SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Case Western Reserve Law Review

Volume 36 | Issue 4 Article 14

1986

Commentary

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INTRODUCTION

THERE EXISTS IN a few file drawers around the country a treasured, unpublished manuscript of a book called *Class Medicine*[1] by the late Ed Sparer, University of Pennsylvania Health Law Professor. *Class Medicine* is a brilliant and moving thesis on the dual-class nature of America's health care system. Professor Sparer argued that Medicaid, because it represented a separate system of health care for the poor, was bound to fail; a separate health system divided by class would inexorably result in an unequal system. The separate and unequal underpinnings of America's health care system are critical in understanding the ramifications of Medicaid cost-containment efforts: specifically, Medicaid freedom-of-choice limits and primary-care, case-management systems.

As Professor Rosenblatt notes, Medicaid, at least initially, aimed at ending dual-class medical care. The publicly insured poor would have freedom to select providers of their choice. The infusion of new Medicaid and Medicare dollars would enable public hospitals, long the hub of the separate and unequal system, to improve the care provided the poor and to compete for privately insured patients.[2]

This optimistic picture was not to be realized. As Professor Rosenblatt demonstrates, the underpinnings of a separate system, while weakened somewhat for a time, were never eliminated. Physicians quickly understood that accepting Medicaid patients was not in their financial best interests. By 1975, two Medicaid authorities

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1. E. SPARER, CLASS MEDICINE (1973) (unpublished manuscript).

2. One authority writing in 1969 noted:

> It does not take [a] sharp-eyed soothsayer to observe that this country is entering a period of hospital care that will have one class of hospital facilities. No longer will we have one set for those who are paying their own way. Most important among the factors moving us in this direction is the advent of the Medicare and Medicaid program.

Gerdes, *Anticipated Directions for the Future of Public General Hospitals*, 59 AM. J. PUB. HEALTH 684 (1969).

noted that "[m]anpower problems plagued Medicaid from its inception . . . . In some areas of the nation, an orthopedist or periodontist willing to accept Medicaid patients was as rare as a tropical bird in Alaska."[3] Nor were Medicare and Medicaid funds generous enough to help most "providers of last resort" improve services to the poor and compete with their private sector brethren. Indeed, since 1965 a number of large and small public hospitals have restructured their management, have closed, or have been sold to for-profit hospital chains.[4] Others have remained open, only to shut their doors to the poor. And those that remain, whether it be Los Angeles County-USC Medical Center, Harlem Hospital, Cook County General, or D.C. General, continue to struggle with inadequate funding, inadequate personnel, inadequate physical plants and equipment, and inadequate political support. Is it any wonder, then, that the care provided by these facilities is sometimes inadequate as well?[5]

Moreover, this increasingly segregated and inadequate system costs both the states and the federal government an ever growing amount of tax revenues. Today, the program consumes fully ten percent of the nation's health care dollar and is one of the largest, if not the largest, line item in most state budgets.

Thus, it can certainly be argued that reform is in order—and what better reform than Medicaid primary-care case management. Case-management systems promise to increase access to medical care for recipients, to encourage greater use of primary and preventive care, to decrease overutilization and inappropriate utilization, and to increase quality—all for less money than is currently being spent. Unfortunately, although these systems promise to be a Medicaid panacea, they can also be a pandora's box, which, when opened, results in decreased access to care, underutilization of services, and entrenchment of poor quality providers.[6]

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3. A. SPIEGAL & S. PODAIR, MEDICAID: LESSONS FOR NATIONAL HEALTH INSURANCE 49 (1975).

4. *See generally* Dallek & Lowe, *The For-Profit Hospital Juggernaut*, 13 S. EXPOSURE 78-87 (Mar.-June 1985).

5. For a recent discussion of quality problems at a public hospital, see Pierson, *'Widespread Problems' Uncovered at Harlem Hospital*, N.Y. Post, Mar. 26, 1986, at 1; Memorandum from Vector Botic, New York City Health and Hospital Corporation, to the Board of Directors, Harlem Hospital Center (Mar. 22, 1986) (article 28 survey).

6. For a general discussion of the potential problems of Medicaid case management systems, see Dallek & Wulsin, *Limits on Medicaid Patients' Rights to Chose Their Own Doctors and Hospitals*, 17 CLEARINGHOUSE REV. 280-89 (1983); Dallek, Parks & Waxman, *Medicaid Primary Care Case Management Systems: What We've Learned*, 18 CLEARINGHOUSE REV. 270-74 (1983).

