COMMENT

THE DOCTOR WILL SEE YOU NOW: MEDICAID MANAGED CARE AND INDIGENT CHILDREN

*Colleen A. Foley**

I. Introduction

Today, over twenty-two percent of American children live at or below the federal poverty level.[1] Nearly one out of every four children — playing on swings, standing on street corners, and sitting in classrooms — is poor.[2] As a society we have addressed this problem through a loosely constructed safety net of publicly and privately funded initiatives designed to meet at least some of the basic needs of our poorest children and their families.[3]

---

* B.A., State University of New York at Plattsburgh (1979); J.D., Seton Hall University School of Law, anticipated May 1997.

1 *See* Paul W. Newacheck et al., *Children and Health Insurance: An Overview of Recent Trends*, 14 HEALTH AFF. 244, 250 (1995). "Between 1988 and 1992 the percentage of children living in poor families rose from 19.7 percent to 22.2 percent - a net increase of 2.3 million children." *Id.*

2 *See id.*

3 *See* Sara Rosenbaum, *Children in Heavy Traffic: Health Status,* Health Policy, and Prospects for Reform, 4 HEALTH MATRIX 129, 130-31 (1994) [hereinafter HEAVY TRAFFIC]. Rosenbaum states, "[i]t is a tenet of American life that the proper role of government in social policy affecting families with children is a last resort intercessor . . . . " *Id.* at 131.

Since 1965 one of the most important of the public programs has been Medicaid, which is a vehicle for financing the health care services provided to some poor children.[4] Modeled on traditional fee-for-service medicine, Medicaid aimed to give certain poor Americans access to a wide range of health care services.[5] While Medicaid has achieved some success in opening up health care services to poor children,[6] it has also become a substantial financial burden at nearly every level of government.[7] As a result, Medicaid has become a target for the 'reform' efforts of public policy-makers.[8]

How these reform efforts will translate in terms of the ultimate structure and funding of Medicaid is currently uncertain. Throughout much of 1996, the President, Congress, and various constituency groups vigorously debated a series of measures to "reform" both welfare and Medicaid.[9] Although a wholesale revamping of Medicaid was eventually dropped by Congress,[10] Medicaid will not remain unchanged. In particular, one point seems quite clear: managed care will become the predominant method for delivering health care services to Medicaid beneficiaries (and probably the population as a whole). Managed care is not a perfect solution either to the problems of the health care system generally, or to the problems of the Medicaid program specifically. Yet on balance, Medicaid managed care does represent a significant opportunity to improve the access of poor children to quality health care services and to introduce a greater degree of fiscal control. Warts and all, managed care is the future of Medicaid.

---

4 *See* Rand E. Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 647 (1975) (reviewing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974)).

5 *See id.* at 647-48.

6 *See* HEAVY TRAFFIC, *supra* note 3, at 143.

7 *See, e.g., Some State Officials Fear Lower Growth Could Jeopardize Momentum For Reform*, HEALTH CARE POL'Y REP., Oct. 14, 1996.

8 *See id.*

9 *See, e.g.*, David Nather and Vandana Mathur, *GOP Leaders Defend Link to Welfare, But Pressure Increases to Split Issues*, HEALTH CARE POL'Y REP., July 1, 1996 (noting that Republican proposals to reform Medicaid and Welfare were combined in a single budget reconciliation package).

10 *See Medicaid Reform Provisions Dropped So House, Senate Take Up Welfare Reform Bill*, HEALTH CARE POL'Y REP., July 22, 1996 (indicating that the Medicaid provisions were removed by Republican leaders to avoid a veto of welfare reform measures by President Clinton).

II. Medicaid Overview

In the United States the notion of providing for the medical needs of the poor, largely in the form of charity care, dates back to the early 1700s with the founding of public hospitals in several larger American cities.[11] Interestingly, the focus of the care provided was not the ill patient, but rather the protection of the healthy population from contagious disease.[12] By the mid-nineteenth century, a supplemental purpose of charity care had developed: to aid medical education by providing a stream of patients who could serve as "teaching material."[13]

In the wake of the Depression and prior to 1965, there was a gradual expansion of federal funds to assist states in paying for the health care needs of the poor and elderly.[14] An example of this trend was the Hill-Burton Act[15] which conditioned the grant of federal funds for the construction of hospitals on the grantee hospital promising to provide a "reasonable volume" of charity care.[16] An-

---

11 *See* Rosenblatt, *supra*, note 4, at 644. Public hospitals were established at that time in Philadelphia, Charleston, and New York. *Id.* Private hospitals dedicated to the poor were established in the 1750s. *Id.* One commentator asserts that the first federal public health measure was proposed by George Washington when he sought approval to convene Congress outside of Washington during an epidemic of yellow fever—not surprisingly the measure met with little opposition. *See also* Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334 (1970).

12 *See* Rosenblatt, *supra* note 4, at 644. The author also suggests that the purpose of charitable care was to insulate the financially well-off from the "socially disruptive poor." *Id.*

13 *Id.* at 644. The author points out that charity patients were perceived to "pay" for the services provided to them by agreeing to act as educational subjects. *Id.* at 644-45 n.8 (citations omitted). Rosenblatt concludes that "the institutional pattern as a whole was designed to extract the maximum advantage for medical education and the health of the well-off citizens with minimal public investment for the poor." *Id.* at 645.

14 *Id.* at 645. The Social Security Act of 1935 provided financial assistance to the elderly, the blind, and to dependent children. *Id.* In 1950, individuals who were totally and permanently disabled were also provided with federal financial assistance. *Id.*

15 Hill-Burton Act, ch. 958, § 2, 60 Stat. 1041 (codified at 42 U.S.C. §§ 291-291(o) (1970)). Hill-Burton Act is the popular name for the Hospital Survey and Construction Act of August 13, 1946. *Id.*

16 42 U.S.C. § 291(e) (1991). However, Rosenblatt asserts that the lack of federal action to establish standards against which to measure compliance or to engage in even minimal enforcement efforts seriously undermined the value of the Hill-Burton Act as a vehicle for providing health care for the indigent. Rosenblatt, *supra* note 4, at 645-46.

other example, the Kerr-Mills Act,[17] provided for a system of open-ended matching federal grants to pay for the medical and hospital costs of certain categories of the indigent elderly.[18]

It was against this legislative patchwork that Congress enacted the Medicaid program, along with the Medicare program, in amendments to the Social Security Act of 1965.[19] While some liberal policy-makers and observers apparently hoped Medicaid was a tentative first step toward comprehensive national health insurance, others perceived a more pragmatic rationale for the program.[20] It seems clear that Medicaid offered, at least partially, a compromise attempt by members of Congress to garner sufficient votes to enact Medicare.[21] At the time, conservative southern Democrats as well as some Republicans disagreed with the universal coverage approach taken in Medicare.[22] The legislators agreed to support Medicare on the condition that other Democrats support the Republicans' Medicaid program.[23] Many legislators undoubtedly saw Medicaid as a way to further increase the federal funding which had begun to flow under Kerr-Mills.[24] At the time, the nation's, and certainly Congress's, attention focused largely on Medi-

---

17 Pub. L. No. 86-778, 74 Stat. 987 (1960). Congressman Wilbur Mills was one of the sponsors of the legislation. Rosemary Stevens & Robert Stevens, *Medicaid: An Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 354 (1970).

18 *See* Rosemary Stevens & Robert Stevens, *Medicaid: An Anatomy of Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 359-62 (1970) (describing the multi-year legislative process shaped by the differing viewpoints of Representatives Mills, King, Herling, Byrnes, and Curtis).

19 Pub. L. No. 89-97, 79 Stat. 286 (1965). Medicaid is codified as Title XIX and Medicare is codified as Title XVIII of the Social Security Act. *Id.*

20 *See* Rosemary Stevens & Robert Stevens, *Medicaid: An Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348 (1970).

21 *See* Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1, 3-4 n.2 (1983).

22 *See* Henry J. Aaron & Robert D. Reishauer, *The Medicare Reform Debate: What Is the Next Step?*, 14 HEALTH AFF. 8, 9-10 (1995). Some commentators have suggested that among those advocating an expanded program of federal funding of medical services for the poor were health care vendors and the individual states. Stevens & Stevens, *supra* note 20, at 354-62. Under Kerr-Mills, both groups benefited by having the federal government assume partial financial responsibility for the costs of charity care which they had previously shouldered alone. *Id.* at 355-56. The authors point out that the reimbursement formula used in Kerr-Mills, and transplanted to Medicaid, favored low-income states (including those of the two sponsors of the measure). *Id.* at 354.

23 *See* Aaron & Reischauer, *supra* note 22, at 9-10.

24 *See* Wing, *supra* note 21, at 4 n.2.

care.[25] As a result there were no committee hearings and only minimal debate on the Medicaid legislation.[26]

In fact, the Medicare-Medicaid package appears to have been a calculated response on the part of Congressman Wilbur Mills (D-Ark), then chairman of the House Ways and Means Committee, to concerns raised by varying constituencies including the American Medical Association and Social Security Administration officials.[27] By constructing a benefits package which addressed several competing interests and ideologies in one comprehensive piece of legislation, the members of the House Ways and Means Committee gave a little something to everyone, neutralized opposition, and thus ensured passage of the bill.[28] Some commentators contend that the Medicaid statute was little more than "Kerr-Mills applied to a much wider audience: an extension of state welfare provisions rather than a new health service program."[29] Regardless of whether or not Medicaid was specifically modeled on Kerr-Mills, it came to be understood as a welfare program rather than an insurance plan (as Medicare was, and is, perceived). The significant consequences of Medicaid being perceived as a welfare program will be explored throughout this comment.

Since its inception, Medicaid has been primarily concerned with increasing access of specific disadvantaged groups to mainstream medicine.[30] Today, Medicaid exists as a largely state-run vehicle for the federal and state financing of medical costs for certain poor or disabled persons.[31] Medicaid is but one illustration of the

---

25 *See* Wing, *supra* note 21, at 4 n.2.

26 *See Wing, supra* note 21, at 3-4 n.2. Wing points out that some critics contend that Medicaid was not well or fully understood by Congress when it was first enacted. *Id.* The author notes that Medicaid appears to have been more of an afterthought, and that it was amended into Medicare legislation only after debate had begun on Medicare. *Id.*

27 *See* EDWARD BERKOWITZ & KIM MCQUAID, CREATING THE WELFARE STATE: THE POLITICAL ECONOMY OF TWENTIETH-CENTURY REFORM, 212-13 (1988). Apparently, some social security officials were inclined toward some form of national health insurance which would have covered the working population, but deemed it more politically realistic to limit coverage to individuals who had already retired. *Id.*

28 *See* Stevens & Stevens, *supra* note 20, at 359-62.

29 *Id.* at 362.

30 *See* Report of the Advisory Committee on Intergovernmental Relations, *Medicaid: Intergovernmental Trends and Options, reprinted in* Medicare & Medicaid Guide (CCH) 40,371A, at 31,464 June, 1992 [hereinafter *Medicaid Trends*].

31 *See* R.A. Zaldivar, *Parties take gentler stands on Medicaid; "Ways to do things in a bipartisan spirit!"*, HOUSTON CHRONICLE, Oct. 20, 1996, at A6.

concept of "cooperative federalism" in which programs are designed, implemented and administered by individual states using federal funds and following federal guidelines.[32] In this critical way Medicaid differs from its sister program, Medicare, which is run by the federal government.[33]

State participation in Medicaid is optional,[34] and requires development of a state plan which meets federal statutory requirements and is approved by the federal Health Care Financing Administration (HCFA).[35] Operating within federal guidelines, each state has considerable flexibility to determine eligibility criteria, covered benefits, provider reimbursement rates, and program administrative and financial structures.[36] Unless granted a waiver by HCFA, however, state Medicaid plans must meet certain basic programmatic requirements, including assurances that: services provided will be comparable between eligible groups, recipients will be able to select any participating provider, service coverage will be consistent across the state, and the amount, duration, and scope of services will be sufficient to achieve their purpose.[37]

For its part, the federal government is responsible for setting broad program policies, monitoring state compliance, and providing matching funding.[38] The actual funding of Medicaid is one of the more straightforward aspects of the program. The federal government helps states pay for Medicaid services through the use of a matching formula which is subject to annual adjustments.[39] "The federal share of a state's Medicaid payments is called the Federal Medical Assistance Percentage (FMAP) and is determined through a statutory formula that takes into account the state's per capita

---

32 *See* C. David Flower, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage*, 79 MINN. L. REV. 1233, 1236 n.12 (1995).

33 *See* Flower, *supra* note 32, at 1236 n.3.

34 *See* 42 U.S.C. § 1396 (1991 & Supp. 1996). Flower notes that all states participate in Medicaid, although Arizona is a recent addition. Flower, *supra* note 32, at 1236 n.14.

35 *See* 42 U.S.C. §§ 1396, 1396(a), 1396a(b), 1396b(a) (1991 & Supp.V 1996).

36 *See Medicaid Trends*, *supra* note 30, at 31,464.

37 *See id.* at 31,474.

38 *See* 42 U.S.C. § 1396b(a) (1991 & Supp.V 1996). The future role of the federal government is one of the major issues at stake in the current debate over Medicaid reform.

