

# Federalism and medicaid assignment



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The waiver process did not avoid transparency or due process. There was however circumstances where the White House did get involved to quicken the pace of the approval process and there have been strong political party support for waivers. Research My review deals with the recent waivers issued to states. It is necessary for the states to take control of the Medicaid funds they receive and make a decision as to how recipients are going to be covered. As each state has its own challenges, a one size fits all attitude will not be economical or effective.

State programmatic expertise is an important asset to federal systems, but this expertise is not always informative to federal decision-makers. I argue the degree to which state expertise is informative to federal decision-makers depends on how well the policy interests of state and federal levels are aligned. I illustrate variation in these conditions using case studies of congressional politics over the Medicaid program. I then apply a statistical test, which demonstrates that states' programmatic expertise regarding Medicaid is less persuasive to congressional committee members compared to other witnesses who are equally knowledgeable.

The results suggest a “ failure of federalism,” where the public good potential of state programmatic expertise often is not realized in the federal system (Sterling, 2009) Federal waivers to state governments from mandates attached to grants-in-aid and other programs have become a precarious factor in U. S. Intergovernmental relations, but there is no rhyme or reason as to why some States get waivers or more waivers than other state. There is no formal policy and waivers are granted on a program to

program basis. Are the larger states receiving or waivers due to the population size they serve?

If the program size is relatively large, is it best served by the state or federal government? Section 1115 waivers offer states flexibility to test new approaches in Medicaid that differ from federal program rules and can have major impacts for recipients, providers, and states. Recent waivers and waiver proposals are different in their specific goals and tactics, some main themes are developing, including using Section 1115 waiver ability to get a jump start on the 2014 Medicaid increase and to reorganize the delivery and payment systems.

There has been a recent increase in Section 1115 waiver activity, with the Centers for Medicare and Medicaid Services (CMS) making numerous waiver judgments and a number of states submitting new waiver proposals. The waivers and waiver proposals differ in their precise goals and tactics, but some key themes are obvious. With the enforcement of the Affordable Care Act, seven states (CA, CO, DC, MN, MO, NJ, and WA) have obtained section 1115 waivers to expand Medicaid early in planning for 2014. Two states (MA and NY) also have also been granted waivers to simplify enrollment and renewal processes for adults.

Federal rules prohibit states from effecting entitlement and enrollment constraints. However, four states (AZ, HI, NV, WI) were granted approval to start limitations when their waivers expired or under a limited exception to the federal rule. In addition, several states have sought waiver requests to charge higher payments and cost sharing than then allowed. In general,

these requests have not been permitted. Florist's had a proposal to charge a \$10 monthly premium and \$100 escapement for non-emergency use of the ERE for most Medicaid beneficiaries which was denied.

Connecticut requested a waiver for the state's Medicaid Low-Income Adult Coverage Demonstration to raise the asset test limit for eligibility which would save the Tate about \$50 million. The coverage for 13, 381 individuals would have reduced for one year. Health and Human Services (HAS) rejected the request because such restrictions and ineligibility periods are consistent with the Medicaid plan. California, Delaware, New York, and Texas have all received waiver for the increasing managed care to take into account high-need populations and additional services.

Several other states (FL, KS, NJ, and NM) have waiver proposals to change elderly and disabled participants into managed care. Also, the waiver approval in Delaware and a number of other ending waiver proposals would increase managed care to more services, including long-term services. Medical's cost has exploded to \$250 billion and is expected to rise even faster once AC expands by 30 million. So everyone wants to reduce costs, and Rhode Island is the place to look. The Bush Administration approved Rhode Island a one-of-a-kind waiver from federal Medicaid rules in exchange for a cap on federal costs.

An analysis by Gary Alexander, the former secretary Of Rhode Island's health and human services shows the state's increases in annual cost have fallen to less than Alfa the pace of the rest of the nation. And health care for the poor has improved. Rhode Island had two major reforms, reduce ERE visits for

non-emergency visit and reduce pricey nursing home expenditures by providing in home care. The Rhode Island waiver is doing what it was supposed to do: bend the health-care cost curve. The savings through 2012 are close to \$2. Billion. Sanctioned waiver initiatives in several states (CA, FL, MA, and TX) make federal matching funds accessible for safety-net pools that will be used to cover both uncompensated care costs and hospital delivery system improvement initiatives. These initiatives include organized development, new care delivery models (e. G. , medical homes, chronic disease management), and quality improvement projects. Arkansas has been approved to use Medicaid dollars to purchase private health insurance for its new public program enrollees.

