NOTES

THE TREND TOWARD MEDICAID MANAGED CARE: IS THE GOVERNMENT SELLING OUT THE MEDICAID POOR?*

> Last year expenditures under Medicare amounted to $74 billion; Medicaid cost $25 billion; and the tax subsidy program [to employers who provide health insurance] resulted in about $32 billion in lost revenues. Yet with all this spending we still have children who receive no healthcare services; pregnant women who receive no prenatal care; disabled individuals who are forced to live away from their families and communities; families financially devastated and torn apart because of illness; 37 million people with no health insurance at all; and senior citizens who have to impoverish themselves in order to receive long-term care. Our system is a disaster.[1]

I. INTRODUCTION

With the costs of the Medicaid program still rising, federal and state governments alike are counting on managed care to ease their budgetary troubles. While strong evidence exists that managed care has the potential to save states a significant amount of money, states cannot pursue their cost-cutting objective to the exclusion of quality of care. The Medicaid population has different needs than the general population and therefore requires different treatment and services. Unfortunately, after receiving the necessary federal waivers from the Health Care Financing Administration,[2] many states have rushed forward to implement Medicaid managed care programs with little consideration of those needs, only to later discover such problems as systemic fraud and abuse, dis-

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* The author dedicates this Note to her parents and sister, for all their love and support.

[1] John K. Iglehart & Jane K. White, *Experiments with Medicaid: Cost Containment Versus Access*, 68 HEALTH PROGRESS 26, 26 (1987) (quoting Sen. John H. Chafee, R-R.I., a member of the Senate Finance Committee which oversees Medicaid, from his statement on July 10, 1987, at a hearing on Medicaid and the Maternal and Child Health Care Block Grant).

[2] Congress granted the Department of Health and Human Services ("DHHS") the discretion to grant Section 1115 waivers. DHHS delegated this authority to the Health Care Financing Administration ("HCFA"), the federal agency which administers Medicaid. *See* Suzanne Rotwein et al., *Medicaid and State Health Care Reform: Process, Programs, and Policy Options*, 16 HEALTH CARE FINANCING REV. 105, 105-06 (1995).

crimination, inadequate access to health care and, not surprisingly, poor quality of care. Part II of this Note will provide a brief history of the trend toward Medicaid managed care. Part III explains why special consideration of the Medicaid population's medical and social needs prior to its involuntary enrollment in Medicaid managed care is necessary for the health of the Medicaid population, as well as for the health of state and federal budgets. Part IV reveals some of the deficiencies in past and present Medicaid managed care programs. Finally, Part V of this Note will offer some suggestions for improvement at both the state and federal level.

II. MEDICAID MANAGED CARE: BACKGROUND

Congress established the Medicaid program through Title XIX of the Social Security Act of 1965 ("Act").[3] The purpose of the program was to provide better access to health care services for the nation's poorest population through a federal and state cost-sharing venture.[4] During its first fifteen years, the Medicaid program experienced first moderate, then rapid growth.[5] Today, the program covers the costs of health care for thirty-three million low-income Americans.[6] Not surprisingly, as Medicaid grew, the costs of the program grew as well[7],

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[3] The Social Security Act of 1965, 19 U.S.C. §1396-1396s (1965).

[4] *See* STAFF OF SENATE COMM. ON FINANCE , 98TH CONG., 2D SESS., NEW APPROACHES TO PROVIDING HEALTH CARE TO THE POOR: MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES 1 (Comm. Print 1984) (statement of Senator Robert Dole).

[5] *See* ROBERT E. HURLEY ET AL., MANAGED CARE IN MEDICAID 1 (1993).

[6] *See* MICHAEL S. SPARER, MEDICAID AND THE LIMITS OF STATE HEALTH REFORM 31 (1996).

[7] Alarmingly, the costs to the federal government tripled between 1985 and 1995. *See* William Alvarado Rivera, *A Future for Medicaid Managed Care: The Lessons of California's San Mateo County,* 7 STAN. L. & POL'Y REV. 105, 111 (1996). From $24.8 billion in 1980, these costs have skyrocketed to $47 billion in 1987, $71.3 billion in 1990, $88 billion in 1991, and $131 billion in 1993. *See* ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, MEDICAID: INTERGOVERNMENTAL TRENDS AND OPTIONS V (1992). *See also* SPARER, *supra* note 6. The United States General Accounting Office (GAO) predicts that Medicaid costs, if uncontrolled, will again double in the next five to seven years. *See* Rivera, *supra.* Today, Medicaid composes about six percent of the federal budget, and is expected to rise to eight percent of the federal budget by the year 2002. *See id.* As of 1995, the federal government paid states more money for Medicaid than for anything else, including transportation and education. *See* Richard A. Knox, *Mass. Spared Cutbacks in Medicaid Plan. Low Rate of Spending Growth Gives State a $1.1 Billion Cushion Under Federal Formula,* BOSTON GLOBE, Nov. 21, 1995, at 8.

These cost increases have been particularly burdensome for state and local governments, which must share the costs with the federal government. The Congressional Budget Office estimated that state and local costs of Medicaid would increase from $39.6 billion in 1991 to $95.1 billion in 1997. *See* Steven D. Gold, *The State Budget Context: How Medicaid Fits In, in* MEDICAID FINANCING CRISIS: BALANCING RESPONSIBILITIES, PRIORITIES, AND DOLLARS 133, 146 (Diane Rowland et al. eds., 1993). In 1992, states spent, on average, 17.1 % of their state budgets on Medicaid, up from 10.8 % in 1980. *See*

often at the expense of other governmental programs[8], such as "expanding social services (for children, senior citizens, and persons with special needs), improving infrastructure, aiding local governments, and strengthening the system of higher education."[9] A study by the Urban Institute and the Kaiser Commission on the Future of Medicaid found that between 1988 and 1992 approximately thirty-six percent of the growth in the Medicaid bill was the result of increased enrollment.[10] The study also found that general health care inflation, a sicker Medicaid population with more expensive illnesses (such as AIDS), increased use of certain Medicaid benefits, and increased provider payments also played a part in the growth of Medicaid expenses.[11]

Medicaid's seemingly infinite growth has had federal and state governments scrambling to devise and implement a method of cost containment.[12] One of the methods most commonly used by the states to curtail Medicaid growth has been the rationing of health care services through managed care.[13] Prior to 1981, managed care organizations ("MCOs") typically had been used to control health care costs only in the private sector, by limiting unnecessary care or by promoting increased use of cost-effective alternatives.[14] This method of cost reduction was largely ineffective for the public sector before 1981 since, under the Act, states were unable to require Medicaid recipients to enroll in MCOs.[15] Although some states encouraged Medicaid beneficiaries to voluntarily enroll in one type of MCO called a Health Maintenance Organization ("HMO") in the mid-1970s,[16] results were limited. Under a fee-for-service system, the Medicaid benefit package the beneficiaries were receiving was already quite generous[17] and HMOs offered beneficiaries little incentive to join.[18]

Mandatory enrollment of Medicaid beneficiaries in managed care is necessary in order to achieve any significant cost savings. It is difficult for MCOs to at-

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SPARER, *supra* note 6, at 25. *See also* Trish Riley, *State Health Reform and the Role of 1115 Waivers,* 16 HEALTH CARE FINANCING REV. 139, 142 (1995). Medicaid is now the second largest expenditure in most state budgets (just after expenditures for education). *See* SPARER, *supra* note 6, at 31.

