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Sidney D. Watson

Saint Louis University School of Law, sidney.watson@slu.edu

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COMMERCIALIZATION OF MEDICAID

SIDNEY D. WATSON*

I. INTRODUCTION

Today, I am an inner-city doctor working at the Upper Cardozo, Community Health Center at 14th and Irving Streets in Washington, D.C., a federally assisted, privately run, community-governed medical clinic. Our neighborhood is made up of a large Central American community, a Vietnamese enclave, an African-American population scattered throughout the region, a mixture of refugees, legal immigrants, and illegal immigrants struggling to find someone to treat them despite their lack of money and insurance. I have seen Ethiopians, Somalis, Kurds, West Africans, Chinese, Afghanistans, and Bosnians. Less than a quarter of our patients have Medicaid, almost none have private insurance, and all are poor. Medical life for our patients—like their lives in general—is not easy.

The majority of the patients at Cardozo are “self pay”—meaning they have no insurance, no money, and can pay little or nothing. Put differently, if the Cardozo health center didn’t continue to receive several million dollars a year of federal funding based on the vintage 1960s Office of Economic Opportunity idea of a community health center, there would be no payroll, no receptionists, no nurses, no doctors, and no medical care. Grants for the treatment of AIDS and the homeless as well as the Women, Infant and Childrens (WIC) Program round out the budget at Cardozo. Government funding remains the operative principle of health care finance in our neighborhood. Without the programs legislated and managed by the federal government, there would be no medical care at 14th and Irving. The commercial market hasn’t found our patients and doesn’t seem to be looking for them.

Dr. Fitzhugh Mullan¹

* Professor of Law, Mercer University School of Law. A Mercer Law School Faculty Research Grant supported this work. My thanks to the participants in the AALS Annual Meeting Poverty Law Program and the Saint Louis University School of Law Health Law Symposium for comments on earlier drafts of this work. I am grateful to Nateesha Gupte and Laura Bedingfield for research help.

1. Dr. Fitzhugh Mullan, *What One Doctor Learned: Going from Policy Making to Caring for Real Patients at an Inner-City Clinic*, WASH. MONTHLY, Apr. 1998, at 31.

Welcome to the world of welfare medicine: the world of poor people and the health care professionals and institutions that serve them. Dr. Mullan paints a graphic and accurate picture of the world of welfare medicine. Yet, the commercial market has found some of welfare medicine's patients—those who have Medicaid. Today, sixty-four percent of Medicaid enrollees obtain care through commercial HMOs—private, for-profit entities.² This article is about the promises and the pitfalls that accompany the commercial market's move into Medicaid and the world of welfare medicine.

Part II begins by describing the welfare medicine system: who gets welfare medicine, who does welfare medicine, and how care for the poor is funded by Medicaid and other sources. Part III traces the recent commercialization of Medicaid, the move from a fee-for-service system to one dominated by commercial managed care plans. Part IV exposes the false premises that prompted the commercialization of Medicaid, while Part V explores the dangers commercialization bodes for the larger world of welfare medicine. Part VI returns to the world of welfare medicine, rethinking the role that managed care and Medicaid can play in the larger context of welfare medicine.

II. WHAT IS WELFARE MEDICINE?

Welfare medicine is the health care system, or non-system, that serves poor people. Welfare medicine is practiced at public hospitals, teaching hospitals, and the few private, not-for-profit hospitals that remain in inner cities and other places where large numbers of poor people live. It is care provided by clinics and federally qualified health centers staffed by physicians and others with a commitment to serve the poor.³ Although not all poor people use welfare medicine, most poor people must rely on it for their care.

Who are the poor people who rely on welfare medicine? According to the federal government, poor people are those who live at or below the federal poverty guideline, \$8350 for a single person, \$11,250 for a couple and \$14,150 for a family of three in the year 2000.⁴ This includes one of five U.S. children,⁵

2. SUZANNE FELT-LISK, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE CHANGING MEDICAID MANAGED CARE MARKET: TRENDS IN COMMERCIAL PLANS' PARTICIPATION vi (1999), available at <http://www.kff.org>.

3. See Lewis D. Solomon & Tricia Asaro, *Community Based Health Care: A Legal and Policy Analysis*, 24 FORDHAM URB. L.J. 235, 248-60 (1997) (discussing the various entities that provide care to poor people).

4. Annual Update of the Health and Human Services Poverty Guidelines, 65 Fed. Reg. 7555, 7555-56 (2000). The guidelines for Hawaii and Alaska are slightly higher. *Id.* at 7556.

5. See U.S. DEPARTMENT OF COMMERCE, U.S. CENSUS BUREAU, POVERTY: 1998 HIGHLIGHTS 1 (1999), available at <http://www.census.gov/hhes/poverty/poverty98/pov98hi.html>. In 1998, 18.9% of children were poor. *Id.*

one of ten seniors,⁶ and one of three persons with a disability.⁷ Most people living in poverty are low-wage workers,⁸ and a decreasing number are welfare recipients.⁹ While most poor people are white, disproportionate percentages are racial and ethnic minorities. Twenty-six percent of African Americans and twenty-five percent of Hispanics are poor compared with only ten percent of whites.¹⁰ An increasing number of those who rely on welfare medicine are recent immigrants.¹¹

Welfare medicine is a separate, segregated system of care that continues despite the enactment of Medicaid, America's health insurance system for the poor. Proponents of Medicaid envisioned it would end America's dual system of care; one system for poor people and another for those with private insurance.¹² However, this vision did not come to pass. Medicaid suffers from the same limitations that plague any voucher system, be they health insurance vouchers, housing vouchers or school vouchers.

First, Medicaid rates, particularly physician payment rates, do not compete with private insurance and Medicare rates. Medicaid fee-for-service reimbursements average less than fifty percent of private insurance

6. See U.S. DEPARTMENT OF COMMERCE, U.S. CENSUS BUREAU, POVERTY IN THE UNITED STATES 1998 B-6 tbl.B-2 (1999), available at <http://www.census.gov/prod/99pubs/p60-270.pdf>.

7. NATIONAL ORGANIZATION ON DISABILITY, SURVEY PROGRAM ON PARTICIPATION AND ATTITUDES 3 (2000), available at <http://www.nod.org/hs2000.html>. A Harris Survey for the National Organization on Disability found that among people of working age, eighteen to sixty-four, only thirty-two percent with disabilities held full or part-time jobs, compared to eighty-one percent of those without disabilities. It also showed that twenty-nine percent of people with disabilities live in poverty (household incomes of \$15,000 or less) compared to ten percent of people without disabilities. And people with disabilities are much less likely to live in households with incomes of more than \$50,000 annually (sixteen percent versus thirty-nine percent). *Id.* The full report is available at <http://www.nod.org/attitudes.html>.

8. See POVERTY IN THE UNITED STATES 1998, *supra* note 6, at 17 tbl.3.

9. See MARK GREENBERG, CENTER FOR LAW AND SOCIAL POLICY, LOOKING AHEAD TO REAUTHORIZATION OF TANF: SOME PRELIMINARY THOUGHTS 2 (2000), available at <http://www.clasp.org/pubs/TANF/LookingAheadtoReauthorization.htm> (showing welfare caseloads are down forty-three percent since Temporary Assistance for Needy Families (TANF) was enacted, and fifty percent since the peak caseloads in 1994); Marilyn R. Ellwod & Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, HEALTH AFF., May 1998, at 137 (TANF caseloads dropped twenty-six percent from 1993 to 1997).

10. POVERTY IN THE UNITED STATES 1998, *supra* note 6, at vi tbl.A.

11. See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, IMMIGRANTS' HEALTH CARE: COVERAGE AND ACCESS fig.18 (2000), available at <http://www.kff.org>; see also POVERTY IN THE UNITED STATES 1998, *supra* note 6, at ix (discussing poverty rates between United States natives and non-natives).