39 *See* MADELYN DEWOODY, MEDICAID AND SUPPLEMENTAL SECURITY INCOME: OPTIONS AND STRATEGIES FOR CHILD WELFARE AGENCIES, 11 (1991).

income in relation to the national per capita income."[40] For fiscal year 1996, reimbursement levels ranged from a minimum of fifty percent of the program's costs (in the highest income states, e.g., New Jersey) to a high of seventy-eight percent (in lowest income states, e.g., Mississippi).[41]

The federal government also administers a waiver process.[42] Under the statute and current regulations, states must obtain waivers from the federal government in order to deviate from certain basic regulatory requirements.[43] Today, the Clinton Administration encourages states to use the waiver process to restructure their Medicaid programs.[44] In the wake of the failure of national health care reform, the waiver program presents a backdoor opportunity for the states and the Clinton Administration to revamp this element of the health care delivery system without input from Congress.[45]

III. Medicaid Eligibility

Medicaid, while theoretically simple, in practice comprises an intricate web of state and federal regulations which seem almost designed to obscure and confuse. Chief Justice Burger characterized the Medicaid statute as "a morass of bureaucratic complexity."[46] The Medicaid eligibility provisions are a striking example of the degree of that complexity. Medicaid is a means-tested program which creates two fundamental groups that are eligible under the program: the "categorically needy" and the "medically needy."[47]

The "categorically needy" group is further subdivided into the "mandatory categorically needy" and the "optionally categorically

---

40 *Id.*

41 *See Medicaid: Federal Medical Assistance Percentages, reprinted in* Medicare & Medicaid Guide (CCH), 43,064, at 43,362 February, 1995.

42 *See* 42 U.S.C.A. § 1396(n) (1991 & Supp. 1996).

43 *See id.*

44 *See Statewide Managed Care Demonstrations Spreading Rapidly, Despite Resistance,* HEALTH CARE POL'Y REP., Oct. 10, 1994.

45 *See infra* notes 126-35 and accompanying text.

46 *See* Herweg v. Ray, 455 U.S. 265, 279 (1982) (Burger, C.J. dissenting). A number of jurists have indulged in their own bits of rhetoric when commenting on Medicaid. My personal favorite describes the statute as a "Serbonian Bog." Feld v. Berger, 424 F. Supp. 1356, 1357 (S.D.N.Y. 1976); Robert L. Schwartz, *Medicaid Reform Through Setting Health Care Priorities,* 35 ST. LOUIS U. L.J. 837 (1991).

47 *See Medicaid Trends, supra* note 30, at 31,472.

needy."[48] States are required to offer Medicaid coverage to the "mandatory categorically needy" which includes individuals who receive cash benefits through either Aid to Families with Dependent Children (AFDC)[49] or Supplemental Security Income (SSI).[50] Additionally, individuals who are blind or suffer from severe disabilities are "categorically" eligible for Medicaid.[51] Medicaid defines the "optionally categorically needy" group to include individuals who are financially eligible for AFDC or SSI but fail to qualify for other reasons: states have discretion to include or exclude these individuals from Medicaid.[52]

Coverage of individuals who satisfy the "medically needy"[53] cri-

---

48 *See* 42 U.S.C. § 1396a(10)(A) (Supp.I 1991); 42 C.F.R. 435.4 (1993). The "categorically needy" group is made up of financially needy families, qualified pregnant woman and children as defined in § 1396(d) and groups of individuals chosen by the state. *Id.*

49 42 U.S.C. §§ 601-617 (1991 & Supp.V 1996). It should be noted that AFDC eligibility requirements differ significantly among the states because states have the discretion to set those limits. *Medicaid Trends, supra* note 30, at 31,472-73. "In 1993, the qualifying level for AFDC varied across states from 17 to 93 percent of the federal poverty level, which in 1993 was income of $11,890 for a family of three." General Accounting Office Report, *Medicaid: Program Reinvention, reprinted in* Medicare & Medicaid Guide (CCH), 43,184, at 43,853 n.3 [hereinafter *Reinvention*].

50 42 U.S.C. §§ 1381-1383d (1991). Section 1396a(f) permits states that are "'section 209(b) states' to use more restrictive criteria for eligibility than the SSI criteria." Flower, *supra* note 31, 1238 n.25 (1995). Otherwise the federal government determines uniform eligibility standards for SSI. *See Medicaid Trends, supra* note 30, at 31,473.

51 *See* 42 U.S.C. § 1396d(q)(2) (1991 & Supp. 1996). Flower notes that this provision positions Medicaid as a major source of health care for the disabled. Flower, *supra* note 32, at 1238 n.26 (citation omitted). "In fiscal year 1992, approximately 4.4 million persons received Medicaid coverage on the basis of blindness or disability." *Id.*

52 *See* Flower, *supra* note 32, at 1237-38 n.23. The author suggests this category is used in states with more restrictive eligibility criteria for AFDC as a means of expanding "Medicaid coverage to individuals who do not meet state criteria for AFDC eligibility but who would qualify if the state extended AFDC eligibility to the full extent allowed by federal law." *Id.*

53 *See* 42 U.S.C. § 1396a(a)(10)(C) (1991 & Supp. 1996); 42 C.F.R. 435.1(e)(3) (1993). If a state chooses to provide medical assistance for any group of individuals described in § 1396a(A) or (E), than the state plan must include:

> (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income pro-

teria is optional on the state level, and each state has significant flexibility in setting eligibility requirements within federal guidelines.[54] Generally, the income and resources of medically needy recipients are too high to qualify for AFDC or SSI eligibility criteria, but are insufficient to meet medical costs.[55] Typically, individuals in this category attempt to "spend down" their assets on medical care in order to qualify for Medicaid.[56] This situation occurs most frequently in the case of disabled or elderly individuals who require some form of long-term institutional care such as a nursing home.[57]

What is perhaps most striking about Medicaid eligibility is not just its complexity, but its lack of uniformity. Unlike Medicare, which is much more akin to a national insurance plan, Medicaid clearly follows a welfare model.[58] As a welfare program, rather than a national insurance plan, the states have significant power to shape Medicaid (unlike Medicare) — a fact which seems in keeping with their traditional role in the public welfare area.[59] However, by permitting the states to exercise broad discretion within

---

> gram in the case of groups consisting of aged, blind, or disabled individuals in the State in which such program is in effect, and which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups[.]

Id.

54 *See* 42 C.F.R. 435.811 (1993). The Code of Federal Regulations provides a framework which a state may follow to determine eligibility of medically needy individuals. *Id.*

55 *See* Flower, *supra* note 32, at 1238 (*citing* 42 C.F.R. 435.4 (1993)).

56 *See* Flower, *supra* note 32, at 1238. "In 1993, 15 states did not extend coverage to any serious deemed 'medically needy' (Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota, and Wyoming)." *Id.* at 1239 n.32. (citing House Commission on Ways and Means, 103rd Cong., Sess., Overview of Entitlement Programs: 1994 Green Book 798 (1994)).

57 *See* Flower, *supra* note 32, at 1238 n.30. (noting that the per capita spending for the medically needy is nearly twice that of the categorically needy—largely as a result of the high cost of institutional care for the elderly).

58 *See* Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 856-57 (1990). Congress created the Medicare and Medicaid programs by borrowing from two basic models in the Social Security Act. *Id.* at 856. By choosing the welfare model for the Medicaid program's basic design, Congress intended that the states and federal government would jointly administer this program, that state and general revenue would finance it, and that eligibility would be beyond a means test. *Id.*

59 *See id.* at 859.

prescribed federal guidelines, the federal government has created a regulatory structure which, in its current form, leads inevitably to significant disparities in eligibility across states.[60] Thus, individuals who are similarly situated routinely find themselves treated quite differently depending on the eligibility requirements of their individual state's Medicaid program.[61]

For children, this regulatory framework had serious implications and demonstrated their vulnerability to both economic and public policy shifts. During the early 1980's, the United States experienced a significant economic recession which caused many families to lose their employment-based health insurance.[62] At the same time, the Reagan Administration enacted major benefit cuts in the AFDC and Medicaid programs.[63] As a result, the need for Medicaid coverage was expanding while eligibility was contracting and the health status of low-income children began to deteriorate.[64]

Beginning in 1984, Congress enacted a series of Medicaid expansions that altered the eligibility requirements for poor children — expanding eligibility for Medicaid coverage beyond the narrow bounds of AFDC eligibility.[65] While state Medicaid programs must cover all AFDC recipients, Medicaid coverage also extends to chil-

---

60 *See id.* at 857. Professor Kinney notes that the use of the welfare model in shaping the Medicaid program has resulted in great disparity among state programs. *Id.* Not only has this disparity among state programs led to significantly different eligibility requirements, it has also helped to explain the difference between Medicaid expenditures for states of similar size. *Id.* For example, "in 1985, New York with 16 million people spent $75 billion on its Medicaid program and Texas, with a population of comparable size, spent only $1.4 billion." *Id.*

61 *See* Kinney, *supra* note 58, at 857. (citations omitted).

62 *See* Heavy Traffic, *supra* note 3, at 144.

63 *See* Heavy Traffic, *supra* note 3, at 144.

64 *See* Heavy Traffic, *supra* note 3, at 144. The impact of these changes cannot be understated. For example, one government study noted that over 400,000 families lost their AFDC, and thus Medicaid coverage. *See* An Evaluation of the 1981 AFDC Changes: Final Report, Publication No. GAO/PEMD-85-4. Gaithersburg, MD, U.S. General Accounting Office, July 2, 1985.

65 *See Heavy Traffic, supra* note 3, at 145-46. Rosenbaum notes that policy-makers were particularly sympathetic to the working poor, whose incomes were insufficient to participate in the private insurance market, but otherwise too high to qualify for public assistance. *Id.* at 145. Rosenbaum suggests that the legislation passed largely because there was, at the time, no interest in large-scale health reform, and the cost of services to children was relatively inexpensive. *Id.* Rosenbaum asserts that legislators "[ ]were aided in their efforts by a large constituency of children's advocates, state- and local-elected public officials, and the religious movement, in particular the Cath-

dren through age five who live in families with incomes up to 133% of the federal poverty level.[66] States have the option of expanding coverage to pregnant (or postpartum) women and infants under age one who live in families with incomes up to 185% of the federal poverty level.[67] In addition, children ages six through eighteen, who were born after September 30, 1983, and who live in families with incomes below the federal poverty level are gradually being phased into the program.[68] Some of the recent reform efforts would jeopardize the eligibility expansions of the 1980's by granting states increased discretion in the setting of eligibility requirements and by canceling the phased-in expansions for older children.[69] While these proposals did not come to fruition, they may be replaced by other initiatives, and advocates for poor children may find themselves battling simply to maintain the eligibility gains of the 1980's.

IV. Medicaid Benefits

Medicaid also employs a two-tier approach to covered services by classifying certain services as mandatory and others as optional.[70] Specifically, the Medicaid statute requires that "categorically needy" recipients receive the following categories of services:

---

olic church, which took up the cause of child health and loaned its assistance in warding off restrictive abortion funding amendments." *Id.*

66 *See* 42 U.S.C.A. § 1396a(1) (1991). *See* Sara Rosenbaum, *Rationing Without Justice: Children and the American Health System*, 140 U. PA. L. REV. 1859, 1876 n.79 (1992) [hereinafter *Rationing*].

67 *See* Jenifer D. C. Cartland et al., *A Decade of Medicaid in Perspective: What Have Been the Effects on Children?*, 91 PEDIATRICS 287, 288 (1993). This option was first proposed in the late 1980's. *Id.* At that time, Congress adopted a series of modifications to the financial and family structure eligibility requirements relating to children. *Id.* While many of these modifications required states to conform with federal mandates, some of these modifications still allowed states to excuse broad discretion with respect to who received coverage. *Id.*

68 *See* Cartland, *supra* note 67, at 288. While expanding eligibility for Medicaid, Congress also strengthened the program's mandatory preventive benefit for children—"the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program." *Id.*

69 *See* News Release and Policy Statement by the National Governors' Association, *Governors Reach Bipartisan Agreements on Medicaid, Welfare, and Federal Employment and Training Programs at NGA Winter Meeting*, at 9 (February 6, 1996). For example, the proposal sponsored by the National Governors' Association would cancel the eligibility phase-in for children between the ages of 12 and 18 and also allow states to develop their own definitions of covered disabilities. *Id.*

70 *See* 42 U.S.C. §§ 1396d(a)(1)-(24) (1991 & Supp. 1996).

inpatient and outpatient hospital services; laboratory and x-ray services; services of a physician, midwife, and certified nurse practitioner; nursing home services; family planning services; and early periodic screening, diagnosis, and treatment (EPSDT) for children under twenty-one.[71] It is important to note, however, that some courts have permitted states to restrict mandatory services, so long as those restrictions are not unreasonable or arbitrary.[72]

As for optional services, states have enormous discretion to develop their own unique blend of covered services.[73] Included in the optional services category are prescription drugs, clinic services, prosthetic devices, hearing aids, and intermediate care facilities for the mentally retarded.[74] While states can theoretically decide not to provide any optional services, all states do provide at least some of them.[75] States have the further discretion to exclude the "medically needy" from use of optional services.[76] However, once a state decides to extend optional services to the medically needy, it is required to offer a basic package of services, that must

---

71 *See* Flower, *supra* note 32, at 1240 n.38 (citing 42 U.S.C. §§ 1396d(a)(1)-(5), (17), (21)). Flower notes that the statute defines mandatory services by broad groups, rather than specifying exact procedures. *Id.*

72 *See generally* Flower, *supra* note 32, at 1241-42 nn. 48-49. While Flower states this proposition quite broadly, a review of the cases cited suggests that the courts permit limitations as to the amount or duration of mandatory services—not the elimination of those services. *Id.* at 1242-43 nn.49-52 (citations omitted). For example, the Court of Appeals for the Fourth Circuit permitted South Carolina to limit each state Medicaid beneficiary to no more than 12 days of covered inpatient hospital visits each year. Charleston Memorial Hosp. v. Conrad, 693 F.2d 324, 328-30 (4th Cir. 1982). The court pointed out that Medicaid only required that the provided service be adequate to meet the needs of most Medicaid beneficiaries. *Id.* at 330. Additionally, the Supreme Court has recognized "a State's long-standing discretion to set otherwise reasonable Medicaid coverage rules . . . ." Alexander v. Choate, 469 U.S. 287, 307 n.32 (1985).

