REACHING THE FINAL FRONTIERS IN MEDICAID MANAGED CARE

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INTRODUCTION

The original 1965 Medicaid statute prescribed an entitlement to health care for many of the country's uninsured poor.[1] Included in the entitlement was a right to free choice of provider.[2] This meant that, in theory, individual patients could receive care from any provider willing to participate in the Medicaid program. The unlimited free choice ideal was largely that, an ideal. In reality, the low reimbursement rates the government gave to providers diminished the number of providers willing to participate in the Medicaid program and effectively limited the choice of providers available to Medicaid recipients.[3]

A system of symbolic ideals has given way to a system in which legislators and administrators must confront tough choices in the face of harsh realities. Policy-makers must make several tradeoffs between goals. They aim to provide access to care for as many uninsured people as possible, to ensure that care is of high quality, and to contain costs. Forced to make tradeoffs, government officials have adopted managed care as a way to maximize achievement of these goals, a shift that has been accompanied by a large recession of freedom of choice principles.[4]

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1. 42 U.S.C.A. §§ 1396–1396v (2005). The Medicaid program as set forth by the Medicaid law provides health care services to eligible low-income persons, subject to coverage limitations as provided in the law and subject to limitations as set in each state's federally-approved Medicaid program, through a combination of federal and state financing. *See generally* RAND ROSENBLATT ET AL., LAW & THE AMERICAN HEALTH CARE SYSTEM 410–66 (1997).

2. 42 U.S.C.A. § 1396a(a)23 (2005).

3. *See infra* Section III.A.

4. Robert Hurley & Debra Draper, *Medicaid Confronts a Changing Managed Care Marketplace*, HEALTH CARE FINANCING REV., Fall 2002, at 11, 18.

Managed care has come to be the dominant mechanism for financing the Medicaid program in most states,[5] coordinating care for beneficiaries, but limiting their choices. While Managed Care Organizations ("MCOs") have not been the panacea that was once envisioned, they have presented a workable model for the Medicaid system.[6] The benefits arising from the MCO system have been modest, in part because it has not been the much anticipated magic bullet, but also because of correctable problems in the structure of the Medicaid system.[7]

While the use of MCOs could create greater benefits through improvements to the structure of the Medicaid program, the MCO model will realize its full potential only when extended to cover the elderly Medicaid beneficiaries and their needs for long-term care services. For no clear reason, "free choice of provider" continues to be the governing principle in the long-term care[8] component of Medicaid.[9] Government officials, perhaps acting for political gain, have resisted the extension of the MCO system to long-term care at the expense of the Medicaid program.[10]

Although originally created to entitle health care services to the poor, Medicaid has gradually become a second statute for the elderly, supplementing Medicare[11] in providing care to the elderly,

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

6. *See, e.g.*, Sidney Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J. 53, 71 (2001); Carlos Zarabozo, *Issues in Managed Care*, HEALTH CARE FIN. REV., Fall 2002, at 1, 2; Lisa Axelrod, Note, *The Trend Toward Medicaid Managed Care: Is the Government Selling out the Medicaid Poor?*, 7 B.U. PUB. INT. L.J. 251, 270 (1998).

7. *See, e.g.*, VICTORIA WACHINO ET AL., THE HENRY J. KAISER FOUND., FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL & STATE MATCHING FUNDS ii (2004), http://www.kff.org/medicaid/upload/Financing-the-Medicaid-Program-The-Many-Roles-of-Federal-and-State-Matching-Funds-Policy-Brief.pdf; Watson, *supra* note 6, at 65–66.

8. Long-term care, though difficult to define, typically addresses the needs of persons with chronic conditions. ROSENBLATT ET AL., *supra* note 1, at 1141. The majority of long-term care addresses the needs of the elderly. *Id.* at 1143. Common forms of long-term care include nursing home care, home health care and rehabilitation services. *Id.* at 1141–46.

9. *See, e.g.*, Marsha Gold & Jessica Mittler, *"Second Generation" Medicaid Managed Care: Can it Deliver?*, HEALTH CARE FIN. REV., Winter 2000, at 29, 43–44 (noting that long-term care in many states is not included in Medicaid managed care and is not likely to be for some time).

10. *See infra* Section IV (describing the potential costs of keeping long-term care beneficiaries in fee-for-service Medicaid plans).

11. 42 U.S.C.A., §§ 1395–1395ggg (2005). Medicare, subject to limitations provided in the law, generally provides health care services to people over age 65,

while the law entitling health care to the poor has receded.[12] State officials have significant discretion in Medicaid budget allocation.[13] As a result, increasing amounts of Medicaid funds have flowed toward care for the elderly, while the proportion of the Medicaid budget providing for the non-elderly poor has declined.[14]

This Note argues that Medicaid should apply the managed care model consistently across Medicaid, and eliminate the last relic of free choice: free choice of long-term care providers. The cost savings that would result would bring better quality care to more Americans in need of Medicaid coverage.

Section I provides background information about the historical rise of health care costs in the United States and the implementation of managed care in the private sector as a medium to contain these costs. While the benefits of managed care may be modest, the MCO model has come to dominate health care financing in the private sector. Section II describes the creation of Medicaid as a means for providing health care to many Americans who would otherwise lack the means of accessing health care. Section III examines the transition in Medicaid financing, from the original fee-for-service-system of reimbursing health care providers to a managed care system. There this Note surveys the legal changes that allowed for managed care and attempts to make a positive analysis of the effects of managed care on Medicaid. Section IV addresses several proposals for changes in the current Medicaid structure. In particular this Note focuses on the inherent problems resulting from a system financed in part by the federal government but managed primarily by state governments. Finally, Section V explores the potential benefits of expanding the managed care model to cover the large expenditures of long-term care services. This Note concludes that the primary reason that long-term care has been immune from the transition to managed care is that Medicaid has become splintered into two programs: one for the disenfranchised and truly poor and one for the politically influential elderly middle-class, the

as well as to some younger people with disabilities. *See generally* ROSENBLATT ET AL., *supra* note 1, at 368–410.

12. *See infra* Section IV.A.

13. Andy Schneider et al., *Medicaid Financing*, *in* THE MEDICAID RESOURCE BOOK 83 (The Henry J. Kaiser Family Found. 2002), *available at* http://www.kff.org/medicaid/2236-index.cfm.

14. *See* LEIGHTON KU & MATTHEW BROADDUS, WHY ARE STATES' MEDICAID EXPENDITURES RISING? 1–2 (Ctr. on Budget and Policy Priorities 2003), http://www.cbpp.org/1-13-03health.pdf (although the elderly and disabled only make up 25% of enrollees in Medicaid, 70% of Medicaid funds are spent on this group); Schneider et al., *supra* note 13, at 83.

members of which have become poor largely through divestitures of assets.

I.
THE HISTORICAL RISE OF HEALTH CARE COSTS IN THE UNITED STATES AND THE ATTEMPT TO STEM GROWTH THROUGH MANAGED CARE

A. Rise in the Costs of Health Care in the U.S. and the Increased Role of the Government

Since the nineteenth century, advances in science and medicine have created tremendous opportunities to improve the health of individuals, to cure disease, to alleviate pain, and to extend lives. Corresponding with these advances has been a rise in the cost of health care in the United States. Health expenditures comprised 3.5% of the national income in 1929, growing to 13% of the national income in the 1990s.[15] As costs have risen, the proportion of expenditures paid for by the public rather than by the private sector have also risen, such as through the Federal Medicaid and Medicare programs adopted in 1965.[16] Federal and state governments combined incurred 45% of all health care expenditures in the United States in 1999.[17]

There are many complex and interrelated factors driving up the costs of health care.[18] One factor in particular that is fundamental to health care financing is the historical evolution of the

15. William D. White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 140 (2004).

16. *Id.* at 144.

17. Steffie Woolhandler & David U. Himmelstein, *Paying For National Health Insurance—And Not Getting It*, HEALTH AFF., July–Aug. 2002, at 88, 88.

18. *See, e.g.*, Thomas R. McLean & Edward P. Richards, *Health Care's "Thirty Years War": The Origins & Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283 (2004). McLean and Richards discuss a number of factors that drive medical inflation. First, social problems have been "medicalized." *Id.* at 294, 308. For example, shifts in cultural values have led more families to look toward nursing homes as sources of care for the elderly. *Id.* at 294–95. Second, the health care industry seeks medical advances, without regard to cost. *Id.* at 295–96. As a result, we incur large costs for slight improvements. *Id.* at 321–22. Third, there is a lack of focus on preventative medicine in U.S health care. *Id.* at 322–26. The costs of curing an illness once it has developed are larger than the costs of trying to prevent illness. *Id.* at 322. Fourth, the demographic shift in the U.S. population toward a larger elderly population has driven costs up since the elderly represent a disproportionate part of the general population in need of medical care. *Id.* at 295, 318, 325–26. *See also* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 13 (2004), http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf (noting that prescription

relationship between patient, provider and health care associations.[19] In the first third of the twentieth century, health care financing was driven primarily by market forces. In 1929, for example, out of pocket payments by consumers represented 79% of all health care expenditures.[20] Providers such as physicians and hospitals were forced to respond to consumers and consumers were forced to be well informed in their decisions.

As providers responded to consumers with "competitive schemes," the American Medical Association (the "AMA") sought to eliminate price-competition in the 1930s, claiming that it demoralized the medical business.[21] The AMA was influential in shaping policy that shifted the method of financing for medical care in the United States.[22] The anti-competitive principles supported by the AMA shaped the development of Blue Cross plans for hospital care and Blue Shield plans for physician services.[23] Through the fee-for-service system that developed, providers were paid based on cost reimbursement for services.[24] Providers determined costs and charged insurance companies accordingly, leaving little incentive to cut costs.[25] As a result of the AMA policy, providers and purchasers of medicine could only buy and sell medicine through community wide plans, such as the provider controlled Blue Cross and Blue Shields.[26] Individual patients subscribed to these community wide plans, with free choice of providers in the plan.[27] Providers operated within the framework of this guild system from 1933 until the early 1980s.[28]

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drug spending and payments for physician services have contributed the most to increased hospital spending).

19. *See, e.g.*, White *supra* note 15, at 141–43.

20. *Id.* at 141.

21. Charles D. Weller, *Free Choice as a Restraint on Trade in American Health Care Delivery & Insurance*, 69 IOWA L. REV. 1351, 1356–62 (1983).

22. *Id.* at 1364. The AMA was not only influential in shaping the structure of health care financing, but also in creating a self-regulated industry, largely insulated from both government and from private market forces. Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445–47 (1988). The AMA, among other things, created a state-sanctioned monopoly in which doctors controlled licensing of doctors and monitored quality of care. *Id.* at 446. Efforts to impose accountability by external review were thwarted, and efforts by insurance companies to steer patients toward preferred providers were largely prohibited. White, *supra* note 15, at 142, 144–45.

23. Weller, *supra* note 21, at 1371–72.

24. *Id.* at 1372.

25. *Id.* at 1371–72.

26. *Id.* at 1370.

27. *Id.* at 1370.

28. *Id.* at 1352.