12. Rand Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 649-50 (1975); see also ADVISORY COMMISSION REPORT ON MEDICAID, MEDICAID: TRENDS AND OPTIONS, reprinted in Medicare & Medicaid Guide (CCH) ¶ 40,371A, at 31,464 (1992); John V. Jacobi, *Mission and Markets in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1437-40 (1997).

payments.¹³ Nationally, nearly one-quarter of physicians refuse to treat Medicaid patients,¹⁴ and three-quarters of doctors who see Medicaid patients severely limit their Medicaid practice, billing less than \$10,000 a year to Medicaid.¹⁵ A mere 5.5% of Medicaid participating physicians treat thirty-two percent of Medicaid patients, while one-quarter of participating physicians treat three-quarters of Medicaid patients.¹⁶

Second, the overwhelming majority of health care providers do not live and work where poor people live and work.¹⁷ Caregiving professionals have fled the inner city for areas with good schools, nice houses and fancy malls, to avoid neighborhoods with high unemployment, substandard housing, violence and poor schools.¹⁸ Medicaid helps fund welfare medicine where it is practiced, but it has not kept health care providers from fleeing to the suburbs.¹⁹

Third, welfare medicine requires a calling, a mission of service. Poor people are sicker than others.²⁰ The stress of low wages, high unemployment, substandard housing, violence, and high food costs contribute to physical and mental illness, and substance use.²¹ The stresses of poverty make it harder for poor people to cooperate with care regimes. A special calling is required to

13. PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT 352 (1994).

14. *See* PHYSICIAN PAYMENT REVIEW COMMISSION, PHYSICIAN PAYMENT UNDER MEDICAID, REPORT TO CONGRESS (1991), *reprinted in* Medicare and Medicaid Guide (CCH) at 23 (1991) (noting that 23.7% of physicians do not treat Medicaid patients).

15. PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS, *reprinted in* Medicare and Medicaid Guide (CCH) at 3, 278 (1991).

16. Janet B. Mitchell & Jerry Cromwell, *Medicaid Mills: Fact or Fiction*, HEALTH CARE FIN. REV., Summer 1980, at 41. Janet B. Mitchell & Jerry Cromwell, *President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare*, in SECURING ACCESS TO HEALTH CARE 105, 107 (1982); PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS, ENSURING QUALITY IN MEDICAID MANAGED CARE 259 (1993).

17. *See* Miriam Komaromy et al., *The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations*, 334 NEW ENG. J. MED. 1305, 1306 (1996) (noting that poor urban communities with high proportions of African Americans and Hispanics show only twenty-four physicians per 100,000 people); Katherine Huang, *Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce*, 16 YALE J. ON REG. 175, 179-80 (1999) (noting that the national average is 190 physicians per 100,000 people).

18. *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 175-76 (1999).

19. *See id.* at 175-81.

20. Good health correlates primarily with higher socioeconomic status; poor health correlates directly with poverty. Marianne Foley & Glen R. Johnson, *Health Care of Blacks in American Inner Cities*, in HEALTH CARE ISSUES IN BLACK AMERICA: POLICIES, PROBLEMS, AND PROSPECTS 211, 212 (1987).

21. *See generally* Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647 (1993) (discussing the interaction between race and health care).

care for people who have difficulty following instructions and who often miss follow-up appointments. Practicing welfare medicine requires a sense of mission to learn to care for those from vastly different racial, ethnic and socioeconomic backgrounds. Some caregivers and institutions are drawn to the practice of medicine by this passion; most are not.²²

Welfare medicine cares for those with Medicaid, but it also treats an even larger number of people without health insurance.²³ Medicaid insures almost forty-one million poor and near poor people: children and some parents, pregnant women, those who are permanently and totally disabled, and the elderly.²⁴ The new state Children's Health Insurance Program (CHIP) covers an additional 1.8 million children.²⁵ Together, Medicaid and CHIP cover 42.8 million Americans. However, this number includes only forty-four percent of Americans with incomes at or below the federal poverty line.²⁶ An even larger number of Americans, forty-four million, eighteen percent of the population, remain uninsured.²⁷ In today's world of welfare medicine, for every Medicaid patient there is an uninsured patient.

Moreover, no clear distinction exists between patients who have Medicaid and those who are uninsured. Today's Medicaid patient is tomorrow's uninsured.²⁸ Some people, primarily the poor elderly and the severely disabled, maintain their Medicaid status for years. For most people, though, Medicaid eligibility comes and goes. A pregnant woman is eligible for Medicaid while she is pregnant, but four months after delivery she is likely to be ineligible because income limits for parents are less than a third of those for pregnant women and infants.²⁹ A mother with children can get Medicaid while

22. The same is true in the practice of law where a special cadre of lawyers practice public defense in the criminal system and legal services on the civil side.

23. *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 760 (1997).

24. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID ENROLLMENT AND SPENDING TRENDS 1 (1999), available at <http://www.kff.org/content/archive/2113.2113.pdf>. In 1997, 40.6 million people were enrolled in Medicaid. *Id.*

25. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, CHIP PROGRAM ENROLLMENT: DECEMBER 1998 TO DECEMBER 1999 7 (2000), available at <http://www.kff.org>.

26. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID'S ROLE FOR SELECTED POPULATIONS fig.7 (1997), available at <http://www.kff.org>.

27. CATHERINE HOFFMAN & ALAN SCHLOBOHM, UNINSURED IN AMERICA: A CHART BOOK 10 (2000).

28. One year after leaving welfare and Medicaid forty-nine percent of women and twenty-nine percent of children were uninsured. *Id.* at 51.

29. Although parents of children are categorically eligible for Medicaid, on average, a mother earning more than forty-one percent of the federal poverty line, which was \$5802 in 2000, makes too much money to qualify. In contrast, the income guidelines for pregnant women range from 133% to 185% of the federal poverty guideline, depending upon the state. In 2000, a pregnant woman in a three-person family would be eligible for Medicaid as long as the family's income falls below \$18,820 or \$26,178. See HOFFMAN & SCHLOBOHM, *supra* note 27, at 48.

she is unemployed, but becomes uninsured when she gets a minimum wage job without health insurance that puts her, but not the children, over Medicaid's income guidelines.³⁰ Fluidity reigns in a system in which most people who lose Medicaid become uninsured.³¹ Lack of insurance abounds in a system in which more than eighty percent of the uninsured are connected to the workforce, either as workers or their dependents who are not offered or cannot afford employer-provided coverage, but make too much money to qualify for Medicaid.³²

Welfare medicine is a system financed almost exclusively by government dollars. Despite the talk about cost-shifting between private insurance and welfare care, in reality, most welfare medicine providers have few, if any, privately insured patients to whom they can shift costs.³³ The government, through Medicaid, Medicare, and other programs, shoulders almost half the cost of U.S. health care.³⁴ Medicaid, the safety net for poor people, costs the federal government over ninety billion dollars a year and the states over seventy billion dollars.³⁵ The federal government is the single largest purchaser of maternity care, nursing home and other long term care services,³⁶ and the single most important source of funding for welfare medicine caregivers.

30. *See id.* at 49 (indicating that in thirty-two states a parent who works full-time for minimum wage is not eligible for Medicaid).

31. *See* Bowen Garrett & John Holahan, *Health Insurance Coverage After Welfare*, HEALTH AFF., Jan. 2000, at 175, 177 (noting that forty-one percent of former female welfare recipients were uninsured in 1997); *see also* HOFFMAN & SCHLOBOHM, *supra* note 27, at 51 (indicating that forty-nine percent of women and twenty-nine percent of children were uninsured one year after leaving welfare's Medicaid benefits).

32. HOFFMAN & SCHLOBOHM, *supra* note 27, at 12. Three quarters of the uninsured are in families with at least one full-time worker. Almost twenty percent are in families with two full-time workers. Almost sixty percent of low-wage workers do not have employer based health coverage. *Id.* While almost half, forty-five percent, were not offered insurance, thirteen percent declined coverage because of cost. *Id.* at 46.

33. *See The Impact of Medicaid Managed Care on the Uninsured*, *supra* note 23, at 760-61. Only twelve percent of public hospital patients have private insurance; at urban community health centers 14.3% of patients are privately insured. *Id.* at n.84. *See also* PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, REPORT TO THE CONGRESS: MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM 33 (1995).

34. *See* LARRY LEVITT & JANET LUNDY, THE KAISER CHANGING HEALTH CARE MARKETPLACE PROJECT, TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE: CHART BOOK 8 (1998), available at <http://www.kff.org>. Government programs account for 46.7% of national health expenditures. *Id.*

35. In 1997, the federal cost was \$90.8 billion while the state cost was \$70.4 billion. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER 1 (1999), available at <http://www.kff.org>.

36. In 1995, Medicaid paid for thirty-nine percent of the births in the U.S. and financed forty-seven percent of nursing home costs and thirty-eight percent of long-term care expenses. *Id.* at 2.