73 *See* Flower, *supra* note 32, at 1240. For example, some states offer optional services to "categorically needy" recipients, but not to "medically needy" recipients. *Id.* at 1241 n.42.

74 *See* Kaiser Commission on the Future of Medicaid, *Medicaid Facts: The Medicaid Program at a Glance*, 1 February, 1995.

75 *See* Flower, *supra* note 32, at 1240-41 n. 42. "State coverage of optional services ranged from a low of 14 covered services (in Alabama, Georgia, and Louisiana) to 30 (in California and Wisconsin)." *Id.* at 1241 n.42.

76 *See* Flower, *supra* note 32, at 1240-41. "Title XIX requires states, however, to insure that services to the categorically needy are at least as extensive as those offered to the medically needy, and prohibits states from making distinctions among recipients qualifying as categorically needy." *Id.* at 1241 (citing 42 U.S.C. 1396a(a)(10)(B) (1988)).

include prenatal care and birth delivery services, and certain institutional services for mentally ill or mentally retarded.[77]

As noted earlier, permitting states to exercise broad discretion (and essentially employ a menu approach to constructing a package of covered services) has significant implications for the Medicaid program; similarly situated individuals can easily find themselves entitled to very different services depending on where they live.[78] Fortunately for children, a number of the services which are required to meet their basic health care needs are included as mandatory.[79] However, many other services which are clearly critical to providing care for children with more specialized needs (eg., rehabilitative care, case management, and inpatient psychiatric services) are considered optional.[80]

In addition to mandatory services such as physician and hospital care, arguably the most powerful health care tool available to children under the Medicaid program is the EPSDT.[81] Congress designed EPSDT to provide comprehensive health screening and treatment services to Medicaid eligible children under the age of twenty-one in order to detect and ameliorate their physical or mental conditions.[82] The EPSDT program entitles children to a broad range of vision, dental, hearing and screening services provided at reasonable intervals by qualified practitioners.[83] The requirements of the EPSDT program are extensive, as an examination of the screening requirement illustrates.[84] Under the

---

77 *See* Flower, *supra* note 32, at 1241 n.42.

78 *See* Kinney, *supra* note 58, at 857. "Because states have great flexibility in structuring eligibility, benefits, coverage, and payment policies, the Medicaid program is really 50 very different programs serving different populations and providing different benefits." *Id.*

79 *See infra* notes 81-93 and accompanying text discussing these important services under the EPSDT requirement.

80 *See* DEWOODY, *supra* note 39, at 15-17.

81 42 U.S.C. § 1396d(r) (Supp. IV 1992). The EPSDT was added to Medicaid in 1967 and improved use of the program was mandated in 1989. *See* Maija L. Selby et al., *Increasing Participation by Private Physicians in the EPSDT Program in Rural North Carolina*, 107 PUB. HEALTH REP. 561 (1992).

82 *See* Selby et al., *supra* note 81, at 561. This provision was created by the 1967 Amendments to the Social Security Act. *Id.*

83 *See* 42 U.S.C. § 1905(r) (1991).

84 *See Exhibit A Expected Improvement in EPSDT Participation*, Medicare & Medicaid Guide (CCH), 14,551.17, at 6271-5. New Jersey's participation rate was 11 percent. *Id.* at 6271-6. That EPSDT requirements are so comprehensive may partially explain the wide disparity among states in EPSDT participation rates: it may be difficult to

screening element of EPSDT, a child would be entitled to a comprehensive physical exam including a detailed medical and developmental history, routine immunizations, and laboratory tests. An example of one important series of laboratory tests is evaluation of lead levels in the bloodstream.[85]

In addition to comprehensive diagnostic services, EPSDT also requires treatment of identified health care conditions.[86] What makes EPSDT so extraordinarily powerful is that in theory, states are required to provide the prescribed follow-up services even when those same services would not be otherwise covered by the state Medicaid program.[87] The state must provide services that are federally allowed and medically necessary — regardless of whether or not the state provides those same services to other Medicaid recipients.[88] The federal regulations also require states to include partial screening providers, interperiodic screening coverage, and screening at minimum of eighty percent of all eligible children by 1995.[89] Thus, for poor children EPSDT essentially mandates the provision of necessary health care, and potentially unlocks a treasure trove of vital medical resources. Yet, despite the comprehensive and generous nature of the program, EPSDT has fallen short of complete success.[90] While studies have demonstrated that EPSDT can improve children's health,[91] as few as thirty-one to thirty-seven percent of all children eligible receive EPSDT screenings in the United States.[92] Clearly, if the EPSDT program were

---

find enough providers to deliver the requisite number of services. *Id.* The 1989 participation rates ranged from 7 percent in Delaware to 94 percent in Colorado. *Id.*

85 *See* 42 U.S.C. § 1905(r) (1991). The regulations prescribe particular services and require that they meet reasonable professional standards as determined by professional health care organizations. *Id.*

86 *See* 42 U.S.C. § 1905(r) (1991).

87 *See* Paul W. Newacheck, *Improving Access to Health Care for Children, Youth, and Pregnant Women*, 86 PEDIATRICS 626, 628 (1990). Newacheck's commentary focuses on the financial barriers to health care. *Id.* Although private health insurance is the primary manner of financing health care costs, the author points out that some who are financed by private insurance still encounter serious problems obtaining required health services. *Id.*

88 *See id.*

89 *See* Samuel S. Flint et al., *Children's Medicaid Entitlement: What have We Got to Lose?*, 96 PEDIATRICS 967, 968 (1995).

90 *See generally,* Selby et.al., *supra* note 81.

91 *See* Selby et al., *supra* note 81, at 561 (citations omitted).

92 *See* Selby et al., *supra* note 81, at 561 (citations omitted). Selby suggests that a major factor in the low rate of EPSDT is the small number of private physicians who

more widely implemented, it would be a major health benefit to poor children.[93] EPSDT will be discussed in the context of Medicaid managed care later in this comment.

V. Health Status of Indigent American Children

While the scope of this comment precludes a comprehensive review of the health status of poor children, it is important to have some understanding of the relationship between poverty and health, and the extent to which the health care needs of the poor differ from those of the general population. Additionally, this basic understanding constitutes an important element in assessing the appropriateness and scope of the services offered and available to the poor.

In 1989, over 12.6 million children, or approximately one in five, lived at or below federal poverty levels.[94] Just three years later, that number had grown to 14.6 million, of which one-quarter were children under age six.[95] From 1969 through 1993, the number of children under age eighteen living in poverty grew by 56.4%, while the number of poor children under age six, swelled by 63.4%.[96]

Poverty impacts children's health in two distinct and interrelated ways.[97] First, living in poverty increases a child's exposure to a broad range of environmental risks and social conditions which increases the risk of death or disability.[98] Second, poor children are more likely to have inadequate health insurance and live in communities that are underserved by health care resources.[99] In

---

provide the screening service. *Id.* Reasons cited by these physicians are low reimbursement levels and a perception of significant bureaucratic constraints. *Id.*

93 *See generally,* Melden, *infra* note 152; and *see also* Hughes et al., *infra* note 170 for a discussion of EPSDT in the context of Medicaid managed care.

94 *See Rationing, supra* note 66, at 1860 (citing CLIFFORD M. JOHNSON ET AL., CHILDREN'S DEFENSE FUND, CHILD POVERTY IN AMERICA, 5 (1991)).

95 *See Heavy Traffic, supra* note 3, at 132 (citations omitted). Rosenbaum notes that these figures were even higher for black and Latino children—46.6% and 39.9% respectively who lived below the poverty line. *Id.*

96 *See Heavy Traffic, supra* note 3, at 132 (citations omitted).

97 *See Rationing, supra* note 66, at 1861.

98 *See Rationing, supra* note 66, at 1861. Not surprisingly, studies have suggested that adult health status is not only a function of current socioeconomic status, but also of the long-term consequences of socioeconomic status early in life—including childhood. *See* David R. Williams & Chiquita Collins, 21 ANN. REV. SOC. 349 (1995).

99 *See Rationing, supra* note 66, at 1861.

other words, poor children are more likely to be sick and less likely to be able to do anything about it.

A review of the health status of poor children compared to the general population of children illustrates a significant fact: poor kids are sicker than other kids.[100] This is true both in terms of the frequency and the seriousness of the illness.[101] Specifically, poor children have a two to three times greater likelihood that they will be of low birth weight,[102] have delayed immunizations, get bacterial meningitis, be exposed to lead poison, and contract rheumatic fever.[103] Low-income children are more likely to have vision, dental, speech, and behavioral problems.[104] Poor children also have a higher incidence of asthma[105] — the most prevalent chronic illness that affects American children today.[106] Teenaged girls in poor urban communities have an increased risk of pregnancy.[107] For poor black male adolescents living in inner cities, violence is the leading cause of death.[108] Finally, the poor have the highest rates of neonatal and infant mortality.[109] It is this generally compromised

---

100 *See* Barbara Starfield, *Childhood Morbidity: Comparisons, Clusters, and Trends*, 88 PEDIATRICS 519, 522 (1991).

101 *See id.* The author notes that poor children experience three to four times greater risk of serious problems than other children. *Id.* "This is the case for illness progressing to death, for injuries progressing to death, for complications of various illnesses, for severely impaired vision, and for severe iron-deficiency anemia." *Id.*

102 *See Heavy Traffic*, *supra* note 3, at 135. Low birth weight (LBW) is one of the leading causes of infant death. *Id.* "In 1991, disorders relating to short gestation and LBW were the primary cause of death among black infants and the third leading cause among white infants." *Id.* Low birth weight babies also have a greater risk of having other long term health problems including cerebral palsy, mental retardation, and autism. *Rationing*, *supra* note 66, at 1862 (citing INSTITUTE OF MEDICINE, PREVENTING LOW BIRTHWEIGHT, 31-32 (1985)). *See also* Ellice Lieberman, *Low Birth Weight—Not a Black-and-White Issue*, 332 NEW ENG. J.MED. 117 (1995).

103 *See* Starfield, *supra* note 100, at 521.

104 *See* Starfield, *supra* note 100, at 521.

105 *See* Neal Halfon & Paul Newacheck, *Childhood Asthma and Poverty: Differential Impacts and Utilization of Health Services*, 91 PEDIATRICS 56 (1993). The authors note that the differential between poor and non-poor children is most significant for children under age six (4.2% poor compared to 3.1% non-poor). *Id.* at 57.

106 *See id.* at 56.

107 *See* Robert M. Kliegman, *Child Health and the Underclass*, 89 PEDIATRICS 710, 711 (1992) (citations omitted) (noting that 66% of teenage mothers living in the inner city do not finish high school, and thus increase the likelihood that they and their children will continue to live in poverty). *Id.*

108 *See id.* (citing N.Y. TIMES, July 17, 1990 at A10).

109 *See id.* "Postneonatal death rates from sudden infant death syndrome, unintentional injuries, burns, diarrhea, and respiratory infections are related inversely to in-

health status that poor children bring to Medicaid.[110]

VI. Overview of Medicaid Problems

Even the most cursory analysis of Medicaid reveals that a number of significant problems exist with the program. While some of these problems seem directly attributable to the present design and administration of Medicaid, others appear to be more endemic and result from the way American health care is delivered. Among the broader systemic problems is the preference among physicians for specialty practices,[111] rather than primary care practices, the lack of health care resources in urban and rural areas, and the absence of universal health insurance coverage (public or private). Although these issues have an impact on the Medicaid program, they also have an effect on many others seeking health care. Thus, in order to effectively revamp Medicaid, all of the problems and inefficiencies in the general health care system must be addressed as well. In the wake of President Clinton's failed efforts to reform health care, the prospect for any type of truly comprehensive health care reform seems very remote.

