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MEDICAID PRIMARY CARE CASE MANAGEMENT, THE DOCTOR-PATIENT RELATIONSHIP, AND THE POLITICS OF PRIVATIZATION

*Rand E. Rosenblatt**

Many state Medicaid programs have recently adopted primary care case management (PCCM) strategies as a means of containing costs and providing medical services to the poor. At its best, PCCM may improve care for the poor by deterring unnecessary services, monitoring quality of care, and expanding the number of physicians willing to serve Medicaid patients. At its worst, PCCM may create financial incentives to cut program budgets and maximize provider income at the expense of medically necessary services to the poor. This Article examines the opportunities and perils of the PCCM model as influenced by two opposing legal and public policy traditions. The first tradition rests on the proposition that the well-being and autonomy of the patient is central to the doctor-patient relationship and to related legal and public policy issues. The second tradition is defined by reduction of the federal social welfare role and by privatization—that is, a transfer of government's social welfare role to for-profit organizations. Professor Rosenblatt argues that the success of Medicaid primary care case management depends upon transcending a simple public/private dichotomy, and integrating the patient-centered ideal into increasingly private and cost-conscious administration of medical care to the poor.

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INTRODUCTION

AMERICANS HAVE LONG been deeply ambivalent about health care and the poor. On the one hand, most Americans apparently believe that adequate health care should be widely available to all regardless of ability to pay.¹ However, actual practices have provided most low-income patients with a markedly inferior, "dual track" version of prevailing models of mainstream care.² From the colonial era through the nineteenth century, for example, patients with economic and family resources received care in their own homes from private physicians and family members.³ In contrast, the poorest patients had to enter underfunded and often dangerous public hospitals, which provided a kind of "substitute household" organized on increasingly bureaucratic lines.⁴ Simi-

1. See, e.g., PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH [hereinafter cited as PRESIDENT'S COMMISSION], 1 SECURING ACCESS TO HEALTH CARE 4, 11, 18 (1983) [hereinafter cited as SECURING ACCESS TO HEALTH CARE]; M. WALZER, SPHERES OF JUSTICE 88 (1983); Arras, *Retreat from the Right to Health Care: The President's Commission and Access to Care*, 6 CARDOZO L. REV. 321, 321 (1984); Iglehart, *Medical Care of the Poor—A Growing Problem*, 313 NEW ENG. J. MED. 59, 59 (1985) (describing the United States as "a society that likes to believe that it provides the essentials of life to its most vulnerable citizens, not by chance but by law . . ."). Even Alain Enthoven, a strong proponent of market competition as the preferred means of organizing and distributing health care, states that "[m]ost Americans consider access to a decent level of medical care to be a part of the right to 'life, liberty, and the pursuit of happiness.' Thus we are not willing to leave the distribution of medical purchasing power to the market and other forces that determine income distribution." A. ENTHOVEN, HEALTH PLAN 81 (1980).

2. See P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 72, 151-52 (1982); Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 644-45 (1975); Rosenberg, *Social Class and Medical Care in 19th Century America: The Rise and Fall of the Dispensary*, 29 J. HIST. MED. 32 (1974), reprinted in SICKNESS AND HEALTH IN AMERICA 157 (J. Leavitt & R. Numbers eds. 1978). The phrase "dual track" assumes the existence of two "tracks" or sub-systems of health care: an adequate track based on fee-for-service practice for those who can afford to pay, and an inferior track based on charity care for those who cannot. The realities of health care have always been more complex than this simple model, as reflected, for example, in the traditional hospital accommodation distinctions among "ward," "semi-private," and "private" patients. See R. DUFF & A. HOLLINGSHEAD, SICKNESS AND SOCIETY (1968). Analysts of contemporary health policy now tend to speak of a three-tiered health care system: a government-financed tier providing a "minimal level of health care for the poor and the elderly;" an employer-financed middle tier; and a third, "free-market" tier for individuals who can pay more than the bargained-for, wholesale rates paid by the government and employers. See Thurow, *Medicine versus Economics*, 313 NEW ENG. J. MED. 611, 613 (1985); Dallek, *Commentary*, in this Symposium.

3. See P. STARR, *supra* note 2, at 147-52, 72-77 (discussing the complex forces that maintained and then undermined the family as the preferred locus of health care in the eighteenth and nineteenth centuries).

4. See *id.* at 149. In the colonial era, almshouses (where the sick poor often received care) resembled ordinary residences, and were staffed by a "steward and a matron, who might

larly, by the 1950's and 1960's most middle-income Americans were covered by insurance that paid hospitals and doctors virtually whatever they asked, at least for technical procedures and acute care hospital stays, thereby securing financial access to hospitals and private physicians.⁵ In contrast, public insurance for poor patients under the Medicaid program is typically characterized by restrictive eligibility and substandard coverage, reimbursement, and administration.⁶ With little purchasing power and other access disabilities, many Medicaid patients are excluded from mainstream hospital and medical care and are relegated to secondary markets of less well-trained physicians and often seriously underfunded public clinics and hospitals.⁷ The more than twenty million Americans

be husband and wife, [and who] presided over the hospital family . . . [P]atients entered at the sufferance of their benefactors and had the moral status of children." *Id.* The development of hospitals in the nineteenth century saw an increasingly public architecture and bureaucratic, rather than familial, organization, still designed "to take care of people who did not fit into the system of family care." *Id.* at 151. On the dangerousness of early hospitals, see *id.* at 72; on underfunding, see *id.* at 172.

5. See, e.g., Relman, *What Is Happening to Our Health Care System?*, BULL. AM. ACAD. ARTS & SCI., Mar. 1986, at 11, 15. For current data on health insurance, see SECURING ACCESS TO HEALTH CARE, *supra* note 1, at 90-92. On the relationship between increasing health insurance for middle-income patients and increasing access to hospitals and doctors, see Fox, *The Consequences of Consensus: American Health Policy in the Twentieth Century*, 64 MILLBANK Q. 76, 84 (1986).

6. On the inadequacies of Medicaid coverage, reimbursement, and administration up to the early 1970's, see R. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974); Rosenblatt, *supra* note 2, at 643; REPORT OF THE SECRETARY'S TASK FORCE ON MEDICAID AND RELATED PROGRAMS (1972); F. THOMPSON, HEALTH POLICY AND THE BUREAUCRACY 115-18 (1981); Bellin, *Foreshortened Frank Memoirs of a Former Medicaid Administrator*, in MEDICAID: LESSONS FOR NATIONAL HEALTH INSURANCE 325 (A. Spiegel & S. Podair eds. 1975). On continued inadequacies (together with some achievements) through the early 1980's, see R. BOVBERG & J. HOLAHAN, MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES (1982); K. DAVIS & C. SCHOEN, HEALTH AND THE WAR ON POVERTY 49-91 (1978).

7. Almost half (45.6%) of all Medicaid patients treated in private office practices are treated by only 10% of physicians. Mitchell & Cromwell, *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare*, in 3 SECURING ACCESS TO HEALTH CARE, *supra* note 1, at 105, 113. Although these "large Medicaid practices" (LMPs) should not be generally characterized as "Medicaid mills," there is "a serious 'credentials gap'" between primary care LMPs and those doctors serving fewer Medicaid patients. Mitchell and Cromwell describe the Medicaid program as "a residual market that is secondary to the better insured private market. . . ." *Id.* at 115. See also Dallek, *Health Care for America's Poor: Separate and Unequal*, 20 CLEARINGHOUSE REV. 361, 366 (1986); NATIONAL HEALTH LAW PROGRAM (NHELP), *Increasing Clients' Access to Medicaid Providers: New Developments*, 19 CLEARINGHOUSE REV. 1269, 1269-70 (1985) [hereinafter cited as *Increasing Clients' Access*]; Rosenblatt, *supra* note 2, at 652-53; H. LUFT, HEALTH MAINTENANCE ORGANIZATIONS 322-23 (1981) (noting that in mid-1972 less than 20% of Orange County, California, Medicaid eligibles received care through "mainstream providers"); Blake, *Medicaid: The Fading of a Dream*, HEALTH/PAC BULL., Apr. 1973, at 13, reprinted in MEDICAID: LESSONS FOR NATIONAL HEALTH INSURANCE, *supra* note 6, at 341.