In addition to insuring patients, Medicaid and Medicare support welfare medicine for the uninsured through reimbursement enhancements. Medicaid and Medicare disproportionate share hospital (DSH) payments help support institutions that care for large numbers of publicly insured and uninsured patients.³⁷ Medicaid and Medicare graduate medical education money, while not earmarked for indigent care, help fund the welfare medicine practiced by academic medical centers.³⁸ The historic system of cost-based Medicaid reimbursement for federally qualified community health clinics was designed to support their mission to serve the uninsured.³⁹

As important as Medicaid is to welfare medicine, a patchwork of federal and state programs contribute almost as many dollars.⁴⁰ A plethora of federal block grants provide states with money for child and maternal health, mental health care, alcohol and substance abuse, and other specialized health programs.⁴¹ The federal government funds Ryan White programs to provide direct medical care and prescription drugs to people with HIV.⁴² The federal Health Care for the Homeless program pays for outreach and health services to homeless people.⁴³ Indian Health Service supports care for Native

37. See 42 U.S.C. § 1395ww(a) (1998); 42 C.F.R. § 412.106 (2000); 42 U.S.C. § 1396a(10)(A)(ii)(XIII) (1998); see generally TERESA A. COGLIN & DAVID LISKA, THE URBAN INSTITUTE, THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAM: BACKGROUND AND ISSUES 1 (1997) (discussing DSH payments), available at <http://www.urban.org>.

38. See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 528-42 (1997).

39. Solomon & Asaro, *supra* note 3, at 265-67.

40. See *infra* notes 41-48 and accompanying text.

41. For a partial listing of federal block grant funds, see Federal Money Retriever, Federal Government Funding: Maternal and Child Health, at <http://www.fedmoney.com/grants/su0159.htm> (last visited Oct. 9, 2000).

42. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (1990) (codified as amended at 42 U.S.C. § 300ff (Supp. II 1990)). Title II of the act provides funding to states to provide HIV care to uninsured, underinsured and low-income people living with HIV. In 1999, services provided through the CARE Act reached about 400,000 individuals. About \$6.4 billion has been appropriated for the CARE Act since its inception. Almost \$965.5 million of this amount has been allocated to ADAP funds to allow states to purchase HIV treatment drugs. HIV and AIDS: US DHHS Funds Ryan White Act (June 20, 1999), at http://www.hivandhepatitis.com/hiv/rmhiv6_20_99_04.htm.

43. In 1987, Congress enacted Title VI of the Stewart B. McKinney Homeless Assistance Act, authorizing grants for the provision of health care to homeless individuals. Stewart B. McKinney Homeless Assistance Act, Pub. L. No. 100-77, 101 Stat. 482 (1987) (codified as amended at 42 U.S.C. § 11301 (1988)). In 1998, grants were awarded to 128 community-based organizations that, in turn, expanded their service network through arrangements with over 300 health care providers. In that year, the HCH programs served more than 430,000 clients nationwide. NATIONAL COALITION FOR THE HOMELESS, HEALTH CARE AT HOMELESSNESS 2 (1999), at <http://nch.ari.net/health.html>.

Americans.⁴⁴ The Veterans Health Administration offers inpatient, outpatient, respite and long term care services to poor veterans.⁴⁵ Public mental health systems, both inpatient and outpatient services, are primarily funded by state dollars.⁴⁶ State and local grants and tax dollars support public hospitals, public clinics and private not-for-profit providers that treat the uninsured.⁴⁷ Government funding for this hodge-podge of programs comprises 12.8% of national health expenditures, compared to 14.3% spent on Medicaid.⁴⁸

While the numbers help illustrate the size and scope of welfare medicine, they cannot paint the human picture. Community health clinics, like Dr. Mullan's Cardozo Community Health Center in Washington, D.C., have a long tradition of compassionate, high quality care.⁴⁹ Other government funded welfare medicine programs offer inspiring models of medical care at its best.⁵⁰ Throughout the country, concerned, committed and highly skilled caregivers work in welfare medicine.⁵¹

However, welfare medicine can also be dysfunctional. Welfare medicine breaks down when the community clinic does not have evening hours or an after-hours phone line, and the hospital, which runs the clinic and receives over seventeen million dollars a year for indigent care, garnishes the minimum wage salary of a young mother who forgot, in the midst of a nighttime medical crisis, to bring her two year old son's Medicaid card with her to the emergency

44. See Indian Health Service Internet Home Page, <http://www.ihs.gov> (last modified Sept. 8, 2000).

45. See VETERANS BENEFITS AND SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS, GATEWAY TO VA HEALTH CARE 1, at <http://www.va.gov/vbs/health/index.htm> (last modified July 28, 2000).

46. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 4 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec2.html>.

47. See JACK A. MEYER ET AL., THE URBAN INSTITUTE, THE ROLE OF LOCAL GOVERNMENTS IN FINANCING SAFETY NET HOSPITALS: HOUSTON, OAKLAND, AND MIAMI 9-10 (1999), available at <http://www.urban.org> (quantifying local support to public hospitals in three communities); see also *The Impact of Medicaid Managed Care on the Uninsured*, supra note 23, at 761 (indicating that in 1991, nearly eighteen percent of public hospital revenues came from local government subsidies).

48. LEVITT & LUNDY, supra note 34, at 8. See also *The Impact of Medicaid Managed Care on the Uninsured*, supra note 23, at 762 (thirty-five percent of the funding for community health centers comes from government and foundation grants).

49. SARA ROSENBAUM & ANNE DIEVLER, A LITERATURE REVIEW OF THE COMMUNITY AND MIGRANT HEALTH CENTER PROGRAMS 12-13, 35 (1992), available at <http://gwis.circ.gwu.edu/~chsrp/rp.html>.

50. See, e.g., PEDRO JOSE GREGG, JR., WAKING UP IN AMERICAN 180-89 (1999); see also Howard Larkin, *Community Care Gets Competitive*, 40 AM. MED. NEWS 7, 7-9 (1997) (describing the example of the 16th Street Community Health Center in Milwaukee).

51. See, e.g., DAVID HILKIKER, NOT ALL OF USE ARE SAINTS: A DOCTOR'S JOURNEY WITH THE POOR 1 (1994).

room.⁵² Welfare medicine is myopic when Medicaid pays for nursing home care for a forty-seven year old woman with cerebral palsy, but will not cover the cost of the attendant care that would allow her to live in the community.⁵³ Welfare medicine fails when Medicaid pays for psychiatric hospitalizations to save a homeless woman diagnosed with paranoid schizophrenia when she crashes, but will not reimburse the services of an Assertive Community Treatment Team, an interdisciplinary outreach team, that can provide the psychiatric, social and medical services needed to help her remain stable and become housed.⁵⁴

This is welfare medicine, health care for poor people, both its accomplishments and its shortcomings. At its core, welfare medicine remains a segregated system funded by state and federal money. Medicaid pays for much of welfare medicine, but a patchwork of other government programs play a significant role as do federal, state and local tax subsidies. However, changes in Medicaid are affecting all of welfare medicine.

III. COMMERCIALIZATION OF MEDICAID

Medicaid has changed. What was once a fee-for-service system financed with government dollars and delivered by public and private not-for-profit institutions has morphed into a managed care system dominated by for-profit entities. Forty-eight states use managed care for at least some Medicaid recipients, only rural Alaska and Wyoming have no recipients enrolled in managed care.⁵⁵ Nationwide, fifty-four percent of Medicaid recipients are enrolled in managed care, up from less than ten percent in 1991.⁵⁶ Twelve states have more than seventy-five percent of their Medicaid enrollees in managed care.⁵⁷ Sixty-four percent of Medicaid enrollees receive managed care in commercial Health Maintenance Organizations (HMOs).⁵⁸

Medicaid managed care is accomplished in two ways. Some states use primary care case management systems (PCCM) to match beneficiaries with

52. Confidential memorandum from Sidney Watson, to the File 1 (May 8, 1999) (on file with the Saint Louis University Law Journal).

53. Debbie Rhyne, *Looking For a Home: Mary Hicks is Going to Court to Get Out of a Nursing Home*, THE MACON TELEGRAPH, July 30, 2000, at A1.

54. See Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. (forthcoming 2000) (on file with author).

55. MARSHA REGENSTEIN & STEPHANIE E. ANTHONY, THE URBAN INSTITUTE, MEDICAID MANAGED CARE FOR PERSONS WITH DISABILITIES 3 (1998), available at <http://www.urban.org>.

56. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID AND MANAGED CARE fig.1 (1999), available at <http://www.kff.org> (noting that in 1998, 53.6% of Medicaid enrollees were in managed care compare with 9.5% in 1991).

57. Marsha Gold & Anna Aizer, *Growing An Industry: How Managed is TennCare's Managed Care?*, HEALTH AFF., Jan. 2000, at 86.