Since its inception in the mid 1960's, one of the primary goals of the Medicaid program has been to increase the access of certain poor Americans to necessary health care services.[112] In fact, structuring Medicaid on a traditional fee-for-service model was intended to specifically help integrate the poor into the mainstream health care delivery system by removing financial barriers to care.[113] After thirty years, Medicaid has improved the access of poor children to medical services.[114]

---

come." *Id.* at 711 (citations omitted). In 1993, the infant mortality (death before age one) rate was approximately 8.3 infant deaths per 1000 live-born infants. Kleigman, *supra* note 107. This aggregate figure obscures the fact that certain sub-groups have significantly higher rates: specifically, the mortality rate for black infants was more than twice the rate for white infants. *Id.*

110 *See* Starfield, *supra* note 100, at 522 tbl. 4.

111 *See* Gordon K. MacLeod, *An Overview of Managed Health Care*, ESSENTIALS OF MANAGED HEALTH CARE 1, 2 (Peter R. Kongstredt ed. 1995). "By 1966, some 70% of physicians called themselves specialists." *Id.* (citation omitted).

112 *See* Paul W. Newacheck & Neal Halfon, *Access to Ambulatory Care Services for Economically Disadvantaged Children*, 78 PEDIATRICS 813, 817 (1986).

113 *See* Margaret McManus et al., *The Adequacy of Physician Reimbursement for Pediatric Care Under Medicaid*, 87 PEDIATRICS 909, 917 (1991).

114 *See* Robert F. St. Peter et al., *Access to Care for Poor Children: Separate and Unequal?*, 267 JAMA 2760 (1992). *See also* Paul W. Newacheck & Neal Halfon, *Preventive Care Use*

Access to adequate medical care is more complex than the simple ability to periodically use health services. Access can also be evaluated in terms of a number of criteria including the quality of care received, the availability of emergency care and the ability to establish an enduring physician-patient relationship with a properly trained and culturally sensitive health care provider. Measured against these criteria, Medicaid appears less successful.[115] While children covered under Medicaid are as likely as non-poor children to have a regular source of care[116] and to receive routine care at appropriate intervals,[117] they are much less likely to receive that care in a physician's office.[118] Clearly, this pattern creates significant issues with respect to continuity of care, and the ability of children to form long-term relationships with providers.[119] Thus, despite Medicaid's ability to improve access to care for poor children, it nevertheless fails to ensure that these children will have access to the same locations and continuity as other children.[120] Instead, a primary effect of Medicare is providing access to public resources such as emergency rooms, clinics, and hospital outpatient services, rather than enabling poor patients to gain equal access to private providers of care.[121]

---

by School-Aged Children: Differences by Socioeconomic Status, 82 PEDIATRICS 462 (1988). The authors found that Medicaid enrollment was associated with a 20% increase in the probability that a child would receive a routine physical examination at the recommended interval. *Id.*

115 *See generally*, St. Peter et al., *supra* note 114, for data related to access issues for children covered by Medicaid.

116 *See* St. Peter et al., *supra* note 114, at 2763. For example, 92.1% of non-poor children had a routine source of care as compared to 90.9% of children in Medicaid. *Id.* at 2763 tbl. 2.

117 *See* St. Peter et al., *supra* note 114, at 2763 tbl. 3.

118 *See* St. Peter et al., *supra* note 114, at 2763 tbl. 3. Approximately, 81.55 % of non-poor children received their care in a doctor's office, as opposed to only 55.9% of children covered under Medicaid. *Id.* at 2763 tbl. 4. By comparison, 47.3% of poor children without Medicaid reported using a doctor's office as the source of their routine care. *Id.* Generally, poor children were much more likely than non-poor children to receive care at community and hospital clinics. St. Peter et al., *supra* note 114, at 2763.

119 *See* St. Peter et al., *supra* note 114, at 2763. The authors concluded that "Medicaid coverage is not associated with an improvement in continuity." *Id.*

120 *See* St. Peter et al., *supra* note 114, at 2763.

121 *See* David L. Wood et al., *Access to Medical Care for Children and Adolescents in the United States*, 86 PEDIATRICS 666, 672 (1990). The authors noted that more than half of the surveyed Medicaid recipients reporting a regular source of care indicated that the source of care was some form of public provider, as compared to only a quarter of

While it may be argued that access to some care is better than no care at all, reliance on public sources of care creates quality and cost problems. First, health services obtained from public providers may lack the critical element of continuity. Using public facilities increases the likelihood of seeing a different treating physician on each visit which, in turn, leads to the duplication of services to diagnose and assess problems which have been previously identified.[122] Ultimately, using services in this manner undermines any type of coordinated approach to care and denies the patient an opportunity to have his medical condition evaluated over a period of time. Furthermore, public sources such as hospital emergency rooms are generally more expensive sources of care than physicians' offices. In addition to being more costly, when the public care provider is forced to perform diagnostic testing which were already completed at a different location, another layer of unnecessary costs is created.[123]

Thus, by receiving care from a patchwork of providers at separate locations, poor children forgo the benefit of a long-term relationship in which medical problems can be diagnosed, monitored, and treated in a consistent and coherent fashion.

The reasons underpinning the access problems of Medicaid beneficiaries are complex, interrelated, and have much to do with the structure of the health care system. First, a significant number of Americans live in rural and inner city communities that are medically underserved.[124] Because racial and ethnic minorities and the poor are disproportionately located in these areas, they are significantly burdened by the uneven distribution of medical resources.[125] For members of minority groups this distributional problem is further exacerbated by the impact of racism.[126] Specifi-

---

the uninsured respondents and a third of the poor respondents who reported using public providers. *Id.* at 668.

122 *See* ROBERT E. HURLEY ET AL., MANAGED CARE IN MEDICAID 27 (1993). The authors note that episodic care provided in public facilities results in redundant diagnostic work, incomplete medical records, and lack of follow-up on referrals. *Id.* at 28.

123 *See* HURLEY, ET AL., *supra* note 122, at 28.

124 *See* Shirley Aaron, *Special Needs of Vulnerable and Underserved Populations: Models, Existing and Proposed, to Meet Them*, 96 PEDIATRICS 858, (1995) (estimating that 70% of U.S. counties could be considered either wholly or partially underserved, covering more than 43 million people).

125 *See id.*

126 *See* Sidney Dean Watson, *Minority Access and Health Reform: A Civil Right to Health*

cally, there are strong indications that minority groups, particularly African-Americans, receive not only less medical care but care of a generally lower quality.[127] While this difference might be explained merely as a function of economic disparity, studies suggest otherwise.[128] Even in situations where minority Americans have access to the same source of payment as non-minority Americans, they tend to visit physicians less, and have fewer hospital and nursing home admissions.[129] In addition, minorities receive less care than that given to the majority, even when their symptoms and sources of payment are the same.[130] In the case of poor, non-white children, studies conclude that the access barriers they face are even more significant than those faced by non-white adults.[131]

A second issue is the low participation rate among physicians in the Medicaid program.[132] Many factors ranging from the obvious to the insidious combine to discourage or limit physician participation in Medicaid.[133] Among the most frequently mentioned obstacles are perceived restrictions on physician autonomy,[134] the regulatory and bureaucratic complexities of the program, payment delays, frequent patient eligibility changes, and the undesirable location of patients.[135] Chief among these deterrents is the low fee levels that typically are below those of Medicare for comparable

---

Care, 22 J.L. MED. & ETHICS 127, 127-28 (1994) (noting the unequal treatment of African-Americans receive from the health care system).

127 *See* Robert J. Blendon et al., *Access to Medical Care for Black and White Americans: A Matter of Continuing Concern*, 261 JAMA 278, 279-80 (1989).

128 *See* Watson, *supra* note 126, at 127-28.

129 *See* Watson, *supra* note 126, at 127.

130 *See* Watson, *supra* note 126, at 128. During the late 1970's, Medicaid covered up to 75% of impoverished children. *Id.* However, despite the 25% increase in the number of poor children since that time, Medicaid has been repeatedly cut and now only covers about one-half of all those children. Wood, *supra* note 121, at 666.

131 *See* Wood, *supra* note 121, at 670.

132 *See generally*, McManus et al., *supra* note 113.

133 *See* HURLEY ET AL., *supra* note 122, at 26. One source indicated that some physicians were not interested in treating Medicaid patients because they missed appointments and because of their inappropriate behavior in the waiting room. *Id.* This strikes me as thinly veiled racism. HURLEY ET AL, also note that stigmatizing stereotypes of Medicaid patients (as unreliable, uneducated, and practicing unhealthy lifestyles) are an impediment to increasing physician participation. *Id.*

134 *See* HURLEY ET AL., *supra* note 122, at 25-26.

135 *See* Wood, *supra* note 121, at 672. Medicaid has contributed to a "two-tiered" system which segregates the poor from the non-poor and limits their care to public providers and emergency rooms, where care is less comprehensive. *Id.*

services and well below the levels of private fees.[136]

Depressed reimbursement levels are largely the result of state cost-cutting efforts beginning in the 1970's and 1980's which gave higher priority to cost containment than to reasonable compensation levels for doctors.[137] As a result of these efforts, fewer doctors began to accept Medicaid patients, and beneficiaries were forced to look elsewhere for care.[138] The net effect of these cost-cutting decisions was a movement away from the more efficient office-based care toward more expensive hospital emergency rooms and outpatient clinics.[139] Ironically, this negative effect was caused by the budget-minded efforts of the states which created a programmatic and beneficiary bias toward institutional provision of services — the most expensive care delivery option. In 1989, Congress addressed growing concerns about the effects of low reimbursement levels, and enacted legislation requiring the states to demonstrate that reimbursement levels are sufficient to ensure that children in the Medicaid program have access to basic pediatric services.[140]

In many respects, the drive by state and federal government to control costs is an understandable reaction to the dramatic in-

---

136 *See* Philip R. Lee & Paul W. Newacheck, *Physician Reimbursement Under Medicaid*, 89 PEDIATRICS 778 (1992) (discussing studies which indicate that increased Medicaid fees do not significantly increase the likelihood that Medicaid beneficiaries will see a private doctor nor increase the number of services they receive). While this finding may be partly a function of reimbursement rates which have not reached a minimum acceptable threshold, it is also consistent with earlier discussions in this comment that indicate that financial barriers are not the only barriers faced by the Medicaid population. *Id.* at 778-79.

137 *See* McManus et al., *supra* note 113, at 918. Since 1986, minimal adjustments in physician reimbursement rates have not increased the Medicaid payments for physician services which currently averages less than 80% of all allowable charges. *Id.* Two states, Kentucky and North Dakota, have not increased reimbursement rates since before 1984. *Id.* at 913.

138 *See generally*, McManus et al., *supra* note 113 (discussing the impact of reimbursement rates on physical participation in Medicaid). *See also*, Lee and Newacheck, *supra* note 136 (discussing the declining levels of participation in Medicaid among pediatricians).

139 *See* Lee and Newacheck, *supra* note 136 at 778 (citing one study that reported that Medicaid "children who began an illness episode in an outpatient hospital department had expenditures between 68% and 119% greater than other Medicaid-eligible children who began their episodes of care in office practices[ ]"). *Id.*

140 *See* Lee and Newacheck, *supra* note 136 at 778. However, the impact of the provisions contained in the Omnibus Budget Reconciliation Act of 1989 appears to have been minimal since research was unable to find any source to suggest they were responsible for dramatically improving reimbursement rates. *Id.*

crease in program costs.[141] By 1993, Medicaid cost $125.2 billion and covered 32.1 million Americans.[142] During the early and mid-1980's, Medicaid costs increased ten percent annually.[143] By the late 1980's, costs were escalating even more rapidly, causing total state Medicaid expenditures to more than double from $22.5 billion in 1988 to $48.1 billion in 1992.[144] During this period, Medicaid was the fastest-growing item in many state budgets and was consuming larger and larger percentages of states' general revenues.[145] As a percentage of state budget expenditures, Medicaid grew from about three percent in 1966 to nearly seventeen percent by 1995.[146] The growth of Medicaid, however, was not felt equally among the states.[147] In 1990, Medicaid represented only 4.2 percent of the state budget in Alaska but over nineteen percent of Rhode Island's budget.[148] Several of the reasons for the dramatic increases in Medicaid spending have already been discussed in this comment: expanded eligibility, enhanced services, higher reimbursement levels, and the use of more expensive service delivery options.[149]

From the federal government's perspective, Medicaid costs represent a significant financial commitment which the government has only a limited ability to control or budget.[150] For 1995,

---

141 *See, e.g.*, Scott Gottlieb, *Swapping Education for Medicaid*, THE PLAIN DEALER, October 6, 1996 at 5c.

142 *See* The Kaiser Commission on the Future of Medicaid, *Medicaid Facts*, 1 February, 1995.

143 *See* Teresa A. Coughlin et al., *State Responses to the Medicaid Spending Crisis: 1988 to 1992*, 19 J. HEALTH POL. POL'Y & L. 837, 839 (1994).

144 *See id.* at 838.

145 *See id.*

146 *See Medicaid Trends*, *supra* note 30, at 31,465.

147 *See Medicaid Trends*, *supra* note 30, at 31,465.

148 *See Medicaid Trends*, *supra* note 30, at 31,465.