[8] *See* Gold, *supra* note 7, at 139. In the 1991-92 school year, state expenditures on higher education fell for the first time in 30 years; at the same time, average tuition increased more than eight percent. *See id.* at 137.

[9] *See id.* at 146.

[10] *See* SPARER, *supra* note 6, at 58.

[11] *See id.*

[12] State and local governments paid for approximately 48% of the total Medicaid bill in 1993 (around $56 billion). *See id.* at 31.

[13] JANE SNEDDON LITTLE, FEDERAL RESERVE BANK OF BOSTON, WHY STATE MEDICAID COSTS VARY: A FIRST LOOK 42 (1991).

[14] *See* Jeffrey A. Buck & Herbert A. Silverman, *Use of Utilization Management Methods in State Medicaid Programs*, 17 HEALTH CARE FINANCING REV. 77, 77 (1996).

[15] *See* HURLEY, *supra* note 5, at 29.

[16] *See id.*

[17] *See id.* at 29-30.

[18] *See id.*

tract and retain Medicaid enrollees where enrollment is voluntary. There is no financial incentive for Medicaid beneficiaries to enroll in an MCO since they do not pay for their own health care.[19] Furthermore, other disadvantages exist for Medicaid beneficiaries who join a managed care organization, such as giving up a non-MCO provider.[20] Another reason mandatory managed care is necessary to reduce Medicaid costs is because adverse selection is a problem under voluntary enrollment.[21] Since the Medicaid beneficiaries who are most in need of health care are more likely to enroll in managed care than those who are healthy, the MCO will become very costly to run, and savings will disappear.[22]

Over the last sixteen years, the federal government has slowly been easing the Medicaid requirements which prevented states from mandating enrollment of all Medicaid beneficiaries in a managed care organization. In 1981, Congress passed the Omnibus Budget Reconciliation Act of 1981 ("OBRA-81").[23] Under section 2175 of OBRA-81, states could apply to the federal government for two kinds of waivers of Medicaid requirements to facilitate the use of MCOs.[24] The first type of waiver was a section 1915(b) "program" waiver, also known as a "freedom of choice" waiver.[25] Prior to OBRA-81, the Medicaid statute only allowed states to make Medicaid beneficiaries' enrollment in an MCO voluntary and did not allow states to restrict the providers from whom the Medicaid beneficiaries could receive services.[26] Since only a small percentage of recipients would be likely to self-enroll in an MCO, these restrictions limited the effectiveness of managed care as a cost-saving device.[27] The section 1915(b) waiver permitted by OBRA-81, however, enabled states to mandate Medicaid beneficiaries' participation in an MCO and allowed states to restrict the providers available to Medi-

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[19] *See* Susan I. DesHarnais, *Enrollment in and Disenrollment from Health Maintenance Organizations by Medicaid Recipients*, 6 HEALTH CARE FINANCING REV. 39, 41 (1985). *See also* W. Pete Welch & Mark E. Miller, *Mandatory HMO Enrollment in Medicaid: The Issue of Freedom of Choice,* 66 MILBANK Q. 618, 624 (1988); *see also* James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis,* 59 TEX. L. REV. 1345, 1355 (1981) (incentive for Medicaid patient to conserve is minimal).

[20] *See* DesHarnais, *supra* note 19, at 41.

[21] *See id.* Adverse selection is the theory that those patients who are the sickest and most in need of health care will be more likely to enroll in a MCO, thus increasing health care costs to the MCO. *See id.* However, with mandatory enrollment, both healthy and sick patients would be forced to enroll, thus making the program less expensive. *See id.*

[22] *See id.*

[23] *See* The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2175, 95 Stat. 809 (1981); STAFF OF SENATE COMM. ON FINANCE, 98TH CONG., 2D SESS., NEW APPROACHES TO PROVIDING HEALTH CARE TO THE POOR: MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES 1 (Comm. Print 1984) (statement of Senator Robert Dole).

[24] *See* STAFF OF SENATE COMM. ON FINANCE, 98TH CONG., 2D SESS., *supra* note 23.

[25] *See* Rotwein, *supra* note 2, at 106.

[26] *See* STAFF OF SENATE COMM. ON FINANCE, 98TH CONG., 2D SESS., *supra* note 23.

[27] *See* Rotwein, *supra* note 2, at 106.

caid beneficiaries.[28]

The second type of waiver available to states through OBRA-81 was a waiver of Section 1115 of the Social Security Act, also known as a "research and demonstration" waiver.[29] This type of waiver was broader in scope than the Section 1915(b) waiver because it allowed the waiver of any statutory requirements which the Secretary of the Department of Health and Human Service believed were "likely to assist in promoting the objectives of the Medicaid statute."[30] For example, under the Act a Medicaid beneficiary could be "locked-in" to using one provider for up to six months, but with a section 1115 waiver a beneficiary could be "locked-in" for twelve months.[31] A longer lock-in period benefits states since locking-in Medicaid beneficiaries for a certain period of time helps control high turnover rates in the Medicaid program which make the administration of such programs a logistical nightmare.[32] Therefore, section 1115 and 1915 waivers gave states greater freedom to design and implement creative and cost-effective approaches such as managed care programs, to provide health care to the Medicaid population.[33]

Since the enactment of OBRA-81, enrollment of Medicaid beneficiaries in managed care plans has been the preferred strategy of states to reduce the costs of the Medicaid program.[34] By February 1984, twenty-four states had already submitted seventy-four waiver requests under Section 2175 of OBRA-81.[35] The number of Medicaid clients in managed care has increased markedly, from only 750,000 enrollees in 1983 (three percent of the total Medicaid population) to 7.8 million enrollees in 1994 (twenty-three percent of the total Medicaid population) to 11.6 million enrollees in 1995 (thirty-two percent of the total Medicaid population).[36] As of 1996, all but eight states have had either an optional or mandatory Medicaid managed care program in place.[37] Several states, including New York[38] and Kentucky[39] are now in the process of implementing mandatory

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[28] *See* Buck & Silverman, *supra* note 14, at 77.

[29] *See* Rotwein, *supra* note 2, at 106.

[30] *Id.* at 107.

[31] *See id.*

[32] *See* Janet Firshein, *Medicaid HMO Plans Tackle Quality Questions*, 60 HOSPITALS 76, 76 (1986).