Economists evaluating the medical care market, as it was structured under this guild method, found it to represent a market failure.[29] The health care industry, under a guild system, represented a market failure because there was no price competition between providers and no incentive to perform efficiently.[30] Rather, physicians had every incentive to maximize costs of care for patients because they had full discretion, within physician controlled Blue Shields, to decide patient needs and were compensated accordingly.[31] The providers profited nicely as they were reimbursed for costs on a fee-for-service basis.[32] Insurers were largely prohibited by law from imposing any form of competition on providers despite being the purchasers of health care, and were therefore reduced to being mere conduits of funds.[33] Although patients may have been insulated in the short-term from seeing the implications of this inflationary system, ultimately insurers would transfer these costs back to consumers in the form of higher insurance premiums. The fee-for-service reimbursement mechanism thus contributed to the rise in the cost of health care.[34]

B. The Transition Towards Managed Care

Prior to the early 1980s, in both the private and public sectors, doctors were generally free from external accountability in their decisions of necessary medical expenses. As a consequence, costs rose rapidly.[35] Although economists realized the inefficiency of the provider controlled Blue Cross and Blue Shields, it took some time for the legal system to recognize the problem and intervene. In 1979 the Federal Trade Commission found that physician control of Blue Shields was a restraint on trade and required divestiture.[36] The U.S. Supreme Court affirmed this finding in *Arizona v. Maricopa*

29. *See, e.g.*, Kenneth Arrow, *Uncertainty & the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). Arrow found generally that the medical care industry has a number of characteristics that depart from the classical competitive model, such as the manner in which physicians provide services compared to an ordinary businessman, the uncertainty of the quality of the services received, and the nature of the supply of medical services. *Id.* at 948–54.

30. Weller, *supra* note 21, at 1354.

31. *Id.* at 1354–55.

32. *Id.* at 1355, 1372.

33. White, *supra* note 15, at 144–45.

34. McLean & Richards, *supra* note 18, at 293; Weller, *supra* note 21, at 1372; White, *supra* note 15, at 144–45.

35. White, *supra* note 15, at 144–45.

36. Weller, *supra* note 21, at 1351.

County Medical Society.[37] Courts began to recognize cost control as a legitimate goal and recognized alternative financing structures such as managed care as legitimate means of achieving cost control.[38] As a result, the period since the early 1980s has been dominated by attempts to impose economic accountability on the health care industry, with efforts from health care associations and companies to control costs and recreate competition.[39]

From 1980 to 2000, MCOs gradually replaced conventional private insurance plans as the major players in the health care financing market.[40] As a result of increased competition and pressure, MCOs were responsible for slowing the growth of insurance premiums during the 1980s and 1990s.[41] However, in light of the resurgence of growth in insurance premiums in recent years, critics have grown skeptical of the success of managed care.[42] The effectiveness of managed care will continue to be debated as people try to identify the sources of growing costs today. Nevertheless, managed care has brought cost savings relative to fee-for-service health care, and will continue to be the predominant form of financing health care in this country for some time.

C. How Managed Care Works

There are many forms of MCOs but there are some common features typical of many MCOs. MCOs are generally hired by employers to insure medical care of employees, although individuals are entitled to join MCOs as well.[43] The employer pays the MCO a pre-set fee per employee, in contrast with the traditional fee-for-

37. 457 U.S. 332, 336 (1982).

38. *See* McLean & Richards, *supra* note 18, at 316–17. *See also* Hall, *supra* note 22, at 435–36 (noting the aggressive initiatives for cost containment adopted by federal, state, and private actors).

39. *See, e.g.*, Hall, *supra* note 22, at 435, 437; White, *supra* note 15, at 146.

40. *See* THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 1999 ANNUAL SURVEY 57 (1999), http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13268. *See also* KAISER COMM'N ON MEDICAID AND THE UNINSURED, UNDERINSURED IN AMERICA: IS HEALTH COVERAGE ADEQUATE? 1–2 (2002), *available at* http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14136.

41. White, *supra* note 15, at 153.

42. *See, e.g.*, *id.* at 157–58.

43. *See, e.g.*, Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 5 (noting that employers pay for over 80% of the money spent on health insurance); DEP'T OF JUSTICE & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 14 (2004), http://www.ftc.gov/reports/healthcare/

service method, so that MCOs incur the risk if the actual costs of providing care for the pool of employees exceeds the pre-set fee.[44]

The organizations arrange for care by contracting selectively with specific providers and steering patients towards these preferred providers.[45] In some forms of MCOs, the organization gives providers capitated per patient fees, shifting risk to providers to keep costs down.[46] However, many MCOs control costs in other ways.[47] For example, MCOs aim to contract selectively with providers who they determine to be cost-effective.[48] Other MCOs control costs by giving providers bonuses and penalties based on the provider's cost-effectiveness.[49] In addition, MCOs maintain close oversight and influence on doctor decisions regarding the need for various services.[50] Through this system, MCOs aim to squeeze down high provider price margins.[51] In theory, these market based reforms produce savings that are passed on to the enrollees in exchange for relinquishing their freedom of choice of provider.[52]

D. Criticisms of the MCO System

Regardless of cost savings, MCOs have not been without criticism. For one, many claim that the quality of care has declined as a result of pressure on providers from MCOs.[53] While the reports on the impact of managed care on quality are mixed and difficult to assess, the impact on consumer perception of quality is clearer. Consumers have been skeptical and less trusting of providers in an

040723healthcarerpt.pdf (saying that 16 million Americans purchased individual insurance policies in 1999).

44. ROSENBLATT ET AL., *supra* note 1, at 551–52.

45. White, *supra* note 15, at 151.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.* at 148–49.

52. *Id.* at 147–50. Of course, if MCOs do not pass on the savings to enrollees, the costs of insurance remain high.

53. *See, e.g.*, Eleanor D. Kinney, *Behind the Veil Where the Action is: Private Policy Making and American Health Care*, 51 ADMIN. L. REV. 145, 156 (1999) (noting that the manner that MCOs pay providers results in incentives to under provide care); Julia A. Martin & Lisa K. Bjerknes, Note, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J. L. & MED. 433, 438–39 (1996) (arguing that patient care suffers from MCO influence on physicians).

MCO system.[54] Many are skeptical of the quality of care because MCOs have incentives to under-provide care in order to maximize profits.[55]

Theorists envisioned that the agency problem of under-providing care would be prevented through competition between plans.[56] In reality, however, employees are not given a sufficient number of standardized plans to choose from. Only 41% of employees are given a choice between plans, with the result that the numerous plan do not compete for enrollees.[57] Therefore, the MCO system does not represent an efficient market.

The problems resulting from the inability to assure quality of care through market competition are compounded by the difficulty in using the legal system as a means of assuring quality of care. MCOs have been very successful in escaping legal accountability for providing inadequate health care.[58] Federal law, through the Employee Retirement Income Security Act of 1974 ("ERISA"),[59] preempts state law remedies with respect to MCOs structured as self-insured plans, yet there are few federal remedies under ERISA.[60]

In addition to questions of quality, many consumers find the idea of limited choice of provider objectionable. Consumer satisfaction with MCOs has been linked to the amount of choice available.[61] However, restriction of choice may not be as drastic a measure as it is perceived to be. For example, some forms of MCOs

54. *See* White, *supra* note 15, at 156–58. *See also* Frank Sloan & Mark Hall, *Is the Health Care Revolution Finished? Market Failures & the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169, 170 (2002).

55. Sloan & Hall, *supra* note 54, at 170.

56. White, *supra* note 15, at 148.

57. Karen Davis & Cathy Schoen, *Assuring Quality, Information & Choice in Managed Care*, 35 INQUIRY 104, 109 (1998).

58. Sylvia Law, *Do We Still Need a Federal Patients' Bill of Rights?*, 3 YALE J. HEALTH POL'Y L. & ETHICS 1, 6 (2002).

59. 29 U.S.C. §§ 1001–1461 (2000). ERISA was enacted primarily to protect employee pensions, but the statute extends to address employee benefit plans, including the associated health benefits. ROSENBLATT ET AL., *supra* note 1, at 159–95.

60. *See* Kentucky Ass'n of Health Plans v. Miller, 538 U.S. 329 (2003); Rush Prudential HMO v. Moran, 536 U.S. 355 (2002) (showing court analysis on ERISA preemption and its effects on MCOs); Pegram v. Herdrich, 530 U.S. 211 (2000). For a more extensive discussion on the complex effects of ERISA preemption on the liability of MCOS, see generally Law, *supra* note 58.

61. *See* Davis & Schoen, *supra* note 57, at 110. Many states, such as Kentucky, enacted laws to enhance and protect patient access to physicians and providers including "any willing provider" ("AWP") laws. Sloan & Hall, *supra* note 54, at 173–74. *See also Kentucky Ass'n of Health Plans*, 538 U.S. at 330–32 (describing Kentucky's statute). Initially preempted by ERISA, in 2003 the U.S. Supreme Court

allow patients to see doctors outside of network as long as they are willing to pay a portion of out-of-pocket expenses.[62] Additionally, in response to consumers, there has been a shift toward less stringent forms of managed care.[63]

Time will allow for a more accurate assessment of the impact of managed care. However, this section has shown how MCOs came into existence as a way to contain costs and how they have come to dominate the private health care landscape. As this Note will proceed to demonstrate, the transition in the model of financing private health care has come to have profound effects in financing public health care, particularly in Medicaid services for the poor.

II.
PROVIDING HEALTH CARE FOR THE POOR: ENACTMENT OF MEDICAID LAW AND THE COSTS OF THE PROGRAM

A. Rights to Health Care and the Origin of the Medicaid Entitlement

As the cost of health care grew during the twentieth century, more and more people found themselves without access to care because they lacked the means to pay for medical necessities.[64] Today, even with public programs that help pay for certain kinds of care for populations such as the poor and the elderly, 18% of the non-elderly U.S. population still has neither public nor private health insurance.[65]

In 1965 the federal government created health care entitlements through the Medicaid[66] and Medicare laws.[67] Prior to 1965 there were a variety of state medical assistance programs.[68] The Medicare statute, enacted by Congress for the benefit of the elderly,

held that States could adopt AWP laws without running afoul of ERISA. *Kentucky Ass'n of Health Plans*, 538 U.S. at 334–41.

62. *See* Linda Peeno, *The Second Coming of Managed Care*, 40 TRIAL 18, 22 (describing tiered health insurance plans, where a patient could chose a higher tier that allows access to more doctors for higher out- of-pocket expenses).

63. *See* White, *supra* note 15, at 159. *See also* Peeno, *supra* note 62, at 21–22 (detailing more flexible types of managed care plans).

64. THE USA TODAY ET. AL., SUMMARY AND COURSEPACK: HEALTH CARE COSTS SURVEY 15 (2005), *available at* http://www.kff.org/newsmedia/upload/7371.pdf.

65. KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED AND THEIR ACCESS TO HEALTH CARE (2004), http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49531.

66. 42 U.S.C.A §§ 1396–1396v (2005).

67. *Id.* §§ 1395–1395ggg.