One can distinguish between "ethical" cost containment, which is designed to avoid the denial of appropriate care, and "unethical" cost containment, which entails budget cutting without adequate protective measures against unjustified underservice, excess profiteering, and denial of human dignity. It is critical to explore this distinction, and, more important, to address the question of why "unethical" systems develop. After all, no state explicitly plans to implement an unethical system. Indeed, states are convinced that primary-care case management will improve both access to and quality of care. One state was so confident of the equity of its proposed system that it has named it "Expanded Choice."[7] Yet, as often as not, state efforts in these areas lead to "unethical" systems. Why the difference between rhetoric and reality?

I. PROMOTING SEPARATE (AND UNEQUAL?) CARE FOR THE POOR

The first reason for the disparity between the rhetoric of ethical systems and the reality of unethical ones is that states have adopted the notion of separate health care for the poor.[8] It is a notion supported by many academics as well. Uwe Rienhardt, a health economist at Princeton University, posits that the nation could improve care for the poor

> if only the champions of the poor [abandon] their futile search for complete egalitarianism in a nation that favors two tiers for just about everything else, including education and justice, if not *de jure*, then *de facto*. Having tried unsuccessfully since 1948 to introduce National Health Insurance into the United States, it must have dawned even on the most ardent proponent of that strategy that such an approach may just not be workable in this country.[9]

Professor Reinhardt argues that the "best the champions of the poor can hope for in health care at this time" would be a three-tiered system:

> Tourist Class Care—Publicly financed health care paid for primarily through competitively bid, prepaid capitation, with ra-

7. California's Expanded Choice Case Management program was to have begun in San Diego in the summer of 1986 after three years of planning. However, last minute opposition by San Diego physicians and unexpected costs halted implementation. *See California Drops Expanded Choice*, 149 HEALTH ADVOC., Summer 1986, at 17.

8. For a fuller discussion of this issue, see Dallek, *Health Care For America's Poor: Separate and Unequal*, 20 CLEARINGHOUSE REV. 361 (1986).

9. Reinhardt, *The Problem of Uncompensated Care, or are Americans Really as Mean as They Look?*, Sept. 1984, at 18 (presented before the National Council on Health Planning and Development).

> tioning on the British style; Business Class Care—Health care financed through employer-paid health insurance and delivered under a mixture of prepaid capitation, Preferred Provider Organizations, and the traditional fee-for-service system; Designer Care—Health care delivered in VIP suites of hospitals or in health-care resorts, and paid for privately by the well-to-do.[10]

Professor Lester Thurow, a Harvard economist, although an "egalitarian when it comes to health care," also writes that we are headed for a "segregated, three-tiered health care system," the bottom tier consisting of a "set of government health care providers who will provide the minimal level of health care for the poor and the elderly [for a] fixed annual fee."[11] Dr. Thurow believes that the level of this fee will dictate the level of care provided and fears that "Americans may be willing to tolerate a minimal quality of health care that is much lower than some of us thought politically possible."[12]

Unfortunately, many Medicaid case-management systems and Medicaid health maintenance organizations (HMOs) are premised on this separate system. Well-established federally qualified HMOs shun the Medicaid program. According to Congressman Henry Waxman, fewer than one in four federally qualified HMOs have enrolled Medicaid beneficiaries.[13] And those that do enroll them substantially limit the number of enrollees. In 1984, less than two percent of HMO enrollees in Pennsylvania were Medicaid recipients.[14] Despite state efforts to increase Medicaid HMO enrollment in Massachusetts, only seven of the state's approximately twenty-five HMOs have signed Medicaid contracts.[15]

In 1976, Congress enacted regulations to protect Medicaid bene-

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10. Reinhardt, *Economics, Ethics, and the American Health Care System or Why Some People Can't Get Decent Care*, 34 NEW PHYSICIAN, Oct. 1985, at 24.

11. Thurow, *Medicine Versus Economics*, 313 NEW ENG. J. MED. 613 (1985).

12. *Id.*

13. *See HMOs Must Help Solve Plight of the Uninsured*, 16 MOD. HEALTH CARE 24 (1986).

14. *See Rx: Preserve Health Care Rights*, 1 PA. SUPPORT REP., Winter 1986, at 10 (publication of Pennsylvania Law Coordination Center).

