gov/medicaid/1115/wiappv.pdf).

<sup>67</sup> "Saving a Worthy Program," *Milwaukee Journal Sentinel*, October 13, 2005, p. 16.

<sup>68</sup> Callender, David. "Keeping State SeniorCare Would Save Feds \$25M," *The Capital Times*, May 4, 2005, Second Edition, p. 4A.

<sup>69</sup> Wisconsin SeniorCare Approval Letter.

<sup>70</sup> Wisconsin 1115 Demonstration Fact Sheet, [www.cms.gov/medicaid/1115/wiscfact.pdf](http://www.cms.gov/medicaid/1115/wiscfact.pdf).

<sup>71</sup> "Governor Doyle Urges Republicans Not to Follow Through on Threat to End SeniorCare," *US Fed News*, April 25, 2005.

citizens \$82 million per year and the federal government \$25 million per year compared with Medicare Part D because state officials negotiate rebates and discounts with drug manufacturers under SeniorCare.<sup>72</sup> Similarly, a 2004 Department of Health and Family Services study showed that 94 percent of SeniorCare participants would fare better under SeniorCare than under Medicare Part D, because out-of-pocket cost is lower and benefits are more comprehensive. Those who fare better under the federal plan tend to be seniors with very low income and very low assets.<sup>73</sup>

## **V. NEW GOVERNANCE ASPECTS OF MEDICAID WAIVER PROGRAMS**

### **a.) Devolution of Authority: Enhanced Multilevel Interaction**

A major concept of New Governance is devolution of authority to lower levels of government. This is the strongest aspect of New Governance found in Medicaid waiver programs. The concept behind Medicaid waiver programs is the federal government empowering states to experiment with the administration of Medicaid, which is a state-administered program with federal match funding.

The operation of Medicaid waivers is similar to an intergovernmental tennis match. First, the federal government must pass enabling legislation, such as Section 1115 and 1915(c) of the Social Security Act. This legislation gives states the authority to apply to the Secretary of Health & Human Services (HHS) for a waiver of certain federal Medicaid requirements, for the purpose of innovation and experimentation with the administration of Medicaid. This represents the first devolution of authority. Then the state must submit a waiver application detailing its proposed alternative use of federal

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<sup>72</sup> "Saving a Worthy Program," *Milwaukee Journal Sentinel*, October 13, 2005, p. 16.

<sup>73</sup> "SeniorCare Is Ok'd As Drug Plan," *The Capital Times*, October 11, 2005, p. 1A.

funding and its fulfillment of the purpose of the federal Medicaid Act. Moreover, the alternative use of federal funding must be unique and not be under experimentation in other states. The state and federal government then enter formal and informal negotiations, which eventually constitute a contract between the parties called the “Terms and Conditions” of the Medicaid waiver. Next, the parties submit the proposal to the Secretary for approval. If the Secretary approves, the state may implement the waiver program and may continue the waiver for a period of 3-5 years, before the renewal process takes effect.

The implementation stage of waiver programs differs based upon the Terms and Conditions of the particular waiver. Under SeniorCare, Florida Medicaid Reform Waiver, and MassHealth, the state manages implementation of the program. However, under the COP program, the state devolves its authority to local government to implement and administer the program with state and ultimately federal government oversight. In some cases, an additional devolution of oversight occurs whereby the state contracts with private entities to oversee individual programs. For instance, Wisconsin contracts with a private entity to review the provision of services under COP at the county level.<sup>74</sup> Additionally, the local government may devolve its authority for administering the program to private entities.

The federal government oversees implementation based upon the Terms and Conditions of the program. Under SeniorCare, the state must submit regular reports during implementation for federal review. Under COP, however, federal review is less frequent. Because COP has successfully existed for nearly 20 years, the federal

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<sup>74</sup> Telephone Interview with Irene Anderson, Social Services Supervisor, Bureau of Long Term Support, in Madison, Wis. (October 20, 2005).

government has unofficially granted the Wisconsin more leeway (and less federal oversight) in its administration.<sup>75</sup>

There is some question as to how much devolution is necessary for a program to be considered “New Governance.” In the case of Medicaid waivers, the federal government never fully relinquishes authority over Medicaid. The relationship between the state and federal government is best described as a cooperative and contractual. Both parties must comply with the Terms and Conditions of the waiver, or risk termination of the contract by the other party. The federal government retains superior bargaining power over waiver negotiations because it has authority not only over the federal match resources, but also over the administration of the program under the Medicaid Act. However, Medicaid waivers represent New Governance to the extent that the parties are not engaged in the traditional contractual paradigm, where the parties are lobbying in their own separate interests. Instead of being adversarial, the parties have a significant incentive to work together toward their mutual best interest of administering the Medicaid program in the most efficient manner possible.