149 *See Medicaid Trends*, *supra* note 30, at 31,465. Many additional reasons exist for the increases in the cost of Medicaid. *Id.* Two factors are particularly significant and worth noting. *Id.* One is the general background increase in the cost of medical care, and the other is the increase in the cost of caring for the elderly. *Id.* By the late 1980's, over a third of the Medicaid budget was being expended on services (particularly long-term nursing home care) for the elderly who comprised only about 14% of the Medicaid beneficiaries. ROBERT P. RHODES, HEALTH CARE POLITICS, POLICY, AND DISTRIBUTIVE JUSTICE: THE IRONIC TRIUMPH 86-90 (1992). By way of comparison, in 1993 children represented about half of the Medicaid population-yet they consumed only about 15% of the resources. *Id.*

150 *See generally*, footnotes 24 through 27 and accompanying text (indicating that the federal government reimburses states for their spending on Medicaid recipients.

the federal government's share of the Medicaid bill has been estimated at ninety billion dollars.[151] It was against this general backdrop of rapidly escalating medical costs (to government, to business, and to individuals) that President Clinton proposed his program of national health care reform. The Clinton plan would have provided universal health care coverage (effectively eliminating Medicaid as we now know it), while controlling the cost of that coverage.[152] When Congress failed to enact any type of reform measure, the states were essentially forced to fill the leadership void and to resume their efforts to devise cost-effective ways to deliver health care to the Medicaid population.[153]

Beginning in the early 1980s, several states began to consider in earnest initiatives aimed at controlling the costs associated with Medicaid.[154] However, within the confines of the Medicaid statute, states have only limited flexibility to devise alternative delivery systems.[155] For example, among the more restrictive provisions are those that require that services offered to Medicaid beneficiaries are "comparable"[156] to those offered to other individuals, and the requirement that beneficiaries must be free to choose any Medicaid-eligible service provider.[157]

To increase their regulatory flexibility, states may apply to the Secretary of Health and Human Services for waivers of these, and other Medicaid program requirements.[158] There are two major statutory provisions which permit waivers: Sections 1115 and

---

As a result, actual federal spending is largely a function of financial decisions made at the State level).

151 *See* Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 546 (1995) (citation omitted).

152 *See* Michele Melden, *The Health Security Act: Will There Be Adequate Protection Against Sub Rosa Rationing? Lessons Learned From Medicaid*, 21 W. ST. U. L. REV. 149 (1993).

153 *See* Rosenberg & Zaring, *supra* note 151, at 545.

154 *See* HURLEY ET AL., *supra* note 122, at 1.

155 *See* Rosenberg & Zaring, *supra* note 151, at 546-47.

156 *See* Rosenberg & Zaring, *supra* note 151, at 546. "Medical Services provided to an eligible individual shall not be less in amount, duration, or scope from those provided to any other individual." *Id.*

157 *See id.* "Most eligible individuals may obtain medical services from any institution, agency, pharmacy or person qualified to perform the services provided". *Id.* (citing Social Security Amendments of 1967, 42 U.S.C. §1396a(23)(1988)).

158 *See* Rosenberg & Zaring, *supra* note 151, at 546-47.

1915(b) of the Social Security Act.[159] By excusing states from complying with routine Medicaid provisions, Section 1115 waivers permit states to create demonstration projects that employ experimental approaches to Medicaid.[160] Congress intended that programs approved through the waiver process would focus on alternative techniques for improving the delivery of services to beneficiaries of public assistance programs contained in the Social Security Act.[161] Generally, Section 1115 waiver applications are required if a state proposes an experimental approach which would be formally evaluated, run for a limited period, and not increase federal matching expenditures over the amount that would have been spent without the waiver. [162]

Recently, several states have used waivers to launch mandatory statewide managed care demonstration projects.[163] A key aspect of these programs is that they set aside the Medicaid requirement that beneficiaries are free to select any participating provider of health care services.[164] The freedom of choice requirement can be waived either under Section 1115 or Section 1915(b), which permits states to contract with HMOs, limit provider choice, and use managed care techniques such as primary care case management.[165]

Applying for a waiver to implement a Medicaid demonstration project was once a complex bureaucratic process which discouraged states from experimenting.[166] In keeping with its policy of encouraging reform, the Clinton Administration has significantly streamlined the waiver process and relaxed the review criteria.[167] In fact, HCFA now grants Section 1115 waivers to demonstration projects that appear to have the primary goal of reducing Medicaid

159 *See* Rosenberg & Zaring, *supra* note 151, at 546-47.

160 *See Reinvention*, *supra* note 49, at 43,850-1.

161 *See* Rosenberg & Zaring, *supra* note 151, at 547 (citations omitted). "The projects to be approved were 'those which are designed to improve the techniques of administering assistance and the related rehabilitative services under the assistance titles.'" *Id.* (quotation omitted). Thus, waiver projects that are designed only to control costs may be beyond the scope of the statutory provisions. *Id.*

162 *See Reinvention*, *supra* note 49, at 43,856.

163 *See Reinvention*, *supra* note 49, at 43,856.

164 *See Reinvention*, *supra* note 49, at 43,856-61.

165 *Reinvention*, *supra* note 49, at 43,860. Mandatory programs may also violate the requirement that HMO's may not serve only Medicaid patients: Section 1115 may be used to waive this rule also. *Id.* at 43,861.

166 Rosenberg & Zaring, *supra* note 151, at 549.

167 Rosenberg & Zaring, *supra* note 151, at 549-50 (citations omitted).

costs, rather than enhancing service delivery through attempts at innovation.[168] Also, the permissible scope of the waivers has expanded significantly to include large-scale, long-term programs (in contrast to earlier waivers which were generally small-scale and short-term) so that some states are truly engaged in health care delivery experiments in the broadest social sense.[169]

In many respects, the advent of these demonstration projects represents a sea of change in the Medicaid program. Just as the demonstration projects have come to emphasize the financial implications of Medicaid, so too has the debate shifted. Today the focus of Medicaid reform has become financing the cost of services. Improving access to health care services for the poor appears to be of secondary concern at best. Curiously, current concerns with the Medicaid program mirror the historic purpose of charity care—namely, protecting the healthy population. The difference is that law makers are now attempting to protect the economic health of taxpayers from the deleterious effects of financing health care for the poor. It is in this spirit of trying to confront and minimize the economic consequences of providing health care for over thirty million Americans that policy-makers are increasingly turning to the concept of managed care.

VII. Managed Care and Medicaid

Managed care is a particularly obscure term that can refer to many different types of organizational structures and techniques.[170] It is sometimes used interchangeably with the term

---

168 Rosenberg & Zaring, *supra* note 151, at 550. This reduction in cost is achieved through managed care entities and their prospective payment system. *Id.*

169 Rosenberg & Zaring, *supra* note 151, at 551. There are strong policy reasons for using Section 1115 waivers. Rosenberg & Zaring, *supra* note 151, at 551. For example, state experimentation will result in a more "complete record of health care reform alternatives." *Id.*

170 Rosenberg & Zaring, *supra* note 151, at 551. Managed care organizations tend to fall into three basic models: 1) fee-for-service case management in which a primary care case manager coordinates overall care by providing or arranging routine services, and authorizing access to specialists; 2) partially capitated arrangements in which MCOs or providers are at risk for a package of services; 3) fully capitated arrangements in which the financial risk of providing patient services is borne by the MCO. Dana C. Hughes et al., *Medicaid Managed Care: Can It Work for Children?*, 95 PEDIATRICS 591 (1995) (citing General Accounting Office, *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*, GAO/HRD-93-46 March, 1993).

health maintenance organization (HMO).[171] Managed care is broader than the HMO concept in that managed care describes health care systems that meld the delivery of medical services with the financing of those services.[172] Managed care differs from traditional fee-for-service medicine in its basic structural form and emphasis.[173] For example, managed care programs are more likely than fee-for-service programs to provide a broader range of lower cost preventive services (such as immunizations) to encourage participants to seek preventive care to avoid the onset of disease or other more costly health conditions. The primary goal of managed care is to control costs while providing quality care.[174]

Managed care organizations (MCO) work to achieve their goals by using certain common mechanisms to provide care to individuals who join or "enroll" in their plan.[175] First, MCOs attempt to control the sources of health care services through the use of networks or panels of service providers from whom beneficiaries are either required or strongly encouraged to seek care.[176]

Second, MCOs formally contract with participating health care providers to furnish their services on a discounted basis.[177] Provider payments can take a number of forms ranging from discounts on customary charges to capitation (a fixed monthly fee to provide a negotiated package of services to a patient).[178] In some MCO

---

171 SHELDA HARDEN, WHAT LEGISLATORS NEED TO KNOW ABOUT MANAGED CARE, 29 (1994). The term Health Maintenance Organization (HMO) has been defined as "[a]n organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. *Id.* The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital medical plans." *Id.*

172 *See* HURLEY ET AL., providing the following definition: "Managed care includes, but is not limited to, strategies for controlling costs and improving access that focus on primary care and prepaid arrangements as an alternative to traditional, FFS-based, retrospective reimbursement of costs." HURLEY ET AL., *supra* note 122, at 6 n.1 (1993).

173 *See* HARDEN, *supra* note 171, at 2 (1994).

174 *See* HARDEN, *supra* note 171, at 2 (1994). In other words, an HMO is one form of managed care. *Id.*

175 *See* The Kaiser Commission on the Future of Medicaid, *Policy Brief: Medicaid and Managed Care*, 3 April, 1995. Participants in managed care arrangements are variously referred to as "enrollees" or "members." *Id.*

176 *See* HARDEN, *supra* note 171, at 2.

177 *See* HARDEN, *supra* note 171, at 2-3.

178 For example, under a capitation system of compensation, a primary care physician (PCP) might be paid $15.00 per month per patient enrolled in the MCO who selected that doctor as his PCP. The PCP would then be responsible for providing a basket of services to the patient and would be paid the monthly fee to cover the cost

models, such as the staff model HMO, physicians and other health care providers are actually employed by the MCO.[179] In other models, doctors maintain their private practices (as groups or individuals) but treat patients on a capitated basis.[180] Under structures that use full or partial capitation payment systems, the physician and the MCO essentially share part of the risk of the cost of meeting the patient's health care needs.[181] This occurs because the physician (or the MCO in some models) has agreed to accept the capitation fee as payment in full for the contracted services.[182] If the services can be provided more economically, or are not necessary, the physician (or the MCO) keeps the excess.[183] However, if the patient requires additional services, the health care provider must continue to furnish the needed care without additional compensation.[184]

Capitation arrangements subtly yet fundamentally alter the economic forces at work between the doctor and the patient. Unlike traditional fee-for-service medicine, in which the physician had economic incentives to over-treat a patient, capitation and other tools commonly used by MCOs may provide institutionalized incentives and biases to under-prescribe services. Since the provider prospers only when patients are treated at a cost below total patient revenues, there is pressure to minimize costs by limiting services and substituting less expensive options. In many ways, these economic forces change the physician's role as a patient advocate. Now, patients must wonder which interest is being furthered when a physician prescribes a particular course of treatment—the patient's health or the doctor's finances.

In order for an MCO to survive economically, both the number and types of services rendered to patients must be care-

---

of those services. The PCP would receive the same monthly capitation fee regardless of the actual services rendered to the patient.

179 *See* Eric R. Wagner, *Types of Managed Care Organizations*, ESSENTIALS OF MANAGED HEALTH CARE 24, 29 (Peter R. Kongstvedt ed., 1995).

180 *See id.* at 30-33 (discussing various forms of group and independent network models).

181 *See* Peter R. Konotvedt, *Compensation of Primary Care Physicians in Open Panels*, ESSENTIALS OF MANAGED HEALTH CARE 76 (Peter R. Kongstvedt ed., 1995) (providing a thorough discussion of capitation and other payment arrangements).

182 *See id.*

183 *See id.* at 79-81.

184 *See id.* at 76-81.

fully controlled.[185] This raises the third mechanism common to MCOs: the primary care gatekeeper.[186] In the managed care setting, MCO members select a primary care physician who often provides the bulk of the patient's services but who must also coordinate care provided to the patient and make referrals to specialists (in order for the service to be covered by the MCO).[187] The gatekeeper role may be more than simply administrative.[188] In some capitated arrangements a portion of the monthly capitation fee is segregated into a withhold pool that is meant to fund the referral of patients to specialty care.[189] Generally, the physician shares any funds remaining in the withhold pool.[190] Thus, the primary care physician also has incentives to deny referrals to specialists since it would inure to his direct financial benefit.[191]

Finally, MCOs rely upon utilization review to analyze, generally retrospectively, the decisions made by the primary care physician as to the medical necessity of the services and treatments provided to patients.[192] A third party reviewing organization often conducts utilization review, using practice guidelines for the treatment of various health problems.[193] Utilization review seeks to ensure that physicians provide only medically necessary services: a goal which is fairly unobjectionable on its face.[194] However, given the types of compensation arrangements commonly used in MCOs (namely capitated risk-sharing), aggressive utilization review when combined with a provider's economic self-interest may create an environment that overly restricts patient care.[195] In a managed care setting that serves Medicaid recipients, this tendency poses a

185 Peter R. Kongstvedt, *Managing Referral/Consultant Utilization*, ESSENTIALS OF MANAGED HEALTH CARE 136, 136-138 (Peter R. Kongstvedt ed., 1995).

186 *See id.* at 137-38.

187 *See* HARDEN, *supra* note 171, at 2-3.

188 *See* Kongstvedt, *supra* note 181, at 138.

189 *See* Kongstvedt, *supra* note 181, at 79-81.