without Medicaid or any other health care coverage face even more serious access and quality-of-care problems.⁸

In the 1970's and 1980's, the American health care system experienced major changes, focused around the goal of health care cost containment, the bargaining process and market competition. Corporations suddenly acted as aggressive purchasers of health care on behalf of their employees, seeking out prepaid health plans and bargaining with hospitals and other providers to supply services at discount rates.⁹ Entrepreneurs made large gains in the ownership and management of hospitals, health maintenance organizations (HMOs), and other health care sectors, leading to greater managerial control and competitive marketing of health care services.¹⁰ Patients who remained in the traditional fee-for-service system became subject to new restrictions by Blue Cross and other insurers against payment for services that went beyond specified limits or norms.¹¹ Millions of other middle-income Americans began to enroll in HMOs that offered broader coverage in return for more restricted access and different financial incentives for providers. Reflecting the experience with HMOs, the concept of "primary care case management" emerged from several sources as a major cost-containment strategy in the Medicaid program.¹² Under this

8. See 1 SECURING ACCESS TO HEALTH CARE, *supra* note 1, at 92-108; Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the U.S.*, in 3 SECURING ACCESS TO HEALTH CARE, *supra* note 1, at 55; Iglehart, *supra* note 1, at 59.

9. See BUREAU OF NATIONAL AFFAIRS GOVERNMENT EMPLOYEE RELATIONS REPORT, SPECIAL REPORT: CONTROLLING HEALTH CARE COSTS: CRISIS IN EMPLOYEE BENEFITS 1-3 (1983).

10. See, e.g., P. STARR, *supra* note 2, at 420-49; Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980); *Investor Owned Hospitals and Health Care Costs*, 309 NEW ENG. J. MED. 370 (1983); Freedman, *Megacorporate Health Care*, 312 NEW ENG. J. MED. 579 (1985); Kennedy, *The Losses in the Profits: How Proprietaries Affect Public and Voluntary Hospitals*, HEALTH/PAC BULL., Nov.-Dec. 1984, at 5. A fascinating debate on the ethical and policy implications of for-profit ownership can be found in Relman & Reinhardt, *Debating For-Profit Health Care*, HEALTH AFF., Summer 1986, at 5.

11. See, e.g., Berenson, *A Physician's Perspective on Case Management*, BUS. & HEALTH, July-Aug. 1985, at 22, 22-23.

12. See, e.g., Spitz, *Medicaid Case Management: Lessons for Business*, BUS. & HEALTH, July-Aug. 1985, at 16; Iglehart, *Medicaid Turns to Prepaid Managed Care*, 308 NEW ENG. J. MED. 976 (1983); Gibson, *Quiet Revolutions in Medicaid*, in MARKET REFORMS IN HEALTH CARE 75, 84-85, 100-01 (J. Meyer ed. 1983); G. Omenn, *Medicaid Under Reagan, Part One: Fiscal Year 1982*, at 2-8 (1984) (unpublished manuscript); Dallek & Wulsin, *Limits on Medicaid Patients' Rights to Choose Their Own Doctors and Hospitals*, 17 CLEARINGHOUSE REV. 281 (1983).

The term "case management" refers to several different concepts and programs, categorized by Jeffrey Merrill as "social, primary care, and medical/social." Merrill, *Defining Case Management*, BUS. & HEALTH, July-Aug. 1985, at 5, 6. "Social" case management provides non-medical supportive services to well individuals (such as the elderly) to prevent a need for

model, the patient chooses or is assigned to a particular primary care provider, who then controls the patient's access to hospitals, specialists, and most of the rest of the health care system.¹³ The primary care provider or "case manager" is given a direct financial incentive to control costs, since in most plans the provider's income will decrease if he or she approves expensive specialist or hospital care.¹⁴

The rapid adoption of the primary care case management (PCCM) strategy by more than twenty state Medicaid programs¹⁵ presents a moment of some opportunity and great peril for the poor. The opportunity lies in the fact that under PCCM, the state Medicaid agency actually undertakes to enroll Medicaid patients with particular physicians who have contractually promised to provide them with adequate care as part of a prepaid, organized system. If these arrangements are adequately funded and regulated, they could overcome Medicaid patients' long-standing difficulties in finding doctors who will accept them, improve the quality of care through a variety of monitoring programs by professionals and patients, and deter unnecessary costs. As a result, the political and financial viability of publicly funded health care for the poor would probably be strengthened.¹⁶ The peril lies in the fact that PCCM, like all pre-

institutionalization. "Medical/social" case management supplies medical and non-medical services to a population "already at risk," e.g., the elderly or the disabled children who need provision and coordination of medical and non-medical care in order to be able to live in the home or community. As discussed below, "primary care" case management, the subject of this Article, focuses on a "gatekeeper" (almost always a physician) who provides primary care and who controls access to the rest of the health care system. *Id.* at 6-7. See also Somers, *And Who Shall Be the Gatekeeper? The Role of the Primary Physician in the Health Care Delivery System*, 20 INQUIRY 301 (1983).

13. See, e.g., Somers, *supra* note 12, at 301, 303; Berenson, *supra* note 11, at 23-24; Spitz, *supra* note 12, at 16; Iglehart, *supra* note 12, at 978; K. SQUARRELL, S. HANSEN & E. NEUSCHLER, PREPAID AND MANAGED CARE UNDER MEDICAID: CHARACTERISTICS OF CURRENT INITIATIVES 4 (Oct. 1985) (National Governors' Association) [hereinafter cited as SQUARRELL/NGA].

14. See sources cited *supra* note 13. Under these and other prepaid health plans, providers are said to be "at risk" for some of the costs of their patients' care.

15. According to Spitz, between 1981 and 1984, 18 state Medicaid programs initiated "primary care networks" involving versions of primary care case management with over 350,000 Medicaid enrollees. In addition, Arizona, Utah, and Colorado established statewide PCCM systems, and California, New York, Pennsylvania, Wisconsin, Michigan, Ohio, and Illinois embarked on "large-scale programs that employ alternative delivery systems." Spitz, *supra* note 12, at 17; see also Iglehart, *supra* note 12, at 977-78; SQUARRELL/NGA, *supra* note 13 (providing detailed descriptions of most state programs).

16. For discussions of the positive potential (as well as problems) of prepaid case management in Medicaid, see Gibson, *supra* note 12, at 75, 84-85, 100-01; D. FREUND, MEDICAID REFORM: FOUR STUDIES IN CASE MANAGEMENT 5 (1984); Spitz, *supra* note 12, at 16; Dallek & Wulsin, *supra* note 12, at 282-87. For more general arguments about the positive

paid at-risk payment systems, creates a financial incentive to "contain costs" and maximize provider income by denying adequate care. If PCCM programs are inadequately funded and regulated, they are likely to perpetuate and even worsen the dual-track tradition through "poor people's HMOs," characterized by significant underservice, inadequate quality, and gross profiteering.¹⁷ As Geraldine Dallek points out in this Symposium, such perils have already occurred,¹⁸ and they highlight the special dangers of creating financial incentives to deny care to the poor.¹⁹

This Article examines two sets of concepts and practices that push in opposite directions with respect to the opportunity and the peril. On one side stand a diverse set of concepts and practices that I term the "patient-centered ideal." Part I of this Article explores the expression of this ideal with particular reference to the poor in medical ethics, malpractice law, the federal Medicaid statute, and in concepts of market competition and democratic participation as applied to health policy. These themes are linked by a commitment to the well-being and autonomy of patients, including low-income patients, on as equal a basis as possible and a commitment to making these values operational in concrete policies and practices.

On the other side stand a set of concepts and practices that, although difficult to name, clearly threaten the patient-centered

impact of health care competition on the poor, see A. ENTHOVEN, *supra* note 1, at 88-89, 139-40, 142; Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716, 750 (1970).

17. See H. Luft, *supra* note 7, at 328-31; Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U.L. REV. 90, 126-38 (1975).

18. See Dallek, *supra* note 2, in this Symposium; see also Schneider & Stern, *supra* note 17, at 97-100; H. Luft, *supra* note 7, at 328-33.