#### **b.) Continuous Revision, Transparency & Benchmarking**

Continuous revision is another major component of the New Governance ideal. There are four significant mechanisms for continuous revision in the Medicaid waiver program. First, the state can adjust its administration of the program within the Terms and Conditions of its waiver wherever necessary, so long as the adjustments do not violate the contract. There is often interaction between the state and federal government to implement these revisions, particularly at the beginning stages. These reports detail

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<sup>75</sup> *Id.*

the initial successes and failures of the program and its implementation. The state and federal government then communicate in writing or verbally concerning how the state will address implementation and programmatic problems. It is the state's burden to convey to the federal government at all stages that it can sustain the program in a workable fashion, meeting the expectations of the federal government.

The COP program has less continuous revision structurally built into it. According to Irene Anderson, the state only has to provide the federal government with reports once yearly, and even then only a financial statement is required.<sup>76</sup> However, revision within the COP program tends to occur as the politics of Medicaid evolve at the state and federal levels, usually following elections. That is, even though COP has been successfully run in Wisconsin for approximately twenty years, it tends to undergo changes of a cyclical nature due to politics and staffing changes. For instance, the federal government is becoming less comfortable with local government administration of the COP program, which is mainly due to personnel changes at Centers for Medicare and Medicaid (CMS).<sup>77</sup> This may represent change for the mere sake of change, which is antithetical to New Governance, or an infusion of new blood into the administration of the program, which is not.

Under the Florida Medicaid Reform Waiver, the waiver provides the state with the authority to expand the program at its will. For example, the contract calls for Florida to administer the program in two counties. However, following implementation in those two counties, the Florida Legislature retains the authority to expand the program to

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<sup>76</sup> Interview with Irene Anderson, *supra* note 73.

<sup>77</sup> *Id.*

additional counties, if it so desires. This is a perfect example of the Terms and Conditions of the Waiver providing for continuous revision.

The second mechanism for continuous revision is a formal amendment process. In order to amend an established waiver program, the state must again apply to the Secretary of Health and Human Services, at the federal level for approval. The federal government may also amend the waiver program if it observes problems with its administration or opportunities for efficient expansion. Federal amendment, however, does not seem to be very common within Medicaid waiver programs.

The formal amendment process is an example of new governance working within the framework of old governance. Allowing the opportunity for amendment is a new governance, continuous revision concept. Yet the process for amendment is very formalistic, command-and-control style, and smacks of old governance. This seems to be the purposeful coexistence of old and new governance.

The third mechanism for continuous revision exists in the waiver renewal process. When a waiver program is approved, it is granted a three-year term of operation. After the initial three years, the state must apply to the federal government for renewal. Through mutual review and analysis of individual waiver programs, the state and federal government have the opportunity to renegotiate the continuing terms and conditions of the waiver. At this point, the state must prove to the federal government that its program is working and serving the purpose of the Medicaid legislation. Additionally, the state must show that its program is cost-neutral, if not cost-saving, compared to traditional Medicaid programs. If the federal government agrees the program is working appropriately, it may renew the program for a five-year period. This process continues

indefinitely; there is no limitation on the number of renewals a program may receive. COP, for example, has been continuously renewed since its inception in 1986. While it may seem redundant to require review of a successful program every five years, the renewal process provides the opportunity for periodic benchmarking and revision. MassHealth and BadgerCare are newer programs, having been renewed since their implementation in 1995 and 1999, respectively.

The final mechanism of continuous revision in Medicaid waiver programs is revocation or the threat of revocation. Because the federal government never completely turns over authority to the states, it may revoke a waiver program at any time. The threat of revocation can serve as an effective catalyst for negotiation and revision. If a state is not complying with the terms and conditions of its contract, the federal government may use the threat of revocation as bargaining power for obtaining compliance. Additionally, if a state determines that its waiver program is inefficient, overly burdensome, or simply not working, it may revoke the program. Revocation without penalty allows states greater freedom and provides incentive to innovate. Revocation is generally a last resort given the great investment involved in most programs. States are often given sufficient opportunity to comply before the federal government actually revokes its waiver.