68. *See* Letty Carpenter, *Medicaid Eligibility for Persons in Nursing Homes*, HEALTH CARE FIN. REV., Winter 1988, at 67, 67.

was the driving force that led to the enactment of Medicaid.[69] Both laws were patterned after health insurance available to the mainstream working population.[70] Congress, through Medicaid, sought not just to give care to those without the means, but to ensure "mainstream health care," of the same quality as that obtained by the general population.[71] Through Medicaid, a substantial number of people who otherwise lacked any access to care were granted a statutory entitlement: a right to demand health care.

B. Medicaid Eligibility

The Medicaid program covers approximately 50 million people in the U.S. at any time.[72] Individuals qualify for Medicaid through a number of requirements which focus on economic need, making it a means-tested entitlement program.[73] The law mandates coverage for "categorically needy" individuals, determined by assessing whether the candidate has income or economic resources below a certain level; and whether the candidate is in one of the coverage categories which include persons receiving welfare, minors and parents of minors, pregnant women, the elderly, and disabled persons.[74] The law allows states to opt to cover additional groups that are "medically needy," those who are in the specific coverage categories mentioned above but whose income level or economic resources are too high to qualify as "categorically needy."[75] A "medically needy" person becomes eligible for Medicaid coverage by spending a certain amount of personal resources on medical care.[76] Once the proscribed amount of expenditures is incurred by the "medically needy" person, the additional expenditures will be covered by Medicaid.[77] Individuals who qualify for

69. *See* Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 8 (2001).

70. *See* Carpenter, *supra* note 68, at 67.

71. *See, e.g.*, Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 978–79 (2001–2002); Judith Rosenberg & David Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 545–46, 554 (1995).

72. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 416–17 (2004).

73. Schneider et al., *supra* note 13, at 83.

74. 42 U.S.C.A § 1396a(a)(10)(A)(i) (2005). *See* ROSENBLATT ET AL., *supra* note 1, at 426–27.

75. 42 U.S.C.A § 1396a(a)(10)(A)(ii) (2005). *See* ROSENBLATT ET AL., *supra* note 1, at 426–27.

76. ROSENBLATT ET AL., *supra* note 1, at 426–27.

77. *Id.* at 426.

Medicaid have a right to health care that is accompanied by a private right to sue the government for inadequate care, pursuant to 42 U.S.C. §1983.[78]

Many commentators are critical of the eligibility requirements. The patchwork of rules governing who qualifies and who does not qualify leads to arcane and inequitable results.[79] Often people who are poor, and in need of care, find themselves outside of the strict eligibility requirements for Medicaid.[80] Many individuals move in and out of the Medicaid program for months at a time.[81] This occurs not because of any change in economic status but because of the regulations governing the Medicaid program.[82] For example, a pregnant woman is eligible for Medicaid but is likely to lose eligibility within months after delivery.[83] Likewise, an unemployed mother is eligible, but will lose eligibility when she earns a minimum wage job even though the job lacks health insurance benefits.[84]

On the other hand, there are individuals who would ordinarily be considered too wealthy to qualify for Medicaid but are able to qualify for Medicaid through various methods. For example, many elderly middle-class individuals qualify as "medically needy" by spending down a large portion of their resources on medical expenditures.[85] Other individuals, particularly the middle-class elderly, transfer much of their resources to other people such as family members and are therefore eligible to qualify for Medicaid a few years later.[86] Michael Leavitt, the Secretary of the Department of Health and Human Services, critical of the ability of many elderly to become Medicaid eligible through transfer of assets, recently noted

78. *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 509–10, 524 (1990); Martin v. Taft, 222 F. Supp. 2d 940, 977–79 (S.D. Ohio 2002). *See also* Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 32–33 (2002).

79. Carpenter, *supra* note 68, at 76; Mann & Westmoreland, *supra* note 72, at 421–22.

80. Carpenter, *supra* note 68, at 69; Herrin Hopper, *Purchasing Fraud: Contracting in Medicaid Capitated Managed Care*, 31 PUB. CONT. L.J. 781, 783 (2002).

81. Watson, *supra* note 6, at 65.

82. *Id.*

83. *Id.*

84. *Id.* at 57–58.

85. ELLEN O'BRIEN & RISA ELIAS, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND LONG-TERM CARE 7 (May 2004), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296. *See also* Carpenter, *supra* note 68, at 71.

86. Timothy Takacs & David McGuffey, *Medicaid Planning: Can it be Justified? Legal & Ethical Implications of Medicaid Planning*, 29 WM. MITCHELL L. REV. 111, 122, 127–28, 131 (2002).

that "Medicaid must not become an inheritance protection plan."[87] The large role of the middle-class elderly in Medicaid is a critical problem that fundamentally changes the nature of the Medicaid program.[88]

C. Modeling the Medicaid System on the Private Health Care System

When the Medicaid statute was drafted in 1965, it was modeled on prevailing private insurance models such as Blue Cross and Blue Shield.[89] The goal was to achieve the same quality of care for Medicaid patients as for private insurance patients, and to avoid a dual track of health care that would give Medicaid enrollees access to only lower tier care.[90] Consistent with this goal, lawmakers attempted to give Medicaid patients free choice of provider, allowing patients to receive care from any provider willing to participate in the Medicaid program.[91]

Medicaid also attempted to mirror private health care financing. Like mainstream health care financing, Medicaid financing was based on a fee-for-service system.[92] The fee-for-service model had cost-generating incentives for providers under Medicaid programs just as it did for providers under private insurance.[93]

The shifts in the methods of financing the health care of the general population have strongly influenced the methods by which we finance health care for the poor and elderly. As health care financing shifted in the 1980s for the general population, the meth-

87. Robert Pear, *Health Secretary Calls for Medicaid Changes*, N.Y. TIMES, Feb. 2, 2005, at A12.

88. *See infra* Section V.

89. Hall, *supra* note 22, at 446.

90. Rosenberg & Zaring, *supra* note 71, at 554.

91. "Any individual eligible . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the services . . . who undertakes to provide him such services . . . ." 42 U.S.C.A. § 1396a(a)23 (2005). *See also* 42 C.F.R. § 431.51(a)(1), (a)(4), (b)(1), (b)(2); Martin v. Taft, 222 F. Supp. 2d 940, 979 (S.D. Ohio 2002) (recognizing the right to free choice of provider as a limited rather than absolute right); Clark v. Kizer, 758 F. Supp. 572, 579–80 (E.D. Cal. 1990) (interpreting the free choice of provider provision to create a right for Medicaid recipients to receive treatment from any providers who agree to participate in the Medicaid program); Morgan v. Cohen, 665 F. Supp. 1164, 1176 (E.D. Pa. 1987) (finding that the State must provide transportation as necessary to give Medicaid recipients sufficient free choice of qualified providers).

92. Peter Welch & Mark Miller, *Mandatory HMO Enrollment in Medicaid: Issue of Freedom of Choice*, 66 MILBANK Q. 618, 618 (1988). *See also* Weller, *supra* note 21, at 1371.

93. Weller, *supra* note 21, at 1372.

ods of financing Medicaid changed as well. As private insurance began to use MCOs in an effort to save costs, state governments began to look to MCOs as a way to finance health care for Medicaid enrollees.[94]

D. The Relationship of the Federal and State Governments in Financing and Administering the Medicaid Program

The Medicaid program is jointly financed by the federal government and by state governments that opt into the program.[95] States that opt in, and all do, are given matching funds from the federal government.[96] The federal government matches state expenditures under Medicaid, contributing between 50% and 83% of total Medicaid expenditures.[97] The larger payments are made to states with lower per capita income, creating a redistribution of wealth benefiting poorer states.[98]

Despite joint financing, the states alone are responsible for administering Medicaid programs consistent with federal guidelines.[99] State discretion produces great variation among state programs.[100] Each state decides which services to fund and how much funding to give to each service.[101] As a consequence, no two states' programs are alike. For example, total spending per enrollee averages $7,749 in New York, in contrast with California's average of $2,334 per enrollee.[102]

State discretion is not unfettered, however. Federal guidelines set forth not only mandatory and optional populations for coverage, but also mandatory and optional services.[103] For example,

94. Welch & Miller, *supra* note 92, at 618. *See also infra* Section III.

95. Mann & Westmoreland, *supra* note 72, at 418; WACHINO ET AL., *supra* note 7, at 3.

96. WACHINO ET AL., *supra* note 7, at 3.

97. *Id.*

98. Perkins, *supra* note 78, at 10. *See also* WACHINO ET AL., *supra* note 7, at 3 (noting that the funding system is designed to take income variations among states into account); Schneider et al., *supra* note 13, at 88 (describing the effective distribution of wealth from wealthy states to poor states and noting that the impact of redistribution is growing). Schneider et al. suggest that the policy rationale for the matching program is to prevent a race to the bottom between states. Schneider et al., *supra* note 13, at 86. In other words, if states did not receive federal funding, they would create their own programs with few benefits, hoping low income people would settle in states with better benefits. *Id.*

99. Mann & Westmoreland, *supra* note 72, at 418.

100. Perkins, *supra* note 78, at 9.

101. *Id.* at 9, 14.

102. Mann & Westmoreland, *supra* note 72, at 418.

103. Perkins, *supra* note 78, at 13–14.

mandatory services include inpatient and outpatient hospital services, physician services, and certain nursing facilities.[104] Optional services include prescription drugs, dental services, physical therapy, and transportation services.[105] Nevertheless, state discretion in administering programs has grown tremendously through waiver programs that allow states to avoid certain federal requirements in their state Medicaid programs.[106] As a result of state discretion, in conjunction with the incentives created by the federal matching funds system, two thirds of Medicaid spending is for either optional services or optional populations.[107]

E. The Cost of Medicaid and the Proportionate Cost of Long-Term Care

Regardless of the relationship between state and federal responsibilities and expenses, the overall cost of the Medicaid program comprises an enormous portion of state aid from the federal government, representing 40% of all federal grants in aid to states.[108] Total projected expenditures in 2004 were $305 million for Medicaid and $278 million for Medicare.[109]

In terms of the efficiency of Medicaid, it might seem to appear that private insurers may be more efficient than Medicaid. Private insurance companies incur about 33% of all health care expenditures in the U.S. while providing insurance to 63% of the population.[110] Medicaid incurs 16% of health care expenditures while providing insurance to about 10% of the population.[111] Although this seems to signal that private insurers are able to cover six times as many people for only twice the cost, this may not be an accurate indicator of efficiency because of the population treated by Medicaid. Medicaid enrollees, especially the elderly and disabled, tend to be more susceptible to illness and disease relative to the general

104. *Id.*

105. *Id.* For a list of mandatory and optional services *see* KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID "MANDATORY" AND "OPTIONAL" ELIGIBILITY & BENEFITS (2001), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13767.

106. *See* Matthew, *supra* note 71, at 974–75, 982. *See also infra* Section III.B.

107. *See* WACHINO ET AL., *supra* note 7, at 4.

108. Perkins, *supra* note 78, at 10.

109. Mann & Westmoreland, *supra* note 72, at 417; Watson, *supra* note 6, at 59.

110. Schneider et al., *supra* note 13, at 85.

111. *Id.*

population.[112] Therefore, on a risk adjusted basis, the relative cost per patient may be comparable between Medicaid and private insurance.[113] Medicaid may therefore be more efficient than a raw observation of the data suggests.