15. HMOs in Massachusetts also attempt, through selective marketing, to keep ill Medicare patients from joining. According to one Massachusetts Advocacy Group, HMOs use "subtle and not so subtle strategies to capture the healthier and more financially well off elderly." These efforts include holding an orientation meeting on the third floor of a building without an elevator (thus barring participation by the disabled elderly) or sending direct mail solicitation only to targeted middle class elderly communities. *See Will HMOs Cure Our Health Care Woes?*, 14 STAYING ALIVE, Winter 1986, at 5-6 (publication of CommonHealth).

ficiaries enrolled in capitated, at-risk systems.[16] One of these regulations prohibited HMOs serving the Medicaid population from enrolling a Medicaid and Medicare population of greater than fifty percent. Although Congress changed the limitation from fifty percent to seventy-five percent in 1981,[17] the clear intent of the legislation remains—to promote access for the poor to an integrated health care system.

Unfortunately, this protection has only been partially successful. The Secretary of Health and Human Services (HHS) can grant a waiver of the rule for up to three years,[18] and some HMOs are able to nominally meet the requirement but still operate separate systems. For example, several of the HMOs in Wisconsin's Medicaid Case Management System subcontract with a number of Independent Practice Associations (IPAs), some of which refuse to serve Medicaid patients. Although the HMOs meet the seventy-five percent rule, care remains segregated. One study found "specific IPAs . . . designated as 'Medicaid' providers while other IPAs are 'commercial' providers."[19] States have also sought to avoid the seventy-five percent requirement through a number of strategems. For example, in November of 1985, Ohio sent to the Health Care Financing Administration (HCFA) a section 1115 waiver request to "experiment" with an Aid to Families with Dependent Children (AFDC) case-management system in Cuyahoga County.[20] The waiver seeks, among other proposals, to exempt the "experiment" from the seventy-five percent requirement. Putting aside questions of whether another Medicaid case-management "experiment" is needed and whether an exemption from the seventy-five percent requirement is legal,[21] Ohio's proposed case-management system would serve to strengthen the foundation of Cleveland's separate health system of care for the Medicaid population. Because of a

16. *See* § 1903(m) of the Medicaid Act, 42 U.S.C. § 1396b (1982), *amended by* Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, 90 Stat. 1945, 1957-58.

17. *See* The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2178, 95 Stat. 357, 813-14, *amending* sec. 1903(m)(2)(A) of the Medicaid Act, 42 U.S.C. sec. 1396(m)(2)(A) (1982). The Amendments required only 25% non-Medicare and Medicaid enrollees.

18. *See* § 1903(m)(2)(C) of the Medicaid Act, 42 U.S.C. § 1396(m)(2)(C) (1982).

19. N. CROSS-DUNHAM, C. SCHRAMM, K. JEWELL & R. CARR, EVALUATION OF THE HMO ENROLLMENT INITIATIVE FOR WISCONSIN'S MEDICAL ASSISTANCE PROGRAM: KEY HMO ORGANIZATIONAL ISSUES FOR CONSIDERATION 9 (1985).

20. Section 1115 Waiver Application submitted by the Ohio Department of Human Services, Office of Medicaid Administration, to the Secretary of HHS (Nov. 11, 1985).

21. *See generally Opposition to the Granting of a Waiver for the Cleveland Medicaid Enrollment Demonstration*, filed by the Legal Aid Society of Cleveland (Jan. 21, 1986).

loophole in the Medicaid law, entities known as Health Insuring Organizations (HIOs)[22] have also been used by states to bypass Medicaid HMO protections, including the seventy-five percent requirement.[23]

A continuation of this class system ties too many poor to Medicaid-only HMOs providing questionable care. A case in point is Health Power, Ohio's largest Medicaid HMO, which began serving Medicaid recipients in Columbus in June of 1984. According to a series of December of 1985 articles in the Cleveland *Plain Dealer*, Ohio signed the Health Power contract even though the state had developed no quality assurance standards and even though several of Health Power's owners and providers had been previously implicated in Medicaid fraud.[24] For example, Health Power's largest stockholder had been under "close surveillance" for more than ten years because of questionable Medicaid practices. At the same time that he was negotiating a state Medicaid contract, the Department of Human Services was negotiating with one of his clinics to repay $104,000, which the state claimed was due from overbilled Medicaid charges. Several other Health Power providers and stockholders had also been charged or convicted of defrauding the federal or state government.[25]

In November of 1984, six months after Health Power began its HMO operations, the Ohio Department of Health Services contracted with the Ohio Area XI Physicians Peer Review Organizations, Inc., to evaluate the care received by the HMO's 10,000 patients. The audit found that patient charts were "illegible" and

22. See 42 C.F.R. 434.1-424.2 (1985), which permitted states to contract with Health Insuring Organizations (HIOs) on a capitated basis for the provision of Medicaid services. A HIO was defined as an entity that "pays for medical services provided to recipients in exchange for a premium or subscription charge paid by the agency [and] assumes an underwriting risk." Section 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 216, 1986 U.S. CODE CONG. & AD. NEWS closed the HIO loophole, although the legislation did permit existing HIOs to continue operating.