[33] *See* Rotwein, *supra* note 2, at 105. As of December 1994, the Department of Health and Human Services had granted section 1115 waivers to 6 states: Oregon, Hawaii, Tennessee, Rhode Island, Kentucky, and Florida. *See id.* at 108.

[34] *See id.* at 105. *See also* Michael S. Sparer, *Medicaid Managed Care and the Health Reform Debate: Lessons from New York and California*, 21 J. HEALTH POL., POL'Y, & L. 433, 434 (1996).

[35] *See* STAFF OF SENATE COMM. ON FINANCE, 98TH CONG., 2D SESS., *supra* note 23.

[36] *See id. See also* Buck & Silverman, *supra* note 14, at 77.

[37] The eight states without some type of managed care are Arkansas, Connecticut, Indiana, Maine, Nebraska, Oklahoma, Vermont and Wyoming. *See* Sheryl T. Dasco, *Recent Legislative Case Law, Economic, and Other Developments Affecting Health Care Providers in Integrated Delivery Systems*, A.L.I. 479, 486 (Feb. 15, 1996).

[38] *See* Mark Mooney, *Medicaid Overall HMO Enrollment Set*, N.Y. DAILY NEWS, Aug.

enrollment in MCOs for their entire Medicaid population.

The enactment of the Balanced Budget Act of 1997 created another option for states interested in forming mandatory Medicaid managed care programs.[40] The Balanced Budget Act made two important changes to the Medicaid managed care initiative: "(1) it added a number of new statutory requirements applicable to managed care organizations and (2) it authorized States to operate mandatory managed care programs without obtaining a waiver."[41]

The increasing ease of implementing Medicaid managed care programs and rising Medicaid costs has spurred the nationwide trend toward managed care.[42] Managed care, which emphasizes the elimination of all unnecessary care, curtails the growth of health care costs.[43] States can save an estimated five to fifteen percent by using managed care instead of fee-for-service alternatives.[44] However, it is unrealistic for states to expect managed care to solve the problem of rising health care costs completely. For example, in Massachusetts, MassHealth, the state Medicaid plan, saved only $20 million in its first full year of operation — "a pittance compared to Medicaid's $3.5 billion annual cost."[45]

Even if Medicaid managed care should prove to be an effective method of cost containment, any money spent would be wasted money if Medicaid beneficiaries do not receive quality health care. There is a fine line between managed care and mismanaged care — if MCOs eliminate coverage of too many services, Medicaid beneficiaries will be certain to pay the price with their health.[46] Furthermore, the rising costs of Medicaid cannot be blamed entirely on the inefficiencies of the current system addressed by managed care. The costs of Medicaid will continue to rise in spite of managed care, due to technology-based inflation.[47] Just as in the private sector, the costs of medical care for Medicaid recipients increase over time.[48] Unless society is willing to deny modern medical

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15, 1996, at 1.

[39] *See* Marybeth Burke, *State Managed Care Initiatives Spur Medicaid Policy Debate,* HOSPITALS, Aug. 20, 1991, at 46.

[40] *See* Mark S. Jaffee, Medicaid Risk Program Development Initiatives (Dec. 8-10, 1997) (unpublished manuscript, on file with NHLA/AAHA Managed Care Law Institute).

[41] *Id.*

[42] *See* SPARER, *supra* note 6, at 11.

[43] *See* Sparer, *supra* note 34, at 59. *See also* Michael Grunwald, *Fight Brews Over US Cap on Medicaid,* BOSTON GLOBE, Feb. 4, 1997, at A9 (In Massachusetts, growth has slowed from 18% to 3% as a result of Medicaid managed care).

[44] *See* The Robert Wood Johnson Foundation, *Advance Summer 1995: Medicaid Managed Care: Promises and Pitfalls* (visited Nov. 3, 1996) <http://www.rwjf.org/library/sums95cov.htm>.

[45] *See* Richard A. Knox, *Managed Care System Curtails Mass. Costs,* BOSTON GLOBE, Nov. 21, 1995, at 8.

[46] *See* Buck & Silverman, *supra* note 14, at 85.

[47] *See* LITTLE, *supra* note 13, at 43. Medicaid, in addition to providing health care to the poor, also pays much of the increasingly expensive costs of long-term health care for the rising elderly population. *See id.*

[48] *See* THOMAS W. GRANNEMANN & MARK V. PAULEY, CONTROLLING MEDICAID COSTS:

technology to Medicaid beneficiaries, society must expect some increases in Medicaid costs.[49] Demographics have also contributed to rising health care costs, especially the rising elderly population, which increasingly turns to Medicaid for the costs of its long term care; thus, even if states implement managed care, as the population ages and needs more long-term care services, we can expect Medicaid costs to rise.[50]

III. HEALTH CARE NEEDS OF THE MEDICAID POPULATION

Managed care has the potential to improve the health of Medicaid beneficiaries through its emphasis on preventive health services and its ability to coordinate all of a patient's health care needs.[51] Under fee-for-service payment mechanisms, many Medicaid beneficiaries had problems with access to health services, since physicians often would not accept Medicaid patients due to the Government's low rates of reimbursement.[52] However, physicians who contract with managed care organizations often do not even know which of their patients are on Medicaid.[53] Furthermore, the combined Medicaid population represents a large portion of business which many physicians are eager to have.[54] One Medicaid recipient expressed her dissatisfaction with Medicaid under fee-for-service: "I can't find a good doctor for myself. There is a stigma attached to Medicaid when it comes to doctors."[55] Under Medicaid managed care, however, beneficiaries are less stigmatized.[56] As one beneficiary put it: "Being on Medicaid means the doctor treats you differently, because you are not a paying customer. Being in [sic] HMO is different."[57]

Despite its positive aspects, managed care, if mismanaged, may also expose the Medicaid population to serious health risks. The Medicaid population in-

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FEDERALISM, COMPETITION, AND CHOICE 27 (1983).

[49] *See id.*

[50] *See* John Holahan et al., *Understanding the Recent Growth in Medicaid Spending, in* MEDICAID FINANCING CRISIS: BALANCING RESPONSIBILITIES, PRIORITIES, AND DOLLARS 23, 41 (Diane Rowland et al., eds., 1993).

[51] *See* Sparer, *supra* note 34, at 456.

[52] *See* Frank Sloan et al., *Physician Participation in State Medicaid Programs*, 13 J. HUM. RESOURCES 211, 212 (1978) (prior to Medicaid managed care, "access to private practice physicians [was] limited because many of the providers [were] unwilling to participate at all or . . . accepted Medicaid patients on a very limited basis.") Fee-for-service is a physician payment method where a doctor is paid for each service he provides, rather than a set fee for all services he provides, as in managed care. *See* GEORGE C. HALVORSON, STRONG MEDICINE 234 (1993). Thus, in fee-for-service, there is a financial incentive for doctors to provide excessive health care services. *See id.* at 20-23, 47-48.