19. See Ware, Rogers, Davies, Goldberg, Brook, Keeler, Sherbourne, Camp & Newhouse, *Comparison of Health Outcomes at a Health Maintenance Organization With Those of Fee-For-Service Care*, 1 LANCET 1017 (1986) [hereinafter cited as RAND HMO Study] (finding that a prepaid group practice HMO produced lower costs and better health outcomes than fee-for-service practice for "high income" at-risk enrollees (defined as patients in the upper two-fifths of the income distribution with specified health problems) but produced worse outcomes compared with fee-for-service practice for "low-income" at-risk enrollees (defined as patients in the lowest fifth of the income distribution with specified health problems)).

There are other perils to the poor inherent in the entire range of cost-containment programs. Prominent among them are: (1) tightened reimbursement to hospitals for most or all patients, thereby eliminating budget surpluses that had been used to at least some extent to finance care for the uninsured poor; and (2) reduced eligibility for Medicaid and other publicly-financed health programs, thereby placing more people among the ranks of the uninsured. See Iglehart, *supra* note 1, at 59; Iglehart, *Federal Policies and the Poor*, 307 NEW ENG. J. MED. 836, 840 (1982); Davis & Rowland, *supra* note 8, at 74 (estimating that post-1981 state cutbacks in AFDC and Medicaid eligibility "could swell the ranks of the uninsured poor by over one million people").

ideal. Part II of this Article explores how these threats have manifested themselves in the federal legislative and administrative arenas. The detailed stories of legislative and administrative developments suggest some defining characteristics of this "privatization" perspective: a commitment to reduce the redistributive and social-welfare role of the federal government and even of state governments, to transfer that role to the greatest extent possible to "private" (i.e., for-profit) entities under minimal public regulation, and to avoid, as much as possible, the translation of patient-centered statutory provisions into concrete, operational policy.²⁰ Part III examines creative efforts at the state and local levels to go beyond the simple transfer of public functions to private entities and to combine them constructively to grapple with the policy and ethical dilemmas of health care cost containment. Part IV briefly explores how the experience of Medicaid primary care case management relates to broader debates about the politics of privatization.

I. THE PATIENT-CENTERED IDEAL AND ITS APPLICATION TO THE POOR

A. *The Tensions in the Doctor-Patient Relationship*

The doctor-patient relationship presents in extreme form the general contradiction between individuals' need for mutual support and cooperation and their fear of exploitation by those same others from whom support is needed.²¹ Part of this tension is emotional: the patient often wants to be cared for as a child by a benign parent and is simultaneously threatened by this relationship.²² Another part of the tension is economic, in that the patient's interest in the most appropriate and affordable care may conflict with the doctor's

20. The concept of "privatization" is used in many different ways. See, e.g., Starr, *The Meaning of Privatization*, in PROJECT ON THE FEDERAL SOCIAL ROLE, WORKING PAPER 6: PRIVATIZATION 1 (1985). As discussed in Part IV, the perspective referred to here corresponds most closely with what Paul Starr terms "radical privatization," which "regards public provision [of services] as a massive error or usurpation, requiring a drastic withdrawal of government or reconstruction of property rights." *Id.* at 10. For overviews of the Reagan administration's general privatization strategy with respect to health care, see Iglehart, *Drawing the Lines for the Debate on Competition*, 305 NEW ENG. J. MED. 291 (1981); Sidel, *Health Care: Privatization, Privilege, Pollution, and Profit*, in WHAT REAGAN IS DOING TO US 24 (A. Gartner, C. Greer & F. Riessman eds. 1982).

21. See Kennedy, *The Structure of Blackstone's Commentaries*, 28 BUFF. L. REV. 209, 211-13 (1979).

22. See, e.g., J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 100-03 (1984).

economic self-interest.²³ This economic tension typically arises in two forms: first, whether the doctor will enter into a relationship with a patient who cannot pay the doctor's price; and second, once the doctor-patient relationship has been established, whether different methods of reimbursement may influence the doctor's recommendations and decisions.

Although this Article necessarily touches on the first question, its primary focus is on the second. If payment is on a fee-for-service basis, then the doctor has an economic incentive to perform more services, even when the benefits for the patient are unclear or are less than the economic and personal costs.²⁴ Conversely, if payment is based on a flat fee for a range of services or a bonus for restricting access to more expensive services (as in some HMOs and PCCM programs), the doctor has an economic incentive to perform or authorize fewer services, even when the benefits to the patient from additional services would justify the costs.²⁵ This is not to suggest that doctors' practice styles, including the rates at which different procedures are done, are motivated solely by economics or that doctors do not seek to promote their patients' well-being. Rather, it reflects strong evidence that many doctors and hospitals refuse to serve Medicaid and uninsured patients, presumably for economic reasons,²⁶ and that doctors' views on how to promote patients' well-being vary considerably, in part because of differences in

23. See, e.g., Berenson, *Capitation and Conflict of Interest*, HEALTH AFF., Spr. 1986, at 141, 142-44.

24. See, e.g., Relman, *Dealing with Conflicts of Interest*, 313 NEW ENG. J. MED. 749 (1985); Berenson, *supra* note 23, at 143-44; Havighurst & Blumstein, *Coping With Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 15-21, 25-28 (1975).

25. See, e.g., Havighurst & Blumstein, *supra* note 24, at 36-37; Berenson, *supra* note 23, at 141; Relman, *supra* note 24, at 749.

26. With respect to doctors' refusal to serve Medicaid patients, see Mitchell & Cromwell, *supra* note 7, at 106-20 (reporting that 23% of physicians nationwide refuse to see any Medicaid patients and that the average physician devotes only 12.7% of his patient load to Medicaid patients. These proportions vary greatly by geographic region and medical specialty); Elias, *Physicians Who Limit Their Office Practice To Insured And Paying Patients*, 314 NEW ENG. J. MED. 391 (1986). With respect to hospitals' discharging or refusing to admit patients for economic reasons (commonly referred to as "patient dumping"), see Schiff, Ansell, Schlosser, Idris, Morrison & Whitman, *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986) (finding that 89% of transferred patients were black or Hispanic, 87% were transferred because they lacked adequate medical insurance, and many were in unstable condition at the time of transfer); Relman, *Texas Eliminates Dumping: A Start Toward Equity in Hospital Care*, 314 NEW ENG. J. MED. 578 (1986); *Economic Considerations in Emergency Care: What Are Hospitals For?*, 312 NEW ENG. J. MED. 372 (1985); Wrenn, *No Insurance, No Admission*, 312 NEW ENG. J. MED. 373 (1985); *Thompson v. Sun City Community Hosp.*, 141 Ariz. 597, 688 P.2d 605 (1984).

reimbursement.²⁷

Medical ethics and malpractice law have traditionally sought to resolve these tensions by proclaiming the patient's benefit or well-being as the central purpose and ideal of the doctor-patient relationship.²⁸ The following sections explore the expression of this patient-centered ideal in medical ethics, malpractice law, the federal Medicaid statute, and in the theory of cost containment itself.

B. *The Patient-Centered Ideal in Medical Ethics and Medical Malpractice Law*

Despite the rich diversity of traditions of medical ethics and the absence of a single authoritative source,²⁹ "the core of professional

27. On the general issue of variation in physicians' views about appropriate care, see *infra* text accompanying notes 72-77. It is widely believed that physicians' treatment decisions are influenced by how they are paid. See, e.g., Blumenthal, Schlesinger, Drumheller & the Harvard Medicare Project, *Special Report: The Future of Medicare*, 314 NEW ENG. J. MED. 722, 726-27 (1986) (noting that Medicare's fee-for-service reimbursement of physicians "creates a built-in incentive for physicians to provide more services," while Medicare's prospective reimbursement of hospitals may lead "to a tendency to discharge older persons 'sicker and quicker.'"); Glaser, *Controlling Costs Through Methods of Paying Doctors: Experiences from Abroad*, in POLICIES FOR THE CONTAINMENT OF HEALTH CARE COSTS AND EXPENDITURES 209 (S. Schweitzer ed. 1978); Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, in this Symposium.

