has been implemented.[4] In combination with the lack of mandatory team building involving specialists from both the ambulatory care and hospital sectors, these HIT limitations will probably hamper the flow of information, the coordination of care, and possibly the quality of care.

In addition, although the government intends to develop a specific, lump-sum payment system for IASC, it's unclear whether that system will link payment to outcomes — indeed, there are no mechanisms in place for changing the payment scheme from a volume-driven to a value-driven one. With an extrabudgetary reimbursement system and without planning of demand on the basis of morbidity and demographic changes, the payment system will probably provide an incentive for providers to expand services.

But the most important limitation may be that, as with the precursors to patient-centered medical homes in the United States, implementation of IASC does not systematically or fundamentally transform practice or service delivery.[5] Given these facts, it remains to be seen whether the new care model can be put into practice in such a way as to reorganize health care delivery to increase value for patients, achieve good medical outcomes at acceptable costs, and improve the experience of specialist care for both patients and providers.

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Restructuring Medicaid as Block Grants — Unconstitutional Coercion?

Sara Rosenbaum, J.D., and Timothy Westmoreland, J.D.

In February 2015, Senators Orrin Hatch (R-UT) and Richard Burr (R-NC), along with Representative Fred Upton (R-MI), unveiled the Patient Choice, Affordability, Responsibility, and Empowerment Act (Patient CARE Act).[1] Although its terms remain sketchy, the proposal deserves serious attention. The Budget Resolutions passed by each House of Congress in late March, though nonbinding, assume enactment of some version of the proposal, and Hatch and Upton chair the Senate Finance Committee and the House Energy and Commerce Committee, respectively, two of Congress's most powerful health committees.

The Patient CARE Act would repeal the insurance reforms of the Affordable Care Act (ACA) and substantially scale back its insurance-premium tax subsidies.[2] In addition, in the name of "modernizing" and "reforming" Medicaid, it would fundamentally restructure the program. First, the proposal would eliminate all federal funding for the ACA' s expansion of Medicaid eligibility for adults. Second, it would end Medicaid's historical entitlement to comprehensive coverage for low-income children, pregnant women, and families with dependent children, along with the entitlement to long-term care services and support for elderly or disabled Medicaid beneficiaries. For these groups and services, it would replace Medicaid's open-ended financing structure with a block grant that would allocate a fixed sum to each state; these allotments would be allowed to grow over time only in accordance with a specified formula, at a rate well below that of medical inflation. As if to underscore the seriousness of its effect, the proposal notes that "Importantly, no changes would be made to the funding for the acute care of low-income elderly and disabled individuals and traditional Federal matching payments would

be continued for services to these groups." In other words, Medicaid would be block-granted for children, families, and people with long-term care needs, whereas a smaller cluster of non–long-term care services for elderly and disabled beneficiaries would remain legal entitlements.

Such a law would be bad news for beneficiaries and for providers, especially those that serve low-income communities, since under such financing terms few, if any, states could maintain existing coverage for affected populations. With projected federal budget cuts from Medicaid of nearly $2 trillion over 10 years, these changes would force most states to put eligibility, benefit, and cost-sharing protections on the line as they attempted to cope with the brunt of future cost growth. Financial risks associated with health care inflation, changes in technologies and services, and the long-term care needs of an aging population would be largely shifted to the states, as they reached the limits of their capped federal allotments. Moreover, over time, the federal government could ratchet down the caps in an effort to avert further outlays.

By shifting the risk of future cost growth to the states, a block grant might save the federal budget money, but it would retain many administrative complexities and create new ones. Federal funding would still be available only for permissible state expenditures and would impose federal spending rules and oversight. Experience with far smaller block-grant programs such as the Children's Health Insurance Program suggests that allotment disputes and shortfalls are ongoing problems that almost certainly would grow bigger given the hundreds of billions of dollars in federal funding at stake in Medicaid annually.

The likely adverse effects on the poor and state economies of block-granting Medicaid have been well documented.[3] Indeed, experts attribute the size of Medicaid's budget to the sheer number of people it serves (more than 66 million by 2014) and their health status. On a per-capita basis, spending is actually modest.[4] Put another way, there is little to cut in Medicaid other than people, health care, and (already heavily discounted) provider payments.