[53] *See id.*

[54] *See id.*

[55] *See* Helena Temkin-Greener, *Medicaid Families under Managed Care: Anticipated Behavior*, 24 MEDICAL CARE 721, 731 (1986).

[56] *See* Buck & Silverman, *supra* note 14, at 78.

[57] *See id.*

cludes some of the least healthy and most physically vulnerable people in the country.[58] For this reason, the federal and state governments must take great care in planning and implementing these programs. "[A] conversion of Medicaid beneficiaries from a fee-for-service system to a capitated prepayment approach requires real commitment and careful planning by the state, the active participation and support of the provider community, and sufficient leadtime and cooperation at all levels."[59] Poorly planned and managed reforms could have the undesirable effect of worsening the health care available to the medically needy and increasing costs to state and federal governments.[60]

The Medicaid population is composed primarily of women, children, mentally disabled, and chronically ill individuals.[61] These patients often require more continuous medical supervision and nursing home care than HMOs typically offer.[62] Poor people are more vulnerable than the general population because of health risks associated with poverty, such as "poor sanitation and housing, inadequate diet, [and] general family stress and hardships."[63] It is widely recognized that poor people are more likely to become sick, less likely to receive adequate medical care, and more likely to die at an early age.[64]

Ideally, the greater health needs of the Medicaid poor should translate into more thorough care. Managed care organizations, however, provide financial in-

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[58] *See* Sara Rosenbaum et al., *Incantations in the Dark: Medicaid, Managed Care, and Maternity Care*, 66 MILBANK Q. 661, 662 (1988) (discussing the low health status of Medicaid births). *See also* Maren D. Anderson & Peter D. Fox, *Lessons Learned From Medicaid Managed Care Approaches*, 6 HEALTH AFFAIRS 71, 80 (1987); Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 240 (1994).

[59] Iglehart & White, *supra* note 1, at 28. "[First,] implementation of state reform initiatives is complex and difficult, and acceleration of program implementation may become problematic. Second, a shift from primarily fee-for-service delivery systems to managed care models requires paying careful attention to the establishment of adequate organizational and administrative structures, as well as beneficiary outreach and education." Rotwein, *supra* note 2, at 120.

[60] *See* Dan Morgan, *Medicaid May be Vehicle for Health Reform; Plans in South Carolina and Other States Could Add Coverage for More Than 3 Million*, THE WASH. POST, Nov. 19, 1994, at A9.

[61] *See* Marin D. Anderson & Peter D. Fox, *Lessons Learned From Medicaid Managed Care Approaches*, 6 HEALTH AFFAIRS 71, 80 (1987).

[62] *See id.*

[63] *See* Dana C. Hughes, *Medicaid Managed Care: Can it Work for Children?*, 95 PEDIATRICS 591, 592 (Apr. 1995) (discussing additional health risks in children associated with poverty).

[64] *See* RUTH SIDEL, WOMEN AND CHILDREN LAST: THE PLIGHT OF POOR WOMEN IN AFFLUENT AMERICA 136 (1986). *See also* Melvin D. Nelson, Jr., *Socioeconomic Status and Childhood Mortality in North Carolina*, 82 AM. J. OF PUB. HEALTH 1131, 1131 (1992); H. Jack Geiger, *Community Health Centers: Health Care as an Instrument of Social Change, in* REFORMING MEDICINE: LESSONS OF THE LAST QUARTER CENTURY 11, 14-15 (Victor W. Sidel et al. eds., 1984).

centives to physicians to provide less care for them.[65] For example, under the "capitated" payment system of HMOs, doctors are paid a fixed amount per patient, and all patient expenses come out of that sum.[66] Typically, the unused portion of the fixed sum is the doctor's profits.[67] Thus, doctors have an incentive to provide fewer services to their patients.[68]

The fact that managed care provides incentives for doctors to provide less care may have serious implications for Medicaid beneficiaries.[69] A 1993 federally sponsored report, based on interviews of over 17,000 patients nationwide, found "widespread dissatisfaction" with HMOs.[70] Some of the interviewees' complaints included "less well-developed and less responsive relationships with doctors, greater difficulty arranging for treatment, longer waits for services, and shorter medical visits,"[71] as compared to fee-for-service doctors. "HMOs also have lower hospital admission rates and shorter inpatient stays compared to doctors paid under fee-for-service plans."[72] The founder of Kaiser, an HMO, once admitted that HMOs are best suited "for middle class, working class people who do not expect to be very sick."[73] A medical care plan that is structured to meet the health care needs of the middle-class, and provides fewer services, is diametrically opposed to the needs of the poor.[74]

The tendency of MCOs to provide fewer services is further exacerbated by the fluctuating eligibility of Medicaid recipients.[75] If MCOs could be certain that current Medicaid beneficiaries would maintain enrollment for years to come, they would be more inclined to make an investment in these patients' future health.[76] Often, however, there is no certainty that a particular Medicaid recipient

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[65] *See* Wally R. Smith et al., *System Change: Quality Assessment and Improvement for Medicaid Managed Care*, 17 HEALTH CARE FINANCING REV. 97, 97 (1996). *See also* Norman A. Fuller et al., *Medicaid Utilization of Services in a Prepaid Group Practice Health Plan*, 15 MEDICAL CARE 705, 707 (1977) ("HMO entails hazards of underservicing").

[66] *See* Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 217-18 (1997).

[67] *See id.* at 218.

[68] *See id.*

[69] *See* Robert Pear, *Elderly and Poor Do Worse Under H.M.O. Plans' Care*, N.Y. TIMES, Oct. 2, 1996, at A10 (comment by Dr. Paul M. Ellwood, Jr., the health policy analyst who coined the term HMO in the early 1970s).

[70] *See* Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COL. L. REV. 1674, 1686 (1994).

[71] *Id.* at 1686-87..

[72] *Id.* at 1687.

[73] *See* Mark S. Tanaka, *Matching Medicaid with Managed Care*, PRACTICING L. INST. 773, 776 (Apr. 1996).

[74] *See* DesHarnais, *supra* note 19, at 39.

[75] *See* Hughes, *supra* note 63, at 595.