23. *See* Pennsylvania's 1915(b) Waiver Request of April 12, 1985 from Walter W. Cohen, Secretary, Commonwealth of Pennsylvania, Department of Public Welfare, to the Department of Human Services. *See also Opposition to the Granting of a Waiver to Pennsylvania's Case Management Proposal*, (Apr. 1985); *Supplemental Response In Opposition to the Granting of a Waiver to Pennsylvania's Case Management Proposal* (May 15, 1985); *Opposition to the Supplement of Pennsylvania's Application for a Waiver Under the Social Security Act* (Nov. 12, 1985); (each submitted by Community Legal Services of Philadelphia).

24. For a summary of the *Plain Dealer* articles, see Dallek, *Ohio HMO Scandal Reported*, HEALTH ADVOC., Feb. 1986, at 5-7.

25. *See HMO Chief Watched for Decade by State*, Plain Dealer, Dec. 2, 1985, at 12-A; *Care Not Up to Par, Audits Show*, Plain Dealer, Dec. 2, 1985, at 1-A, 12-A, 13-A.

"indecipherable," laboratory reports were "sporadic" and "in total disarray," and EKGs were "ordered, put in the chart, and never interpreted." Moreover, referrals to specialists were "sporadic and poorly documented," and not one of the medical records reviewed showed that therapy or rehabilitation had been ordered.[26]

The auditors found that at one Health Power clinic, two physicians were seeing 400 patients per day. (Based on a seven and one-half hour work day, this computes to slightly over two minutes per patient.) According to the *Plain Dealer* article, "doctors simply rotated through 20 examination rooms."[27] The audit team medical director concluded that "[t]he program was chaos, total unadulterated chaos. In that mess, you couldn't tell diddly-squat. There was no quality assurance there that I could find."[28] At the time, the state failed to act on the audit findings. In fact, it gave Health Power a $25,000 grant a few months later to expand operations to Dayton and Cincinnati.[29]

Health Power did accomplish a dramatic reduction in hospital utilization; its enrollees were hospitalized at a rate less than any other HMO population in the state. This reduction resulted in a $1 million bonus for the HMO and its clinics for the first seven months of the HMO's operation.[30]

The point is not to single out Ohio; other states have been equally lax about protecting Medicaid HMO recipients. Rather, it is to note that a Health Power-like HMO serving the privately insured middle class would have been out of business before it began. If we are to encourage or require Medicaid recipients to join a separate, capitated system of health care, strong protections are needed to ensure that the care provided is adequate.

This is especially important since providers, as well as states, often accept the notion that a separate standard of care for the poor is acceptable. One particularly egregious example of this view is the response by a California Medicaid HMO to audit findings that its patients had to wait over two hours to obtain care. While promising to correct the problem, the HMO cautioned the state

> to keep in perspective the differences that exist with subcultures within this society and that "standards" must be seen in a

26. *See Unadulterated Chaos, Doctor Says of First HMO*, Plain Dealer, Dec. 1, 1985, at 27-A.

27. *Id.*

28. *Id.*

29. *See id*; *Care Not Up to Par, Audits Show*, *supra* note 25, at 1-A.

30. *See Care Not Up to Par, Audit Shows*, *supra* note 25, at 13-A.

> broader context. . . . Although we are a health care facility, we are also a social institution. For many of our patients, the . . . Center is a safe, air-conditioned meeting place for a community that is devoid of these amenities. In other words, we caution you to use restraint in utilizing "White middle-class standards" without also *carefully* examining all other relevant factors.[31]

Second (or third) class care is acceptable at large public hospitals as well if a 1984 University of Southern California (USC) publication is any evidence. The report explains why the USC medical school wants a new private hospital built for the use of its faculty and students. The large public hospital, L.A. County-USC Medical Center, with which the medical school has been associated for years, does not provide appropriate learning opportunities for medical students and house officers, the report states. It continues:

> [The county hospital] is a marvelous experience for understanding the diseases of the poor and uneducated. Patients from such a population present illnesses of different stages of evolution although frequently these patients have diseases which are past the stage of treatment at the time of presentation. [However], both students and house officers have the need to gain experience with patients whose approach to illness from a cultural and sociologic perspective is different. They need to take a medical history from a college graduate, a businessman or a housewife who has some knowledge of disease and disease prevention.[32]

To this end, USC has made arrangements with National Medical Enterprises, a large for-profit hospital chain, to build a new hospital next to the county facility in one of the poorest sections of Los Angeles to care for privately insured patients only.