This is hardly the first Medicaid block-grant proposal. But the Patient CARE Act differs from past proposals in that it comes 3 years after the Supreme Court decision in *National Federation of Independent Business v. Sebelius (NFIB)*.[5] *NFIB* is a landmark not only because it upheld the ACA's so-called individual mandate as a constitutional tax but also because in an unprecedented decision, seven justices struck down the adult Medicaid expansion as unconstitutional state coercion in violation of the Tenth Amendment. (The question of unconstitutional coercion has now also appeared in *King v. Burwell*, which raises the question of whether states must operate their own health insurance exchanges in order for their residents to qualify for federal tax subsidies.)

In his *NFIB* opinion, Chief Justice John Roberts concluded that although the ACA simply added a new eligibility group to existing law, that was enough to transform Medicaid from a program for selected needy populations into "an element of a comprehensive national plan to provide universal health insurance coverage." The amendment constituted a "shift in kind, not merely degree," fundamentally transforming Medicaid into a cornerstone of national health care reform. In the chief justice's view, by conditioning states' continued receipt of massive federal funding on accepting a fundamentally repurposed program, the ACA effectively commandeered the states to administer a central component of national health care reform, placing a "gun to the head" of states that wanted no part of that scheme. Furthermore, Roberts argued, this sweeping alteration of Medicaid violated states' Tenth Amendment right, as independent sovereigns, to "voluntarily and knowingly" accept the terms of constitutional Spending Clause programs. The proper remedy was to bar the federal government from enforcing the Medicaid expansion as a mandate, thereby rendering it optional.

Viewed through the lens of the *NFIB* decision, the Patient CARE Act may suffer from similar constitutional infirmities. For 50 years, the federal–state Medicaid compact has rested on a basic premise: in exchange for reliable, open-ended financing, states will entitle traditional populations to comprehensive benefits. Congress has sometimes altered the eligibility rules for traditional groups such as children, but as Roberts noted, these were simply changes of degree, not kind. The federal compact stood untouched.

But the Patient CARE Act would cast aside the fundamental economic basis on which Medicaid rests and thus represent a dramatic shift in kind, not merely degree — fundamentally alter-

ing the program's structure to achieve a purpose (shielding the federal government from health care costs) that was not part of the deal 50 years ago. The proposal would predicate ongoing federal funding on the states' agreement to a new budgeting arrangement that forced them to accept and absorb enormous financial risk by altering their obligations to pregnant women, children, and parents, while reducing long-term care commitments to elderly and disabled beneficiaries. By radically restructuring federal Medicaid financing, the Patient CARE Act becomes a legal "gun to the head": a state that wished to receive continued federal Medicaid funding would be compelled to conform to a new compact without the requisite advance notice of how Medicaid would ultimately be profoundly altered.

An audio interview with Prof. Rosenbaum is available at NEJM.org

Perhaps Congress could give states the option of a block grant as an alternative to open-ended funding. Some states might take such an option — but they'd be foolish to do so, since children and families are the least costly beneficiaries, and Medicaid funding for long-term care is politically popular. States would forgo billions of dollars in federal funding while inflicting terrible pain and generating virtually no savings. They could attempt to replace lost funding with state tax funds, but state tax hikes are even less popular than federal taxes.

Congress could repeal Medicaid altogether and replace it with a new program. Such a strategy might avert the constitutional problems associated with fundamentally altering Medicaid. But in our view that would be a terrible idea. Furthermore, achieving any sensible alternative program would be impossible in such a politically riven atmosphere.

Before 2012, Congress's power to redesign Medicaid seemed a legal given. After *NFIB*, that's no longer the case. Legislation that would radically transform the federal–state Medicaid bargain without states' consent may no longer pass the Tenth Amendment test.

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Lessons in Medicine, Mortality, and Reflexive Verbs

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Everywhere I turned during my clerkships and internship at a county hospital in southern California, I heard Spanish. My classmates and I came from places like Long Island and Kentucky and often had terrible pronunciation, but we spent entire days speaking only Spanish: Spanish on rounds, Spanish to nurses, Spanish with patients.

We learned much of our Spanish from patients who were hospitalized for long periods, especially those who had a high tolerance for bumbling med students with pitiful accents. My own best teacher was a young woman named Julia Gonzalez, who was admitted in October of my internship year with acute myeloid leukemia. Younger than I was, she insisted that I call her Julia, and during several months of chemotherapy, she taught me considerably more than Spanish nouns and verbs.

The oncology team showed me how to manage her treatment and its toxic effects. When side effects bloomed, the team taught me what orders to write and how to use my new medical language, while I told Julia in Spanish what the medications were called and what they did. I'd often add that the doctors promised she would rally ("se mejoraría"), even when neither of us believed it.

And she did get better. In December, after four rounds of chemo and what I'd learned we