[76] *See id.*

will be enrolled even six months into the future.[77] Thus, from the managed care perspective, there is little financial incentive to provide preventive health care to Medicaid enrollees.[78]

IV. MANAGED, OR MISMANAGED, CARE FOR MEDICAID BENEFICIARIES?

In light of the very basic difference between the medical needs of the Medicaid population and the financial goals of MCOs, federal and state governments should be extremely cautious about contracting with an MCO to supply health care to their Medicaid populations. However, this has not been the case. State and federal governments have effectively transferred the responsibility for the Medicaid program to MCOs, despite the lack of evidence on whether this system sufficiently protects the Medicaid population against undertreatment.[79]

Many states have repeatedly rushed into agreements with MCOs even when participating plans clearly lacked the experience and resources required to care for state Medicaid populations.[80] Arizona is one example of such rapid enrollment. Governor Babbit of Arizona admitted that his state allotted an insufficient amount of time to planning the Arizona Medicaid managed care program, the Arizona Health Care Cost Containment System ("AHCCCS"). The Governor stated, "[w]e had difficulties in establishing and qualifying health care plans, implementing uniform accounting requirements, obtaining necessary financial reports and information, maintaining adequate computer capability and implementing appropriate screening procedures."[81] In California, consumer advocates complained about the speed of state enrollment of Medicaid recipients in HMOs.[82] In October 1994, the state had enrolled only 927,000 Medicaid beneficiaries into its Medi-Cal managed care program, but expected that amount to triple by late 1996.[83] Tennessee, a state in which MCOs were not initially suc-

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[77] *See id.*

[78] *See id.*

[79] *See* Stayn, *supra* note 70, at 1676.

[80] *See* Anderson & Fox, *supra* note 61, at 77. *See also* Alex Pham, *Privatization of Medicaid Eyed by State*, BOSTON GLOBE, Oct. 30, 1996, at A1; Geraldine Dallek, *Politics of Privatization: Commentary*, 36 CASE W. RES. L. REV. 969, 978 (1986).

[81] *Id.* at 982 (quoting Testimony of Arizona Governor Bruce Babbitt before the U.S. House of Representatives, Subcommittee on Health and the Environment, *An Oversight Hearing on the Management of the Arizona Health Care Cost System Medicaid Waiver by the Health Care Financing Administration* (June 15, 1984)). At one point, Arizona was having such problems with eligibility processing for its Medicaid program that a federal district court ruled in *Guild v. Schaller* that the state would have to pay $50 per week to beneficiaries whose eligibility to AHCCCS was improperly delayed or accidentally terminated. Thereafter, Arizona showed immediate improvement. *See id.* at 979 n.39. It is perhaps ironic that AHCCCS is pronounced "access." *See* Julie Johnson, *Medicaid: New Generation of Managed Care Improves Access, Delivery,* HOSPITALS, at 34 (Mar. 20, 1992).

[82] *See* SPARER, *supra* note 6, at 168.

[83] *See id.*

cessful, implemented a managed care program within one year by enrolling about 25% of the state's population in MCOs, a figure comprised of all Medicaid beneficiaries and a significant number of uninsured persons.[84] Maryland has enrolled 25% of its Medicaid population in HMOs, and expects to have 80% signed up by summer 1997.[85] Experts estimate that it takes at least one to two years to effectively implement these programs.[86] These states' attempts to shift their responsibility for their Medicaid populations to MCOs will surely be problematic.[87]

The federal government has likewise faltered in its duty to protect Medicaid beneficiaries. In recently enacting the Balanced Budget Act of 1997, the federal government released states from obtaining a federal waiver prior to implementing mandatory Medicaid managed care programs.[88] This relaxation of state requirements will increase the number of unqualified or deficient managed care plans that will be providing healthcare to the country's Medicaid population.

V. MANAGING THE MEDICAID MANAGED CARE PROBLEM

A. *Stricter State Oversight*

1. Ensuring Quality of Care

Any inadequacy in a Medicaid MCO is particularly troublesome because, unlike many enrollees of private insurers, Medicaid beneficiaries cannot afford to go outside the plan for health care.[89] If the state Medicaid program they are enrolled in does not provide a particular service, Medicaid beneficiaries most likely will not receive treatment elsewhere. If states could recognize deficiencies in their managed care programs before implementing them, it would save money and improve the quality of care for Medicaid beneficiaries in those programs. Avedis Donabedian, a leader in the theory of health care assessment, has identified three different methods of assessing quality of care: structure, process and outcome.[90] These indicators may serve as a framework for states to detect problems in their Medicaid managed care programs.

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[84] *See* Gregg S. Meyer & David Blumenthal, *TennCare and Academic Medical Centers: The Lessons from Tennessee*, 276 J. AM. MED. ASS'N 672, 672-73 (1996). Interestingly, Tennessee, the state Vice President Al Gore represented, was the first state to be granted a section 1115 waiver to implement its program. *See id. See also* Telephone Interview with Anne Jacobs, Health Care Consultant, Tucker Alan, Inc. In Washington, D.C. (Feb. 28, 1997).

[85] *See HCFA Reorganizing Patient, Provider Services,* 12 NAT'L HEALTH LAWYERS NEWS REP. 6 (1996).

[86] *See* Dallek, *supra* note 80, at 982.

[87] *See id.* at 978.

[88] *See* Joffe, *supra* note 40, at 7.

[89] *See* Dallek, *supra* note 80, at 977.

[90] *See* BARRY R. FURROW ET AL., HEALTH LAW 18-19 (2d ed. 1991).

a. Structural Problems

According to Donabedian, "structure" in the health care system is the "relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal; and of the physical and organizational settings in which they work."[91] Structure helps predict whether or not a patient will receive high quality health care.[92] States have not always determined whether the necessary and proper structure for Medicaid managed care was in place before implementing their programs. For example, some states have failed to confirm the ability of the existing state MCO infrastructure to handle the often rapid enrollment of a large number of Medicaid beneficiaries.[93] States that do not have a sufficient infrastructure are also those that are likely to have more problems implementing Medicaid managed care. According to A. James Lee of Health Economics Research in Waltham, Massachusetts, "[t]he experience has been highly variable . . . . The states that have not done well tend to be the ones that don't have very well developed managed care systems. You can't simply migrate people into managed care if the providers are inexperienced."[94]

Low commercial MCO participation, which affects access to health care, and therefore quality of care, is another structural problem with Medicaid managed care in many states.[95] In 1986, fewer than one in four federally qualified MCOs enrolled Medicaid recipients.[96] Although the number of participating MCOs is on the rise, it is unclear at this time whether there is a sufficient number to support the entire Medicaid population.[97] There are several reasons why MCO participation may be low. First, MCOs, which are not typically conveniently located near poor areas, do not see the Medicaid population as a viable market.[98] In fact, evidence suggests that the privatization of Medicaid is actually quite profitable for commercial MCOs.[99] Second, commercial MCOs see the Medicaid population as an administratively burdensome population because of their high turnover rate.[100] Longer lock-in periods would help alleviate some of the burden.[101] Third, HMOs find Medicaid rates non competitive as compared to private employers and other

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[91] *Id.* at 19.

[92] *See id.*

[93] *See* Sparer, *supra* note 34, at 454-55.

[94] *See* Alex Pham, *A Case for HMOs*, BOSTON GLOBE, Oct. 31, 1996, at D5.

[95] *See* Anderson & Fox, *supra* note 61, at 82.

[96] *See* Dallek, *supra* note 80, at 972.