While revocation seems to be an example of hard law, viewed through the lens of new governance, it is actually characteristic of soft law. That is, the penalty that may ultimately be imposed, revocation, is a “hard” remedy, but the federal government appears “soft” in imposing that remedy by allowing states flexibility and latitude in compliance. Because the federal government generally has a great deal vested in these waiver programs, both in terms of federal resources and human capital, it is hesitant to

revoke, and is willing to review and renegotiate the programs with the states before it resorts to revocation. Also, the bilateral nature of the power to revoke is indicative of greater flexibility rather than the rigidity of hard law.

Transparency is essential for effective stakeholder involvement. Medicaid waiver programs utilize a variety of transparency-promoting measures, including benchmarking, reporting requirements, external audits and monitoring, and town hall meetings. For its part, the federal government requires the incorporation of certain transparency measures in Medicaid waiver agreements. Wisconsin, for example, must provide the federal government with an annual report concerning the COP program funding and accounting for the purpose of showing program composition and solvency.<sup>78</sup> Likewise, the federal government requires Health Care Reform Demonstration Projects, such as Badgercare, MassHealth and the Florida Health Reform Waiver, to collect, analyze and disseminate program utilization and encounter data in order to promote the provision of high quality health care services for Medicaid beneficiaries.<sup>79</sup> Pharmacy Plus Demonstration Projects, such as SeniorCare, also incorporate significant benchmarking and monitoring measures into their programmatic structures. Moreover, provisions related to program payment rates were established to ensure the success of the SeniorCare program in terms of patient access to services, consistency with the Wisconsin Medicaid program, and participation of recipients, pharmacies, and manufacturers."<sup>80</sup> Finally, and perhaps most importantly, the Center for Medicare and Medicaid Services publishes all documents relating to

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<sup>78</sup> *Id.*

<sup>79</sup> Joyce Jordan, *supra* note 26.

<sup>80</sup> "SeniorCare Demonstration Program: Operational Protocol," Wisconsin Department of Health & Family Services, August 30, 2002, p. 16. See [www.cms.hhs.gov/medicaid/1115/wioperprot.pdf](http://www.cms.hhs.gov/medicaid/1115/wioperprot.pdf).

waiver application, authorization, reporting and renewal on its website for public consumption.<sup>81</sup>

Transparency measures are New Governance to the extent that they promotes dissemination of the information stakeholders, program officials and the public need to critique a program's successes and failures and seek continuous reflection and revision. Moreover, dissemination of information promotes accountability by nurturing public involvement in the administration of waivers and holding not just the federal government, but also state and local participants, accountable for meeting program objectives.

### **c.) Mechanisms of Experimentation**

New governance is also present in the mechanisms used to accomplish the goals of Medicaid waivers. The central objective of waivers is to encourage experimentation that may lead to more efficient and effective use of federal Medicaid funds. States utilize a variety of mechanisms in their effort to more productively administer Medicaid. Some of the mechanisms modeling new governance ideas used within the waiver programs include preventative care, pooling risk through targeting groups, leveraging market clout, simplification of eligibility requirements, and privatization.

#### **i.) Preventative Care**

Preventative care embodies the concept that an ounce of prevention costs is worth a pound of cure. Through screening and early detection treatment, states hope to offset high costs of catastrophic illness that can be more cheaply treated if detected and treated at an early stage. An example of this principle in practice is vaccination programs, which

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<sup>81</sup> [www.cms.hhs.gov/medicaid/1115/statesum.pdf](http://www.cms.hhs.gov/medicaid/1115/statesum.pdf).

prevent children from developing costly diseases. Preventative care is a common feature of waiver programs. BadgerCare, for instance, targeted child enrollment and has successfully provided a majority of children with a wide spectrum of care aimed toward preventing disease at an older age. MassHealth also utilizes preventative care through enhanced services for groups such as pregnant women and certain cancer patients. It is in the best interests of the state to invest additional resources in pregnant women because preventable childhood medical problems are an enormous drain on resources and can often be averted during pregnancy. Seniorcare represents another example of an infusion of funds into preventative care because the elderly are at greater risk for certain health problems avoidable by disease management in the form of medication. Additionally, senior citizens can prevent certain illnesses through early detection and medication. The proactive nature of preventative medicine is new governance because it invests today's Medicaid dollars to prevent future health costs.

Preventative care becomes difficult to achieve when the system requires no increase in funding to administer programs, and even requires cost saving on an annual basis, in some cases. Moreover, cost savings can often be found in other government-sponsored programs. For example, SeniorCare makes prescription drugs more affordable for the elderly, freeing up resources for other essential social services, such as food stamps.