58. FELT-LISK, *supra* note 2, at 17.

primary care physicians who coordinate the patient's care and serve as gatekeepers to specialty and inpatient services.⁵⁹ These PCCM gatekeepers are generally paid a monthly case management fee with all other services paid on a fee-for-service basis.⁶⁰ Most states, though, contract with managed care organizations (MCOs) paying them a monthly capitation payment on behalf of each enrollee to provide a specified package of benefits.⁶¹

States rushed into Medicaid managed care primarily for financial reasons. First, and foremost, states saw Medicaid managed care as a cost containment strategy.⁶² Managed care's rhetoric of competition and cost-effectiveness promised to do what state policy makers had been unable to do, stop the growth in Medicaid spending by using "the market as the toughest regulator." Moreover, capitated Medicaid managed care shifts the risk of Medicaid cost increases from state budgets to the managed care contractor.

States also rushed into commercial Medicaid managed care because the commercial HMOs came calling. For years, the private HMO industry shunned Medicaid because it was unprofitable: reimbursement was low, and, as long as enrollment was voluntary, few Medicaid recipients opted for managed care.⁶³ However, in the early 1990s, the Clinton administration began granting waivers of federal Medicaid freedom of choice requirements so states could force Medicaid recipients into managed care.⁶⁴ Since 1997, the Balanced Budget Act allows states to require most Medicaid enrollees to participate in managed care without obtaining federal approval.⁶⁵ With almost eleven percent of the U.S. population enrolled in Medicaid, commercial HMOs saw a better business opportunity.⁶⁶

59. REGENSTEIN & ANTHONY, *supra* note 55, at 3.

60. *See id.*

61. *See id.*; John Holahan et al., *Medicaid Managed Care in Thirteen States*, HEALTH AFF. May 1998, at 43, 51 (two-thirds of Medicaid managed care enrollees are in risk-bearing MCOs).

62. *Id.* at 45.

63. Holahan, *supra* note 61, at 52; *see generally* ROSENBLATT, *supra* note 12.

64. *See* Colleen A. Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS. J. 93, 99, 116, 121 (1997); *see also* Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty and Physician Self-Interest*, 11 AM. J.L. & MED. 191, 203-04 (1995) (discussing the story of Tennessee's Medicaid waiver); Vernellia Randall et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069 (1996) (reviewing and comparing state Medicaid waivers granted by the Clinton administration).

65. The Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 489 (1997) (codified at 42 U.S.C. § 1397u-2 (Supp. IV 1998)). The BBA allows states to make managed care mandatory without a federal waiver except for those who are eligible for both Medicaid and Medicare and children with special needs. The BBA also mandates requirements for managed care enrollment procedures and choice of plans. It also requires that states establish Medicaid managed care access standards and procedures for monitoring quality and appropriateness of care. *Id.*

66. Holahan et al., *supra* note 61, at 52.

Moreover, the timing was right for commercial Medicaid managed care because managed care was exploding in the private sector. Insurance companies like Cigna, Aetna and Blue Cross/Blue Shield were organizing for-profit HMOs to take advantage of new managed care opportunities in the private sector. These commercial, for-profit HMOs now dominate the private HMO market, accounting for sixty-three percent of enrollees and seventy-five percent of plans.⁶⁷ They have the administrative infrastructure to operate managed care systems. Expanding into the growing Medicaid managed care field seemed like a promising business opportunity.

Using commercial HMOs to deliver Medicaid services coincides with two important trends: a societal trend to privatize government services, and a health care trend toward corporatization. Throughout government, a move is afoot to use private contractors to provide services traditionally offered by public schools, prisons and the cash welfare system.⁶⁸ Medicaid has always relied on private institutions and caregivers to deliver medical services. Medicaid has even used private corporations, like Ross Perot's Electronic Data Systems (EDS) for utilization review and claims processing.⁶⁹ It is an easy next step to draw private actors into designing Medicaid's delivery system and to morph from fee-for-service Medicaid into managed care.

In addition, health care is becoming corporatized. Public hospitals are closing or converting to private status.⁷⁰ Many communities have seen their not-for-profit hospitals become for-profit entities.⁷¹ Commercial insurers and HMOs dominate the insurance and managed care fields, and even Blue

67. Sylvia Fubini, *2000 Industry Outlook*, HEALTHCARE TRENDS REP., Jan. 2000, at 7-8.

68. See generally Barbara Ehrenreich, *Spinning the Poor into Gold: How Corporations Seek to Profit from Welfare Reform*, HARPER'S MAG., Aug. 1997, at 44.

69. See, e.g., STATE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH, DIVISION OF MEDICAL ASSISTANCE PROVIDER MANUALS 1-2 pt.1 (n.d.). In Georgia, a number of different private entities handle various administrative functions for Medicaid. Electronic Data Systems (EDS), a for-profit corporation, provides claims processing, provider enrollment, prior approval for some services, and determines eligibility for nursing home services. A different corporation, First Health Services, handles prior approvals and other functions related to pharmaceuticals. Yet another private entity, Georgia Medical Care Foundation, handles prior approval of physician services. Yet other private entities have responsibility for peer review and utilization review. See *id.* at 13.

70. See generally Phyllis E. Bernard, *Privatization of Rural Public Hospitals: Implications for Access and Indigent Care*, 47 MERCER L. REV. 991 (1996) (discussing various corporate models for restructuring public hospitals); THE COMMONWEALTH FUND, PUBLIC HOSPITALS—A PRESCRIPTION FOR SURVIVAL 1 (1996), at <http://www.cmwf.org/programs/minority/siegelbf.as>.

71. See generally Gary J. Young & Kamal R. Desai, *Nonprofit Hospital Conversions and Community Benefits: New Evidence from Three States*, HEALTH AFF., Sept. 1999, at 146 (discussing the conversion of nonprofit hospitals that come under the control of a for-profit company); Jack Needleman et al., *Hospital Conversion Trends*, HEALTH AFF., Mar. 1997 at 187 (presenting information on the extent, geographic distribution, and other issues related to hospital conversions).

Cross/Blue Shield has become a for-profit firm.⁷² The stampede to corporate status even includes doctors who are more and more likely to be employees or shareholders of increasingly large group practices.⁷³

Not only was the time right for commercial HMOs to enter Medicaid, Medicaid managed care, particularly when delivered by commercial HMOs, offers exciting possibilities. Commercial HMOs offer the allure of finally achieving the single-tier health care system that the original proponents of Medicaid sought: one managed care plan for both privately insured people and those with Medicaid. Commercial managed care also offers a vehicle to overcome the chronic deficiencies of Medicaid. Medicaid enrollees have faced persistent problems in accessing primary care. Commercial HMOs offer to link Medicaid recipients with a physician or other primary care provider who can provide ongoing preventive and primary services.⁷⁴ Many Medicaid recipients and their advocates hailed managed care as a cure for what ails Medicaid.⁷⁵

The result of this confluence of events is that commercial managed care now dominates Medicaid. For-profit HMOs serve six million of the 9.3 million people in Medicaid managed care, sixty-four percent of enrollees.⁷⁶ Commercial HMOs have arrived and Medicaid has changed.

IV. FALSE PREMISES AND FALSE PROMISES

Although commercial HMOs are now a mainstay of Medicaid managed care, the courting ritual between states and commercial entities is fraught with rose colored glasses, flirtation and even tomfoolery. At bottom, the commercialization of Medicaid is based on false premises that doom the experiment for failure.

First, Medicaid managed care cannot deliver the cost savings that states expect. As Sarah Rosenbaum says: "The Medicaid managed care revolution responded to a phantom problem."⁷⁷ In the early and mid 1990s, states were reeling from explosive Medicaid cost increases. From 1988 to 1993, Medicaid

72. See, e.g., Fubini, *supra* note 67, at 7 (stating that for profit HMOs account for 64.2% of all HMO enrollment).

73. See *id.* at 13 (noting that the size of physician practices has increased significantly in the past thirty years).

74. James W. Fossett & Frank J. Thompson, *Back-Off Not Backlash in Medicaid Managed Care*, 24 J. HEALTH POL. POL'Y & L. 1159, 1161 (1999).

75. See Holahan et al., *supra* note 61, at 44-46; see generally Watson, *supra* note 64.

76. FELT-LISK, *supra* note 2, at 17.

77. Sara Rosenbaum, Medicaid at Thirty-Five, Address at the Saint Louis University Health Law Symposium (Mar. 31, 2000) (transcript available with the Saint Louis University Law Journal).

costs grew almost twenty percent per year.⁷⁸ From 1993 to 1995, the growth slowed, but still averaged nine to ten percent annually.⁷⁹ States are desperate to put the brakes on, but these cost increases cannot be controlled by managed care techniques.