[97] *See id.* Many of these MCOs were "newly formed fly-by-night organizations" which experienced higher rates of fraud and abuse. *See id. See also* Sparer, *supra* note 34, at 455-56.

[98] *See* Edward Neuschler, *HMOs and Medicaid: How Can the States Sustain Market Interest?*, 5 BUS. & HEALTH 50, 51 (1988).

[99] *See* Pham, *supra* note 80. In Massachusetts, the privatization of Medicaid would create an $800 million business for the state's HMOs. *See id.*

[100] *See* Neuschler, *supra* note 98, at 51.

[101] *See* Welch & Miller, *supra* note 19, at 635.

consumers.[102] States can therefore improve participation with commercial MCOs by making their rates competitive in the marketplace.[103] Fourth, since Medicaid does not have a single open-enrollment period, as employers do, beneficiaries can enroll in the Medicaid MCO at any time. This is problematic for MCOs because their normal advertising methods, which are targeted directly at a single enrollment date, are less effective with Medicaid beneficiaries.[104]

A recent trend, however, is towards state contracts with "enrollment brokers," who act as liaisons between the state and the MCO, to market the Medicaid managed care program to enrollees.[105] Furthermore, because all the other MCOs contracting with the government would have the same problem competing for enrollees, no single MCO would be at a greater disadvantage. It appears that more MCOs are now participating in state Medicaid managed care programs.[106] In order to continue this trend, it is essential that states maintain reimbursement rates at a level sufficient to ensure MCO profitability.[107]

Although the above-mentioned factors may be valid reasons for MCOs not to participate in Medicaid managed care programs, it is likely that MCOs would nonetheless participate if they felt that to do so would be economically worthwhile.[108] Offering more competitive rates to MCOs might therefore be the proper incentive to entice MCOs to enroll Medicaid beneficiaries.[109] "[T]he quality of these systems is directly linked to the reimbursement levels."[110]

Even in states where the existing MCO infrastructure is sufficient to implement Medicaid managed care, states have not ensured that the contracted MCOs have all the resources necessary for Medicaid beneficiaries. Medicaid patients, particularly pregnant women, children, and patients with chronic illnesses, have special needs which MCOs typically are not prepared to handle. For example, many commercial health plans lack resources such as speciality providers, occupational therapists, and physical therapists.[111] Furthermore, MCOs have little experience in providing long-term care.[112] As the population continues to age, this last factor will become increasingly more important.

Medicaid recipients also have special social needs that influence health status, which MCOs are often structurally unprepared to address. First, MCOs frequently lack staff who speak languages other than English, but language is often a barrier to health care for Medicaid enrollees who do not speak English.[113] Un-

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[102] *See* Neuschler, *supra* note 98, at 51.

[103] *See* Welch & Miller, *supra* note 19, at 635.

[104] *See id.*

[105] *See* Jacobs, *supra,* note 84.

[106] *See* SPARER, *supra* note 6, at 176.

[107] *See id.*

[108] *See* Dallek, *supra* note 80, at 982.

[109] *See id.*

[110] *See id.*

[111] *See* The Robert Wood Johnson Foundation, *supra* note 44, at 3.

[112] *See* Anderson & Fox, *supra* note 61, at 82.

[113] *See* Sparer, *supra* note 34, at 455. *See also* Kathryn Taylor, *The ABCs of HMOs;*

less the MCO has health care providers and staff who speak the client's language, the client will be at a severe disadvantage in understanding the terms and conditions of his managed care plan, communicating health problems to his primary care physician or specialist, and understanding the regimen of care prescribed by the physician.[114] Second, the location of MCO facilities and/or the availability of transportation to health care is a major factor in ensuring that Medicaid beneficiaries receive the proper quality of care.[115] MCOs are not usually located in poor neighborhoods, but rather in communities with a large number of employed persons; thus, Medicaid enrollees often must travel great distances for health care, to their financial and physical detriment.[116] The inconvenience and cost of transportation can prevent Medicaid beneficiaries from receiving necessary care.[117] Several Medicaid enrollees indicated that they must bring many children with them, and the costly bus tokens for each child made getting to a source of care difficult.[118] In some cases, Medicaid will not pay for transportation to a source of care unless the patient arranges for such payment far in advance of a scheduled visit.[119] Even then, reimbursement for bus fare is not cash but a bus token which must be obtained by making a special trip.[120]

b. Process-Based Problems

"Process" is the study of the relationships and activities between patients and providers of health care.[121] Of Donabedian's three determinants, process is the most predictive of quality of care.[122] Medicaid managed care programs could improve in several process-based areas. Fraud and abuse by MCOs or doctors in Medicaid programs, for example, are problems that states are struggling to control. Fraud is a serious problem when a Medicaid managed care program is implemented rapidly or with little planning.[123] This may be because many plans are competing for clients in a deregulated market.[124] One commentator, describing the Arizona experience with Medicaid managed care, stated "[o]ne would not expect a $180 million business with 150,000 customers to set up shop in four

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Medicaid Managed Care Programs Teach Consumers the Basics 'From Every Direction,' HOSPITALS & HEALTH NETWORKS, Nov. 5, 1994, at 53 (discussing Care-Net, Seattle's Harborview Medical Center's HMO, and its effective use of bilingual techniques to enroll new recipients).

[114] *See* Taylor, *supra* note 113.

[115] *See* Pham, *supra* note 94, at D5. *See also* Temkin-Greener, *supra* note 55, at 727-28.

[116] *See* Sparer, *supra* note 34, at 455. *See also* Neuschler, *supra* note 98, at 50.

[117] *See* Temkin-Greener, *supra* note 55, at 727.

[118] *See id.*

[119] *See id.*

[120] *See id.*

[121] *See* FURROW, *supra* note 90, at 18.

[122] *See id.*

[123] *See* Sparer, *supra* note 34, at 433.

[124] *See id.*

months," but that was what Arizona attempted to do.[125] In that type of unregulated environment, it is not surprising that so many states have had trouble with fraud and abuse. Fraud interferes with access to health care and is therefore a problem affecting quality of care.