## **ii.) Pooling Risk by Targeting Groups**

Pooling risk through targeting groups is another mechanism used by Medicaid waiver programs for reducing cost. The concept behind pooling risk through targeting

groups, such as senior citizens or pregnant women, is that insurance companies will be better situated to estimate their risk because the needs of a targeted group are more predictable and pronounced than the Medicaid population at-large. Pooling risk allows insurance companies to identify treatments that are most utilized by a particular population and cover those treatments at the expense of other treatments which are less prevalent or even unnecessary. For example, the Florida Medicaid Reform Program was implemented, in part, with the hope that private competition would create incentive for insurance companies to develop plans targeted to groups with specific medical needs. While targeted plans are not formally required under the Florida Medicaid Reform Program, the market is expected to respond naturally in this fashion. MassHealth utilizes risk pooling in the sense that it provides coverage plans to key targeted groups within the uninsured population, such as children, adults with or without children, adults working for small employers, unemployed individuals, disabled individuals, elderly people on small incomes, and people in need of long-term care. It also provides coverage for certain targeted risk groups, such as pregnant women and women facing breast and cervical cancer.

Pooling risk is new governance to the extent that the waiver program provides incentive for private companies to offer customized plans. These customized plans are more cost-efficient than the former, non-customized plans. In addition, risk pooling decentralizes authority over Medicaid by enabling these private insurers to develop their own plans based on risk models rather than accept an established set of benefits dictated by the government under the pre-waiver Medicaid model.

### **iii.) Leveraging Market Clout**

Another new governance mechanism utilized by Medicaid waiver programs is leveraging market clout. Leveraging market clout involves grouping together the purchasing power, or “market clout,” of a given group to obtain discounts or rebates. The Pharmacy Plus Demonstration Project, which includes Wisconsin SeniorCare, is a prime example of this mechanism at work. SeniorCare expanded pharmaceutical coverage for senior citizens by partially subsidizing that coverage with state and federal dollars. This infusion of government money increases the buying power of the beneficiary group as a whole. Utilizing this greater buying power, the state is then better situated to bargain with pharmaceutical companies to provide discounts for the prescription medications most often utilized by Wisconsin’s senior citizens. Leveraging market clout represents new governance in that the state acts as a third party intermediary in mobilizing market forces to the benefit of a sub-group within the Medicaid population. Viewed on a larger scale, SeniorCare consolidates Wisconsin’s Medicaid buying power with the buying power of certain targeted groups for the purpose of negotiating with private parties for the benefit of the Medicaid waiver beneficiaries.

### **iv.) Simplification of Eligibility Requirements**

Simplification of eligibility requirements is yet another example of the existence of new governance in Medicaid waiver programs. Badgercare epitomizes this mechanism through its eligibility screening process. That is, prospective Badgercare participants are screened simultaneously for BadgerCare and Medicaid, in addition to several other related state assistance programs. BadgerCare also eliminated the

complicated asset test common to many Medicaid programs. MassHealth also chose to simplify its eligibility requirements. Specifically, the program eliminated the traditional Medicaid asset test and utilizes one income level for the entire family unit, rather than distinct income levels based on the age of the children in the family.

Simplification of eligibility requirements is new governance in that simplified screening processes are more accessible to eligible beneficiaries and free of unnecessary overhead costs. Additionally, simplified systems reduce the intimidation that often surrounds the process of applying for government aid, while increasing the transparency of eligibility determinations, thereby reflecting a more equitable process.

#### **v.) Privatization**

Privatization is yet another new governance mechanism utilized by Medicaid waiver programs. The theory driving privatization is that the private sector is a more efficient provider of services because it has greater experience in providing certain health-related services as well as the capacity to be more specialized. Additionally, the private sector is viewed as having a greater incentive to maximize efficiency because it is profit, not public-good, driven. The theory is that private competition for the Medicaid dollar, like competition in any market, leads to reduced prices.

Privatization generally takes two forms in the Medicaid waiver arena: outsourcing of administration and review, and privatization of services and plans. SeniorCare is an excellent example of a state outsourcing the administration of a program to conserve cost. While the ultimate determination of eligibility for SeniorCare is made by a government official (for accountability purposes), pre-eligibility tasks are delegated to the private

sector. SeniorCare out-sources such administrative tasks as gathering eligibility documentation and preparing materials related to eligibility for review. After eligibility is decided, other routine administrative and clerical tasks are outsourced to private entities as well.