190 *See* Kongstvedt, *supra* note 181, at 79-81.

191 *See* Kongstvedt, *supra* note 181, at 80.

192 *See* Kongstvedt, *supra* note 181, at 80.

193 *See* Kongstvedt, *supra* note 181, at 80.

194 *See* Kongstvedt, *supra* note 181, at 139-40.

195 *See generally* Stephen M. Davidson et al., *Prepayment with Office-Based Physicians in Publicly Funded Programs: Results from the Children's Medicaid Program*, 89 PEDIATRICS 761 (1992) (describing a small study in which physicians receiving capitated rates made fewer referrals of Medicaid covered children than did physicians who received fee-for-service rates.)

danger that the poor, a population already struggling to secure adequate health care, will continue to experience access and quality problems.

VIII. Medicaid Managed Care

Managed care arrangements have been used in the Medicaid program since the early 1970s.[196] As of 1994, approximately 7.8 million, or nearly one quarter of Medicaid recipients, participated in some form of managed care program.[197] Much of the growth in the Medicaid managed care population has come in the last few years, as states have turned to managed care as a solution to increasing program costs.[198] As previously described, the federal government has facilitated this trend by loosening the regulatory requirements necessary to obtain waivers from HCFA under sections 1115 and 1915(b).[199]

Medicaid managed care employs the same mechanisms common to private sector plans which require program enrollment by members, limited provider panels, contractual arrangements between the provider and the entity that pays for the care, enrollees' selection of primary care physicians who generally provide services and act as a gatekeeper, and some level of utilization review.[200] Most Medicaid managed care programs fall within one of three prototypes: the fee-for-service primary care case management model (PCCM); shared-risk primary care gatekeeper model; and full-risk model.[201]

Under the PCCM model, the state Medicaid agency contracts with primary care providers (either individually or in groups) to manage the health care use of enrolled patients.[202] The state compensates the physician on a fee-for-service basis for any care provided and pays an additional monthly fee for the management and

---

196 *See* W. Pete Welch & Mark E. Miller, *Mandatory HMO Enrollment in Medicaid: The Issue of Freedom of Choice*, 66 MILBANK QUARTERLY 618, 619 (1989) (suggesting that "scandals" involving various Medicaid HMOs in California in the 1970s contributed to federal legislation that restricted Medicaid payments to federally qualified HMOs).

197 *See* Kaiser, *supra* note 175, at 1.

198 *See* Kaiser, *supra* note 175, at 2 (citing figures from HCFA detailing enrollment increases from 2.3 million in 1990 to 7.8 million in 1994). *Id.* at 2 Figure 1.

199 *See* Kaiser, *supra* note 175, at 2-3.

200 *See* HARDEN, *supra* note 171, 2-3 (1994).

201 *See* Kaiser, *supra* note 175, at 3. *See* HURLEY ET AL., *supra* note 122, at 46-51.

202 *See* HURLEY ET AL., *supra* note 122, at 47 (1993).

gatekeeping tasks he performs.[203] The primary benefits of this model appear to be an expansion of the sources of primary care for Medicaid participants, along with the creation of opportunities for more integrated physician-patient relationships, and increased physician control of ancillary services.[204] Regardless of the degree of control the physician exercises over the patient's referral services, the physician's compensation is unaffected.[205] Enrollee participation in these plans tends to be mandatory, although some special needs groups may be able to opt out.[206]

The second model essentially builds on the PCCM model by leaving the mix of responsibilities unaltered, but introducing an element of shared risk between the physician-gatekeeper and the health care plan.[207] Risk-sharing occurs either through a capitated fee arrangement for primary care services or through apportionment of gains or losses in accounts set aside to fund the use of referral services.[208] Shared-risk models that rely on health insurance organizations (HIO) to act as contractual intermediaries between providers and state Medicaid agencies may have an advantage over plans that contract directly with the state.[209] Because HIO act as intermediaries between the state Medicaid agency and the providers of health care services, HIO may have the economic power to negotiate discounted fee arrangements with the health care providers.[210] As in the PCCM model, beneficiary participation in the shared-risk programs tends to be mandatory.[211]

The last model is the full-risk prepaid health plan or an HMO.[212] This model takes the elements of risk and service provision to their logical extension; the plan is responsible for providing all covered services in exchange for an all-inclusive capitation

---

203 *See* HURLEY ET AL., *supra* note 122, at 47-48.

204 *See* HURLEY ET AL., *supra* note 122, at 47-48.

205 *See* HURLEY ET AL., *supra* note 122, at 48.

206 *See* HURLEY ET AL., *supra* note 122, at 48.

207 *See* HURLEY ET AL., *supra* note 122, at 48. The health plan may be administered either directly by the state or through an intermediary health insurance organization. *Id.*

208 *See* HURLEY ET AL., *supra* note 122, at 48.

209 *See* HURLEY ET AL., *supra* note 122, at 48-49.

210 *See* HURLEY ET AL., *supra* note 122, at 48-49.

211 *See* HURLEY ET AL., *supra* note 122, at 49.

212 While prepaid health plans (PHP) and HMO are not identical, for the purposes of this comment the terms will be used interchangeably.

fee.[213] Enrollment in these plans may be either voluntary or mandatory.[214]

Today, nearly every state has at least a part of its Medicaid population enrolled in some form of managed care.[215] Which model(s) the state selects seems based on a number of factors that each state evaluates in the context of its own fiscal and political calculus. Relevant factors include available financial resources, beneficiary needs, conditions and resources in the state's health care delivery system, and availability of evidence on the efficacy of various managed care approaches.[216] Experimentation and variation have been encouraged by past federal regulation and are being further facilitated by efforts of the Clinton Administration.[217]

A key factor in these state Medicaid contract negotiations is the setting of the rates to be paid to participating providers (organizations and/or individuals).[218] In private sector managed care, rates are often negotiated with employers and are based on the package of services offered and on the population to be covered.[219] However, the negotiation process is very different in the Medicaid managed care context because the state Medicaid agency has superior bargaining power and a clear goal of negotiating a savings for the state.[220] As a result, Medicaid managed care rates have tended to be based on a discount, generally around five percent,[221] of the Medicaid fee-for-service rates for comparable services and populations.[222]

---

213 *See* HURLEY ET AL., *supra* note 122, at 49.

214 *See* HURLEY ET AL., *supra* note 122, at 49.

215 *See* Kaiser, *supra* note 175, at Tbl. 1.

216 *See* HURLEY ET AL., *supra* note 122, at 37-38.

217 *See* HURLEY ET AL., *supra* note 122, at 37.

218 *See* R. ROBERT HERRICK, *Medicaid Managed Care*, ESSENTIALS OF MANAGED HEALTH CARE 234, 240-41 (Peter R. Kongstvedt ed., 1995) (suggesting that managed care entities should not assume they can provide care at a discount on the Medicaid fee-for-service rates because most states have artificially suppressed those provider payments).

219 *See* Joan L. Buchanan et al., *HMOs for Medicaid: The Road to Financial Independence is Often Poorly Paved*, 17 J. HEALTH POL., POL'Y & L. 71, 75 (1992).

220 *See id.* at 76.

221 *See id.* at 74. *See* Paul W. Newacheck et al., *Children with Chronic Illness and Medicaid Managed Care*, 93 PEDIATRICS 497, 498 (1994). Given the size of the typical discount negotiated by state Medicaid agencies and the relatively small percentage of resources used by children and pregnant women (in contrast to the elderly), it seems unlikely to me that Medicaid managed care will yield substantial savings. *See also* Herrick, *supra* note 218, at 240.

222 *See* Buchanan, *supra* note 219, at 74.

The issues of mandatory enrollment and choice of provider are more complex in the context of Medicaid managed care than in the private sector, and in many ways the critical factors influencing behavior are reversed. In the private sector, there may be an incentive for individuals to enroll in managed care because these programs typically combine increased services with little or no out-of-pocket expenses. However, since Medicaid beneficiaries are already entitled to a basic health care package which includes many of the services not covered under traditional fee-for-service plans,[223] Medicaid beneficiaries may not experience the same incentives as private sector managed care participants. Because of the pressure on provider compensation rates, managed care generally does not result in the enhancement of the Medicaid services package which essentially negates a common motivation for participating in managed care.[224]

Surprisingly, the aspect of Medicaid managed care which may be most attractive to beneficiaries is increased, or improved, access to mainstream primary care providers. The notion of increased access in the context of managed care may almost seem to be an oxymoron, but when the traditional Medicaid system is viewed as a preferred provider network it begins to make sense.[225] By enrolling in a managed care organization, a Medicaid beneficiary may be able to select a primary care provider from a broader panel of physicians. Theoretically, once an enrollee has found his "medical home,"[226] he can begin to establish an effective relationship with a treating physician and access health care services.

---

223 *See* Herrick, *supra* note 218, at 236 (noting that Medicaid recipients are often eligible for services that generally are not included in commercial HMO programs such as eyeglasses, chiropractic and dental services).

224 *See* HURLEY ET AL., *supra* note 122, at 105. *See* Welch & Miller, *supra* note 196, at 624.

225 *See* HURLEY ET AL., *supra* note 122, at 25-26. The authors point out that choice of provider has always been constrained in Medicaid. *Id.* In addition, they note that under fee-for-service Medicaid, beneficiaries either paid all of the cost of care (by seeing non-participating physicians) or none of the cost (by using participating doctors who accepted the Medicaid fee as payment in full). *Id.* Assuming that beneficiaries cannot pay the full cost of care, they are forced to see only participating physicians. *Id.*

226 *See* Hughes et al., *supra* note 170, at 591.

IX. Children in Medicaid Managed Care

Medicaid managed care has the potential to offer a great deal to poor children. The emphasis that managed care organizations place on preventive services and on a coordinated approach to health care could be a significant improvement for many underprivileged children. However, as the primary target[227] for the shift to managed care, Medicaid-covered children also have a great deal to lose if programs are not designed and structured to meet their specific needs.

Impoverished children and middle-class children share many but not all health care needs. All children share the need for routine preventive services such as immunizations. However, poor children are at an increased risk of having additional health care problems which stem in part from the economic status of their families.[228] Thus, needy children may require health care services to address problems caused by inadequate prenatal care, untreated or under-treated chronic conditions, and the long-term effects of poverty.[229] Given this broad array of health-related problems, many poor children require treatment strategies which include services not typically considered medical care.[230] While these needs could be addressed by the integrated delivery approach of managed care, they also require a wider range of services than many managed care organizations are accustomed to providing to an insured, middle class population.[231]

The ability of managed care organizations to make the transition from serving middle-income to Medicaid beneficiaries is an open issue. Only limited research exists on the actual experience of Medicaid covered children in managed care settings, particularly with respect to the qualitative outcomes of the care rendered.[232] As a result, it is difficult to assess in any meaningful way the impact of managed care on poor children. Yet, states are rap-

---

227 *See id.* (noting that poor children have been a focus of the move to managed care because they comprise the largest group covered by Medicaid).

228 *See generally* discussion, *supra* notes 89-109.

229 *See generally,* footnotes 74 through 89 and accompanying text discussing the health status of indigent children in America. These problems typically include, poor nutrition, environmental hazards, effects of exposure to violence. *Id.*

230 *See* Hughes et al., *supra* note 170, at 592.

231 *See* Hughes et al., *supra* note 170, at 592.

232 *See* Melden, *supra* note 150, at 154.

idly moving forward to implement Medicaid managed care—illustrating both the vulnerability and powerlessness of poor children.

The available research does suggest a few points. Medicaid managed care appears to reduce reliance on the use of inappropriate and expensive sources of care such as hospital emergency rooms.[233] It is not clear, however, that there have been concomitant increases in the use of primary care providers to offset the decreases in care from public sources.[234] Instead, the studies that have examined access to primary and preventive care suggest that use of routine preventive services either remains the same or increases only slightly.[235] Even where access has increased, the number of services delivered was below guidelines developed by the American Academy of Pediatrics and the federal EPSDT program.[236] For example, a recent study determined that low-income children seeking care via public clinics were more likely to be immunized than those children who received care through private physicians' offices or HMOs.[237] This finding suggests that Medicaid managed care may not be realizing its potential to significantly improve the access of poor children to health care services.[238]

The quality of the services provided to Medicaid managed care beneficiaries is another possible area of concern. States can assess the quality of health care provided by managed care organizations to Medicaid beneficiaries in several ways, including: health outcomes, perceived health status, and patient satisfaction.[239] Such an assessment in the Medicaid context presents a particular challenge in that beneficiaries' shifting eligibility hampers long-term evaluation.[240] One study estimated that as many as forty percent of the

---

233 *See* Hughes et al., *supra* note 170, at 592.

234 *See* Hughes et al., *supra* note 170, at 591.

235 *See* Hughes et al., *supra* note 170, at 591.

236 *See* Hughes et al., *supra* note 170, at 591; *See also* Melden, *supra* note 154, at 154 (citing studies that identified access problems for prenatal and EPSDT services) (citations omitted).

237 *See* Hughes et al., *supra* note 170, at 591.

238 *See* Hughes et al., *supra* note 170, at 591.

239 *See* Michael Pine and Peter R. Kongstvedt, *Quality Management*, ESSENTIALS OF MANAGED CARE 163, 166-168 (Peter R. Kongstvedt ed., 1995) (discussing quality management processes in the context of managed care).