Although no existing statistics measure the extent of fraud in Medicaid managed care programs, there is a great deal of documented evidence of these occurrences. For example, in California in the early 1970s, consumers complained of unethical marketing tactics and denial of care by prepaid managed care plans.[126] The California plans purposely neglected to keep records and to perform grievance and disenrollment procedures.[127] Subsequently, in Ohio's largest HMO, Health Power, two doctors billed for as many as four hundred patients per day.[128] Based on a seven and one-half hour workday, this amounts to one patient every two minutes.[129] Recently in New York City, officials temporarily suspended a plan to move the city's entire 3.5 million Medicaid population into MCOs after the state received numerous complaints of abuse, including reports of MCOs intimidating people to join.[130] New York State has since prohibited MCOs from soliciting patients door to door or by telephone.[131] Also, in Florida, state officials found that twenty-one of the twenty-nine MCOs doing Medicaid business in the state used fraudulent marketing tactics to enroll new members.[132] The state fined these HMOs and prohibited their enrollment of new members or expansion into new territory until they corrected these problems.[133] States hesitate, however, to permanently bar MCOs which commit such practices, since this would only serve to further obstruct access to care.[134] Douglas M. Cook, director of the Florida Agency for Health Care Administration, which runs the state's Medicaid program, warned the rest of the country of the potential consequences of insufficient planning:

> We announced five years ago that, as a matter of state policy, we would move as many Medicaid patients as we could into managed care . . . . But I'm here to tell you it's not easy. Indeed, it's exceedingly difficult. We didn't realize how difficult it was going to be. We see abuses every day that are egregious.[135]

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[125] *See* Dallek, *supra* note 80, at 981.

[126] *See* Welch & Miller, *supra* note 19, at 620.

[127] *See id.*

[128] *See* Dallek, *supra* note 80, at 975.

[129] *See id.*

[130] *See* Pham, *supra* note 94, at A1.

[131] *See* Mooney, *supra* note 38, at 1.

[132] *See* Robert Pear, *Wide Abuses Follow Medicaid Overhaul*, THE PATRIOT LEDGER, Apr. 24, 1995, at 1.

[133] *See id.*

[134] *See* W. Bradley Tully, *New Intermediate Sanctions are Bad News for Managed Care*, 11 HEALTHSPAN 15 (1994).

[135] *See id.*

MCO and physician contracts are another significant process-based indicator of quality of care because they may prevent doctors from using their natural instincts in treating patients by paying them more if they limit "unnecessary treatments."[136] There is great concern that MCOs and their doctors have financial incentives to provide fewer health care services. Some states have devised creative solutions to ensure that physicians are actually available to patients and not just pocketing their monthly capitation payments.[137] In Michigan, for example, state officials call doctors at unusual times to assure their twenty-four hour availability to patients.[138] While some cost control is acceptable, probably even beneficial, it could adversely affect quality of care if taken too far. In just one example of excessive cost control, an HMO denied of a mother's request to bring her baby, who had a fever, to the hospital emergency room.[139] The doctor told the mother to bring her baby to the doctor's office the next morning instead.[140] The next day the baby was dead.[141] This incident demonstrates the dangers of prioritizing cost control above quality of care.

Good provider communication with patients is another process-based factor influencing quality of care. Medicaid beneficiaries must understand what benefits they should be receiving. If patients do not know that they are entitled to a specific service, they cannot request the service, and the result is the same as having no coverage at all. Thus, MCOs and states must give beneficiaries all the information necessary for them to protect their health and well-being.

Additionally, states must consider that many Medicaid beneficiaries are not well educated and may therefore have trouble understanding complicated written materials normally provided by MCOs.[142] MCOs should ensure that all materials are written in a way that Medicaid enrollees can understand. For example, MCOs should ensure that Medicaid participants understand MCO policies and that participants have the opportunity and know-how to voice complaints. Medicaid beneficiaries in HMOs often do not know where to complain, and fear that if they do complain, they will lose their Medicaid benefits.[143]

Another process-based problem affecting access to health care is discrimination against Medicaid beneficiaries, because of low payment rates to MCOs. Medicaid enrollees are scorned by many of the largest HMOs, which fear that inclusion of the Medicaid population will have an adverse effect on utilization

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[136] *See U.S. Rules Put Curbs on HMO Cost-Cutting Plans,* BOSTON GLOBE, Mar. 28, 1996, at 42 (stating that many HMOs encourage doctors to limit treatments which HMOs consider wasteful, such as expensive surgeries and specialist consultations).

[137] *See* Johnson, *supra* note 81, at 31-32, 34.

[138] *See id.*

[139] *See* Dallek, *supra* note 80, at 977.

[140] *See id.*

[141] *See id.*

[142] *See id.* at 976.

[143] *See* Diane Rowland & Barbara Lyons, *Mandatory HMO Care for Milwaukee's Poor,* 6 HEALTH AFFAIRS 87, 97-98 (1987).

and profits.[144] Doctors and hospitals may also discriminate against patients on Medicaid: plenty of anecdotes exist about long waits in doctors' offices[145] and "premature" discharges from hospitals for Medicaid patients.[146] In a Minnesota survey, more than half of the doctors polled stated that at some time, an HMO refused a doctor-recommended course of treatment to a Medicaid patient.[147] If states paid higher rates to doctors, MCOs and hospitals, it is less likely that such discrimination would exist against Medicaid patients.[148]

c. Outcome-Based Problems

Outcome is the last of Donabedian's three health care quality assessment methods.[149] "[Outcome is] . . . a change in a patient's current and future health status that can be attributed to antecedent health care."[150] This measure focuses on "what works."[151] States should use outcome-based data to determine the efficacy of MCO practices, the level of satisfaction among beneficiaries, and other quantitative questions. States must take any positive feedback from Medicaid beneficiaries with a grain of salt, however, since many Medicaid beneficiaries have never had good care and are therefore not the best judges of the level of care they ought to receive.[152] Currently, although states require MCOs to provide them with encounter data (as a means of judging satisfaction), many MCOs have been lagging since their information systems are not yet up to speed.[153] States can force MCOs to comply through fines or other probationary methods.

2. Children and the Mentally Ill

There is cause for special concern as to the quality of health care received by two especially vulnerable groups within the Medicaid population: children and the mentally ill. Children have the most to lose under Medicaid managed care because they are most often targeted for managed care and are still developing.[154] Little is known about the quality of care provided to children on Medicaid.[155] Medicaid managed care disadvantages low-income children in at least

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[144] *See* Pham *supra* note 80, at A1.

[145] *See* Temkin-Greener, *supra* note 55, at 728.

[146] *See* ODIN W. ANDERSON, HEALTH SERVICES AS A GROWTH ENTERPRISE IN THE UNITED STATES SINCE 1875 258 (1990).

[147] *See id.*

[148] *See* Welch & Miller, *supra* note 19, at 635.

[149] *See* FURROW, *supra* note 90, at 19.

[150] *See id.*

[151] *See id.* at 21.

[152] *See* Joseph Berger, *In Westchester, Welfare Meets Managed Care*, N.Y. TIMES, Sept. 9, 1996, at A1 (stating that Medicaid recipients are largely pleased with HMOs because they "never had much choice to begin with."). *See also* FURROW, *supra* note 90, at 19.

[153] *See* Jacobs, *supra* note 84.

[154] *See* Hughes, *supra* note 63, at 591-92.