A dramatic example of differential treatment is presented in a recent study of over 65,000 deliveries in Brooklyn between 1977 and 1982 in which the authors conclude that private physicians performed significantly more cesarean deliveries than "house officers" (residents) caring for clinic patients. De Regt, Minkoff, Feldman & Schwarz, *Relation of Private or Clinic Care to the Cesarean Birth Rate*, 315 NEW ENG. J. MED. 619 (1986). With controls for medically significant factors (such as birth weight and diagnosis), private patients in some categories were 2.48 times more likely to have a cesarean delivery than similarly situated clinic patients. *Id.* at 620-21. Although the authors note that "convenience and financial considerations" are possible explanations, they declare that "a more probable consideration is physicians' concern about professional liability if there is an adverse outcome." *Id.* at 623 (noting that private obstetricians pay their own malpractice insurance premiums while residents do not). Why this factor is not itself a "financial consideration," and why it should outrank income maximization, is not explained. *But see* McPherson, Wennberg, Hovind & Clifford, *Small-Area Variations in the Use of Common Surgical Procedures: An International Comparison of New England, England, and Norway*, 307 NEW ENG. J. MED. 1310 (1982) (suggesting that geographical variations in seven common surgical procedures may not be significantly influenced by reimbursement systems, because similar patterns of variations were found in the United States, the United Kingdom, and Norway, despite differing organization and financing of medical care).

28. See R. VEATCH, A THEORY OF MEDICAL ETHICS 22 (1981); Capron, *supra* note 27, in this Symposium.

29. On the similarities and differences among the Hippocratic, Jewish, Catholic, Protestant, and secular liberal traditions of medical ethics, see R. VEATCH, *supra* note 28, at 3-49. The multiple sources of "the folk ethic of the health professional," *id.* at 4, include the AMA's Principles of Ethics and "the letters appearing in the national and state medical journals, the casual value messages passed from the clinical teacher standing at the bedside to

physician ethics [is the commitment] to produc[e] good for [the] patient and to protec[t] that patient from harm."³⁰ In the Hippocratic tradition, the patient's best interests were determined by the physician's own "ability and judgment,"³¹ with no participation by the patient; indeed, Hippocrates advised physicians to "concea[l] most things from the patient . . . [and] revea[l] nothing of the patient's future or present condition."³² Contemporary exponents of medical ethics have reformulated traditional medical paternalism³³ to include recognition of patient autonomy and self-determination and have even called for a new kind of doctor-patient relationship based on "mutual participation" and "shared decision making."³⁴ A plausible contemporary statement of these expanded ethical principles can be found in what Professor Norman Daniels terms the "ethic of agency," in which physicians' considerable clinical autonomy is in principle constrained by requirements that "clinical decisions be competent, respectful of the patient's autonomy, respectful of the other rights of the patient (e.g., confidentiality), free from consideration of the physician's interests, and uninfluenced by judgments about the patient's worth."³⁵

The patient's ability to pay raises difficult questions with which traditions of medical ethics have sought to deal through two distinc-

neophytes being initiated into the profession, [and] the apparently platitudinous preambles to health policy debate . . ." *Id.*

30. R. VEATCH, *supra* note 28, at 22. *See also* Capron, *supra* note 27, in this Symposium.

31. The Hippocratic Oath, in T. BEAUCHAMP & J. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 330 (2d ed. 1983) [hereinafter cited as T. BEAUCHAMP & J. CHILDRESS]. For an analysis of the Hippocratic tradition and its implication for modern cost containment measures, see Veatch, *DRGs and the Ethical Reallocation of Resources*, 16 HASTINGS CENTER REP., June 1986, at 32, 33-34; R. VEATCH, *supra* note 28, at 22-26, 143-76.

32. 2 HIPPOCRATES, *DECORUM* 297 (W. Jones trans. 1967), cited in Katz, *Limping Is No Sin: Reflections on Making Health Care Decisions*, 6 CARDOZO L. REV. 243 n.24 (1984). Dr. Katz argues forcefully that this advice, and the principle of professional autonomy it reflects, is still widely accepted by doctors in medical practice. *See id. passim.*

33. 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOCHEMICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS* 36 (1982) [hereinafter cited as *MAKING HEALTH CARE DECISIONS*].

34. *Id.*; *see also* Katz, *supra* note 32, at 243; R. VEATCH, *supra* note 28, at 108-38.

35. Daniels, *Why Saying No To Patients in the United States Is So Hard: Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENG. J. MED. 1380, 1382 (1986); *See also* Mechanic, *Therapeutic Relationship: Contemporary Sociological Analysis*, in *ENCYCLOPEDIA OF BIOETHICS* 668 (W. Reich ed. 1978). On the great difficulties of implementing these ideals, see Katz, *supra* note 32, at 247-48; R. DUFF & A. HOLLINGSHEAD, *supra* note 2, at 124-50 (finding that physician-patient relationships are heavily influenced by patient's social status); Roth, *Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service*, 77 AM. J. SOC. 839 (1971) (same finding for hospital emergency rooms).

tions. The first distinction is between the *formation* of the doctor-patient relationship versus conduct *within* the doctor-patient relationship. American doctors have traditionally asserted the freedom "to choose whom to serve,"³⁶ presumably based in part on economics and qualified by at least some recognition of the need to provide charitable care.³⁷ Once the doctor-patient relationship is established, however, that freedom to take economics into account disappears, at least as a matter of principle. There is no explicit or even implicit suggestion in any of the ethical traditions that doctors owe less of a duty of fidelity and care to patients who cannot afford to pay. Rather, ancient and modern ethical codes stress what seems to be a unitary ideal: the doctors' duty is to act "for the benefit of the sick,"³⁸ to provide "competent medical service with compassion

36. See AMERICAN MEDICAL ASSOCIATION (AMA), *Principles of Medical Ethics* § VI (1980), in T. BEAUCHAMP & J. CHILDRESS, *supra* note 31, at 332 [hereinafter cited as AMA PRINCIPLES (1980)]; *Principles of Medical Ethics* § 5 (1957), in R. VEATCH, *CASE STUDIES IN MEDICAL ETHICS* 354 (1977) [hereinafter cited as AMA PRINCIPLES (1957)]; *Principles of Medical Ethics*, ch.II § 4 (1955), in C. MCFADDEN, *MEDICAL ETHICS* 446, 451 (1946, 6th ed., 1967) [hereinafter cited as AMA PRINCIPLES (1955)]. No date is cited for the copy of the AMA PRINCIPLES reprinted in McFadden's *MEDICAL ETHICS*. However, on the basis of a discussion with an AMA archivist, this version can be dated 1955. Telephone interview with Marguerite Fallucco (Aug. 13, 1986).

37. Prior to 1957, the AMA PRINCIPLES contained an ethical duty to render charitable care. See AMA PRINCIPLES (1955), ch. VII § 1, *supra* note 36, at 456 ("Poverty of a patient . . . should command the gratuitous service of a physician. . . .").

The 1955 Principles further stated that physicians "should be ever cognizant of the fact that they are trustees of medical knowledge and skill and that they must dispense the benefits of their special attainments in medicine to all who need them." *Id.*, ch. 1 § 2, at 447. The 1957 revision of the AMA Principles eliminated the reference to gratuitous service, but stated that the doctor's fee "should be commensurate with the services rendered and the patient's ability to pay." AMA PRINCIPLES (1957) § 7, *supra* note 36, at 354.

The 1980 revision does not refer to charitable care and states simply that physicians shall, "except in emergencies, be free to choose whom to serve." AMA PRINCIPLES (1980) § VI, *supra* note 36, at 332. Nevertheless, some physicians continue to regard care for those unable to pay as an ethical duty. See Elias, *supra* note 26, at 391 (criticizing fellow physicians who refuse to see uninsured and Medicaid patients as "demean[ing] the individual physician and cheapen[ing] the profession . . . [a]nd, most important, . . . depriv[ing] a large segment of our fellow humans of care. Physicians who value their professionalism should treat office patients on the basis of need, not remuneration."); Wrenn, *supra* note 26, at 373 (primary care internist in rural community describing refusal of a "well-endowed" university hospital to accept a severely injured emergency patient on economic grounds and characterizing such refusal as a betrayal of ethical principles).