240 *See* The Kaiser Commission on the Future of Medicaid Report, *Medicaid and Managed Care: Lessons from the Literature, reprinted in* Medicare and Medicaid Guide (CCH) 44,035, at 44,046 (1995). The authors note that drawing conclusions as to the value of Medicaid managed care is complicated by the fact that there are so few stud-

total Medicaid AFDC beneficiaries went on and off Medicaid in the course of a year.[241] Consequently, policy-makers can draw only preliminary conclusions based on the limited findings available.[242] For example, one study from the early 1980s found little difference in health status outcomes, for the health measures evaluated, between Medicaid managed care and Medicaid fee-for-service.[243] Other studies report high overall patient satisfaction with Medicaid managed care, especially when patients can continue to see their previous health care provider.[244]

So far it seems fair to say that managed care has neither hurt nor helped Medicaid beneficiaries in any significant way. However, it is clear that managed care has not lived up to the rhetoric of either significant cost-containment or enhanced health care delivery. The failure of Medicaid managed care to deliver on the promise of improved health care appears to be the result of several factors which work in tandem to undermine the value of Medicaid managed care for poor children.

First, providers may not be sufficiently trained or sensitive to the unique needs of poor children. Providers who have dealt with a predominantly middle-class patient base may lack experience in dealing with the health care problems of poor and frequently minority patients. As a result, providers may not identify a poor child's increased risk for certain conditions, and thus fail to provide necessary treatment. In addition, the Medicaid EPSDT program provides a broader array of services than many managed care plans, so that providers may be unaware of the comprehensive nature of this entitlement and their treatment responsibilities and obligations.[245]

Second, the financial arrangements typically used by managed

---

ies that evaluate the quality of Medicaid fee-for-service—making comparisons difficult. *Id.* at 44,047.

241 *See* Hughes et al., *supra* note 170, at 593 (citation omitted). Cycling on and off Medicaid managed care has another unfortunate effect. Enrollee eligibility fluctuations may undermine the MCO's incentive to invest in preventive services since the MCO may not benefit from the patient's improved long-term health status. *Id.*

242 *See* Hughes et al., *supra* note 170, at 591.

243 *See* Hughes et al., *supra* note 170, at 591 (citing D. Freund & L. Rossiter, P. Fox et al., *Evaluation of the Medicaid Competition Demonstrations.*, 11 HEALTH CARE FINAN. REV. 91, 97 (1989)).

244 *See* Kaiser Commission, *supra* note 240, at 44,046.

245 *See* Hughes et al., *supra* note 170, at 593.

care organizations give providers incentives to tightly control service utilization.[246] Frequently, states negotiate Medicaid managed care rates at a discount on average Medicaid fee-for-service reimbursement rates (which are already quite low).[247] In addition, states may consider the child's Medicaid eligibility category in establishing rates.[248] "For example, most states pay a higher per capita rate for children who are enrolled in Medicaid's Medically Needy program than for children enrolled in the Aid to Families with Dependent Children (AFDC) program, because medically needy children tend to experience greater health problems."[249] While this rate-setting methodology would seem to enhance the care of chronically ill children covered under the Medically Needy category, it does not ensure that rates are adequate to provide necessary care for children who are "merely" poor—or even for chronically ill children.

Third, states may not be adequately monitoring Medicaid managed care organizations.[250] Instead, state agencies appear to rely on the managed care organizations themselves to collect and assess patient data on outcomes and satisfaction.[251] Over-reliance on self-reported data can jeopardize the state Medicaid agency's ability to effectively regulate the MCO and thus places beneficiaries at risk.[252]

Fourth, states may have failed to recognize that the introduction of managed care transforms the role of the state Medicaid agency from third party payor to patient advocate. Because of capitation and other types of prospective payment systems, states pay in advance for a basket of services for Medicaid patients. Thus, states and patients have the same interest in ensuring that the services government has paid for are actually delivered to Medicaid beneficiaries. Yet, some states appear to be slow in advocating on behalf of Medicaid beneficiaries. For example, one survey found that

---

246 *See* Hughes et al., *supra* note 170, at 593.

247 *See* Newacheck et al., *supra* note 221, at 497.

248 *See* Newacheck et al., *supra* note 221, at 497.

249 *See* Newacheck et al., *supra* note 221, at 497.

250 *See* Melden, *supra* note 152, at 154-55 (citations omitted). *See also* Kaiser Commission, *supra* note 240, at 44,046.

251 *See* Draft Report of the Office of the Inspector General, *Quality Assurance in Medicaid HMOs.*, reprinted in Medicare & Medicaid Guide (CCH) 40,082, at 29,981 (March, 1992).

252 *See id.*

only half of the states with children in Medicaid managed care intended to ensure that their managed care contracts required compliance with improved federal EPSDT standards.[253] Thus, a critical opportunity for children to access needed health care services may be lost in the managed care setting by a failure on the part of the state Medicaid agency to insist that the MCO comply with federal EPSDT standards.

Fifth, managed care programs may not have been adequately tailored to meet the unique needs of some groups of children. Although beyond the scope of this comment, it is worth noting that groups such as the disabled, the chronically ill, or adolescents, have specialized needs which affect their ability to access care. Children with a need for more expensive specialist care or merely more frequent primary care, may be vulnerable to the financial incentives involved in managed care.[254]

The health care needs of adolescents are illustrative of this general tension. By age group, adolescents experience the lowest level of primary care use.[255] Yet many of the health problems of adolescents (for example contraception and mental health concerns) can be readily addressed through primary and preventive care services.[256] For adolescents, the dilemma may revolve around their need for certain types of services which managed care organizations attempt to control tightly (and so are less available than under a traditional Medicaid fee-for-service approach): namely mental health and substance abuse programs.[257] Thus, adolescents are vulnerable in a managed care setting unless benefits packages are designed to deliver the types of services they need rather than the types of services managed care organizations customarily supply to middle-class patients.

Finally, states turn to managed care for Medicaid beneficiaries

---

253 *See* Hughes et al., *supra* note 170, at 593.

254 *See* Melden, *supra* note 152, at 153 (noting that a survey of "pediatricians participating in managed care plans revealed that one-third felt that plan denials of children to specialists and in-patient care resulted in compromised health[ ]").

255 *See* Claire Brindis, *Promising approaches for adolescent reproductive health service delivery: the role of school-based health centers in a managed care environment.*, 163 WEST. J. OF MED. 50, (1995).

256 *See id.*

257 *See id.*

primarily to control costs.[258] Yet, Medicaid managed care has only a limited ability to realize significant cost savings over the fee-for-service approach.[259] Savings do appear to be greatest in managed care models that use fully capitated compensation arrangements such as HMOs.[260] Additionally, programs which make enrollment in managed care mandatory, rather than voluntary, may be able to generate more savings.[261]

X. *The Next Wave: Reform Proposals*

The future of Medicaid is very much in question. While there appears to be consensus among decision-makers that Medicaid must change, at this writing, Congress and the President have been unable to reach an agreement on Medicaid reform.[262] An examination of recent Medicaid reform proposals, however, will illustrate some common themes and direction.

This round of Medicaid reform began in earnest during the late summer of 1995, when Republicans in the House of Representatives sponsored legislation which would have replaced Medicaid with a system of block grants, called Medigrants, which would go directly to the states.[263] The Republican proposal would have essentially eliminated federal involvement in Medicaid and the entitlement nature of the program.[264] The federal government's only role would be to accept state proposals for their own programs, ensure that states do what they promised, and continue to share the costs.[265] Additionally, the proposal would have repealed a number of important federal regulations, including spousal impoverishment protections and nursing home standards, and permitted

---

258 The discussion of managed care cost savings is quite brief because the topic is beyond the scope of this comment.

259 *See* Hughes et al., *supra* note 170, at 592. *See* Kaiser Commission, *supra* note 240, at 44,045.

260 Kaiser Commission, *supra* note 240, at 44,045.

261 Kaiser Commission, *supra* note 240, at 44,045 (noting that voluntary programs have been shown to generate savings, but that the savings may result from healthier beneficiaries selecting managed care).

262 *See* Zaldivar, *supra* note 31, at A6 (noting that reform efforts will be more "measured" if President Clinton is re-elected).

263 *See House Commerce Approves Proposals To Give States Full Control of Program*, HEALTH CARE POL'Y REP., Sept. 25, 1995.

264 *See id.*

265 *See id.*

states to devise their own standards.[266] Finally, the proposal contained annual growth limits of about four percent per year which were projected to generate savings of $182 billion over seven years.[267]

By November 1995, the House Republicans' legislation had reached the Senate.[268] The Senate maintained the Medigrant approach giving states the freedom to determine covered benefits, but mandated that state spending remain at a minimum level of eighty-five percent of the spending in fiscal years 1992-1994.[269] The most significant difference between the two plans was the Senate's requirement that the disabled, pregnant women, and poor children under the age of fourteen continue to be covered by the program.[270] Additionally, the Senate reduced the savings targets by twelve billion dollars, to a total of $170 billion over the seven-year period.[271]

In early December 1995, President Clinton released a seven-year budget plan that contained several proposals for revising the Medicaid program.[272] The President's plan targeted more modest savings of fifty-four billion dollars over seven years, and made some significant regulatory changes.[273] Essentially, the Clinton plan had three key elements: a per capita cap; enhanced state flexibility; and a reduction and refocusing of funds paid under the disproportionate share hospital program.[274]

The Clinton plan would have maintained eligibility for those currently entitled to Medicaid.[275] However, the plan proposed a per capita cap that would have been based on 1995 combined state and federal expenditures adjusted annually to account for nominal

---

266 *See id.*

267 *See House Commerce Approves Proposals To Give States Full Control of Program*, HEALTH CARE POL'Y REP., Sept. 25, 1995. On its face, a four percent growth rate may not sound unreasonable. However, some projections peg the Medicaid growth rate at ten percent. *Id.*

268 *See Senate Passes Medicare, Medicaid Plans; GOP Conferees Start Informal Meetings*, HEALTH CARE POL'Y REP., Nov. 6, 1995.

269 *See id.*

270 *See id.*

271 *See id.*

272 *Health Provision of President Clinton's Seven-Year Budget Plan*, HEALTH CARE POL'Y REP., Dec. 11, 1995.[hereinafter *Clinton Plan*].

273 *See id.*

274 *See id.*

275 *See id.*

inflation and progress in meeting the savings target.[276] The caps would have been set on a state-by-state basis, for four subgroups of beneficiaries,[277] with federal spending limited to the product of the per capita cap and the federal medical assistance percentage (FMAP).[278]

The second key aspect of the President's plan was a dramatic increase in state regulatory flexibility. The Boren Amendment[279] and other federal payment requirements (including those related to pediatric and obstetrical services)[280] would have been repealed.[281] The requirement to obtain federal waivers also would have been eliminated in several situations including mandatory enrollment in managed care systems (although states would have been required to provide beneficiaries with a choice between plans).[282] The Clinton Plan also included an elimination of the statewide requirement.[283] Further, the Plan extended "the state's option for a six-month lock-in and guaranteed extension of eligibility to all enrollees of managed care plans."[284] In addition, Clinton's proposal repealed the prohibition on Medicaid-only managed care organizations by eliminating the requirement that twenty-five percent of a plan's members be patients who are privately insured.[285] In order to ensure quality, the Clinton plan required that states implementing managed care devise improved quality assurance programs, consistent with federal standards, to monitor the quality of the care provided to beneficiaries.[286]

---

276 *See id.*, at 1.

277 *See Clinton Plan, supra* note 272. The four groups of beneficiaries were: the elderly, the disabled, non-disabled children, and non-disabled adults. *Id.*

278 *See Clinton Plan, supra* note 272.

279 42 U.S.C. § 1396a(13). The Boren Amendment was enacted in December, 1980 and required that Medicaid payments to hospitals and nursing homes be reasonable and adequate to ensure beneficiaries had access to quality institutional services. *Id.*

280 Philip R. Lee & Paul W. Newacheck, *Physician Reimbursement Under Medicaid*, 89 PEDIATRICS 778 (1992). While the President's plan did not state this provision explicitly, this maybe a reference to a provision in the Omnibus Budget Reconciliation Act of 1989 which required states to annually demonstrate "that their fees are sufficient to ensure that Medicaid-enrolled children have access to pediatric services comparable with that of children in the general population." *Id.*

281 *See Clinton Plan, supra* note 272, at 1.

282 *See Clinton Plan, supra* note 272, at 1.

283 *See Clinton Plan, supra* note 272, at 1.

284 *See Clinton Plan, supra* note 272, at 1.

285 *See Clinton Plan, supra* note 272, at 1.

286 *See Clinton Plan, supra* note 272, at 1.