One of the largest expenses of the Medicaid program is long-term care services, particularly nursing home care.[114] Of the $243.5 billion spent by the Medicaid program in 2002, 34% was spent on long-term care.[115] The elderly who are eligible for Medicare look to Medicaid to fill the gaps where Medicare denies services, such as in long-term care. Medicaid paid for 47% of nursing home expenditures in 2001, primarily for elderly and disabled patients.[116] Medicaid covered 42% of all long-term care expenditures which include other services such as personal care services.[117]

F. Sources of Continuing Growth in the Cost of Medicaid

There is a general consensus that there has been at least some growth in health care expenditures that are attributable to the Medicaid program.[118] There are many barometers by which to measure growth in Medicaid expenditures over time. They are all imperfect, however, because there are so many variables that need to be identified and isolated.[119] Some of the sources of increased Medicaid spending include an increase in enrollees, the growth of

112. *See* KU & BROADDUS, *supra* note 14, at 2 (noting that the rise in Medicaid costs can be partially attributed to the demographics of Medicaid enrollee, particularly to the increasing number of aged and disabled persons covered by Medicaid).

113. Jack Hadley & John Holahan, *Is Health Care Spending Higher Under Medicaid or Private Insurance?*, 40 INQUIRY 323, 340 (2003). It has also been said that, relative to private insurance, Medicaid has been more effective in controlling inflationary costs attributable to a general rise in health care service costs and demographic changes. KU & BROADDUS, *supra* note 14, at 1–2, 8.

114. WACHINO ET AL., *supra* note 7, at 13; O'BRIEN & ELIAS, *supra* note 85, at 8–9.

115. O'BRIEN & ELIAS, *supra* note 85, at 8 fig.9.

116. WACHINO ET AL., *supra* note 7, at 13 fig.7.

117. *Id.*

118. Medicaid expenditures grow at 8% per year. KU & BROADDUS, *supra* note 14, at 9. *See also* Pear, *supra* note 87 (claiming Medicaid spending has grown 63% in the last five years).

119. For example, between 1989 and 1999, federal Medicaid spending as a percent of all federal grants to states grew from 28% to 41%. Schneider et al *supra* note 13, at 88. Total federal grants to states were in the amount of $122 billion on 1989 and $267 billion in 1999. *Id.* It is also important to consider the changing roles over time of the federal government relative to state governments in covering these expenses. The changing roles of Medicare and Medicaid should also be considered in examining increased spending because some changes may result in less Medicaid spending but more Medicare spending. For example, many services for

health care costs across the country, and a rise in administrative costs.[120]

The increase in the number of Medicaid enrollees in recent years is a growth factor worth considering further. Between 1988 and 1992, 36% of the growth in Medicaid expenditures was attributable to increased enrollment.[121] Some enrollment increase is a result of demographic shifts in the U.S. population.[122] Life expectancies are longer today than they have ever been and consequently the proportion of elderly, including those in need of long-term care, has increased.[123]

Demographic shifts have increased enrollment, but enrollment in Medicaid has also expanded because states have made efforts in recent years to expand eligibility to those who previously did not qualify for Medicaid.[124] States applied to the federal government for permission to waive certain criteria Medicaid requirements, thus allowing them to provide Medicaid to more people than required by law.[125] States may have expanded Medicaid coverage to more Americans because they were optimistic that budget surpluses would arise as a result of new cost containment mechanisms, enabling expanded enrollment. However, the states may have miscalculated anticipated surpluses. Instead they have been left with mounting costs to the Medicaid budget.[126]

III.
INTRODUCTION OF MCOS TO MEDICAID AND THE IMPACT OF MANAGED CARE ON MEDICAID

A. A Change in Philosophy: States Reevaluate the Goals of Medicaid

The difficult task of containing health care costs has plagued state and federal officials for years. However, with the development

"dual eligibles" were previously covered only under Medicaid but are now covered under Medicare. See *infra* Section V.B. for a discussion of dual eligibles.

120. KU & BROADDUS, *supra* note 14, at 2, 6.

121. Axelrod, *supra* note 6, at 253.

122. KU & BROADDUS, *supra* note 14, at 2.

123. *See, e.g.*, JAMES LUBITZ, TESTIMONY BEFORE THE JOINT ECONOMIC COMMITTEE UNITED STATES CONGRESS: GETTING OLDER, STAYING HEALTHIER: THE DEMOGRAPHICS OF HEALTH CARE 9 (2004), *available at* http://jec.senate.gov/_files/Lubitztestimony.pdf (arguing that an increase in life expectancy causes a disproportionately large increase in long-term care costs).

124. Watson, *supra* note 6, at 65.

125. Schneider et al. *supra* note 13, at 84.

126. *See infra* Section III.D.

of MCOs in the private sector through the 1970s and 1980s, officials began to envision the use of managed care to contain costs and improve the Medicaid system.[127]

Historically, Medicaid, under freedom of choice principles, allowed enrollees to see any doctor willing to provide services at the rates dictated by the government.[128] However, because the rates were less than 50% of what doctors could earn from seeing private patients, many doctors did not participate in Medicaid.[129] Patients therefore had the theoretical right to choose their health care providers, but no real effective choice because of low reimbursement rates. They had limited access to some providers, and not to the same providers to whom private patients typically had access.[130] The vision of eliminating dual track health care did not materialize.[131]

Given the lack of success of the preexisting system and the changing landscape in private health care financing, government officials in the 1970s and early 1980s began to reevaluate the effects of striving for free choice of provider on the ability to fulfill the other goals of Medicaid.[132] If restricted choice would improve access to providers willing to participate, enable improved quality of care, and produce cost savings that could be used to expand eligibility, then perhaps the goal of freedom of choice should be reevaluated.

Managed care, as an alternative to the traditional Medicaid system, was first explored in the 1970s in California, where patients were given the option, with incentives, to join a managed care plan.[133] However, the California plan lacked sufficient oversight, leading to problems such as fraud.[134] Although this may have temporarily set back states' forays into Medicaid managed care, it did not take long for states to begin experimenting with the idea of placing Medicaid patients in MCOs.[135]

Politicians hoped that through the coordinated care of MCOs, they could achieve cost savings, improve quality of care, and restore

127. Welch & Miller, *supra* note 92, at 619–22.

128. 42 U.S.C.A. § 1396a(a)23 (2005).

129. Watson, *supra* note 6, at 55–56.

130. *Id.* at 55.

131. *Id. See also* Welch & Miller, *supra* note 92, at 630.

132. *See, e.g.*, Welch & Miller, *supra* note 92, at 619–22 (detailing early state experiments with HMOs).

133. Welch & Miller, *supra* note 92, at 620.

134. Hopper, *supra* note 80, at 786; Welch & Miller, *supra* note 92, at 621.

135. Welch & Miller, *supra* note 92, at 621.

adequate access while avoiding a dual track health care system.[136] Before evaluating the impact of MCOs on the Medicaid program however, it is important to address the legal obstacles that were overcome in order to implement Medicaid managed care.

B. Amending the Medicaid Law to Allow for Managed Care

The path to Medicaid managed care required several changes in the law. The free choice of provider provision prohibited states from forcing Medicaid patients into managed care. Unlike private patients, who had the incentive to join MCOs because of the cost savings, Medicaid patients, who were paying nothing under preexisting fee-for-service care, had little incentive to opt into managed care.[137]

Another constraint preventing Medicaid managed care was the Health Maintenance Organization Act of 1973 (the "HMO Act").[138] The HMO Act aimed to contain health care costs by creating incentives for the increased use of prepaid health care through Health Maintenance Organizations ("HMOs") as opposed to the traditional fee-for service insurance plans.[139] The federal government required employers, subject to exceptions, to offer employees at least one qualifying HMO as an option for health insurance.[140] The HMO Act also imposed qualification standards on HMOs as a precondition for HMOs to be eligible for federal grants and loans.[141] In addition, and most relevant here, in order to comply with the HMO Act and to be qualified as a federally-approved HMO, an HMO was required to have populations of Medicare and Medicaid beneficiaries comprising less than a given percent of the HMO's enrollees.[142] In other words, the HMO Act sought to prevent Medicaid-only plans in order to protect Medicaid beneficiaries from being forced into second tier programs. In reality though,

136. *See infra* Section III.D. (assessing the success of Medicaid in achieving these goals).

137. Welch & Miller, *supra* note 92, at 624.

138. 42 U.S.C.A. § 300e (2005). *See also* Nancy A. Burke, *Medicaid-HMOs: A Device For Delivering Health-Care Service To The Poor?*, 3 NOTRE DAME J. L. ETHICS & PUB. POL'Y 281, 286–87 (1988).

139. ROSENBLATT ET AL., *supra* note 1, at 549.

140. *Id.*

141. *Id.*

142. 42 U.S.C.A. § 300e(c) (2005). The law prior to 1981 required that at least 50% of enrollees be from the general population. ANDY SCHNEIDER, OVERVIEW OF MEDICAID PROVISIONS IN THE BALANCED BUDGET ACT OF 1997 n.31 P.L. 105-33 (1997), http://www.cbpp.org/908mcaid.htm. In 1981 that changed to 75%. *Id.*

HMOs were in their early stages and were not interested in taking on the risk of Medicaid patients when there were healthier enrollees to attract.

States succeeded in changing Medicaid law. Over time, the process for states to circumvent federal Medicaid requirements became significantly easier.[143] States have been able to obtain flexibility in shaping their Medicaid programs and are largely free of oversight from either federal agencies or the courts.[144] For better and for worse, this transformation of the law facilitated movement of Medicaid patients into MCOs.

Historically, states were able to apply for waivers of Medicaid program requirements from the Health Care Financing Agency (the "HCFA") under the federal Department of Health and Human Services (the "DHHS").[145] One form of waiver, the 1915b waiver, allowed states to waive the freedom of choice provision from their Medicaid programs.[146] A second form of waiver, the 1115 waiver, was made available for research and demonstration projects, and was intended to encourage state experimentation in Medicaid programs.[147] A 1115 waiver, when granted, allowed states to waive any statutory requirements if for the purpose of promoting the objectives of the Medicaid statute.[148] Therefore, states could bypass the requirements of the HMO Act and create Medicaid-only managed care plans.[149] Together, the two waivers allowed states to mandate Medicaid beneficiary enrollment in MCOs.[150]

Courts have approved broad federal authority to waive Medicaid requirements.[151] Gradually, waivers were requested and

143. Matthew, *supra* note 71, at 982.

144. *Id.*

145. Elizabeth Andersen, *Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 216–17 (1994).

146. Axelrod, *supra* note 6, at 254–55.

147. *Id.* at 255; Schneider et al., *supra* note 13, at 97–99.

148. Axelrod, *supra* note 6, at 255.

149. *Id.* at 254–55.

150. *See, e.g.*, Matthew, *supra* note 71, at 981–82. For a more thorough discussion of the various waivers made available to states and how they operate, see Axelrod, *supra* note 6, at 254–56; Schneider et al., *supra* note 13, at 97–99.