Two factors primarily contributed to the staggering growth in Medicaid costs. One, eligibility expansions substantially increased the size of Medicaid rolls.⁸⁰ Two, much of the rest of the growth resulted from clever state manipulation of reimbursement rules for payments to disproportionate share hospitals and the shifting of state mental health and mental retardation costs to Medicaid.⁸¹ Altering service delivery patterns via managed care cannot reverse these cost increases. Cost increases can, and have been, halted by drops in Medicaid eligibility and reductions in disproportionate share funding.⁸²

Second, Medicaid is not a program with a great deal of fat. Medicaid fee-for-service reimbursement rates average less than half that of private insurance rates.⁸³ Medicaid's administrative overhead is less than five percent.⁸⁴ Such a lean program leaves little room, if any, for further cost reductions. Estimates indicate that managed care may, at best, reduce Medicaid costs by five to ten percent.⁸⁵

Even if Medicaid managed care can reduce the costs of services per enrollee, overall program costs are unlikely to show significant savings because the groups being enrolled—parents and children—use relatively few services. Although parents and children make up almost seventy-five percent of Medicaid enrollees, they use only twenty-five percent of Medicaid services.⁸⁶ Even if Medicaid managed care can produce a five to ten percent

78. MEDICAID: A PRIMER, *supra* note 35, at 5. Between 1988 and 1993, Medicaid spending grew at an average annual rate of 19.6%. *Id.*

79. MEDICAID ENROLLMENT AND SPENDING TRENDS, *supra* note 24, at 2.

80. Fossett & Thompson, *supra* note 74, at 1160.

81. *Id.*; John Holahan & David Liska, *The Slowdown in Medicaid Spending Growth: Will it Continue?*, HEALTH AFF., Mar. 1997, at 157-58.

82. *See id.* at 157; BRIAN BRUEN & JOHN HOLAHAN, THE URBAN INSTITUTE, SLOW GROWTH IN MEDICAID SPENDING CONTINUES IN 1997 1, 4 (1999), available at www.urban.org/health/slow_growth_medicaid.pdf.

83. *See supra* note 13 and accompanying text.

84. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 725 (1997). Administrative overhead is 5.5% in large group markets and twenty-five percent in small group markets. This means that overhead is similar between Medicaid and similarly sized programs. *Id.*

85. Holahan et al., *supra* note 61, at 46.

86. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE, at 1 fig.1 (1999) (parents and children comprise seventy-three percent of enrollees and use 25.1% of expenditures), available at <http://www.kff.org>. Their average yearly per enrollee cost is only \$741 for children and \$1874 for parents. In contrast, the aged use on average \$10,804 per year, and those with disabilities use \$8841 a year. *Id.*

savings, which many doubt, as long as enrollment efforts focus on parents and children, the overall program savings will be an uninspiring 1.2 to 2.5%.⁸⁷ A savings, but no panacea either.

Third, managed care theory, saving money by using preventive medicine and well care rather than paying for expensive high end care after people get sick, does not work with Medicaid because of its byzantine eligibility criteria. It is impossible to use Medicaid services to prevent people from getting sick when childless adults only qualify for Medicaid after they are “permanently and totally disabled.”⁸⁸ Under Medicaid rules, a person with HIV or any other progressive or chronic disease cannot qualify to get the drugs that will keep her healthy and in the workforce.⁸⁹ Medicaid is available only after people are too sick to work and need acute or end stage care.

Moreover, many Medicaid enrollees move on and off Medicaid rolls making continuity of care and preventive care impossible. Nearly half of Medicaid enrollees lose their coverage within one year and seventy percent are out of the program within two years.⁹⁰ In a study of California and Florida’s Medicaid programs, one-quarter to one-third of enrollees left Medicaid during the year.⁹¹ Another seven to ten percent went off Medicaid and returned during the year, a phenomenon called churning.⁹² Some people lose Medicaid eligibility because they begin earning too much money. Others, like pregnant women, no longer fit into one of Medicaid’s categorical eligibility pigeonholes. Whatever the reason, most Medicaid enrollees who lose Medicaid become uninsured.⁹³ When the commercial HMO only serves Medicaid and privately insured patients, the newly uninsured patient is out of luck. She has no ongoing source of care and must begin navigating the welfare system of care, public hospitals and public clinics, to find someone who will treat her.

Fourth, commercial HMOs have no experience practicing welfare medicine. Cigna, Aetna, Blue Cross/Blue Shield and other commercial HMOs have built a track record providing services to large employer groups. Commercial health care, the brand the middle class receives, does not work

87. See Holahan et al., *supra* note 61, at 46.

88. To qualify for Medicaid, adults must either be “permanently and totally disabled” or caretaker parents. Most adults on Medicaid qualify because of their status as a parent or other caretaker. MEDICAID: A PRIMER, *supra* note 35, at 3.

89. *See id.*

90. Arnold M. Epstein, *Medicaid Managed Care and High Quality Can We Have Both?*, 278 J. AM. MED. ASS’N 1617, 1621 (1997).

91. MARILYN R. ELLWOOD & KIMBALL LEWIS, THE URBAN INSTITUTE, ON AND OFF MEDICAID: ENROLLMENT PATTERNS FOR CALIFORNIA AND FLORIDA IN 1995 2 (1999), available at <http://newfederalism.urban.org/html/occa27.pdf>.

92. *Id.*

93. Epstein, *supra* note 90, at 1621.

well for poor people. Commercial HMOs provide a fairly standard set of medical benefits: inpatient and outpatient care, and prescription drugs. They set up daytime office hours with telephone numbers for after-hours service and assume that enrollees can take care of the rest of their lives. People with private insurance tend to have houses, stable jobs, and support from family, friends and co-workers. Many poor people, though, do not have jobs, housing, telephones, reliable transportation or support networks.

Commercial HMOs simply do not know how to practice and administer welfare medicine. They do not have systems for helping a homeless man who, after having his life saved by \$30,000 to \$40,000 of ICU treatment, no longer needs acute care hospital services, but has no place to go upon discharge but to the street.⁹⁴ Commercial insurers have no experience creating networks to treat a woman with diabetes who needs insulin but does not have a refrigerator in which to keep it. Commercial HMOs are set up to deliver a discrete set of medical benefits. They do not have experience in the world of welfare medicine, which requires integrating medical and social services.

Moreover, commercial HMOs have little, if any, experience treating the elderly and disabled who, although they make up only about twenty-five percent of Medicaid recipients, use sixty-five percent of Medicaid services.⁹⁵ These enrollees include people with AIDS, children with mental retardation and developmental disabilities, people with severe mental illness and others with chronic alcohol and substance abuse problems.⁹⁶ Commercial HMOs have little experience with these diseases and the specialized providers who treat them.⁹⁷ Commercial HMOs focus on acute care services. The elderly and those with disabilities need more long-term care: nursing home care, home health services and mental health treatment.⁹⁸

In addition, commercial HMOs are unlikely to have providers in their networks that practice where welfare patients seek care. Commercial HMOs

94. See LISBETH B. SCHORR, *WITHIN OUR REACH: BREAKING THE CYCLE OF DISADVANTAGE* 137 (1988).

95. THE MEDICAID PROGRAM AT A GLANCE, *supra* note 86, at 1 fig.1. The elderly comprise 10.1% of Medicaid enrollees. Those with disabilities account for 16.8%. *Id.* However, the elderly use 27.6% of expenditures while the disabilities use 37.5%. *Id.*

96. See MARSHA REGENSTEIN & STEPHANIE E. ANTHONY, THE URBAN INSTITUTE, *MEDICAID MANAGED CARE FOR PERSONS WITH DISABILITIES 2* (1998), available at <http://newfederalism.urban.org/html/occal1.pdf>; see also Foley, *supra* note 64, at 128-29 (discussing the problems of disabled children and others).

97. See, e.g., John A. Flippen, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*, 50 VAND. L. REV. 683 (1997) (discussing the special needs of people with mental illness and special service package Medicaid provides for children).

98. Holahan et al., *supra* note 61, at 49, 63 n.22. Medicaid has covered services not offered by most commercial plans, including substance abuse treatment, mental health care, rehabilitation, home and personal care, and case management. *Id.*

market to employers who are likely to have enrollees who live in suburbs and exurbs where few poor people live. Commercial HMOs create networks of primary physicians who are easily accessible to enrollees. These practitioners, like their patients, live beyond the neighborhoods with high concentrations of Medicaid patients. Geographically, these HMO network providers are unlikely to practice welfare medicine.