On the other hand, many physicians reject such ethical concepts on economic or political grounds. According to Mitchell and Cromwell, 23% of doctors nationwide refuse to accept any Medicaid patients. This percentage rises to 36.8 in obstetrics/gynecology, 39.2 in cardiology, 39.9 in psychiatry, and 40.0 in allergy. See Mitchell & Cromwell, *supra* note 7, at 107. Reasons for nonparticipation in Medicaid considered "very important" by physicians include inadequate fees (44.4%), payment delays (40.4%), administrative burdens (38% to 39%), and "opposition to government in medicine" (38.8%). *Id.* at 117.

38. The Hippocratic Oath, in T. BEAUCHAMP & J. CHILDRESS, *supra* note 31, at 330.

and respect for human dignity;"³⁹ and to make "the health of my patient . . . my first consideration . . . [and] not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient."⁴⁰ Contemporary physicians and ethicists have been even more explicit: "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations,"⁴¹ and any consideration of costs other than for the patient's own benefit is seen as undermining the physician's "unequivocal commitment to the patient."⁴²

These statements on the irrelevance of costs reflect a second important traditional distinction. While the *patient's* economic interests might be taken into account in making treatment decisions in some circumstances,⁴³ the *doctor's* economic interests are in theory

39. AMA PRINCIPLES (1980), *supra* note 36, at 331.

40. The World Medical Association Declaration of Geneva (1948, as amended 1968), in T. BEAUCHAMP & J. CHILDRESS, *supra* note 31, at 331. Moreover, once the physician-patient relationship is formed, medical ethics require the doctor not to "withdraw from the case without [adequate] notice to the patient to secure [alternative care]." AMA PRINCIPLES (1955) ch. II § 4, *supra* note 36, at 451. *See also* AMA PRINCIPLES (1957) § 5, *supra* note 36, at 354. The 1980 revision of the AMA PRINCIPLES does not refer to termination of care. The American Hospital Association's (AHA's) "Patient's Bill of Rights" also prohibits discontinuance of hospital care without notice to the patient and arrangement for adequate alternative care. *See* AHA, A Patient's Bill of Rights § 7, in T. BEAUCHAMP & J. CHILDRESS, *supra* note 31, at 336, 337.

41. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1573 (1984).

42. R. VEATCH, *supra* note 28, at 285. *See also* Morreim, *Cost Containment: Issues of Moral Conflict and Justice for Physicians*, 6 THEORETICAL MED. 257, 259 (1985) (describing the "traditional view"). However, there is evidence that this strong principle of patient-centeredness regardless of cost may not be shared by many physicians. "A national sample of primary care physicians were asked whether they agreed or disagreed with the following statement: 'It is the responsibility of society, through its government, to provide everyone with the best available medical care, whether he can afford it or not' Over one-half of the physicians (53.5%) stated that they disagreed with this statement." Mitchell & Cromwell, *supra* note 7, at 130 n.75. Unfortunately, Mitchell and Cromwell do not provide enough details of this survey to permit evaluation of its significance. For example, the respondents may have been disagreeing with that part of the question that placed responsibility for health care on the "government," or they may have have disagreed that "the best available medical care" (including advanced treatment involving very scarce resources) should be allocated regardless of ability to pay. Either position still might be consistent with the traditional ethical ideal that the physician should not consider costs in his or her relationship with a particular patient.

43. A doctor is not ethically required to pay for hospitalization or drugs that a patient cannot afford, nor to be insensitive to a patient's desire to avoid crushing debts far beyond his or her ability to pay. Thus, in the absence of an adequate national health program, one can infer that a patient's inability to pay may legitimately influence treatment decisions, presumably after full disclosure, informed consent, and efforts by the doctor to help arrange financial assistance. According to one practicing physician and health policy analyst, "it has not been unusual for me . . . to have to negotiate with Medicare patients over my recommended drug

excluded from consideration. The pre-1957 American Medical Association (AMA) Principles tried to channel doctors' economic interests into one economic model—fee-for-service practice⁴⁴—and to discourage both entrepreneurial conflicts of interest⁴⁵ and less costly methods of payment.⁴⁶ To be sure, under fee-for-service systems doctors have always had a financial interest in providing excessive services, but the ethical ideal is clear: physicians are “ethically bound to place the medical care needs of their patients before their own financial interests.”⁴⁷ The same principle applies with even greater force to cost-containment measures, under which the risks of financial conflicts of interest are higher. Cost-containment measures can lead to unrevealed decisions against performing or recommending services that are inherently very difficult for the patient to detect.⁴⁸

American medical malpractice law has generally followed the medical profession's own views of patients' rights and physicians'

regimens in order to accommodate patients' very real budgetary constraints.” Berenson, *supra* note 11, at 22-23.

44. AMA PRINCIPLES (1955) ch. 1 § 6, *supra* note 36, at 449.

45. The pre-1957 Principles limited the sources of professionally-based income to “services rendered the patient,” *id.*, thus implicitly condemning such modern practices as doctors treating patients in hospitals, surgical centers or ambulatory care centers in which they have a financial interest. See Relman, *supra* note 24, at 749. The pre-1957 Principles also explicitly prohibited solicitation, advertising, fee-splitting, and the corporate practice of medicine. AMA PRINCIPLES (1955) ch. 1 §§ 4 & 6; ch. VII § 5, *supra* note 36, at 448, 449, 457. “Corporate practice of medicine” means arrangements whereby an institution or organization realizes a profit from the practice of medicine.

46. Thus the pre-1957 Principles cast a somewhat dim eye on “contract practice,” which included payment by fee schedule, salary, or capitation. See *id.* at ch. VII § 3, at 456. Contract practice was said not to be unethical per se but was declared unethical if it “permits of features or conditions” considered unethical under the Principles, or “causes deterioration” in the quality of care. *Id.*

47. Relman, *supra* note 24, at 750. Ethical practitioners may minimize the inherent conflict of interest in the fee-for-service system by “avoiding self-referral whenever possible, by conservative use of tests and procedures, and by conscientiously attempting to meet their fiduciary responsibilities . . .” *Id.* These ideals may be reinforced by the fact or belief that patients generally understand that doctors make money by delivering services, and that patients have at least the opportunity to question doctors' recommendations. *Id.* at 750; Berenson, *supra* note 11, at 143-44; Morreim, *supra* note 42, at 268.

48. The recently issued Ethics Manual of the American College of Physicians states that “[t]he physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient.” 101 ANN. INTERN. MED. 129 (1984), discussed in Relman, *supra* note 24, at 751. The AMA House of Delegates recently approved physician profitsharing under fee-for-service reimbursement if disclosed in advance to the patient and if consistent with proper care. It disapproved physician profitsharing under diagnostic-related group (DRG) reimbursement, a form of cost containment. House of Delegates of the AMA, Conflict of Interest—guidelines; report of the Judicial Council of the AMA (Dec. 1984), in Relman, *supra* note 24, at 750-51.

duties.⁴⁹ During the first half of the twentieth century, the doctor's legal duty was to render competent care as measured by his or her professional peers in his or her locality.⁵⁰ Disclosure of more than minimal information to the patient and other complex doctor-patient communications were not legally required because the medical profession itself did not require them.⁵¹ But just as medical ethics began to emphasize patient autonomy as an important ethical value, so courts began in the late 1950's to emphasize informed consent as a key means of patient self-determination.⁵² The modern landmark informed consent cases—such as *Canterbury v. Spence*⁵³ and *Cobbs v. Grant*⁵⁴—acknowledge the reality of choices within medical decisionmaking and expand the concept of physician fidelity to mean helping the patient make the crucial decisions.

Similarly, common and statutory law has largely followed professional medical ethics on the relationship of financing to the standard of care. In most circumstances, a doctor has a legal right to choose whom to serve and may reject a patient for economic reasons.⁵⁵ On the other hand, once a doctor-patient relationship has

49. A doctor's legal duty of care is typically defined as "that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances. . . . The standard should be established by the medical profession itself and not by the lay courts. . . ." *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970); for qualifications and discussion, see J. KING, *THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL* 39-54 (2d ed. 1986); A. HOLDER, *MEDICAL MALPRACTICE LAW* 44-45 (2d ed. 1978).