II. PROTECTING THE MOST VULNERABLE

The second root cause of the growth of "unethical" programs is a basic misunderstanding of just how vulnerable Medicaid recipients are in case-management systems, especially those that are capitated. Generally, the poor do not understand how to "use" these systems, which present quite different rules for obtaining care than the fee-for-service system. Several studies have shown that HMO bureaucratic barriers to obtaining care are more difficult for the poor to scale than for the non-poor.[33] Findings of a recent Rand Corporation (RAND) study confirm that the poor need special help

31. Reply to the California Department of Corporations Medical Survey Report of the Watts Health Foundation, Inc., March 8, 1978, by the Watts Health Foundation, Inc. (Undated).

32. *The Need for University Hospital*, UNIV. S. CAL. TRANSCRIPT (Nov. 5, 1984).

33. *See generally* Ware, Rogers, Davies, Goldberg, Brook, Keller, Sherbourne, Camp &

in the HMO setting. RAND researchers found that low-income enrollees who began the study with health problems appeared to deteriorate more if they were in an HMO than they would have had they remained in the fee-for-service system. This was not the case for the economically advantaged in the HMO who also began the experiment in poor health. Statistically significant differences were found in three measures: bed days due to illness; prevalence of serious symptoms; and the risk of dying. The HMO used in the study is well established with a good track record of providing quality care.[34]

Medicaid case-management enrollees are vulnerable for one other reason—they cannot afford to go outside the system and pay for care in the fee-for-service system. Two recent tragedies involving Medicaid HMOs illustrate this point. The first concerned the death of a five-month-old Wisconsin baby, Quincy Terry, who was enrolled in Wisconsin's mandatory Medicaid case-management system. Quincy's mother took him twice to the local emergency room for an illness, which was, according to news accounts, diagnosed as croup. When, despite medication, Quincy's condition worsened and his fever reached 104 degrees, his mother asked for authorization to take him back to the emergency room. Her HMO pediatrician refused the authorization and told her to bring him to the office the next morning. Nevertheless, Ms. Terry called the emergency room to inquire about bringing in her son. She was told that without the pediatrician's authorization, she would have to pay for the visit herself. By this time, according to Quincy's mother, he was "burning up, but his extremities were cold. He was quivering all over and his lips were turning red. He was foaming at the mouth. I could not," she went on, "get the fever to break." Quincy died in her arms at home the next morning.[35] There can be little doubt that Quincy Terry's death was due to HMO rules, a lack of understanding of those rules by Quincy's mother, and her inability to pay out of pocket for an emergency room visit.

In the second case, a California woman, Sharon Ford, was turned away from two private hospitals while in labor. Ford, a Medicaid recipient, had received prenatal care from Rockridge, a

Newhouse, *Comparisons of Health Outcomes at Health Maintenance Organisations with those of Fee-For-Service Care*, 1 LACENT 101-17 (1986).

34. *See id.*

35. *See* Manning, *Mother Says Infant Died After HMO Refused Care*, Milwaukee Sentinel, Dec. 12, 1985, at 1, 10. Since this incident, Wisconsin has revised its contracts with contracting Medicaid HMOs in order to guard against similar occurrences.

for-profit HMO. When labor began, she went to the nearest hospital but was referred to a Rockridge contracting hospital. At this second hospital, a fetal monitor exam indicated that there might be a problem with a compressed cord. Nevertheless, she was told to go immediately to the county's public hospital because, although she had an up-to-date Rockridge card, her name did not appear on the Rockridge HMO computer list. Thus, the hospital would not treat her, sending her instead to the public hospital, without any of her prenatal records. Shortly after Sharon Ford's arrival at the public facility, her baby was born dead.[36]

Again, the HMO system—in this case a computer foul-up—may have contributed to a needless death. However, it was Sharon Ford's vulnerability within that system which also contributed to her inappropriate transfers. Both Ms. Ford and Ms. Terry are black, both are uneducated, both are poor, and both are Medicaid recipients. It is hard to believe that a white, middle-class woman enrolled in an HMO as a privately insured patient would have had a baby die in her arms for lack of care or would have been transferred from two hospitals while in labor.