151. *See, e.g.*, Beno v. Shalala, 30 F.3d 1057, 1060, 1073 (9th Cir. 1994) (finding that the Secretary of Health and Human Services has broad discretion in issuing a waiver for an experimental California work incentive program); Aguayo v. Richardson, 473 F.2d 1090, 1103 (2d Cir. 1973) (holding that a 1115 waiver in context of a welfare program was a valid exercise of authority); Crane v. Matthews, 417 F. Supp. 532, 539 (N.D. Ga. 1976) (permitting a waiver imposing co-payments for certain Medicaid benefits pursuant to a valid exercise of authority if the waiver furthered the objectives of the Medicaid program); California Welfare Rights Org.

granted more regularly through the 1980s and 1990s, but states were interested in a more streamlined process, claiming the waiver request process was prone to being lengthy, expensive, and unpredictable.[152] Above all, states wanted more discretion in administering the Medicaid program and more independence from federal oversight.[153]

The federal government was responsive to the states' interests. The 1997 Balanced Budget Act (the "BBA") effectively eliminated the need for state use of the waiver process to mandate managed care.[154] Under the BBA, states are simply required to file an amendment to their existing Medicaid programs with the federal government in order to implement a program such as Medicaid managed care.[155]

C. The Rise of Medicaid Managed Care: Commercial MCOs and Medicaid-only MCOs

Since the legal obstacles to Medicaid managed care have been removed, there has been a dramatic shift toward moving Medicaid enrollees into MCOs.[156] About 56% of Medicaid beneficiaries are now enrolled in MCOs.[157]

When it became possible to place Medicaid patients in MCOs, commercial MCOs, which had fared well in the private sector, saw an opportunity for profit. Commercial MCOs were encouraged by this prospect in light of the social trend toward privatizing government services and a health trend toward corporatization.[158] Commercial MCOs saw the opportunity for profit and offered the opportunity to place Medicaid patients in a system where there would be one integrated track of health care.[159] It was originally

v. Richardson, 348 F. Supp. 491, 493–94, 498 (N.D. Cal. 1972) (finding that was valid authority to approve a state demonstration project involving co-payments for a Medicaid program, pursuant to waiver). *See also* Andersen, *supra* note 145, at 225–26; Rosenberg & Zaring, *supra* note 71, at 548.

152. Andersen, *supra* note 145, at 235–36.

153. Matthew, *supra* note 71, at 974.

154. 42 U.S.C.A. § 1396u (2005).

155. 42 U.S.C.A. §§ 1396u-2–1396u-3 (2005). *See also* Fossett & Thompson, *supra* note 5, at 1161–62; Hopper, *supra* note 80, at 786 (2002).

156. Perkins, *supra* note 78, at 15.

157. KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND MANAGED CARE 1 (2001) [hereinafter KAISER, MEDICAID AND MANAGED CARE]. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13724.

158. Leighton Ku & Sheila Hoag, *Medicaid Managed Care & the Marketplace*, 35 INQUIRY 332, 335–66 (1998); Watson, *supra* note 6, at 63.

159. Watson, *supra* note 6, at 64.

thought that Medicaid patients would be in the same MCOs as the general population, ensuring them access and quality of care that was equal to that of the general population.[160]

Commercial MCOs have significantly scaled back their ventures in the Medicaid market, particularly since the late 1990s.[161] There are a number of related reasons for this exodus. First, capitation rates that states are willing to pay MCOs have been too low, especially relative to the rates MCOs get for private patients.[162] Second, the administrative costs make Medicaid patients even more expensive for MCOs than private patients partly because of the high rate of flux of patients in and out of Medicaid.[163] Without longer lock-in periods, enrollment of most Medicaid patients is not very stable in MCOs.[164] Finally, before entering the Medicaid market, commercial MCOs had little experience with welfare medicine and the needs and costs associated with it.[165]

In spite of these problems, evidence shows that coverage of Medicaid patients by commercial MCOs can be profitable.[166] Nevertheless, states have trouble attracting commercial MCOs[167] because for-profit MCOs would prefer to focus on the non-Medicaid population.[168] Moreover, many plans that have continued to accept Medicaid patients have provider networks with few to no providers in the urban areas where many of the Medicaid patients live.[169] Commercial plans are leaving Medicaid, forcing states to work with Medicaid-only MCOs.[170] These Medicaid-only MCOs are developed specifically to address the needs of Medicaid patients.

160. *Id.*

161. Fossett & Thompson, *supra* note 5, at 1165.

162. *Id.* at 1166–67. *See also* KAISER, MEDICAID AND MANAGED CARE, *supra* note 157, at 2 (noting that reimbursement rates for Medicaid have historically been below average market rates and arguing that Medicaid managed care will not survive in the future without higher capitation rates).

163. Michael McCue et al., *Reversal of Fortune: Commercial HMOs in the Medicaid Market*, 18 HEALTH AFF. 223, 227 (1999).

164. *Id. See also* Watson, *supra* note 6, at 57 (noting that current Medicaid patients often become uninsured in the future).

165. Watson, *supra* note 6, at 67.

166. Axelrod, *supra* note 6, at 262; Ku & Hoag, *supra* note 158, at 342.

167. Hurley & Draper, *supra* note 4, at 18.

168. *See* Axelrod, *supra* note 6, at 262.

169. Watson, *supra* note 6, at 68.

170. Hurley & Draper, *supra* note 4, at 17–18. *See also* Fossett & Thompson, *supra* note 5, at 1169; KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., COMMERCIAL HEALTH PLAN PARTICIPATION IN MEDICAID MANAGED CARE: AN EXAMINATION OF SIX MARKETS 1 (2000), http://kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13739.

The Medicaid-only MCOs have become the predominant MCO for Medicaid patients,[171] causing a return to a segregated health care system.

With the emergence of Medicaid-only MCOs, we must address the issues of whether these MCOs are separate but equal and whether they represent a worthwhile tradeoff between cost, quality, and access. States seem to have recognized that freedom of choice and an integrated health care system are unrealistic goals, and have decided instead to focus on getting better care for more people under Medicaid-only MCOs.[172] There are risks that Medicaid-only MCOs will provide inadequate care, but there are advantages to them, too. First, they are experienced and specialized with respect to the needs, economics, and red tape of welfare medicine.[173] Second, a mutual dependence between Medicaid-only MCOs and the agencies administering the Medicaid program adds stability to the market.[174] Some argue that Medicaid is actually the ideal place for MCOs to operate because limited resources impose a need for coordinated decisions regarding which sacrifices should be made for a greater overall package.[175] Therefore, in evaluating Medicaid MCOs it is necessary to consider that some of the original principles envisioned by Medicaid may be worth sacrificing in exchange for better quality health care for more people.

D. Material Effects of the Transition to Medicaid Managed Care

It is difficult to evaluate the success of Medicaid managed care for several reasons. For one, programs vary significantly by state. Additionally, many state programs began to grow within the last ten years and are still feeling the effects of the transition, such as the resulting administrative instability.[176] Finally, the biggest challenge in evaluating Medicaid managed care relative to the prior fee-for-service system is the need to assess quality of care and access to care in addition to improvements in cost.

There are signs that managed care has improved quality of care for Medicaid patients. For example, mandatory managed care has lead to less reliance on emergency rooms and hospitals for patient care, and has led to an increased reliance on preventive mea-

171. Hurley & Draper, *supra* note 4, at 18.
172. *Id.* at 20–21.
173. Watson, *supra* note 6, at 69.
174. Hurley & Draper, *supra* note 4, at 21.
175. *Id.* at 23.
176. *See, e.g.*, Axelrod, *supra* note 6, at 260.

sures taken by primary care physicians.[177] This occurs because an MCO is responsible for Medicaid-covered costs of care for a patient.[178] The MCOs have an incentive to provide care for patients before an illness becomes more severe, requiring more expensive types of care.[179] Research has shown that children are better off in Medicaid MCOs than in low-income private insurance.[180] An additional quality of care benefit is the knowledge that there is a provider to care for a particular enrollee.[181] The patient does not incur the burden of finding a doctor willing to provide treatment, which is often a problem under fee-for-service Medicaid programs in inner-cities.[182]

The quality of care of Medicaid-only MCOs has been criticized. One argument suggests that MCOs and their focus on preventive care are better suited for the middle class because lower income people tend to be sicker and have more needs.[183] The MCO system gives incentives to under-provide care.[184] The potential for detrimental results is compounded by a tendency by states to delegate responsibility to MCOs.[185] States rushed into managed care and quickly shifted risk and responsibility to MCOs.[186] For example, many states contract with MCOs, paying a fixed monthly capitation fee per Medicaid patient.[187] The MCO is then responsible for the care of each Medicaid patient.[188] This shift, though expected to help states reduce costs, has reduced accountability and oversight over state Medicaid programs instead.[189]

Access to care depends on the willingness of MCOs and providers to participate in Medicaid plans, which in turn depends on reimbursement rates.[190] The more states are willing to pay MCOs or providers for treating Medicaid patients, the more MCOs and other

177. Stephen Zuckerman et al., *Has Medicaid Managed Care Affected Beneficiary Access and Use?*, 39 INQUIRY 221, 224, 234 (2002).

178. Zuckerman, *supra* note 177, at 224.

179. *Id.* at 224.

180. *Id.* at 234.

181. Axelrod, *supra* note 6, at 257.

182. *Id.*

183. *Id.* at 258–59.

184. *Id.* at 259.

185. *Id.*

186. *Id.* at 260. *See also* Watson, *supra* note 6, at 62.

187. Watson, *supra* note 6, at 62.

188. *Id.*

189. Axelrod, *supra* note 6, at 260.

190. *See* Gold & Mittler, *supra* note 9, at 36. *See also* Zuckerman, *supra* note 177, at 239 (discussing varied effects on access based on different plans).

providers are interested in participating in Medicaid.[191] As reimbursement rates vary from state to state, so do the number of plans and providers willing to participate in Medicaid MCOs.[192] While data regarding access is still unclear, some argue that, at worst, access is at least on the level it was under the fee-for-service system.[193]

In addition to quality of care and access to care, it is important to consider cost savings. States were eager to see economic benefits materialize as a result of the transition to MCOs, hoping to alleviate budget problems.[194] First, they hoped to avoid the cost-generating incentives that the fee-for-service system had encouraged.[195] Second, states hoped that an MCO system of care that focused on preventive care rather than reliance on emergency rooms would reduce costs while improving health.[196] Patients with the same primary care physician for longer periods of time are less likely to be hospitalized, lowering overall costs.[197] Third, the MCO option could allow states to have more predictable cost increases by giving MCOs predetermined dollar allocations per patient.[198]

While the benefit of predictable costs has made budget management more stable, it is harder to estimate the cost saving effects of MCOs. Making such an evaluation requires isolating the MCO versus fee-for-service variable from other cost variables. This is not simple because many factors are interrelated. Cost savings have not been as significant as states anticipated.[199] One critic maintains that this is because the needs of Medicaid patients tend to be higher than those of the general population.[200]

However, managed care may be more likely to stem future growth than it is to reduce current expenditures. Politically, it is hard to make cuts that reduce government expenditures below their existing levels. It is arguably easier to prevent future expansion and growth of expenditures by maintaining a budget that does not stray far from the status quo.[201] In addition, the lack of cost savings may not be problematic if Medicaid programs are receiving better value for the dollar. We might accept the fact that managed

191. Gold & Mittler, *supra* note 9, at 36.
192. *Id.*
193. *Id.* at 39.
194. Fossett & Thompson, *supra* note 5, at 1160.
195. *Id.*
196. *Id.*
197. Davis & Schoen, *supra* note 57, at 111.
198. Hurley & Draper, *supra* note 4, at 13.
199. Gold & Mittler, *supra* note 9, at 40–41.
200. Watson, *supra* note 6, at 65.
201. *See, e.g.*, Gold & Mittler, *supra* note 9, at 40–41.

care has not led to cost savings, if, as some maintain, managed care has improved medical and social services, resulting in healthier lives and keeping people in mainstream society longer and out of institutional forms of care.[202]

Time may paint a clearer picture as to whether MCOs can generate cost savings and to what extent such savings represent a trade off for improved quality and access. Plainly, the MCO model has not been a panacea. However, managed care is a workable model. Further, as the following discussion points out, many of the problems that continue to plague Medicaid are not a function of managed care itself but result from the structure of Medicaid. These problems, if corrected, would allow managed care to more fully realize its potential benefits.