50. See McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558-59 (1959).

51. See Katz, *supra* note 32, at 248-50; see also Pernick, *The Patient's Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy*, in 3 MAKING HEALTH CARE DECISIONS, *supra* note 33, at 14.

52. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); 1 MAKING HEALTH CARE DECISIONS, *supra* note 33, at 20-21. For a recent argument that these and later cases have not adequately recognized a legal interest in patient autonomy and that courts should recognize such an interest, see Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

53. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

54. 8 Cal. 3d 229, 104 Cal. Rptr. 505, 502 P.2d 1 (1972).

55. See, e.g., *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901) (physician may refuse to enter into a contract with any patient, even one who has tendered a fee and needs emergency care); *Becker v. Janinski*, 15 N.Y.S. 675, 677 (N.Y. Com. Pl. 1891) (physician may decline to respond to the call of a patient unable to compensate him) (*dictum*); *Harper v. Baptist Med. Center-Princeton*, 341 So. 2d 133 (Ala. 1976) (neither hospital nor doctor had a duty to accept a patient who had no hospital insurance); 70 C.J.S. *Physicians & Surgeons* § 48b, 52 (1951). Similarly, the federal Medicaid statute does not require physicians to participate in the Medicaid program or to accept Medicaid patients. See discussion of the "freedom of choice" provision, Social Security Act § 1902(a)(23), 42 U.S.C. § 1396a(a)(23) (1982), *infra* note 60. On the other hand, a physician's relationship with a hospital may require him or her to accept Medicaid and other low-income patients under certain circum-

been formed, medical malpractice law, like medical ethics, has traditionally demanded a unitary standard of care. A New York trial judge stated the point eloquently in 1891 in a jury charge:

Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care. He may decline to respond to the call of a patient unable to compensate him; but if he undertake the treatment of such a patient, he cannot defeat a suit for malpractice, nor mitigate a recovery against him, upon the principle that the skill and care required of a physician are proportioned to his expectation of pecuniary recompense. Such a rule would be of the most mischievous consequence; would make the health and life of the indigent the sport of reckless experiment and cruel indifference.⁵⁶

The parallel between medical ethics and malpractice law was drawn

stances. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67 (1986) (codified at 42 U.S.C. § 1395dd) (hospitals that accept Medicare reimbursement must comply with requirements regarding screening, stabilizing treatment, and transfer with respect to *all* patients, regardless of whether eligible for Medicare; penalties for noncompliance include termination or suspension of Medicare provider agreement, civil penalties, and damages and equitable relief for both patients and transferee facilities); *Thompson v. Sun City Community Hosp.*, 141 Ariz. 597, 603-04, 688 P.2d 605, 610 (1984) (hospital has duty to provide "medically indicated" emergency care without consideration of patient's economic circumstances); *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354 (E.D. La. 1972) (federal regulations require private nonprofit hospitals that have received federal construction funds under the Hill-Burton Act to accept Medicaid patients), *discussed in Rosenblatt*, note 64 *infra*, at 278-82; 42 C.F.R. § 124.603(c),(d) (1985) (hospitals that have received federal Hill-Burton funds must make reimbursement arrangements, if eligible to do so, with the Medicaid program, and must assure actual availability of physicians to Medicaid patients).

56. *Becker v. Janinski*, 15 N.Y.S. 675, 677 (N.Y. Com. Pl. 1891). See also *McCandless v. McWha*, 22 Pa. 261, 269 (1853) (surgeon is liable for improper treatment even to patient attended gratis, "because [the surgeon's] situation implies skill in surgery"); *DuBois v. Decker*, 130 N.Y. 325, 29 N.E. 313 (1891) (physician paid by city to attend patients in the city almshouse owes patients the duty to exercise ordinary care and skill); *Napier v. Greenzweig*, 256 F. 196, 198 (2d Cir. 1919); 48 C.J. *Physicians & Surgeons* § 106 (1929); 70 C.J.S. *Physicians & Surgeons* §§ 46, 52 (1951). The only reported case to suggest an alternative rule is *Ritchey v. West*, 23 Ill. 329 (1860). The Illinois Supreme Court stated that "whenever a retainer is shown," a physician will be liable for injuries caused by want of skill "which is ordinarily possessed by members of his profession," but "when the services are rendered as a gratuity, gross negligence will alone create liability." *Id.* at 330. (The physician in this case was represented by Abraham Lincoln and Elliott Herndon.) Six years later, the Illinois Supreme Court reversed itself on this point, although it did not admit to doing so. In *McNeveins v. Lowe*, 40 Ill. 209 (1866), the court held that "[i]f a person holds himself out to the public as a physician he must be held to ordinary care and skill in every case of which he assumes the charge, whether in the particular case he has received fees or not." *Id.* at 210. The court reconciled the *Ritchey* opinion with this rule by stating that the earlier case stood for the proposition that if a person "does not profess to be a physician or to practice as such, and is merely asked his advice as a friend or neighbor, he does not incur any professional responsibility." *Id.*

explicitly by the California Supreme Court in 1963 when it rejected a hospital claim that charitable patients could be required to sign exculpatory clauses waiving their rights to tort recovery. "To immunize the hospital from negligence as to the charitable patient because he does not pay would be as abhorrent to medical ethics as it is to legal principle."⁵⁷

C. *The Patient-Centered Ideal and the Medicaid Program*

For low-income patients, the ideal of patient-centeredness has three important meanings: (1) access to care in spite of inability to pay, (2) adequate quality of care once access is achieved, and (3) equal respect for individual autonomy, including freedom to choose providers and to make decisions based on informed consent. Medicaid, the major federal and state health care program for the poor, was enacted in 1965 with a commitment to overcome the dual-track tradition and to achieve all of these goals. Open-ended federal matching grants were supposed to induce the states to broaden eligibility and services so that by the mid-1970's most low-

57. *Tunkl v. Regents*, 60 Cal. 2d 92, 103, 32 Cal. Rptr. 33, 40, 383 P.2d 441, 448 (1963). The one exception to the unitary standard of care was the doctrine of "charitable immunity" for hospitals in their treatment of charitable patients, which dominated American hospital law between 1876 and the early 1940's. For a comprehensive review and critique of the doctrine and its justifications, see *President and Directors of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942). Charitable immunity protected hospitals from liability for the acts of their employees, such as nurses or salaried physicians, who frequently had responsibility for services to the poor. Physicians in private practice—often termed "attending physicians"—did not receive salaries from hospitals and were not considered hospital employees. Hospitals were typically not liable for such physicians' negligence, because the doctrine of *respondeat superior* did not apply to the hospital-doctor relationship. See, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

Some courts attempted to justify the charitable immunity doctrine on the implied contract grounds that the charitable patient had implicitly "waived" his or her right to legal protection from negligence in return for free care. See, e.g., *Hughes*, 130 F.2d at 826. In the 1940's and 1950's courts increasingly rejected this ground, noting that the waiver was often entirely fictional (e.g., with infants or unconscious patients), that it was almost never announced as hospital policy, that it was not within the normal expectation of patients, and that no patient would voluntarily agree to it. *Id.* Not surprisingly, when some hospitals then required patients to sign exculpatory clauses as a condition of admission, courts refused to enforce them on the grounds that the clauses were contracts of adhesion and represented an effort to revive by contract the abandoned doctrine of charitable immunity. See *Tunkl*, 60 Cal. 2d at 102-03, 32 Cal. Rptr. at 39-40, 383 P.2d at 447-48. Similar reasoning has invalidated releases from future negligence sought by physicians. See, e.g., *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977); *Belshaw v. Feinstein*, 258 Cal. App. 2d 711, 65 Cal. Rptr. 788 (1968).