[155] *See id.*

one respect: it fails to provide certain services that affect health status but are not considered medical care.[156] For example, low-income children are more likely to experience learning disabilities and to have long-term emotional or behavioral problems.[157] Special services such as psychological support would benefit these children, but traditional managed care plans do not offer such services.[158] Furthermore, in the Medicaid population, where demand for maternity services is high, it may be more difficult for MCOs to enlist the necessary number of obstetricians due to ever decreasing physician payments.[159] States should carefully consider whether children are receiving the support and care needed to promote their health and development.

Similar concerns arise concerning mentally ill patients.[160] For example, in January 1996, the Alliance for the Mentally Ill ("Alliance") in Boston opposed a plan to move mentally ill patients into an HMO, a measure which Governor William Weld's administration said would save taxpayers $25 million in the first year.[161] The Advocates for Quality Care, one of the seven groups in the coalition, feared that a private HMO would have incentives to cut corners, and that the shift to private health care would erode mentally ill patients' rights to doctor/patient confidentiality and adequate legal protections.[162] Furthermore, advocates are concerned about MCOs providing lower cost drugs to patients when therapy, albeit more expensive, would be more effective.[163]

3. The Uninsured Poor

Another factor states have seemingly ignored is the serious indirect effect of the shift to managed care on the uninsured poor. "Abrupt, ill conceived changes [to Medicaid] could result in rips in the safety net."[164] The rise in managed care for the Medicaid population could also impact the public hospitals and health clinics on which the uninsured poor rely for their basic health care needs, the so-called "safety net" providers.[165] As Medicaid beneficiaries enroll in large MCOs, traditional community hospitals and health clinics may lose Medicaid dollars when those MCOs direct enrollees to other institutions with whom the MCOs have contracts.[166] Even if safety net providers do contract with MCOs, it

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[156] *See id.*

[157] *See id.*

[158] *See id.*

[159] *See* Sara Rosenbaum et al., *Incantations in the Dark: Medicaid, Managed Care, and Maternity Care*, 66 MILBANK Q. 661 (1988).

[160] *See* Alison Bass, *Group Hits Contract for Mentally Ill Patients*, BOSTON GLOBE, Jan. 19, 1996, at 35.

[161] *See id.*

[162] *See id.*

[163] *See Drug Treatment for Mentally Ill Reported to Rise*, THE PATRIOT LEDGER, Aug. 10, 1995, at 24.

[164] *See* The Robert Wood Johnson Foundation, *supra* note 44, at 1.

[165] *See id.*

[166] *See id.* at 2.

is unlikely that these MCOs will pay as much as the safety net providers have received for their services in the past.[167] The more MCO payments to safety net providers are reduced, the less able the providers will be to give uncompensated care to uninsureds.[168] If that happens, it is unlikely that MCOs will step in to fill the gap left in the safety net.[169]

B. *Stricter Federal Oversight*

The federal government is largely responsible for ensuring that the Medicaid program conforms to Congress' stated purpose in the Social Security Act to provide health care to the country's poorest citizens. Before the passage of the Balanced Budget Act of 1997, the HCFA was in a strategic position to ensure that states had the necessary resources for a successful conversion to Medicaid managed care, and that the quality of care provided in those programs was high. The Balanced Budget Act of 1997 transferred a great deal of the federal government's power to oversee Medicaid managed care programs to the states. This was a mistake, because now states will be able to implement Medicaid managed care programs with even less attention to possible consequences.

With the waiver process eliminated, the federal government can ensure that quality of care in Medicaid managed care programs remains high by providing sufficient substantive and procedural protections to enrollees. Well-structured grievance and appeal procedures would benefit enrollees by increasing their chances of receiving coverage for a treatment improperly denied.[170] Furthermore, these grievance and appeal procedures would "ensure the integrity of HMO decision-making processes" because they would "encourage fair and accurate coverage determinations."[171]

The Federal HMO Act ("HMO Act")[172] requires that all HMOs contracting with the federal government provide enrollees with "meaningful" grievance procedures and a description of the procedures that is "easily understood by the average person who might enroll."[173] However, HMOs are not required under the HMO Act "to inform and explain procedures to [Medicaid] enrollees, even upon denial of services, except by individual request."[174] The HMO Act also gives HMOs wide discretion both to determine the extent to which they investigate complaints and decide whether there has been a policy violation.[175] Enrollees do

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[167] *See id.*

[168] *See* Mark Schlesinger, *Paying the Price: Medical Care, Minorities, and the Newly Competitive Health Care System*, 65 MILBANK Q. 270, 283 (1987).

[169] *See id.*

[170] *See* Stayn, *supra* note 70, at 1676.

[171] *See id.*

[172] 42 U.S.C. § 300(e)(C)(5) (1988) (requiring that an HMO "be organized in such a manner that provides meaningful procedures for hearing and resolving grievances" between the plan and enrollees); 42 C.F.R. §§ 417.107(g), 417.142(a), 417.143(b)(2) (1992).

[173] *See* Stayn, *supra* note 70, at 1702.

[174] *See id.*

[175] *See id.*

not have the right to appeal for an impartial *de novo* review of an HMO decision.[176] DHHS has the authority to investigate complaints, publish a notice of HMO noncompliance in the Federal Register or revoke qualification of the HMO, but only after "all other remedies have been exhausted."[177]

Furthermore, no system is in place to inform enrollees of these existing procedures.[178] It is unfair that Medicare enrollees of HMOs are entitled to "full, specific explanations for the denials and to administrative review by impartial decision-makers," yet "non-Medicare patients who enroll in the same HMOs lack parallel recourse."[179] The relief received by Medicaid HMO enrollees often depends on state law.[180] However, since the Employment Retirement Income Security Act of 1974 ("ERISA") preempts much state tort or contract law, enrollees cannot rely on state law to obtain relief either.[181] The result is that Medicaid HMO enrollees are often inadequately protected against improper denials of coverage by HMOs.[182] It is incumbent upon the federal government to ensure that proper procedural protections exist to prevent such abuses of HMO discretion.

IV. CONCLUSION

Medicaid managed care has the potential to surpass the quality and accessibility of health care currently received by the Medicaid population under the fee-for-service system. However, rapid enrollment of the Medicaid population into managed care programs without sufficient governmental supervision simply opens the door to fraud and abuse, worsens access to care, and decreases quality of care. Furthermore, such a result would negate any potential cost savings. Thus, it is imperative that federal and state governments carefully consider structure-based components of managed care plans prior to implementing Medicaid managed care programs, process-based components in overseeing the programs, and outcome-based components in reviewing the effectiveness of the programs.

Medicaid managed care is not the cure-all for the nation's health care ills that many people wish it were. It does not provide health insurance to the uninsured, and it will not stop costs from increasing indefinitely. But if the programs are adequately monitored in ways this Note has suggested, it will improve the quality and accessibility of health care for the Medicaid population, while providing modest cost savings.

Lisa Axelrod

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[176] *See id.*
[177] *See id.*
[178] *See id.*
[179] *See id.* at 1690.
[180] *See id.*
[181] *See id.*
[182] *See id.*