The Clinton Plan represented a major decrease in federal involvement in the regulation of Medicaid. While it clearly gave the states much more freedom to tailor Medicaid to fit the states' individual needs, it also created greater diversity among state programs, and many more opportunities for poorly-designed programs.[287]

The final major element of the Clinton Plan was a reduction and a refocusing of disproportionate share hospital (DSH) payments.[288] Although this element of the Plan is beyond the scope of this comment, essentially, the President proposed a thirty-five percent reduction in DSH payments by 1998.[289]

By January of 1996, the President and Congress had reached

---

287 *See* Martin Gottlieb, *A Free-for-All in Swapping Medicaid for Managed* Care, N.Y. TIMES, Oct. 2, 1995, at A1. The danger inherent in this regulatory strategy can be seen in the experiences of several states that are attempting to make a large scale transition to managed care. *Id.* New York and Tennessee have each experienced quality of care problems when implementing Medicaid managed care. *Id.* at A14. In each case, significant problems occurred before the state stepped in to take greater control of the programs and a more active oversight role. For example, Tennessee implemented a mandatory managed care program for its entire Medicaid population of 750,000 (plus a voluntary program for about 400,000 uninsured individuals). *Id.* During the enrollment periods, several managed care organizations engaged in marketing practices that ranged from deceptive to fraudulent, including promising free life insurance, enrolling homeless people multiple times, and signing-up prison inmates (who already received free care from the state Corrections Department). *Id.* Additionally, some plans instructed marketing employees in cherry-picking techniques to ensure that only the healthiest, and least-cost, individuals were enrolled in their plan. *Id.* The net result of these abuses is that Tennessee may have wasted millions of dollars and legitimate managed care organizations may be been kept out of the Tennessee health care market. *Id.* While Tennessee's experience was, hopefully, an anomaly, it does illustrate the problem of implementing managed care before there are solid state oversight mechanisms and before the health care structure itself is in place. *Id.*

288 *See Clinton Plan, supra* note 272, at 1.

289 *See Clinton Plan, supra* note 272, at 1. Since DSH payments are intended to compensate hospitals that provide significant amounts of uncompensated care, it is clear that a reduction of federal support in this area will adversely affect institutions that serve the poor. *Id.* Jeopardizing the survival of these institutions will have two main consequences. First, a major source of health care would dry up for many Medicaid-covered children who live in urban areas, thereby removing a familiar health care safety net and making access to care more difficult, particularly during the transition phase to Medicaid managed care. *Id.* Second, major reductions in the DSH payments will have a significant impact on those indigent people who have no other source of care. *Id.* Undoubtedly, many of these individuals will be children who live in families that do not qualify for Medicaid, but are still too poor to afford other care. *Id.*

an impasse, on the future funding and structure of Medicaid.[290] In February, the National Governors' Association (NGA) presented a proposal which attempted to tread a middle ground between the President's and Congress' proposals.[291] The NGA's proposal would have maintained the basic entitlement nature of Medicaid and guaranteed coverage for certain pregnant women and poor children up to the age of twelve.[292] However, it would have canceled the phase-in of children up to age eighteen, and would have allowed the states to develop their own definitions of covered disability.[293] The NGA proposal required coverage of mandatory services with the exception of the EPSDT program, which would be redefined and restricted to include only services specifically covered in the state Medicaid plan.[294] The Governors proposed funding Medicaid programs using the matching contribution concept with the federal government increasing its minimum share to sixty percent of the total program cost.[295] The Governors' plan also extracted some savings from Medicaid, but the savings were more modest than the Republican plan.[296] The NGA plan built in added state regulatory flexibility by eliminating the waiver requirements, permitting Medicaid-only managed care organizations, and repealing the Boren Amendment.[297]

In the wake of Congress' failed effort to reach consensus with President Clinton on Medicaid reform, the Senate and House Republicans proposed a new package of Medicaid reforms.[298] While this plan contained more modest savings targets of seventy-two billion dollars and also permitted significant state flexibility in

---

290 *See Dole, Gingrich Call Off Budget Talks, Saying Clinton Must Make the Next Move,* HEALTH CARE POL'Y REP., (January 22, 1996).

291 *See Governors Endorse Bipartisan Proposal, Raising New Hopes For Budget Agreement,* HEALTH CARE POL'Y REP., Feb. 12, 1996.

292 *See* News Release and Policy Statement by the National Governors' Association, *Governors Reach Bipartisan Agreements on Medicaid, Welfare, and Federal Employment and Training Programs at NGA Winter Meeting,* Feb. 6, 1996, at 8. [hereinafter *NGA Proposal*].

293 *See id.* at 9.

294 *See id.*

295 *See id.* at 11.

296 *Governors Endorse Bipartisan Proposal, Raising New Hopes for Budget Agreement,* Health Care Pol'y Rep., Feb. 12, 1996. Savings were estimated to be between President Clinton's target of $59 billion and the Republican target of $85 billion. *Id.*

297 *See NGA Proposal, supra* note 292, at 9-10.

298 *See* David Nather, *GOP Unveils Medicaid, Welfare Bills; Clinton Likely to Veto Despite Changes,* Health Care Pol'y Rep., May 27, 1996 (quoting Republican sources who claimed the new package was identical to the NGA plan).

program design and administration, it also coupled reform of the Medicaid program with reform of the welfare system in one legislative package.[299] Although some Republican leaders attempted to justify this linkage by pointing to the relationship between welfare and Medicaid,[300] others suggested the linkage was little more than jockeying for advantage in an election year.[301] Almost immediately, President Clinton threatened to veto the package because it would "repeal the guarantee of quality health care for our children."[302]

By July 1996, Republican leaders were under significant pressure to split the Medicaid and welfare reform proposals.[303] Finally, on July 11, 1996, Republican leaders dropped Medicaid reform from their legislative package[304] — effectively ending this round of Medicaid reform efforts.[305]

XI. Conclusion

Today, Medicaid reform remains an open issue. Growth rates

---

299 *See id. See also, Summary of Republican Medicaid Restructuring Act of 1996 Proposed by House Commerce,* Senate Finance Committee Chairmen (Released May 22, 1996) as reprinted in the Health Care Pol'y Rep., May 27, 1996 (detailing provisions of the proposed legislation).

300 *See* Nather, *supra* note 298. Nather quotes House Ways and Means Committee Chairmen Bill Archer (R-Tx.) as saying: "There is a symbiotic relationship between Medicaid and Welfare reform that cannot be ignored . . . [i]f you're going to do the job right, you have to take the two together." *Id.*

301 *Id.* Nather quotes Vermont's Democratic Governor Howard Dean, as saying: "The Republican leadership is not interested in a welfare reform bill, they want to score political points in an election year . . . [Congressional Republicans] want to put Medicaid and welfare together . . . and make it so onerous the President will veto the bill and they can have an election year issue that the President vetoed welfare reform . . . ." *Id.*

302 David Nather, *Clinton Threatens To Veto GOP Reforms, Saying Children Could Lose Health Care,* Health Care Pol'y Rep., June 10, 1996 (quoting from a radio address by President Clinton on June 1, 1996).

303 *See* Nather, *supra* note 298 (noting that 54 House Republicans had requested that Senate Majority Leader Trent Lott (R-Miss.) and House Speaker Newt Gingrich (R-Ga) separate welfare reform from Medicaid because of President Clinton's promise to veto the Medicaid legislation).

304 *See* Vandana Mathur and David Nather, *GOP Leaders Decide to Focus on Welfare, Action on Medicaid Legislation Doubtful,* Health Care Pol'y Rep., (July 15, 1996). The authors state that GOP leaders decided to drop Medicaid reform in response to a request to do so by Bob Dole, and also in response to a rift within the Republican Party about changes made to the proposal in the Senate Finance Committee. *Id.*

305 *See* Mathur and Nathur, *supra* note 304, (quoting a Republican aide as saying, "I think the best thing we can do with Medicaid is just bury it.")

in program spending have declined dramatically,[306] and last November's elections brought a more moderate Congress to Washington. It seems quite possible that these two factors will take some of the urgency out of systemic Medicaid reform. Diminished interest in legislative reforms, however, does not alter the fact that poor children continue to need quality health care services. As states and the federal government move the Medicaid program into the future, the interests of children will be better served by considering the following recommendations.

First, any legislated savings targets must be realistic and phased-in over a longer period to better reflect the long-term benefits of up-front preventive services. A longer phase-in period would permit the states and the health care industry to make lasting, systemic changes in a less painful and more rational manner. Additionally, it would make funds available now to help deal with the transition to managed care and to offset any short-term implementation problems.

Second, provider fees need to be sufficient to cover the cost of services provided. Capitation fees should be set to reflect the cost of services that children need and use at different points in their development. For example, a newborn should see a physician a minimum of six times during the child's first year. Capitation fees need to take the scope and number of services into consideration and compensate the provider accordingly.

Third, health care organizations must have incentives to invest in preventive care services with long-term payoffs for the Medicaid population. To facilitate this, eligibility should be in minimum one-year increments—regardless of whether the child's age or family income changes during the period. This will minimize administrative costs for the managed care organization and provide a stream of revenue for at least a year.

Fourth, health care organizations and providers must be trained and accountable to state Medicaid agencies for complying with the EPSDT program. Studies should be performed in each state to determine the extent to which the EPSDT treatment entitlement has required each state to incur costs that were not other-

306 *See* Zaldivar, *supra* note 31, at A6 (noting that Medicaid spending grew only 3.6 percent during the first ten months of 1996, as compared to annual growth rates of 9.5 percent for the previous three years).

wise covered by the state Medicaid program. Rather than permitting states to eliminate the treatment entitlement, the federal government could reimburse states when care provided under this requirement exceeds a pre-set target by a defined percentage. Thus, children would continue to receive necessary medical care and the state and federal governments would share the risk of extraordinary costs.

Fifth, managed care organizations should be required, as a condition of serving Medicaid patients, to involve traditional providers of care to poor children. States should designate individuals and institutions who have fulfilled this role and require that managed care organizations contract with those institutions for a five-year period. This requirement would minimize the disruption caused by the transition to managed care, allow Medicaid beneficiaries a degree of continuity with current providers, and also create some leverage for these institutions to bargain with managed care organizations. In addition, these traditional providers should play a lead role in training managed care organizations and providers in the health care issues of the poor.

Sixth, Medicaid managed care beneficiaries must receive comprehensive counseling regarding the managed care organizations available to them. They need to understand what the differences are in the programs, who is a participating provider, and where those providers are located. If beneficiaries have a current provider, they should be told with which organizations that provider is now affiliated. Medicaid recipients also need to receive training in how managed care works, what specific benefits and services they are entitled to, and how frequently they may use those services. Grievance and appeals processes should also be discussed in detail so that patients understand their options in the case of a treatment denial. In the early years of the transition to managed care, states may want to employ a patient ombudsman to act as a patient advocate and to identify any developing problems with particular providers, plans, or institutions.

Seventh, adolescents should also receive training in how to access health care services to which they are entitled. This could take place in school-based health centers affiliated with the managed care organizations operating in each community. The school-based centers could become the focus of a broad-based public health, public education initiative that provides both health care

services and also information about moderating risky health-related behaviors (e.g., drug and alcohol abuse, sexual activity).

Eighth, state Medicaid agencies must regulate marketing efforts performed by managed care organizations. States should not permit direct, door-to-door solicitation by individual plans. Instead, states should be responsible for disseminating information through detailed mailings, in public meetings, at welfare agency offices, and as part of the counseling process for qualifying for public assistance. States have a significant interest in ensuring that managed care organizations do not mislead beneficiaries or engage in fraudulent enrollment practices. Tightly regulated enrollment and marketing programs would protect both the state and the Medicaid population. It also would give managed care organizations some measure of comfort that cherry-picking was not being facilitated by lax state oversight.

Ninth, states should not allow the chronically-ill to opt out of managed care. Instead, states should adjust reimbursement rates to reflect the cost of care once it has surpassed a defined percentage of an annual capitation fee (set specifically for the chronically ill). Although this issue is beyond the scope of this comment, keeping the Medicaid population together is an important safeguard. If the chronically ill are permitted, or encouraged, to leave managed care, there will be a real danger that some managed care organizations will push sick children out of the health care plan as soon as they become too expensive (a variation on cherry-picking). Requiring chronically ill children to stay in managed care means that the organization will have an incentive to treat the child because it is obliged to do so and also because its financial exposure is limited. It will also mean that the organization will need to contract with a variety of specialists to ensure that adequate staff resources are available. Additionally, as the managed care system evolves and fee-for-service medicine becomes less prevalent, chronically ill children may have difficulty accessing needed care outside of managed care organizations.

Tenth, managed care organizations should be permitted to use more non-physician professionals to provide care — nurses, nurse practitioners, physicians' assistants, etc. Clearly, the state would have to establish appropriate training, credentialing, and experience requirements for these providers. Once these requirements have been met, these providers would offer a lower cost

alternative to traditional medicine. States could facilitate the growth and availability of these professionals through initiatives in state colleges and universities. Additionally, broadening the base of accepted health care providers may make it easier to recruit more minorities into the health care system. This would be an attractive way to increase the supply of more culturally-sensitive providers. Feeling comfortable with the people who are providing treatment is an important part of getting health care.

Finally, it should be recognized that managed care is not a perfect system for delivering health care. Given both the prevailing sentiment in Washington and in state legislatures nationwide, as well as the shift of the general population to managed care, it will be the vehicle used to provide care to poor Americans. Setting reasonable goals both for cost savings and also for implementing managed care are important first steps in making this transition. When states understand that they can, and should, advocate for Medicaid beneficiaries in the world of managed care, then the pieces will start to fall in place to ensure that a rational, compassionate program develops.