IV.
RECOMMENDED CHANGES TO THE STRUCTURE OF THE MEDICAID PROGRAM

A. The Problem with Waivers: Increased State Discretion and the Inherent Tension in the Federal-State Relationship

While some critics point to the states' delegation of responsibility to MCOs as a problem, perhaps larger problems have resulted from the federal government's delegation of responsibility to the states.[203] Several of the biggest problems with the Medicaid system result from the structure of Medicaid. States receive from 50% to 83% of their funding from the federal government.[204] Yet states are largely free of oversight from the federal government in deciding how to allocate money in the Medicaid budget.[205] This gives states an incentive to use illusory financing practices, such as gaming the system to maximize the number of federal dollars per state

202. Watson, *supra* note 6, at 71. Keeping people healthy and out of institutional care should also further the goal of reducing costs since institutional care is such an expensive form of care.

203. *See, e.g.*, Matthew, *supra* note 71, at 982–83, 989.

204. WACHINO ET AL., *supra* note 7, at 3. This federal financing system creates an effective redistribution to poorer states. *Id.* One result of, and perhaps reason for, federal financing is that the government provides services for the poor based on a more progressive federal tax system as opposed to the more regressive state tax systems. *See, e.g.*, Joel C. Cantor, *Expanding Health Insurance Coverage: Who Will Pay?* 15 J. HEALTH POL. POL'Y & L. 755, 763–64 (1990) (arguing that although Medicaid financing by states is proportionately distributed for higher income levels, the financing become regressive for lower income taxpayers).

205. Andersen, *supra* note 145, at 217–18. *See also* WACHINO ET AL., *supra* note 7, at 24.

dollar spent.[206] Therefore, states do not fully internalize their expenditures, and they operate at less than maximum efficiency.[207] An inference arising from this cost structure is that states would more efficiently oversee their Medicaid budgets if they were forced to finance their Medicaid programs by themselves.[208]

Increased flexibility affects not only how much a state decides to spend, but also where the money is allocated within the Medicaid system. Medicaid provides for a range of services to which states can allocate funds as they see fit, subject to minimum federal requirements.[209] For example, the portion of the Medicaid budget allocated toward long-term care has grown large not only because of the rising costs of care, but also because states have the discretion to allocate more money to this service.[210] One reason that government officials may be interested in increasing allocations to long-term care at the expense of other services is that the beneficiaries tend to be the elderly, who have more political clout than the disenfranchised poor. Because of the spend down provisions in Medicaid, elderly Medicaid beneficiaries include many individuals who were not life-long Medicaid beneficiaries, but rather who depend on Medicaid to fill in the gaps in care later in life. States therefore use their discretionary spending to be politically responsive to the interests of elderly Medicaid beneficiaries, at the expense of the under-funded needs of the disenfranchised poor.[211]

The flexibility that has evolved in Medicaid law has been a mixed blessing. It has facilitated improvements in health care such as those that have come through the transition to an MCO system. However, the flexibility has also become a dangerous tool for abuse.

206. KU & BROADDUS, *supra* note 14, at 4; Schneider et al. *supra* note 13, at 84; Watson *supra* note 6, at 65.

207. Andersen, *supra* note 145, at 218–19. *See also* James Blumstein & Frank Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (Tenncare) as a Case Study & a Paradigm*, 53 VAND. L. REV. 125, 140–42 (2000).

208. *See, e.g.*, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL 12 (2003) [hereinafter BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL], http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14347.

209. Perkins, *supra* note 78, at 13–14.

210. *See, e.g.*, WACHINO ET AL., *supra* note 7, at 4. *See also* BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL, *supra* note 208, at 23 fig. 11 (showing that 83% of Medicaid spending on the elderly is optional).

211. *See infra* Section V.D.

B. Solving the Accountability Problem in Administering the Medicaid Program

In addressing the problems in Medicaid managed care, it is important to note that the flaws do not make the MCO model unworkable. The problems are not inherent in the structure of MCOs but in the structure of Medicaid financing. When done responsibly, through an integrated system of financing and administering, managed care can provide real benefits to Medicaid.[212]

There are several options that might mitigate the problems resulting from the structure of the Medicaid financing system. The federal government could become more involved in administering Medicaid by increasing oversight over management of state programs.[213] This is not a realistic expectation under the current Bush administration that seeks to push more responsibility onto the states.[214] Moreover, it is not clear that the federal government would be able to allocate spending any better than the states do. Nevertheless, some argue that not only should the federal government recognize its obligation to be more involved in Medicaid spending, but that the courts should recognize a larger role for the federal government in overseeing the management of Medicaid.[215]

One proposal put forward by the Bush Administration might improve state accountability. President Bush proposed a system of financing in which states could opt for a block grant, which is a fixed sum of money instead of a matching payment system.[216] States would receive fixed amounts, regardless of the costs of state programs.[217] There would be incentives to join the system, with states receiving fixed sums large enough to alleviate current state burdens.[218] However, states that opt in would be subject to tighter caps in the future, thereby reducing the federal role in funding Medicaid.[219] States would then have more incentives to manage the Medicaid budget efficiently because inefficiencies would no

212. Watson, *supra* note 6, at 71.

213. Matthew, *supra* note 71, at 1005–07.

214. *Id.* at 982.

215. *See, e.g.*, *id.* at 987–89.

216. BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL, *supra* note 208, at 4–8.

217. CINDY MANN, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND BLOCK GRANT FINANCING COMPARED 3 (2004), http://www.kff.org/medicaid/upload/Medicaid-and-Block-Grant-Financing-Compared.pdf.

218. *See* BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL, *supra* note 208, at 1, 12.

219. MANN, *supra* note 217, at 3.

longer be cushioned by matching federal funds.[220] States, working with fixed amounts of federal money, supplemented only by their own money, would be forced to make tougher choices. Further, there would arguably be less ability to delegate blame for underfunding on the federal government, leading to increased political accountability. Therefore, block grants might facilitate efficiency and reduce the problems that result from a system that segregates the roles of financing and administering the Medicaid program.

Increasing state responsibility has its dangers too. First, since the block grants would give states fixed sums and leaves the rest of the Medicaid program to be funded by states, the grants may lead states to under-fund the Medicaid program and under-provide for beneficiaries. Another concern is that a block grant, in contrast with the current system, would no longer create automatic legal entitlements to Medicaid coverage for those qualifying as categorically needy.[221] States would not be subject to Medicaid law and would be free to make choices such as capping enrollment at a maximum number and shutting others out. However, the limited ability of privately insured patients to seek legal redress under the current system makes the argument in favor of legal entitlement for Medicaid beneficiaries less compelling.[222] The danger of states underproviding care and the lack of individual ability to enforce legal rights of entitlement are also concerns. However, these concerns are not new ones that will arise as a result of block grants.

C. Other Suggestions to Improve Medicaid Managed Care

There are additional ways to improve state Medicaid programs beyond changing the federal-state balance in Medicaid financing. First, reimbursement rates could be higher to attract MCOs and to improve quality through greater competition.[223] Second, longer lock-in periods would keep enrollees in an MCO for a longer period rather than having people rotate in and out of the program. This would reduce administrative costs and improve preventive care by maintaining enrollee contact with primary physicians.[224] Third, MCOs need to ensure proximity between providers and high Medi-

220. BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL, *supra* note 208, at 12.

221. Schneider et al. *supra* note 13, at 87.

222. *See, e.g.*, Law, *supra* note 58, at 6.

223. Axelrod, *supra* note 6, at 262–63; Hadley & Holahan, *supra* note 113, at 325.

224. Watson, *supra* note 6, at 72. The average duration of enrollment is currently less than one year. Hopper, *supra* note 80, at 783.

caid concentration neighborhoods.[225] Fourth, there needs to be an improved relationship of accountability in the chain from the federal government to state governments to MCOs to providers to patients. Without improvements in accountability, there are concerns regarding quality of care and management of the Medicaid budget. Otherwise there are too many poor allocation decisions and too many tax dollars being siphoned off.[226] Fifth, fraud, which currently represents 10% of the costs of the Medicaid program, needs to be reduced.[227] Sixth, the efficiency of MCOs could be improved through the use of incentives based on performance criteria, such as bonuses granted to MCOs that demonstrate healthy birth weights.[228]

Although there are several improvements that could be made to the MCO model, the model still has the potential to improve access and quality for Medicaid patients.[229] In order for this to happen states must consider all possible ramifications before delegating responsibility for the health of their citizens to third parties.[230]

Accepting the MCO model as workable, and with potential to provide real benefits, we are left with one question to be addressed. If the MCO model will continue to persist into the future of Medicaid, is there room to expand the model in a way that will bring substantial benefits?

225. Axelrod, *supra* note 6, at 262.

226. *See, e.g.*, Woolhandler & Himmelstein, *supra* note 17, at 94 (arguing that because Americans are essentially paying for universal health care a system providing universal health care coverage would be preferable to the current system by reducing overhead and siphoning of money by private insurers).

227. Hopper, *supra* note 80, at 781. Some analysts expected the MCO model would cut down fraud that was attributed to the fee-for-service model, but fraud persists, even in the MCO model. *Id.* at 788. There are many different types of fraud that exist including fraud in claims submission and billing procedures, underutilization, and procurement of Medicaid managed care contracts. Axelrod, *supra* note 6, at 264; Hopper, *supra* note 80, at 788–92 For example, this could be cut down through reimbursement rates that attract more MCOs and improve competition. However, higher rates could also create more incentives for fraud.

228. Watson, *supra* note 6, at 76.

229. Axelrod, *supra* note 6, at 270; Watson, *supra* note 6, at 77–78.

230. Watson, *supra* note 6, at 77–78. *See also* Axelrod, *supra* note 6, at 270; Gold & Mittler, *supra* note 9, at 45.

V.
BENEFITS OF EXPANDING THE MANDATORY MANAGED CARE STRUCTURE TO LONG-TERM CARE AND THE OBSTACLES TO EXPANSION

As the legal, political and social objections to restricting choice have evaporated, states have looked to managed care to save money and improve Medicaid. Yet Medicaid programs have generally avoided applying restrictions on choice in long-term care. The remainder of this Note will focus on long-term care and the potential cost savings that could be realized by extending the MCO model to cover the associated costs. The biggest obstacle may be political rather than economic or legal. While Medicaid was intended to serve the poor, politicians may be more concerned with the interests of those who become eligible for Medicaid at the end of life, as a result of spending all of their resources on long-term care.