III. REGULATING A COMPETITIVE SYSTEM

Capitated, case-management systems are often viewed as a way of bringing the Medicaid program into the competitive marketplace. This view is a third reason for the development of "unethical systems." If the health care world is dichotomized between a regulatory and competitive (or nonregulatory) approach, then the unwillingness of the states to adequately regulate capitated, case-management systems becomes more comprehensible.

Professor Rosenblatt describes how some states have been unwilling to assume responsibility for case-management systems, turning over administration to for-profit entities. This delegation stems from more than just a state's desire to "wash its hands" of its Medicaid responsibilities. Rather, it is predicated on three things: trust in the private sector, a naive belief that access and quality are intrinsic components of the competitive approach to health care, and a misunderstanding of the strong profit incentives in these systems.

Arizona's implementation of the Arizona Health Care Cost

36. *See* Aleshire, *"Dumped" Patient Had Insurance*, Oakland Tribune, Dec. 5, 1985, at 1; Aleshire, *Woman Denied Help Loses Baby, Doctors Charge*, Oakland Tribune, Dec. 4, 1985, at 1. *See also The Potential Criminal Liability Involved With Improper Patient Transfers* (Feb. 10, 1986) (memorandum from the Alameda County District Attorney's Office to the Alameda Board of Supervisors).

Containment System (AHCCCS) program, a statewide, Medicaid primary-care, case-management program, is a good lesson on why the so called "competitive market" cannot be left alone to provide care to the poor. In enacting AHCCCS, the Arizona legislature mandated private-sector program administration with minimal state oversight. The program hired McAuto Systems Group, Inc., a subsidiary of McDonnell Douglas Corporation, because of the firm's "hands-on experience in establishing experimental prepaid health systems," although the AHCCCS contract was signed just four months after McAuto's formation.[37] In testimony before the House of Representatives Subcommittee on Health and the Environment in 1985, Arizona's Governor, Bruce Babbitt, justified the state's original decision to choose McAuto because "it happened to be the subsidiary of one of the largest aerospace organizations in the United States of America . . . . I mean we didn't, you know, casually go out and just contract with somebody walking by the street corner."[38] Perhaps this is why, the Governor later complained, the McAuto agreement was written "like a defense contract."

Following large overruns, Arizona quickly became disillusioned with outside administration and terminated the contract, resulting in massive multi-million dollar litigation. By all accounts, including the Governor's, the first two years of AHCCCS were an administrative "nightmare."[39] Governor Babbitt concluded from this experience that "social service programs involving the complexity and subtleties of delivering services to large numbers of people cannot be administered by third parties like . . . the selling of so many groceries off a Safeway shelf."[40]

Nor was Kentucky satisfied with the outside for-profit firm, Health America, that it hired to run its Louisville, Kentucky, case-

37. *See* Sitler, *Mercenary Medicine/AHCCCS: Alternative to Medicaid Becomes Administrative Nightmare*, Ariz. Republic, Nov. 13, 1983, at A-1; Sitler, *Funds for AHCCCS Overseer Nearly Gone, State Says*, Ariz. Republic, Jan. 1, 1984, at A-1, A-16. For a general description of the problems faced by AHCCCS during its first year, see Dallek & Parks, *Arizona's AHCCCS Program After One Turbulent Year*, 139 HEALTH ADVOC., Winter 1983-84, at 1-2, 4.

38. Testimony of Arizona Governor Bruce Babbitt before the U.S. House of Representatives, Subcommittee on Health and the Environment, *An Oversight Hearing on the Management of the Arizona Health Care Cost Containment System Medicaid Waiver by the Health Care Financing Administration* (June 15, 1984) [hereinafter cited as *Babbitt Testimony*].

39. At one point, eligibility processing problems were so extreme that on April 23, 1985, a federal court in Guild v. Schaller, No. 83-205b, slip op. (D. Ariz.), ruled that the state would have to pay $50 per week to beneficiaries whose eligibility for AHCCCS was improperly delayed or terminated. In response to this decision, Arizona finally improved its eligibility process.

40. *Babbitt Testimony*, *supra* note 38.

management program called CitiCare, which operated for a year from July of 1983 to July of 1984. In January of 1985, the Kentucky Department of Social Insurance analyzed the CitiCare program and reported that "slightly over $3 million, or 14.2 percent of the total amount of premium payments were spent on administration or profits by the management company, Health America."[41] Not only did the Department conclude that CitiCare ended up costing the state money,[42] it also "did not agree with the diversion of a significant amount of the benefit funds for purposes of additional administrative costs or profit to a managing company."[43] Moreover, because the utilization data provided by Health America was grossly inadequate, the Department determined that it could not even adequately review or assess utilization under the project.[44]