The perceived crisis with respect to medical malpractice insurance, and the growing influence of market-oriented approaches to law and public policy, has led to a new generation of proposals to allow modification of malpractice standards by contracts between providers and patients. See, e.g., Havighurst, *Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spr. 1986, at 143.

income patients would be eligible for comprehensive public health insurance.⁵⁸ Like medical ethics and medical malpractice law, the Medicaid program contemplated that the services provided to low-income patients would be "of high quality and in no way inferior to that enjoyed by the rest of the population."⁵⁹ In addition, a 1967 amendment to the original statute explicitly rejected the dual-track tradition of restricting low-income patients to special public institutions and charitable providers, and established Medicaid patients' right to freedom of choice of any qualified provider who agreed to supply services.⁶⁰

Medicaid's original strategy for achieving these ambitious goals was simple: to provide reimbursement so that low-income patients could buy their way into an otherwise unchanged mainstream health care system. This strategy succeeded in part, as low-income patients dramatically increased their use of hospitals and doctors between 1965 and 1975.⁶¹ On the other hand, it quickly became

58. See Rosenblatt, *supra* note 2, at 649. The original Medicaid statute required the states to broaden the scope of eligibility and services. Social Security Act, Pub. L. No. 89-97, § 121, 79 Stat. 286, 350 (1965). This provision was repealed by the Social Security Amendments of 1972, Pub. L. No. 92-603, § 230, 86 Stat. 1329, 1410 (1972).

59. Dept. of Health, Education & Welfare (HEW), Handbook of Public Assistance Adm'n, Supplement D, § D-5140.

60. See Pub. L. No. 90-248, § 227, 81 Stat. 821, 903 (1967) (adding § 1902(a)(23) to the Social Security Act, codified at 42 U.S.C. § 1396a(a)(23) (1982)). The significance of this provision has been multi-faceted. When enacted in 1967, it probably represented both a safeguard against restricted care for the poor and protection for providers against restricted (and perhaps more efficient) contract purchasing by the state agencies. Thus the House Ways and Means Committee explained that this provision was designed to give Medicaid recipients "freedom in their choice of medical institution or medical practitioner," a freedom "characteristic of our medical care system." H.R. REP. NO. 544, 90th Cong., 1st Sess. 122 (1967). The provision did not, however, require providers to serve Medicaid patients, nor did it require the states to set rates of payment that would induce providers to serve them. See *id.* The Senate modified the House provision to include community pharmacies and drugs among the providers and services with respect to which free choice was assured. S. CONF. REP. NO. 1030, reprinted in 1967 U.S. CODE CONG. & AD. NEWS 3179, 3211; see also *Social Security Amendments of 1967, Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess. 1867 (1967) (statement of Dr. William S. Apple, Exec. Dir. of the American Pharmaceutical Ass'n). Similarly, clinical laboratories used the provision in an effort to block New York City from centralizing the purchase of laboratory services in the Medicaid program. See *Bay Ridge Diagnostic Laboratory, Inc. v. Dumpson*, 400 F. Supp. 1104 (E.D.N.Y. 1975).

On the other hand, from the mid-1970's to the present the freedom of choice provision has functioned less as a protection for providers and more as a major statutory (and political) protection for Medicaid recipients against mandatory (and often ill-conceived) at-risk contracting and PCCM. See *infra* notes 115-34 and accompanying text.

61. Prior to 1965, the poor received substantially less care from doctors than the nonpoor, although their health needs were significantly greater. See K. DAVIS & C. SCHOEN, *supra* note 6, at 26-48. For example, in 1964, children under age 15 from high-income families earning over \$10,000 per year averaged 5.1 physician visits per year, 89% higher than the

apparent that this approach was very expensive and ineffective against deep-seated access barriers such as racial discrimination, lack of health care resources in rural areas, and relocation of physicians and hospitals to affluent areas.⁶² Moreover, the structure of the Medicaid program was ambiguously balanced between state discretionary authority and mandatory federal requirements. As program costs increased sharply from the late 1960's,⁶³ states used their discretionary authority to restrict eligibility, services, and reimbursement.⁶⁴ These restrictive measures enlarged the number of uninsured, deterred the provision of excluded services, and made the Medicaid program less attractive to physicians, thereby undercutting access to quality care and effective freedom of choice.⁶⁵

2.7 visits per year for children from low-income families earning under \$4,000 per year. *Id.* at 41-42. With respect to all ages, high-income families averaged 5.1 physician visits per year, 19% higher than the 4.3 visits for low-income families. *Id.* During this same period, low-income children had far higher rates of chronic conditions with and without limitation of major activity than high-income children. See H. LUFT, POVERTY AND HEALTH 69-70 (1978) ("children" being defined as under 17, "low-income" as under \$2,000 per year, and "high-income" as over \$7,000 per year). Low-income children remain at much greater risk of low birth weight, infant mortality, and birth defects. See K. DAVIS & C. SCHOEN, *supra* note 6, at 34-35. Similar differences in health status remain true for adults. *Id.* at 35-40. By 1975 the utilization pattern had changed, with physician visits and hospitalization for the poor reaching and surpassing the levels for the nonpoor. These changes have been characterized as "really monumental achievements." Rogers, Blendon & Moloney, *Who Needs Medicaid?*, 307 NEW ENG. J. MED. 13, 15 (1982); see also K. DAVIS & C. SCHOEN, *supra* note 6, at 40-48.

62. On the issue of expense, see *infra* note 63. On the issue of nonfinancial barriers, see K. DAVIS & C. SCHOEN, *supra* note 6, at 71-83. The interaction of racial attitudes and pressures for suburban relocation are the subject of NAACP v. Wilmington Med. Center, 491 F. Supp. 290 (D. Del. 1980).

63. The size, sources, and significance of rising Medicaid expenditures are matters of some controversy. Raw dollar figures are dramatic. From FY 1973 to FY 1979, national federal and state Medicaid spending rose from \$8.5 billion to \$20.3 billion—an average annual compound percentage increase of 15.59%. R. BOVBERG & J. HOLAHAN, *supra* note 6, at 4-5. But much of this increase can be explained by the general inflation in health care prices over which Medicaid had no control. *Id.* at 13-16; see Davidson, Cromwell & Schurman, *Medicaid Myths: Trends in Medicaid Expenditures and the Prospects for Reform*, 10 J. HEALTH POL., POL'Y & LAW 699, 700-01 (1986) [hereinafter cited as *Medicaid Myths*]. Indeed, Medicaid's increase in constant dollars between 1973 and 1979 (42.3%) compares very favorably with much higher constant dollar increases in Medicare and health care spending as a whole. See R. BOVBERG & J. HOLAHAN, *supra* note 6, at 16. For conflicting discussions of whether Medicaid expenditures loom large in state budgets, compare *id.* at 3 with *Medicaid Myths*, *supra*, at 701-08. Moreover, with the exception of expanded intermediate care coverage, the number of enrollees and services covered actually *declined* from 1973 to 1979, further emphasizing the role of prices as the major cause of growth in spending. See R. BOVBERG & J. HOLAHAN, *supra* note 6, at 13; *Medicaid Myths*, *supra*, at 711-12, 715-21.

64. See R. STEVENS & R. STEVENS, *supra* note 6; K. DAVIS & C. SCHOEN, *supra* note 6, at 87-89; Blake, *supra* note 7; Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 294-95 (1978).

65. See, e.g., Mitchell & Cromwell, *supra* note 7 (documenting low physician participa-

Despite these developments, the patient-centered ideal of widespread access to high-quality care remained an important political and legal principle in the Medicaid program.⁶⁶ Even when enacting cutbacks, federal and state officials have usually proclaimed fidelity to the principles of access and quality, and have justified restrictions as improvements in efficiency or as temporary measures necessitated by immediate budget constraints.⁶⁷ Moreover, at various times, complex coalitions of political leaders, providers, and Medicaid recipients and their advocates have resisted the pressures toward inferior care and have sought to implement the patient-centered aspects of the program.⁶⁸ A major example of this phenomenon occurred during congressional consideration of the Omnibus Budget Reconciliation Act of 1981 (OBRA), where efforts were made to reconcile innovative cost-containment techniques such as PCCM with the original goals of access to quality care.