A. The Cost of Long-term Care in the U.S. and the Role of Medicaid

Long-term care costs represent a significant portion of Medicaid expenditures. In 2002, Medicaid spent $139 billion on long-term care, with $103 billion going toward nursing home care and $36 billion going toward community based care.[231] The expenses for long-term care represent one third of the Medicaid budget while serving less than 10% of the Medicaid population.[232]

To understand the large role of long-term care in Medicaid spending, it is important to consider the role Medicaid has assumed relative to other potential payers of long-term care. Long-term care coverage was an afterthought in the enactment of Medicaid and was therefore never intended to become a major beneficiary of funding by Medicaid.[233] The results have been quite different though. Medicaid has become a primary payer for long-term care, filling in the gaps where Medicare and private insurance fall short.[234] Private

231. O'BRIEN & ELIAS, *supra* note 85, at 2. *See also* KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID'S ROLE IN LONG–TERM CARE (2001), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13732 [HEREINAFTER MEDICAID'S ROLE IN LONG-TERM CARE] (detailing Medicaid's role in paying for long-term care). Community based care is a way to provide service to those in need while trying to keep them in their own homes and within mainstream society as opposed to being relatively isolated in nursing homes.

232. O'BRIEN & ELIAS, *supra* note 85, at 8.

233. Carpenter, *supra* note 68, at 67.

234. O'BRIEN & ELIAS, *supra* note 85, at 2.

insurance provides for little long-term care.[235] Medicare only covers services up to one hundred days in a nursing home following a hospital stay.[236] As a result, Medicaid pays for 45% of the long-term care expenditures.[237] For the cost of nursing homes specifically, Medicaid pays for around 58%, private insurance pays for around 24%, and Medicare pays for around 15%.[238]

Medicare's role in paying for long-term care has increased dramatically since the 1980s. In 1987 for example, it is estimated that the program only covered 2% of nursing home expenses, compared with 19% in 1996.[239] The overall role of the government in paying for long-term care has increased, and private individuals have increasingly relied on the government to cover long-term care. If long-term care, an afterthought to the Medicaid program, is bogging down the ability to provide proper care for the people that Medicaid originally intended to target, the extent of funding of long-term care ought to be reevaluated.

B. The Elderly as the Primary Beneficiaries of Medicaid Long-term Care and the Sources of Cost

The elderly are the primary users of long-term care. In 2000, 6 million of the 9.5 million Americans with long-term care needs were elderly.[240] Between 40% and 57% of the Medicaid budget is spent on the elderly.[241] Many of the elderly covered by Medicaid are considered "dual eligibles."[242] That is, they are eligible for insurance coverage from both Medicare and Medicaid. Typically, a dual eligible needs Medicaid to supplement the Medicare coverage because Medicare will not cover many long-term care expenses, and

235. *Id.*

236. *See, e.g.*, O'BRIEN & ELIAS, *supra* note 85, at 1.

237. Carpenter, *supra* note 68, at 67.

238. *See, e.g.*, DANN MILNE ET AL., THE HENRY J. KAISER FAMILY FOUND., STATE PERSPECTIVES ON MEDICAID LONG-TERM CARE: REPORT FROM A JULY 2003 STATE FORUM 5 (2004), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31043 (estimating that Medicaid pays for 47% of nursing home care); O'BRIEN & ELIAS, *supra* note 85, at 4 (estimating the amount paid by Medicaid for nursing home expenditures at 57%); Perkins, *supra* note 78, at 16; Schneider et al., *supra* note 13, at 83 (noting that Medicaid pays for 46% of nursing care spending).

239. Jeffrey Rhoades & John Sommers, *Trends in Nursing Home Expenses, 1987 & 1996*, HEALTH CARE FIN. REV., Fall 2003, at 99, 103 tbl.1.

240. O'BRIEN & ELIAS, *supra* note 85, at 1.

241. *See, e.g.*, *id.*, at 1.

242. *See, e.g.*, Edith Walsh & William Clark, *Managed Care and Dually Eligible Beneficiaries: Challenges in Coordination*, HEALTH CARE FIN. REV. Fall 2002, at 63, 64 (noting that 24% of Medicare funding is spent on dual eligibles).

individuals must use all of their own money on costly care. Dual eligibles represented 7 million of 51 million Medicaid enrollees in 2002.[243] Twenty-two percent of dual eligibles are living in institutional, long-term care facilities.[244]

The other constituency that accounts for a large portion of the costs of long-term care is the severely disabled. The disabled and elderly combined represent approximately 70% of Medicaid expenditures.[245] It was projected that three quarters of the increases in Medicaid spending between 2001 and 2006 would be associated with care for the disabled and the elderly.[246]

There are several reasons for the enormous costs and growth projections in long-term care. Caring for the elderly and disabled requires more procedures, more medicine, and more care. In addition, there are problems of coordination of care for dual eligibles, which creates large administrative costs. There has also been a cultural trend of increased reliance on institutional long-term care as opposed to familial care. Finally, there have been increasing changes in the demographics of the country, with the elderly making up an increasingly larger percentage of the population.

The laws and structure of Medicaid and Medicare make it difficult for dual eligible beneficiaries to experience a smooth coordination of care.[247] Information dissemination to beneficiaries is poor at best, in part due to regulatory impediments.[248] Further, the transition from acute care to long-term care and the corresponding transition from Medicare to Medicaid will sometimes require individuals to disenroll in preexisting plans, cutting ties with prior doctors and frustrating any sense of continuity of care.[249] Beneficiaries are not the only ones expressing frustration regarding coordination of the two programs. Medicaid MCOs find it difficult to manage cases of dual eligibles who are using Medicaid as a secondary payer.[250] In addition, providers are often frustrated with the diffi-

243. WACHINO ET AL., *supra* note 7, at 12.

244. Walsh & Clark, *supra* note 242, at 64.

245. Schneider et al., *supra* note 13, at 83; Watson, *supra* note 6, at 67.

246. Perkins, *supra* note 78, at 17.

247. KAISER, MEDICAID AND MANAGED CARE, *supra* note 157, at 2; MILNE, *supra* note 238, at 13.

248. Walsh & Clark, *supra* note 242, at 70. For example, there are restrictions on the types of information that can be included in marketing materials. *Id.* at 70. In addition, marketing materials must be approved by both Medicare and Medicaid. *Id.* at 70–71.

249. Walsh & Clark, *supra* note 242, at 78.

250. *Id.*

culties associated with billing for a dual eligible.[251] The administrative and billing structures of Medicaid and Medicare are quite different.[252] As a result, providers are finding participation in Medicaid MCOs to be excessively burdensome.[253] The costly and inefficient administrative burdens of coordination need to be better managed. This may not be a simple task.

Another contributor to rising long-term care costs is an increasing cultural reliance on long-term care. More Americans today tend to rely on nursing homes for the elderly as opposed to the traditional practice of caring for the elderly in the family home.[254] This trend is largely a result of more families comprised of two wage earners and, correspondingly, fewer homemakers.[255] The trend has also been facilitated by government policy as Medicaid coverage has allowed people to rely on nursing homes as a more common form of care. Middle income Americans have less incentive to care for the elderly at home or to purchase long-term care insurance because they can rely on the government.[256]

Finally, in looking at costs that make long-term care increasingly expensive, one cannot ignore the growing demand for long-term care. Not only are people living longer than ever, but with the aging of baby boomers the elderly will dramatically increase as a proportion of the U.S. population in the near future.[257] This shift highlights the importance of the government correcting the curable problems plaguing Medicaid before they grow worse.

C. Transitioning Medicaid Long-term Care from Fee-for-service to Managed Care

Recently states have made efforts to cut costs in Medicaid, using methods such as cutting reimbursement rates, tightening eligi-

251. *Id.*

252. *See id.* (describing the difficulties in directing care and paying bills for dual eligibles when dual eligibles exhaust their Medicare funding on doctors that are not in-network for Medicaid).

253. *Id.*

254. *See, e.g.*, McLean & Richards, *supra* note 18, at 294–95.

255. *See* ROSENBLATT ET AL., *supra* note 1, at 1139.

256. *See, e.*g., O'BRIEN & ELIAS, *supra* note 85, at 14. It is important to note that some states, like New York, have tried to improve incentives to purchase long-term care insurance through public-private partnerships that allow participants to become eligible for Medicaid coverage of long-term care without spending down as much of their assets as is generally required. *Id.*

257. *Id.* at 19–20, 20 fig. 16; MILNE, *supra* note 238, at 4.

bility criteria, and reducing optional benefits in the program.[258] However, states refuse to focus on one option likely to generate cost savings: extending Medicaid managed care to the elderly in need of long-term care.[259]

While much of the Medicaid program has transitioned toward a system of mandatory managed care, long-term care remains the last bastion of the traditional fee-for-service model in the Medicaid program.[260] Medicare also remains largely a fee-for-service program, with only 15% of enrollees in managed care.[261] While many Medicaid patients are in MCOs, dual eligibles are the primary beneficiaries of fee-for-service care, with very few beneficiaries in all-inclusive MCO programs.[262] These are the beneficiaries who suffer from the lack of coordination between coverage of acute care and long-term care. Dual eligibles need coordination and are ideal candidates for the coordinated care of MCOs.[263]

In addition to the possibility of improving quality of care, the potential for cost savings through managed care for the elderly is profound. Prospective nursing home residents typically consider factors such as proximity to family, proximity to doctors, cleanliness, quality of food, amenities, and activities.[264] In addition, Medicaid-eligible patients currently have unlimited freedom of choice in choosing a nursing home, with no incentive to consider cost.[265] Quality of care, while important, is often difficult for individuals and their families to evaluate. Once cost and quality of care fall away as factors to be considered in choosing a nursing home, the

258. O'BRIEN & ELIAS, *supra* note 85, at 18. *See also* Michael Cooper & Al Baker, *Pataki Aims to Avoid Overhaul by Spreading Medicaid Cuts*, N.Y. TIMES, Jan. 20, 2005, at B1 (detailing Governor Pataki's proposal to cut Medicaid funding in New York).

259. *See, e.g.*, Gold & Mittler, *supra* note 9, at 43.

260. MEDICAID'S ROLE IN LONG-TERM CARE, *supra* note 231, at 2.

261. Zarabozo, *supra* note 6, at 5.

262. *Id.* at 4.

263. *Id.* at 4. *See also* O'BRIEN & ELIAS, *supra* note 85, at 18–19.

264. *See, e.g.*, Choosing a Nursing Home, http://www.oag.state.ny.us/seniors/nursing.html#choose (last visited Apr. 21, 2006).