Florida's Medicaid Reform Program privatizes services and health plans by enabling enrollees to choose their own plan from a number of approved insurers. Florida's program gives the beneficiary a predetermined stipend to spend on an insurance plan, so long as the plan is provided by a government-approved insurer. This process takes the determination of the range of benefits received away from the government and puts it into the hands of the enrollee and the insurance company. In essence, the state is no longer the insurer. Instead, the provision of insurance is provided by private entities. In other words, the state steps into the role of the buyer under the Florida program, whereby the state decides only how much the beneficiary will spend, not what services the beneficiary will receive.

The COP Medicaid waiver program involves privatization both in the outsourcing of administration and the provision of services. It privatizes the provision of services by allowing counties to contract with private providers that ultimately establish housing and services for the targeted groups. COP also out-sources the administration of the program by contracting with a private agency to review the counties' compliance with the terms and conditions of the waiver. The state hires a private company to review and analyze programs provided at the county level, to ensure that the programs comply with the COP waiver contract.<sup>82</sup>

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<sup>82</sup> Interview with Irene Anderson, *supra* note 73.

A new governance trend has emerged in the realm of privatization for Medicaid Waiver programs. While privatization previously occurred in the provision of services, programs seem to be expanding the utilization of privatization in nearly every respect. Florida is on the cutting-edge of experimentation in the area of privatization, with the state ceding authority over the creation of plans and the delineation of benefits to the private insurer. Under the traditional Medicaid arrangement, the state determined what benefits enrollees received and only the provision of insurance was privatized. Florida's new plan takes privatization to the next level. It is important to recognize that the precursor programs to Wisconsin SeniorCare, COP, and Florida Medicaid Reform Waiver all privatized to some degree. However, both new governance and economic pressures seem to have stimulated the increased privatization of these programs at nearly every level, this time to the creation of plans and delineation of benefits.

#### **d.) Stakeholder Participation**

Stakeholder participation and negotiation is an earmark of New Governance. Stakeholder input is crucial to promoting a participatory, decentralized program, as opposed to the command-and-control model, which continues to dominate much of government. Additionally, stakeholder monitoring stimulates continuous revision, which promotes ongoing improvement and efficiency. Stakeholder participation is prevalent throughout Medicaid waiver programs.

Badgercare could not have been implemented without the concentrated efforts of many stakeholders. Advocacy groups, insurers, care providers, and legislators worked together to bring the goal of insurance for the low-income worker to fruition. Following

its initial enrollment success, the state conducted a stakeholder survey in 2000. The survey indicated a high level of satisfaction on the part of stakeholders. Badgercare easily won renewal of its waiver in 2002. Currently, stakeholder visibility is low, reportedly due to satisfaction with the program and no major changes since initial implementation. Most of the stakeholders appear content with the current system, although some business owners, particularly those with small businesses, are beginning to feel that large corporations, such as Wal-Mart and Aurora Healthcare, are taking advantage of the extensive provided by Badgercare to offset their healthcare costs. With budget crises looming, Wisconsin's Medicaid system may be facing a major overhaul. Due to Wisconsin's progressive and politically active nature, it is likely that stakeholders will again emerge to influence the future of health insurance in Wisconsin.

Although the creation of MassHealth required the participation and support of a wide array of stakeholders, one report indicates there has been a lack of outside monitoring, despite the fact that MassHealth continues to have a tremendous impact on both the state's economy and health care system. Specifically, the report notes there is a need for a permanent entity to work collaboratively with state agencies, providers, consumer groups, academic and research organizations and other organizations to promote the ongoing development of innovative, effective policy solutions by providing independent, timely and actionable information to legislators, providers, consumers and other key stakeholders."<sup>83</sup>

Wisconsin SeniorCare appears to have a more balanced record of stakeholder participation. According to one report, "the SeniorCare program was established with the

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<sup>83</sup> "MassHealth: Dispelling Myths and Preserving Progress," *The Massachusetts Health Policy Forum*, 4 (June 5, 2002). See [www.foruminstitute.org/pubs/mass/MASSEALTH\\_Issue\\_Brief.pdf](http://www.foruminstitute.org/pubs/mass/MASSEALTH_Issue_Brief.pdf).

input of representatives from a broad range of stakeholders, including health-care providers, pharmacies, consumer-advocate groups, and the pharmaceutical manufacturing industry. This trend of stakeholder participation seems to have continued beyond implementation as well. Program staff reportedly collaborate with state and community agencies and organizations on a regular basis for the purpose of explaining and promoting the SeniorCare as well as obtaining feedback. They also present reports on the program at conferences and meetings within and outside of the state.<sup>84</sup>