Finally, it is becoming clearer that commercial entities may not be willing to stay in the Medicaid managed care market for the long haul. A few years ago, the commercial HMOs came to Medicaid managed care in droves; now they are leaving in droves.⁹⁹ One-third of states have seen commercial HMOs withdraw from the Medicaid market.¹⁰⁰ Aetna has left New York and Connecticut.¹⁰¹ Utah cannot find a commercial HMO to bid on Medicaid.¹⁰² New York City's Medicaid program has only five commercial HMOs left,¹⁰³ and in the Bronx only one commercial Medicaid HMO remains.¹⁰⁴ Ohio has only one commercial HMO serving its Medicaid enrollees.¹⁰⁵ In Tennessee, Blue Cross/Blue Shield, the state's largest Medicaid contractor, renegotiated its TennCare contract so it is no longer a full risk-bearing HMO.¹⁰⁶

As commercial HMOs abandon the Medicaid ship, often the only Medicaid managed care entities left behind are welfare HMOs: HMOs whose members have Medicaid, Medicare, or other government coverage, rather than private insurance.¹⁰⁷ Today, the fastest growing category of Medicaid managed care is the "Medicaid only" plan, one in which seventy-five percent or more of

99. See Leigh Page, *More Commercial Plans Leave Medicaid*, AM. MED. NEWS, Aug. 23-30, 1999, at 13. See also THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID AND MANAGED CARE fig.4 (1999), available at <http://www.kff.org>; FELT-LISK, *supra* note 2, at 10 (commercial plans withdrew from the Medicaid market more often and entered it less often in 1997 and 1998, compared with previous years. Between 1996 and 1997, more than twice as many commercial plans withdrew from Medicaid as the year before).

100. *Commercial Insurers Shun Medicaid Market: Is it a Bailout or a Shakeout? Nobody's Sure—Yet*, ST. HEALTH WATCH, Nov. 1998, at 1, 4.

101. *Id.* at 1.

102. *Id.* at 4.

103. *Id.*

104. *A Most Dangerous Game: Medicaid Plans and States Rely Exclusively on Each Other for Payments, Enrollees*, ST. HEALTH WATCH, Feb. 1999, at 3.

105. Amy Goldstein, *Managed-Care Medicaid Experiment Fails in Ohio*, WASH. POST, Aug. 14, 1999, at A8.

106. *Tennessee: HCFA Approves Risk-Sharing Plans as Part of TennCare Overhaul Effort*, 9 BNA HEALTH L. REP. 1141 (2000). The TennCare program now assumes risk for Medicaid costs and Blue Cross receives a bonus if it keeps costs within a specified range. *Id.* See also *Not Yet Singing the Blues—TennCare Officials Say Plan's Departure Won't Kill the Program*, ST. HEALTH WATCH, Feb. 2000, at 1.

107. For example, in the Bronx Health Plan, Medicaid covers eighty percent of its members and other government programs cover twenty percent. *A Most Dangerous Game*, *supra* note 104, at 3.

enrollees are Medicaid recipients.¹⁰⁸ Over forty percent of Medicaid managed care enrollees are in “Medicaid only” plans.¹⁰⁹ From 1992 to 1996, the percentage of welfare HMOs participating in Medicaid managed care grew from eleven to eighteen percent.¹¹⁰

At a minimum, the exodus of commercial HMOs and the emergence of welfare HMOs dash hopes that Medicaid managed care will mainstream those on Medicaid. Welfare HMOs return Medicaid recipients to the segregated world of welfare medicine. Segregated care may have its advantages. Many welfare HMOs have networks of long time safety net providers with enviable records of providing quality care based upon their knowledge of welfare medicine. They have a cadre of committed providers and long-term experience providing care to poor people. This background means that many welfare HMOs have the three characteristics that appear most important in predicting successful Medicaid HMO performance: competence, commitment and stability.¹¹¹ However, welfare HMOs create other risks.

Many welfare HMOs are organized, sponsored and financed by traditional safety net providers, public and private not-for-profit hospitals and clinics who historically practiced welfare medicine.¹¹² These institutional providers have always struggled with low Medicaid reimbursement rates and the need to cover the costs of caring for the uninsured. Now though, Medicaid managed care has forced them to become risk bearers as well. As welfare HMOs they are reimbursed by Medicaid on a per enrollee capitation rate that, generally, does not take into account that their other welfare patients, often half their patient load, are uninsured.¹¹³

Welfare HMOs risk insolvency and communities risk losing their welfare medicine system. In 1997, seventy percent of welfare HMOs lost money, while only eleven percent showed a profit.¹¹⁴ In contrast, forty-three percent of commercial HMOs enrolled in Medicaid made money, even though fifty-

108. Fossett & Thompson, *supra* note 74, at 1165.

109. *Id.*

110. *A Most Dangerous Game*, *supra* note 104, at 3. In 1992 10.8% of Medicaid MCOs were welfare HMOs; in 1996 the number was 17.8%. *Id.* Prior to the Balanced Budget Act of 1997, states had to have federal approval to enroll Medicaid recipients in managed care plans that had more than seventy-five percent Medicaid enrollees. However, the 72/25 rule, as it was known, was repealed in 1997 allowing Medicaid-only plans. Sylvia Fubini, *1999 Industry Outlook*, HEALTHCARE TRENDS REP., Jan. 1999, at 14.

111. *A Most Dangerous Game*, *supra* note 104, at 4. See also Bruce E. Landon & Arnold M. Epstein, *Quality Management Practices in Medicaid Managed Care: A National Survey of Medicaid and Commercial Health Plans Participating in the Medicaid Program*, 282 J. AM. MED. ASS'N 1769, 1770 (1999) (welfare HMOs are more likely to provide targeted services to meet the special needs of Medicaid patients).

112. See Holahan et al., *supra* note 61, at 58.

113. See text accompanying notes 23-27, 41-48.

114. *A Most Dangerous Game*, *supra* note 104, at 3.

seven percent showed a loss.¹¹⁵ Although it is too early to predict how welfare HMOs will fare financially, the warning signs signal caution.¹¹⁶

Examination of commercial Medicaid managed care reveals false promises. Medicaid managed care is unlikely to dramatically lower costs. Without substantial guidance and training, commercial HMOs are unlikely to know enough about welfare medicine to improve the quality of care for the poor. Moreover, the experiment is dangerous. The influx and outflow of commercial HMOs are likely to harm patients who end up floundering from one system to the next. The entrance and exit of commercial HMOs is also likely to leave traditional welfare providers in an even more precarious financial position than they were when fee-for-service Medicaid populated the world. Medicaid enrollees are likely to be drawn through a short period of commercial Medicaid managed care only to find themselves dropped back into an even more distinctly two-tiered medical care system than the one which existed before the advent of commercial Medicaid HMOs.

V. RETHINKING WELFARE MEDICINE

Transplanting commercial HMOs into Medicaid does not cure what ails Medicaid and welfare medicine. Commercial HMOs are unlikely to have the networks or the know-how to deliver the specialized medical and social care that welfare medicine requires. However, the graver danger posed by the commercialization of Medicaid is that by focusing too narrowly on transplanting commercial HMOs into Medicaid, we have lost an opportunity to think creatively about welfare medicine and Medicaid and managed care's role in it.

Managed care is fast becoming the curse word of medicine, yet managed care methodology, or what might more accurately be termed "managing care," has much to offer Medicaid and welfare medicine. The term "managed care" refers to many different organizational arrangements,¹¹⁷ but is often popularly associated with systems of overzealous cost cutting. However, managed care when done responsibly, offers to integrate the financing and delivery of welfare medicine care. MCOs contract to create systems of care. The MCO agrees to furnish the enrollee with a specific package of services and providers to deliver those services for a preset fee, usually a capitation rate or a global budget.¹¹⁸

115. *Id.*

116. See generally SUZANNE FELT-LISK, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE CHARACTERISTICS AND ROLES OF MEDICAID-DOMINATED MANAGED CARE PLANS v (2000), available at <http://www.kff.org> (discussing the financial risk of Medicaid-dominated plans in thirteen states)

117. Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 J. AM. MED. ASS'N 1512, 1512 (1994).

118. *Id.*

Under this contractual system, managed care offers possibilities for what ails welfare medicine and Medicaid. The historic fee-for-service Medicaid system is often dysfunctional. It pays providers to treat people after they get sick rather than keeping them well. It fails to attract sufficient physicians. It encourages a welfare medicine system that relies too heavily on hospital emergency rooms and outpatient clinics that provide episodic care. It often does not cover the types of care the aged and people with disabilities most need and want, like home health services and community based mental health care.