265. In New York for example, not only are facility operators prohibited from discriminating against admitting Medicaid eligible patients under N.Y. COMP. CODES R. & REGS. tit. 10, § 415.3(b)(5) (2004), but the law also requires any facility that is new or that makes any changes to services to accept a number of Medicaid patients equal to at least 75% of the county average. N.Y. COMP. CODES R. & REGS. tit. 10, § 670.3(c)(2) (2004). *See also* N.Y. State Health Facilities Ass'n v. Axelrod, 596 N.E.2d 860, 863–65 (N.Y. 1991) (upholding the regulation as a valid exercise of authority by the Public Health Council, and finding that the regulation furthers the goal of preventing discrimination against Medicaid patients seeking access to nursing homes).

other factors tend to come to the forefront in consideration. For example, assume there are two nursing homes in an area. One was built thirty years ago and one had a grand opening two years ago. It is likely that a Medicaid-eligible prospective resident and his or her family would choose the cleaner looking, newer home regardless of any correlation (or lack thereof) between age of the home and quality of care.

What is the problem with this scenario? New nursing homes tend to be significantly more expensive because they generally have larger expenses as a result of the construction costs associated with the building of new homes. Due to the costs of building the homes, in conjunction with natural inflation over an extended period, the capital costs of new homes are significantly higher than the capital costs of older homes.[266] Therefore, the new nursing homes need to charge a higher rate of reimbursement from the government per Medicaid patient in order to cover costs. The reimbursement rates paid by the government to the nursing homes on a cost basis schedule are therefore much higher in the newer nursing homes.

Privately insured patients, in contrast, have incentives to choose more cost-effective homes, where they receive quality care but lack the amenities of newer homes. Since such a large portion of nursing home residents are Medicaid patients,[267] there is no significant competition between nursing homes on a cost effective basis. Selling a cheaper product does not lure consumers the way it does in the market for consumer goods. Instead, it seems that the incentive is for homes to compete for Medicaid patients who are not cost-conscious by making the homes look attractive to prospective patients and their families.

States should look to contain costs and facilitate coordinated care through managed care for the elderly Medicaid patients. There has been slow, but growing experience with voluntary programs of this nature. For example, some states have offered a Program for All-Inclusive Care of the Elderly ("PACE").[268] PACE

266. *See* Tim Grogan, *How to Use ENR's Cost Indexes*, *in* ENERGY NEWS-RECORD FIRST QUARTERLY COST REPORT 39–40 (2006) (providing data showing that building costs have risen over time).

267. One nursing facility in New York for example, that opened in 2002 with 280 beds, had, as of March 15, 2005, 246 beds occupied, 172 of those by patients who were Medicaid eligible. Interview with anonymous nursing home operator, in New York.

268. *See* National PACE Association, http://www.npaonline.org/website/article.asp?id=4 (last visited Apr. 21, 2006). Another program, Medicare Advantage ("MA"), established pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MPDIMA"), intended to replace the former

programs are funded in part by Medicaid and in part by Medicare on a capitated basis.[269] The programs are not limited to dual eligibles, but are typically available to individuals over age 55 who are certified to need nursing home care.[270] Although PACE patients are certified as needing nursing home care, the program makes it possible for a large percentage of patients to have their needs addressed while continuing to live in their communities.[271]

Beneficiaries who opt in to PACE programs agree to receive all services through the PACE program.[272] They are entitled to a full range of services including institutional and non-institutional long-term care services, acute care services, social services and prescription drugs, without any cost sharing requirements.[273] While PACE programs can effectively coordinate the complex needs of patients, many patients are reluctant to opt in to these programs, probably because they are reluctant to give up their ability to make their own choices.[274] Mandatory programs for Medicaid patients may seem less tasteful than these optional programs, but would be consistent with Medicaid managed care generally.

Oregon has experimented with a mandatory PACE program, but even there long-term care services were still carved out as fee-for-service.[275] In Arizona, there has been a capitated long-term care Medicaid program, which intended to promote a Home and Community Based Services (HCBS) program and lower costs.[276] While the program was successful in lowering costs, many view the program skeptically, claiming that it selected only low-risk clients.[277]

Medicare+Choice program (the "M+C program"), aiming to move more Medicare patients toward managed care. Daniel Katz & Monica Deshpande, *An Rx for the Modification of the Medicare Prescription Drug, Improvement,& Modernization Act of 2003: Toward a Reform with Results*, 14 ANNALS HEALTH L. 183, 190 (2005). However, the program creates disincentives for dual eligibles to join an MA plan, through expensive copayments. *Id.*

269. ANDY SCHNEIDER & RISA ELIAS, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AS A LONG-TERM CARE PROGRAM: CURRENT BENEFITS & FLEXIBILITY 9–10 (2003), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28090.

270. *Id.* at 10.

271. National PACE Association, *supra* note 268.

272. SCHNEIDER & ELIAS, *supra* note 269, at 9–10.

273. National PACE Association, *supra* note 268.

274. *See* Lynda Burton et al., *Satisfaction with Health Care of Dually Eligible Older Beneficiaries*, HEALTH CARE FIN. REV., Summer 2001, at 175, 176.

275. Walsh & Clark, *supra* note 242, at 68.

276. William G. Weissert et al., *Cost Savings from Home and Community Based Services: Arizona's Capitated Medicaid Long-Term Care Program*, 22 J. HEALTH POL. POL'Y & L. 1329, 1333, 1343–45 (1997).

277. *Id.* at 1333, 1345.

While there is a dearth of empirical evidence, the little research that has been performed on managed care for the elderly shows that elderly patients in managed care have typically expressed higher satisfaction with MCOs that coordinate care, as compared with elderly patients in fee-for-service plans.[278] However, the managed care plans involved in this data did not cover long-term care.[279] Nevertheless, elderly patients are ideal beneficiaries for the managed care model of health care.[280]

The Medicaid program needs to transition long-term care away from unlimited free choice of provider, and toward an MCO-based, PACE-type mandatory program. Under such a system, a state might pay a capitated rate to an MCO for every Medicaid beneficiary in a particular zip code over a designated age. Through coordinated care, MCOs could reduce the amount of institutionalization of patients, allowing individuals to remain in their communities for longer. In addition, where institutional care is necessary, a restricted choice of provider for Medicaid patients would reduce cost-generating behavior in one of the most expensive portions of the Medicaid budget. Facilities would have to compete, reducing costs, and driving out the newer, fancier facilities.[281]

D. Obstacles to the Extension of the MCO Model to Long-term Care Services

There are several obstacles to extending the MCO model to long-term care services. Maintaining freedom of choice is one such stumbling block. Although freedom of choice was common twenty years ago, restricting choice is a natural and logical extension of the current Medicaid system. Long-term care is the only significant component of Medicaid remaining with freedom of choice. States have acknowledged the impracticality of free choice of provider through the transition of Medicaid to a MCO based system. Realists recognize the need to ration limited resources to give the best care to the most people.[282] This cannot be had by clinging to freedom of choice principles for long-term care.

278. Burton, *supra* note 274, at 182–84.

279. *Id.* at 184.

280. *See, e.g.*, Zarabozo, *supra* note 6, at 4 (arguing that the managed care system could be utilized by dual eligibles to provide a comprehensive package including prescription drugs and long-term care).

281. The newer facilities, with newer technologies, might be put to better use in treating more specialized patients who are in need of the treatments offered by the newer technologies.

282. Hall, *supra* note 22, at 444–45.

Continuing to provide freedom of choice in long-term care also becomes impractical when observing the lack of choice that patients in general population have. Medicaid's original intent was to mimic the care received by the general population. The general population has restricted choice of health care services as a result of MCOs that restrict choice, and as a result of surging costs that effectively restrict out-of-pocket choice. The general population has the least real choice in health care in the context of expensive long-term care. Can we really expect the general population to pay for Medicaid patients to have more choice than taxpayers can afford to obtain for themselves? How can we maintain an argument for a right to freedom of choice for Medicaid patients today when the rest of us no longer have that freedom?

The primary reason for states' resistance to embrace MCO based long-term care for Medicaid beneficiaries is that long-term care accounts for a different class of people than the rest of Medicaid. In contrast with other portions of Medicaid which primarily assist the poor, Medicaid long-term care assists those elderly who are Medicaid eligible, including many who were middle-class citizens most of their lives. In other words, many of the elderly who are eligible for Medicaid have divested assets to effectively qualify as poor.[283] These beneficiaries have political influence, making change a dangerous prospect for a politician to consider. The AARP, a powerful lobbying group that represents the elderly, makes health care for the elderly a third rail in politics.[284] To the extent that state officials have discretion in how to spend Medicaid dollars, they would prefer to continue with bloated budgets that hurt younger, poorer Medicaid patients, rather than bring cost savings through restriction of choice.[285]

An additional obstacle is the federal Medicaid statute itself. As the statute has been amended over time, the law has come to allow

283. *See, e.g.*, Pear, *supra* note 87; Takacs & McGuffey, *supra* note 86, at 122, 127–28, 131.

284. *See* Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1112 (2003) (discussing the power and influence of AARP and the effects on the politics of health care). *See generally* CHARLES MORRIS, AARP: AMERICA'S MOST POWERFUL LOBBY & THE CLASH OF GENERATIONS (1996) (describing the history and political influence of the AARP).

285. *See, e.g.*, Diane Lourdes Dick, *The Impact of Medicaid Estate Recovery on Nontraditional Families*, 15 U. FLA. J.L. & PUB. POL'Y 525, 534, 534 n.50 (2004) (claiming that the influence of AARP causes states to make cuts in portions of Medicaid other than long-term care). *See also* BUSH ADMINISTRATION MEDICAID/SCHIP PROPOSAL, *supra* note 208, at 23 fig. 11.

waivers for virtually any portion of the Medicaid statue.[286] Yet, one of the three categories of people immune from the possibility of Medicaid managed care is the dual eligible population.[287] States cannot mandate enrollment of qualified Medicare beneficiaries into managed care entities pursuant to Medicaid. Why would the Medicaid law, intended to target a population distinct from the population targeted by the Medicare law, single out Medicare eligible individuals as a priority population? The AARP has lobbied effectively at the expense of the originally intended beneficiaries of the Medicaid statute.

VI.
CONCLUSION

If the government philosophy continues to be that the poor are entitled to the same care as the rest of the population, the government has an obligation to provide this care. The federal government imposed a duty on itself to provide care to those who could not care for themselves. When people argue that the Medicaid program lacks funds and gives inadequate access, the government points to limited resources. However, the federal government has failed the people to whom it gave an entitlement. The federal government, it seems, has prioritized the elderly population over the poor population.

The federal government ought to make the needed changes of law and policy that will allow it to fulfill its obligation to the poor. The federal government should make a push for states to use managed care for long-term care, and should also make the states more accountable, restoring an original goal of quality health care through cost savings.

The original goal of freedom of choice has receded in the Medicaid program. Free choice of provider is unlikely to return to Medicaid generally, but in order to make the most of this sacrifice, Medicaid ought to realize the full extent of benefits that can result from this tradeoff. The last relics of freedom of choice are a fair sacrifice in light of twenty-first century health care, if it will bring the cost savings necessary to ensure health care for all Americans.

286. 42 U.S.C.A. § 1396u-2 (2005).

287. "A State may not require . . . the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary . . . ." 42 U.S.C.A. § 1396u-2(a)(2)(B) (2005). The other two categories are "certain children with special needs" and Indian Americans. 42 U.S.C.A. §§ 1396u-2(a)(1)(A), (C) (2005).