Lack of state oversight of capitated programs for the poor has resulted in profiteering by provider groups. For example, Arizona contracted with Health Care Providers of Arizona despite the fact that Medicare had determined that they had performed unnecessary surgery.[45] One audit of Health Care Providers found that less than half of the $8 million the group received in capitated payments had been spent on patient care. Of the money distributed to providers, seven percent went to a drug company also owned in part by the owners of Health Care Provider, and another $290,000 went to two other companies also owned by Health Care Provider owners.[46]

A November of 1985 report by the General Accounting Office (GAO) found gross violations of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[47] in the operation of the AHCCCS program. Specifically, the GAO found that neither

41. KENTUCKY DEPARTMENT OF SOCIAL INSURANCE, CITICARE ANALYSIS (Apr. 17, 1984).

42. The Department of Social Insurance did find that CitiCare substantially reduced recipient utilization. But because state-wide, Medicaid cost-containment actions also reduced recipient utilization, the Department concluded that the state spent approximately $440,000 more in providing services to CitiCare's AFDC population than it would have spent if that population had been in the fee-for-service Medicaid program. *See id.*

43. *Id.*

44. *See id.*; Lyons, *KenPAC to Reflect Hard Lessons Learned from CitiCare, State Says*, Louisville Times, Jan. 29, 1985, at A-5. For a detailed account of problems in the CitiCare program, see Dallek & Parks, *Two Medicaid Case Management Systems: A Post Mortem*, 144 HEALTH ADVOC., Spr. 1985, at 4-6.

45. *See AHCCCS After One Turbulent Year, supra* note 37, at 2.

46. *See id.*; Hawley, *Liquidation of AHCCCS Firm Sought*, Ariz. Republic, Mar. 21, 1985, at 1; La Jeunesse, *AHCCCS to Dump Firm That Cares for 10,000*, Ariz. Republic, Mar. 1, 1985, at B-1.

47. *See* 42 U.S.C. § 1396a(a)(38) 42 U.S.C. § 1320a-3; 42 C.F.R. 455.104(c)&(d) & 455.105(c)&(d) (1985).

AHCCCS nor HCFA complied with federal requirements for disclosure of ownership and control arrangements, as well as related-party transactions, and therefore cannot "know whether capitation funds are being appropriately used to provide health care services for Arizona's Medicaid population."[48]

Ohio also failed to scrutinize profiteering and self-dealing transactions of Health Power. The *Plain Dealer* investigation found that of the $9.9 million that the HMO received from the state between May of 1984 and June of 1985, more than $3 million went to salaries, advertising, and other non-patient care expenses. Moreover, in its first seven months, the HMO gave other businesses owned by its stockholders almost one-half million dollars in cash bonuses and kept another half-million dollars in bonuses for itself.[49]

Although Health Power engaged in myriad self-dealing transactions with businesses owned by its stockholders, *Plain Dealer* reporters found not only that the state failed to undertake a financial audit of the HMO, but that Health Power's reports to the state were so vague as to be meaningless. For example, the HMO's annual report showed that the largest administrative expense of over $450,000 was entered in an "other" category.[50]

Thus, states avoid their responsibility of oversight not just by delegating administration to an outside entity, but also by adopting a laissez-faire attitude toward these systems. States cannot avoid their obligation to regulate these so-called competitive systems for the poor. The more states wash their hands of this responsibility, the dirtier their hands will become.

IV. Looking for a Quick Fix

Finally, unethical systems are given a head start by states looking for a "quick fix" for their Medicaid budgets. While all case-management programs are ostensibly established to improve quality of care, states also have the very real perception that these systems will immediately save them large amounts of money. How else can the rush to establish these systems be explained? One would not expect a $180 million business with 150,000 customers to set up shop in four months, but that is exactly what Arizona did in establishing AHCCCS.

48. U.S. General Accounting Office, Arizona Medicaid: Nondisclosures of Ownership Information by Health Plans, app. I, at 14 (Nov. 14, 1985) (report to the Chairman, Subcommittee on Health and the Environment).

49. *See Care Not up to Par, Audits Show*, *supra* note 25, at 1-A.