Managed care creates the framework to begin reconstructing welfare medicine. Managed care promises to move care out of the emergency room, where continuity of care and an ongoing provider-patient relationship is impossible, and to match enrollees with a primary care provider who will help the patient get preventive care to stay well or, for those with chronic or severe illness, to live as full and functional a life as possible. Capitated or global payments can relieve welfare medicine and Medicaid from the financial constraints of a medical insurance model. Managed care creates a financial structure capable of providing poor people, particularly the elderly and those with disabilities, with the mix of medical and social services they need to lead healthier, more productive lives.

Programs that incorporate capitated payments have shown enormous potential for improving welfare medicine and Medicaid. In Baltimore, a special capitated mental health network serves homeless, mentally ill people. It provides mental health services, case management and housing. The program has proved that it can keep people well and help them return to work at a lower cost than the old Medicaid fee-for-service rate.¹¹⁹ Another Baltimore program for pregnant substance-abusing women combines intensive peer group support and obstetrical care.¹²⁰ The program costs less than fee-for-service Medicaid, and results in a better life for mother and child.¹²¹

However, for managed care theory to work for welfare medicine, poor people need to be able to settle into managed care systems to get the benefits of a “stay healthy” approach. Preventive care is unlikely, as long as people rotate from Medicaid managed care to the world of the uninsured and untreated. Moreover, welfare medicine providers’ financial stability will remain precarious as long as half their patients are “self-pays.”

119. See *Charm City Capitation Covers Chronically Ill Residents*, MANAGED BEHAVIORAL HEALTH NEWS, June 13, 1996, at 4. See also Carol Wilkins, *Building a Model Managed Care System for Homeless Adults With Special Needs: The Health, Housing, and Integrated Services Network*, 2 CURRENT ISSUES IN PUBLIC HEALTH 39 (1996) (describing a model capitated system that delivers housing, health care and other services to formerly homeless, mentally ill people).

120. See *Baltimore Program Uses Residents for Outreach*, ALCOHOLISM & DRUG ABUSE WEEK, Aug. 2, 1993, at 3.

121. *Id.*

One option for reconstructing welfare medicine into a system that can take advantage of what managed care has to offer is to expand insurance coverage to provide more people with Medicaid, private health insurance and state-funded alternatives, thereby reducing the number of uninsured patients.¹²² States have increased flexibility to expand Medicaid eligibility without seeking federal waivers. States may now offer Medicaid to working parents with incomes approaching 150% of the federal poverty line.¹²³ Also, they may offer Medicaid to disabled people with incomes up to 250% of the federal poverty line.¹²⁴ The State Children's Health Insurance Program (CHIP) offers states federal matching funding to insure children in households with incomes up to 200% of the federal poverty guideline through Medicaid or a separate insurance program.¹²⁵ An increase in the number of insured patients means more financial stability for safety net providers. Expanded insurance coverage also means that more people can be enrolled in MCOs or other systems that focus on preventive and long-term care as well as acute care. Tennessee,

122. Medicaid and SCHIP expansions should be particularly attractive to states because it allows them to match state expenditures with federal dollars. For every dollar spent on Medicaid or SCHIP, the federal government contributes fifty to eighty-three cents. Medicaid expansions leverage federal dollars without placing heavier costs on employers, health care providers or local government entities. See MEDICAID: A PRIMER, *supra* note 35, at 1.

States can request section 1115 waivers to allow them to cover non-disabled adults and other groups excluded from categorical eligibility by federal Medicaid law, and to raise income eligibility guidelines above the limits set out in federal law. The only problematic part of the section 1115 process is that states must show that the eligibility expansion will be cost-neutral in terms of the federal Medicaid match. Nevertheless, states have made creative use of section 1115 waivers to dramatically expand Medicaid eligibility. Tennessee has used a section 1115 waiver to expand Medicaid to cover everyone in the state with incomes up to 200% of poverty, and to allow those with higher incomes to buy into the program. See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 205-06 n.143 (1995). Missouri's section 1115 waiver allows it to cover children and pregnant women with incomes up to 300% of poverty, and parents with incomes up to 100% of poverty. Presentation for the Access to Health Committee of St. Louis 2004 (2000) (on file with the Saint Louis University Law Journal). New York just unveiled a section 1115 Medicaid expansion to cover one million additional working adults. *New York Tries to Cover 1 Million Residents in Ambitious Public and Private Initiatives*, ST. HEALTH WATCH, Mar. 2000, at 9. Maine has a new waiver that allows it to offer Medicaid to people with HIV who are not yet disabled and who can stay healthy with the expensive drug therapy that Medicaid normally does not cover until a person becomes disabled. *Medicaid Expansion for HIV Begins in September in Maine*, AIDS POL'Y & L., Mar. 17, 2000, at 1.

123. See JOCELYN GUYER & CINDY MANN, THE KAISER COMMISSION ON MEDICAID AND UNINSURED, TAKING THE NEXT STEP: STATES CAN NOW TAKE ADVANTAGE OF FEDERAL MEDICAID MATCHING FUNDS TO TAKE ADVANTAGE TO EXPAND HEALTH CARE COVERAGE TO LOW-INCOME WORKING PARENTS 22 (1998), available at <http://www.cbpp.org>.

124. *Disabled Workers Move Toward Broader Health Benefits in Current Medicaid Expansion Bill*, ST. HEALTH WATCH, Dec. 1999, at 1, 4.

125. *1999 Industry Outlook*, *supra* note 110, at 14.

Hawaii, Minnesota and Oregon are each experimenting with different ways of accomplishing this goal.¹²⁶

As a compliment to expanded coverage, another option is to pool large numbers of Medicaid enrollees, preferably but not necessarily, with privately insured patients and to funnel these patients to managed care entities that agree to serve the uninsured as well as insured patients. Such a “tie-in” assures that Medicaid patients will remain in the same system of care if they lose their Medicaid coverage. Pooling these patients allows states to direct their non-Medicaid state and federal discretionary health spending to these new-style safety net MCOs to help cover the cost of care for the uninsured.

Creating large pools of Medicaid enrollees, with or without privately insured enrollees, makes good use of managed care theory. First, it allows for continuity of care as people rotate from Medicaid to uninsured status. Second, creating larger pools of patients makes the pooled enrollees more attractive to HMOs. Commercial insurers shunned Medicaid when only a few patients enrolled. When enrollment became mandatory and the number of potential patients grew, commercial HMOs became more interested. Third, the larger the pool the easier it is to average costs between high use and low use patients. Finally, larger pools allow for economies of size and scale. A number of states are limiting the number of Medicaid MCOs and authorizing special need MCOs to create economies of scale and ensure continuity of care.

For example, in some areas California has limited Medicaid HMOs to one per county while contracting with these welfare HMOs to provide other non-Medicaid welfare medical care services.¹²⁷ These HMOs are county-organized health systems (COHS), entities created by state statute and authorized by several Medicaid waivers.¹²⁸ The results are especially promising in Santa Barbara County where the Santa Barbara Regional Health Authority HMO has been called, “Medicaid in paradise; paradise in Medicaid.”¹²⁹ The Authority

126. See generally JESSICA MITTLER ET. AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MANAGED CARE AND LOW-INCOME POPULATIONS: FOUR YEARS' EXPERIENCE WITH THE OREGON HEALTH PLAN (1999) (discussing the Oregon Health Plan), available at <http://www.kff.org/content/1999/2127/pub2127.pdf>; ANNA AIZER ET AL., THE KAISER COMMISSION ON MEDICAID AND UNINSURED, MANAGED CARE AND LOW-INCOME POPULATIONS: FOUR YEARS' EXPERIENCE WITH TENNCARE (1999) (discussing Tennessee's health care system), available at <http://www.kff.org/content/1999/2129/pub2129.pdf>; Pamela A. Paul-Shaheen, *The State and Health Care Reform: The Road Traveled and Lessons Learned from Seven that Took the Lead*, 23 J. HEALTH POL. POL'Y & L. 319 (1998) (discussing Hawaii's and Minnesota's health care systems).

127. DEBBIE DRAPER ET AL., THE KAISER FAMILY FOUNDATION, MANAGED CARE AND LOW INCOME POPULATIONS: A CASE STUDY OF MANAGED CARE IN CALIFORNIA 6 (1999), available at <http://www.kff.org>.

128. *Id.*

129. *Successful County Contracting in Santa Barbara Opens Door for Expansion, Medicare Risk Product*, ST. HEALTH WATCH, May 1999, at 8.

consistently reports stellar clinical outcomes. One reason for the Authority's success is its large enrollment base: it covers virtually everyone who has Medicaid, it is the sole county provider for prenatal care, and it is one of four SCHIP providers in the county.¹³⁰ With a large, solid funding base the Authority can focus on preventive services and continuity of care.