They are the only state in the country that has this approval. The state of Arkansas and the Center for Medicaid and Medicare Services (CMS) worked together to find flexibilities to build a new program from new enrollees.

There are about 200, 000 residents that will alluvial under the expansion but instead of going under a public program they will be able to purchase regular health insurance and Medicaid will pay for the premiums. The approval of this program is based on the fact that it is budget neutral.

There is no extra money being spent than what was already budgeted for. The agreement has a three year approval term at which time either side can decide to renew or not. The Government Accountability Office (GAO) did a study of 10 new waiver demonstrations. GAO inspected expanded states' use of federal funds and approved new coverage strategies. All 10 ministrations were approved to use different coverage strategies or impose

new cost sharing requirements, including limiting benefits or imposing deductibles for certain populations.

The Department of Health and Human Services' (HAS) budget neutrality policy process did not show that these waivers did not show they were budget neutral. For 4 of 10 demonstrations GAO reviewed, HAS approved spending limits that exceeded the actual dollars needed, added dollars for cost that have never been incurred and used out dated information. Over the course off five year span, had the HAS used the correct figures the reduction would have been bout \$32 billion dollars of which the federal share would have been a \$21 billion dollars in savings.

As part of the Affordable Care Act, Congress required that the Center for Medicaid and Medicare Service (SMS) develop new regulations on Section 1 115 waivers because of concerns over the incentive method that often lacked transparency. Some of the key elements of the new rule include a 30-day public comment process at both the federal and state levels on a state's application for a new waiver request or extension of an existing demonstration project. Materials must be publicly available on

State websites and the State must also hold at least two public hearings where there is an opportunity to give comment. A state must show how it has considered the public comments it has received upon submission of the final application. The new rule also includes sections on monitoring and evaluating the demonstrations once approved. Section 1 115 is, after all, research and demonstration authority that was established to allow states to

test new and innovative ideas. Reliable evaluations have not been performed on all Section 1115 waivers.

Section 1115 waivers generally are approved for an initial five-year period. At the end of the initial approval period, a state must obtain a renewal or extension to continue the waiver. Waiver extensions typically are for a three-year period. Some waivers have been continually renewed over many periods, allowing waiver operations to continue for many years. The approval and renewal process of program changes are significant, it is important that there is accountability and transparency.

Section 1115 Medicaid and CHIP demonstration waivers are intended to allow for research and demonstration projects to test new approaches in program design and administration. Given the significant program changes that can occur under waivers, the transparency of the waiver approval process is important. As required by the ACA the new regulations establish a state and federal public notice process designed to enable the public to stay better informed about proposed waiver changes and provide meaningful public input. Kaiser family foundation, 2013) Conclusion Is there a new term of “ executive federalism? Or do we change the name to suit the scholars? Federalism is a system of government in which power is divided between a national (federal) government and various regional overspent (states). As defined by the United States Constitution, federalism is a fundamental aspect of American government, whereby the states are not merely regional representatives of the federal government, but are granted independent powers and responsibilities.

With their own legislative branch, executive branch, and judicial branch, states are empowered to pass, enforce, and interpret laws, provided they do not violate the Constitution. This arrangement not only allows state governments to respond directly to the interests of their local populations, but also serves to check the power of the federal government. Whereas the federal government determines foreign policy, with exclusive power to make treaties, declare war, and control imports and exports, the states have exclusive power to ratify the Constitution.

Most governmental responsibilities, however, are shared by state and federal governments: both levels are involved in such public policy issues as taxation, business regulation, environmental protection, and civil rights. ([http://www. Harmoniously. Com/federalism](http://www.Harmoniously.Com/federalism)) Is there any way to prohibit political influence? As Sterling states in his 2009 article ‘ the degree o which state expertise is informative to federal decision-makers depends on how well the policy interests of state and federal levels are aligned. If there is a push from the top to get a state’s waiver through, then it will get done. It would appear that for the most part both the states and the federal government are working together to address Medicaid needs. The federal government is in charge of the Medicaid funds, states apply for waivers to give themselves control to try a “ pilot” program and see if it works. There is still accountability back to the federal government by the states. The states now what their Medicaid population needs are and what strategies need to be in place to achieve a better product at the lowest cost.