COP utilizes stakeholder participation at virtually every level. Stakeholders were vital to the implementation and creation of COP. While there is little information available documenting the evolution of stakeholder participation because the program was created over 20 years ago, Irene Anderson indicated that COP would not have been implemented without heavy involvement by citizen groups.<sup>85</sup> Aside from implementation, stakeholder participation also plays a crucial role at both the provision of service and review stages. COP participants are required to be actively involved in the creation of their care plans as well as choosing desired services. Every six months, participants are encouraged to review their care plan with county officials and make reform suggestions. Additionally, there is a Local Community Options Planning Committee in every community taking part in the COP program. These committees meet periodically to discuss programmatic issues and resolutions. Moreover, each committee is statutorily required to solicit the involvement of stakeholders, such as community members, nursing home advisors, county board members, and at least five active program

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<sup>84</sup> "SeniorCare Demonstration Program: Quarterly Report," Wisconsin Department of Health & Family Services, February 28, 2003, p. 1.

<sup>85</sup> Interview with Irene Anderson, *supra* note 73.

participants.<sup>86</sup> Last, but not least, each committee is required to report to the state's COP review panel. In sum, even though COP is over 20 years old, active participation and stakeholder participation continues to be an essential factor in the program's success.

## VI. CONCLUSION

Medicaid waiver programs represent the coexistence of new governance within a framework of old governance. Waiver programs are revolutionary in that the federal government delegates a great deal of authority to the state and local levels in order to more effectively achieve the goals of the Medicaid mandate through cooperation. States are given a great deal of autonomy after meeting the initial old governance requirements. Although the initial oversight is rather command-and-control in nature, over time states gain greater independence in the administration of their programs—albeit within statutorily defined limits and contractually negotiated terms and conditions. Medicaid waiver programs illustrate the importance of new governance activism from implementation to renewal. Each program represents a microcosm of the many aspects of new governance at work in Medicaid waivers programs.

While Medicaid waivers seem to be innovative and increasing in number, the question remains whether the results of these experiments will be implemented on a greater scale. It is questionable whether there are horizontal mechanisms in place to allow Medicaid programs to expand amongst the states, and whether there are vertical mechanisms in place to allow waiver programs to “scale up” to the federal level. One possible example of horizontal expansion of Medicaid waiver experimentation is the implementation and use of established waiver programs that have been successful in one

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<sup>86</sup> *Id.*

state in similarly situated states. For example, rural states may adopt a solution tested in one waiver program, while heavily urban states may choose another avenue. This approach may provide the most optimal use of Medicaid funds considering the diversity of states served by Medicaid.

On the other hand, it is questionable whether vertical expansion, or scaling up, will occur. Under the current financial situation, Medicaid is facing serious financial difficulties. It seems to be this economic pressure, combined with intense political forces, that is the driving force behind the scaling up of waiver programs. The most recent, and widely publicized, example of a federal change in health care policy is the implementation of Medicare Part D, scheduled to occur on January 1, 2006. Medicare Part D will displace three of the four Pharmacy Plus Demonstration Waivers.<sup>87</sup> Only Wisconsin's Seniorcare program is scheduled to continue. Even the future of Seniorcare, however, is uncertain. It is questionable whether this is actually an example of the "scaling up" of a particular waiver program. There seems to be a disconnect between the implementation of the Pharmacy Plus Demonstration Waivers and the implementation of Medicare Part D. The Pharmacy Plus Demonstration Waivers were just implemented in 2001. There has not been a significant time lapse to allow the gathering of data and the results of these programs to be analyzed. By not allowing time for the results of the Pharmacy Plus waivers to unfold, it seems that the federal government has foregone some of the intended benefits of the waiver program, specifically the development and emergence of best practices through experimentation.

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<sup>87</sup> Interview with Neil Gebhart, Attorney, Wisconsin Department of Health & Family Services, in Madison, Wis. (November 23, 2005).

Generally, Medicaid Waiver programs seem to represent the successful existence of new governance programs within the framework of old governance. That is, states and even local governments have a fair amount of leeway in the administration and implementation of their waiver programs, but ultimately, they must comply with the terms and conditions of the program, and they must report to the federal government. Medicaid waiver programs illustrate the proposition that, while the federal government may be willing to delegate authority to improve efficiency through experimentation, it will never completely devolve its power.