50. *Id.*

Governor Babbitt admits to the inadequate time allotted to planning AHCCCS: "We had difficulties in establishing and qualifying health care plans, implementing uniform accounting requirements, obtaining necessary financial reports and information, maintaining adequate computer capability and implementing appropriate screening procedures."[51]

Ohio has similarly admitted that it was unable to provide sufficient oversight of the quality of care provided to Medicaid HMO enrollees because it had not promulgated any quality-of-care regulations. Other states have also precipitously rushed into Medicaid case-management systems without adequate appreciation of how complicated these systems are. Studies and experience both show that it takes a minimum of one to two years to effectively implement these programs.[52]

It is not difficult to figure out how to save money in the Medicaid program—just cut reimbursement rates, exactly what case management accomplishes. However, if a state wants to preserve quality as well as reduce expenditures, it must view these systems as long-term investments which may not pay off until a few years down the road. This is especially the case for those states that have already instituted rigorous, hospital-utilization controls in their Medicaid program.

Moreover, it is important to remember Professor Thurow's warning that the quality of these systems is directly linked to the reimbursement levels. How much can be cut from the Medicaid budget is not the correct question to ask. Instead, states must question how much can be cut from Medicaid while still allocating to providers a rate that is compatible with both providing quality care and ensuring the providers' fiscal survival.[53]

V. JOINING IN "COMMON CAUSE"

The best way to protect patients in Medicaid case-management systems is not through law and litigation, but rather through a "quasi-legal, constructive cooperation" approach. This approach

51. *Babbitt Testimony, supra* note 38.

52. *See, e.g.*, Haynes, *Evaluating State Medicaid Reforms*, AM. ENTER. INST. (1985); Welch, *Report on Capitated Reimbursement Systems for Medicaid Eligibles*, GOLDEN EMPIRE HEALTH SYS. AGENCY 29-30 (Apr. 15, 1985).

53. A 1985 California study found a decline in the fiscal viability of those California hospitals which contracted to serve Medicaid patients under the state's elective-contracting system. See Allison, Chico & Polhamus, *An Examination of Revenue Per Day, Utilization, and Financial Condition of 67 Hospitals Before and After Med-Cal Contracting*, CAL. HEALTH FACILITIES COMM'N REP. IV-85-8 (Nov. 8, 1985).

uses legal, political, and ethical concepts to persuade agencies and providers both to allow recipients and recipients' advocates to participate in the planning, evaluation, and administrative processes, and to take their interests into account in a serious fashion.

Unfortunately, this constructive approach has been seldom utilized. Too often, advocates for the poor and state officials find themselves in adversarial proceedings. States view advocates as obstructionists, while advocates question states' real motives in establishing these systems. And even when there is dialogue, it is always frustrating and sometimes fruitless. Issues which advocates believe to be critically important appear to be of little import to state officials implementing a case-management system. Advocates have also been increasingly frustrated by states' willingness to take refuge in the bureaucratic imperative. For example, the Community Board for California's Expanded Choice program was told that the state was forced to drastically limit the amount of information it could send Medicaid recipients, because the automatic "paper stuffer" could not handle more than a few sheets.

On the other side, states' administrators believe that they have done all that is possible to ensure that these systems will work, often thereby delaying implementation. Nor do state officials understand advocates' distrust of a system which the officials truly believe will improve care for the poor.

The conflict between states and advocates over these systems results in part from the different drummers to which they march. Advocates for the poor hear only their clients, whether they be the developmentally disabled, senior citizens, or the AFDC population. State administrations must somehow listen to the often cacophonous sounds of providers, the poor, the elderly, and the disabled for whom these systems are designed, as well as budget cutters and politically sensitive legislators—a difficult task indeed. Thus, it is not surprising that in the ensuing din, the state is unable to differentiate the advocates' melodious tune.

How, then, can we build a better system for the poor, given the seemingly impossible job before us? The answer lies in the concluding chapter of Ed Sparer's *Class Medicine*. Professor Sparer draws a lesson from a story about two frogs:

> Two frogs fell into a pail of milk. One exclaimed: 'Help! Help! I sink! I drown!' The other answered gruffly: 'Kick! Kick! you little devil! Something will surely happen.' The first one continued to gasp and moan, and finally sank out of sight. The other kicked and kicked until nearly morning, when the milk having

been churned to butter, he walked out onto dry land.[54]

Professor Sparer urged us to join in a "common cause" and begin kicking together to forge a one class—not three class—system of care. If we were able to do this, he wrote, "I doubt if the well of human distress would turn to butter. Perhaps, however, we would not drown in it."[55]

It is incumbent on the advocates for the poor, both in and outside of government, to keep trying to kick together to ensure an equitable health care system for the poor, whether it be through capitated, case-management systems or some other method. Professor Sparer would have responded to those who, however much they deplore it, say there is no alternative to a three class system of care, by telling them to keep kicking.

54. E. SPARER, *supra* note 1, at Chapter IX, page 10.
55. *Id.*