Kentucky has gone one step further and designated its traditional welfare medicine providers: public hospitals, teaching hospitals, and community clinics, as the state's only Medicaid HMOs.¹³¹ The state has sole-source Medicaid contracts with HMOs organized by the state's traditional safety net providers.¹³² While the lack of choice of networks raises potential risks, sole sourcing provides a stable funding base for traditional welfare medicine providers and assures continuity of care for those who have always relied on the welfare medicine system. Sole sourcing should also free money for services and higher capitation rates that would otherwise be spent for marketing and other administrative expenses.¹³³

Massachusetts successfully uses sole-source welfare HMO contracting. The state relies on a single HMO, the Massachusetts Behavioral Health Partnership, to deliver mental health services to Medicaid enrollees and the uninsured who, in the past, depended on the state's public mental health system.¹³⁴ The state, the Partnership, and consumer advocates have worked together to develop access, quality and outcome standards. The contract is renewed annually allowing all parties the opportunity to examine the Partnership's performance and to fine-tune and improve the delivery system to better meet the needs of its patients.¹³⁵

Delivering better welfare medicine requires that HMOs be able to meet the unique needs of those who rely most extensively on welfare medicine: the elderly, those with physical and mental disabilities, people with chronic health problems, those with spinal and head trauma, premature babies, and children with special needs. In the past, Medicaid and other welfare medicine programs have been hindered in helping these groups by restrictive and often illogical benefit packages.

130. *Id.*

131. *Kentucky Protects Traditional Providers In Its Rollout of the State's Managed Medicaid Program*, ST. HEALTH WATCH, Nov. 1998, at 2.

132. *Looking on the Bright Side of the Departure of Commercial Plans from Medicaid Market*, ST. HEALTH WATCH, Oct. 1999, at 7; *Kentucky Protects Traditional Providers In Its Rollout of the State's Managed Medicaid Program*, *supra* note 131, at 3.

133. *Looking on the Bright Side of the Departure of Commercial Plans from Medicaid Market*, *supra* note 132, at 7.

134. Watson, *supra* note 54, at n.17.

135. For a description of how the contract has been modified to assure that the network better meets the needs of chronically mentally ill people who are homeless, see generally Watson, *supra* note 54, at nn.119-27.

A shift to managed care, with capitated payments or global budgets, offers an opportunity to alter and expand services to better meet the complex needs of low income people, particularly the elderly and the disabled. It also offers the ability to combine Medicaid funding with funding for targeted health services, special education, housing and rehabilitation services to provide expanded and more integrated services. The challenge is to stop thinking about Medicaid managed care as merely a different way to fund medicine as usual. Instead, we need to think creatively about how to pool funding sources to create new, more responsive systems of care and benefit packages.

For example, the Missouri Interdepartmental Initiative for Children with Severe Needs integrates the financing and delivery of community and home-based services for children with severe behavioral health needs who are at risk of institutionalization, regardless of their eligibility for Medicaid.¹³⁶ Historically, these children bounced around trying to patch together services provided by six different divisions of state government. The Initiative combines funding from each of these agencies, including Medicaid, into a single capitated payment of \$3199 per month per child, which is paid to the Missouri Alliance for Children and Families, a for-profit corporation created by ten community and residential care providers.¹³⁷ The Alliance is responsible for creating a network of medical and service providers. Case managers, the key to the system, work with children and their families to direct the delivery of comprehensive, integrated services. Although the system is not expected to save money, the capitation rate is set to be budget neutral. The hope is that services will shift from out-of-home residential settings to less intensive settings, including the family home.¹³⁸

Similarly, Iowa has combined Medicaid money with state and federal mental health and substance abuse funds to create a Medicaid behavioral health system that successfully integrates mental health and substance abuse services and offers a broad array of previously uncovered services.¹³⁹ The Iowa Plan provides mental health and substance abuse coverage to approximately 180,000 residents, approximately eighty-five percent of those eligible for Medicaid, using a single contractor, Merit Behavioral Care of Iowa, a for-profit corporation.¹⁴⁰ Operated under a Medicaid Section 1115 waiver, the system must be budget-neutral in its use of federal Medicaid funds, a goal the state accomplished by combining Medicaid with other state and federal funds

136. *Missouri Tries Capitated Payment System for Children with Behavioral Health Needs*, ST. HEALTH WATCH, Mar. 1999, at 9.

137. *Id.*

138. *Id.*

139. *See Iowa Ignores Conventional Wisdom on Behavioral Health*, ST. HEALTH WATCH, Sept. 1999, at 1-2.

140. *Id.* at 1.

targeted for mental health and substance abuse treatment.¹⁴¹ Commentators conclude that Iowa's behavioral health system has succeeded where others have faltered because state officials had a clear vision of what they wanted, worked closely with consumers, providers and the managed care contractor, and proceeded slowly in building the system.¹⁴²

Of course, for all its promise, managed care, with its capitated payments and global budgets, carries the risk of under-service and cost-cutting to make money. These risks become even more likely when states limit the number of Medicaid and welfare HMOs or use sole-source contracting. The problems that privately insured workers report, including delays and refusals of care and treatment, are even more likely to occur in Medicaid and welfare capitated systems where patients are less sophisticated consumers and less aggressive advocates for their care. Medicaid and welfare managed care enrollees need the same legal protections as privately insured workers: the right to dispute care denials and a right to proceed against the HMO when services are denied.

One powerful way to guard against the risk of MCO cost cutting is the use of performance criteria: financial penalties and bonuses tied to meeting specific access standards, service requirements and outcome measures. For example, in Kentucky, Medicaid HMOs get a one percent bonus for meeting outcome measures like birth weight and immunizations.¹⁴³ Iowa's behavioral managed care contract requires sixty performance standards, ten of which have financial penalties or incentives attached.¹⁴⁴ In Massachusetts, the mental health HMO gets a financial bonus if it implements an Assertive Community Treatment Team, an interdisciplinary team that takes mental health and social services to hard to reach chronically mentally ill patients in the community and that has been shown to be the most effective treatment modality for those who are homeless or at risk of homelessness.¹⁴⁵

Performance standards allow states to identify the services and outcomes they want and to use financial incentives, rather than expensive law suits or protracted administrative wrangling, to get them. Performance standards are particularly appropriate in the managed care context which is founded on the concept of using financial incentives to encourage preventive care and to change old, ingrained patterns of service delivery. It helps MCOs and providers think about systems of care rather than discrete services.

Yet, the biggest lesson to be learned from state experience with commercial Medicaid managed care is to move slowly and to assure

141. *See id.* at 2.

142. *See id.* at 2-3.

143. *Kentucky Plans Offered Financial Reward for Meeting Health Outcome Measures*, ST. HEALTH WATCH, Nov. 1998, at 8.

144. *Iowa Ignores Conventional Wisdom on Behavioral Health*, *supra* note 139, at 3.

145. Watson, *supra* note 54.

contractors understand their responsibilities, networks are in place, and enrollees understand the system. Detailed contracts that help everyone understand the system and its obligations can help with this educational process. States like Iowa that have taken time to work closely with commercial HMOs report success.¹⁴⁶ Others, like New York, which have moved precipitously, report horror stories.¹⁴⁷

VI. CONCLUSION

As long as neighborhoods are economically and racially segregated, welfare medicine is likely to be an inevitable part of our health care system. Quick fixes for Medicaid, including the wholesale commercialization of Medicaid via commercial HMOs, are doomed to failure if they lose sight of Medicaid's role within the welfare medicine world. We need to remember that Medicaid is only one part of a larger world of welfare medicine.

By focusing on a long-term relationship with primary care providers, managed care offers much to cure what ails welfare medicine. Likewise, capitated payments and global budgets offer financial incentives to move welfare care away from acute, episodic service to preventive care. Tying large numbers of Medicaid patients into substantial purchasing pools and combining Medicaid funds with other government funding for health, social services and housing offers the opportunity to expand services to better meet the needs of welfare medicine patients. The challenge is to begin thinking of welfare medicine as a sub-specialty and a unique system of care.

146. *See id.* at n.127.

147. *See, e.g.*, John K. Iglehart, *Health Policy Report: Medicaid and Managed Care*, 332 *NEW ENG. J. MED.* 1727, 1729-30 (1995) (discussing start-up problems in Arizona, Florida, Tennessee, California and New York where states tried to move too quickly in Medicaid managed care).