D. *The Patient-Centered Ideal and the Theory of Cost Containment*

The physician's ethical duty of fidelity to the patient requires that recommendations and decisions be made on the basis of the patient's medical interests, rather than on the basis of the economic interests of the doctor, insurance company, or society at large.⁶⁹ In contrast, all cost-containment measures attempt to link the physician's decision to consciousness of economic scarcity, whether through out-of-pocket charges to the patient, practice norms set by

tion rates in Medicaid); H. LUFT, *supra* note 7, at 323 (noting impact of eligibility restrictions and low benefits). On the impact of more recent restrictions, see Blendon, Aiken, Freeman, Kirkman-Liff & Murphy, *Uncompensated Care By Hospitals or Public Insurance for the Poor: Does It Make a Difference?*, 314 NEW ENG. J. MED. 1160 (1986) [hereinafter cited as Blendon] (documenting major access barriers for low-income patients not covered by Medicaid); Iglehart, *Cutting Costs of Health Care for the Poor in California*, 311 NEW ENG. J. MED. 745 (1984); Lurie, Ward, Shapiro & Brook, *Termination from Medi-Cal—Does It Affect Health?*, 311 NEW ENG. J. MED. 480, 484 (1984) (215 medically indigent patients terminated from Medi-Cal (the Medicaid program in California) in 1982 found after six months to have "significant deterioration in . . . access to care, satisfaction with care, and health status.")

66. For discussion of court decisions blocking proposed state Medicaid cutbacks, see Rosenblatt, *supra* note 64, at 294-303.

67. See Rosenblatt, *supra* note 64, at 294; R. BOVBJERG & J. HOLAHAN, *supra* note 6, at 6, 17-20.

68. Prominent examples include the long struggles by Medicaid recipients and their allies to implement the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, and the consumer protection provisions of the Medicaid statute regarding HMO enrollment and other at-risk contracting. On the former, see, e.g., Rosenblatt, *supra* note 2, at 655-57; on the latter, see *infra* notes 113-19, 197-99, 217-34 and accompanying text.

69. See *supra* notes 41-42 and accompanying text.

insurers or other entities, or financial incentives to the doctor.⁷⁰ For this reason, cost-containment measures are often perceived as being inconsistent with the patient-centered ethical ideal.⁷¹ On the other hand, three relatively new perspectives on health policy—geographic variations research, market competition, and democratic participation—have the potential to help reconcile cost-containment goals with the patient-centered ideal.

Beginning in the early 1970's, pathbreaking research by Dr. John Wennberg and other analysts demonstrated large variations by geographic location in rates of hospitalization, surgery, and other medical procedures, without differences in rates of illness.⁷² To take one dramatic example, "a child living in Rumford, Maine, has fifteen times the probability of being hospitalized with a diagnosis of pediatric pneumonia as does a child living in Portland."⁷³ Lack of professional consensus and outcome data make it impossible at present to say which of the varying utilization rates are "right," but the low rates do not involve obvious underservice or low quality of care and may represent the better pattern.⁷⁴ Reliance on the judgments of individual doctors—which tend to cluster by locality or region⁷⁵—about patients' best interests is thus often inadequate

70. For discussion of various cost-containment strategies, see Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1073-88 (1981); Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981); Berenson, *supra* note 11, at 22-23.

71. See, e.g., Levinsky, *supra* note 41, at 1573-75; R. VEATCH, *supra* note 28, at 285; Morreim, *supra* note 42, at 259; Capron, *supra* note 27, in this Symposium.

72. See, e.g., Caper, *Variations in Medical Practice: Implications for Health Policy*, 3 HEALTH AFF., Summer 1984, at 110; Wennberg, *Which Rate Is Right?*, 314 NEW ENG. J. MED. 310 (1986).

73. Caper, *supra* note 72, at 113-14. These variations are found in hospital admission rates for more than 80% of medical conditions. See Wennberg, *supra* note 72, at 310. The variations are correlated with the number of available hospital beds per capita (i.e., more beds are correlated with higher rates of hospitalization), the "practice styles" of physicians in a particular area, and lack of physician consensus regarding appropriate treatment. *Id.*

74. See Wennberg, *supra* note 72, at 311 (noting low-use patterns of medical admissions in Iowa City, Palo Alto, and New Haven, "where university hospitals provide high-quality care." Dr. Wennberg suggests that "agreement might well be reached to reduce the use of hospitals for high-variation medical conditions."). Moreover, when doctors have been informed of high variations in procedures (such as tonsillectomies in Vermont and hysterectomies in Saskatchewan), doctors with high rates have lowered their rates dramatically. See Knox, *The Many Faces of Health Care*, Boston Globe, Aug. 20, 1984, at 44.

75. Practice patterns can be observed *within* regions or localities because doctors do not practice idiosyncratically; rather, they "tend to follow what is considered standard and accepted in the community." Eddy, *Variations in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFF., Summer 1984, at 74, 86. This tendency arises because of pervasive uncertainty in medical diagnosis and treatment. Given this uncertainty, there is "'safety in numbers.' A physician who follows the practices of his or her colleagues is safe from criticism,

without more careful analysis of practice styles and conscious choices among them. Consumers could and should participate in making these choices,⁷⁶ for example, by being members of boards attached to HMO and PCCM projects.⁷⁷ Cost-containment programs that foster patient participation of this sort may redefine and strengthen the patient-centered ideal.

Also beginning in the early 1970's, analysts such as Paul Ellwood, Clark Havighurst, and Alain Enthoven argued that health care cost containment should be severed from its roots in regulation and collectivist consumerism⁷⁸ and linked to the ostensibly more

free from having to explain his or her actions, and defended by the concurrence of colleagues." *Id.* The community standard in turn derives from such diverse sources as statements in national journals and textbooks, opinions of established physicians, new ideas brought in by new physicians, and incentives provided by reimbursement systems and malpractice law. The latter two factors have, until very recently, strongly pushed for increased services and expenditures. *Id.* at 86, 85. Differences *between* community standards exist "because not enough is known to establish which opinion is correct." *Id.* at 86. Few procedures and incentives exist to compare various practice standards and to attempt to reach a more defensible and general consensus.

76. According to Dr. Wennberg, geographic variations research "tells me that there is a lot of choice for the patient. We need to know what those choices imply. We need to find out which of these practice patterns we would prefer as patients." Knox, *supra* note 74, at 44.

77. Federal law requires HMOs seeking federal qualification to have one-third of their policymaking bodies be members (i.e., enrolled consumers) of the HMO, with "equitable representation" of members from medically underserved populations served by the HMO. See 42 U.S.C. § 300e(c)(5)(A)(i), (ii), & § 300e-1(3). (For a critique of the adequacy of this provision, see Schneider & Stern, *supra* note 17, at 104 n.66.) Some state laws contain similar provisions; see, e.g., 40 PA. CONS. STAT. ANN. § 1557 (Purdon Supp. 1986). Given lack of support by society and by most HMOs themselves, the effectiveness of such consumer participation remains unknown. See H. LUFT, *supra* note 7, at 348-51. On consumer participation in Medicaid PCCM programs, see discussion *infra* at notes 219-33.

78. Prior to the 1970's, health care cost containment had taken two primary forms which have continued, with important modifications, to the present: (1) regulation by government and quasi-government agencies, and (2) alternatives to fee-for-service reimbursement, typically known as "prepaid group practices." On regulatory efforts such as utilization review, see J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 33-51 (1977); S. LAW, *BLUE CROSS: WHAT WENT WRONG?* 115-44 (2d ed. 1976); on health planning, see, e.g., Rosenblatt, *supra* note 64, at 304-10; Morone & Marmor, *Representing Consumer Interests: The Case of American Health Planning*, in T. MARMOR, *POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE* 76 (1983). Without strong federal leadership and appropriate financial incentives, it quickly became apparent that these regulatory efforts would have little impact on costs. See, e.g., in addition to sources cited above, Brown, *Technocratic Corporatism and Administrative Reform in Medicare*, 10 J. HEALTH POL., POL'Y & LAW 579-90 (1985).

Beginning around the turn of the twentieth century and expanding in the 1920's and 1930's, prepaid plans were sponsored by employers, unions, and consumer co-ops. See P. STARR, *supra* note 2, at 200-03, 301-06, 320-27. They were often non-profit in form and reflected a desire for rational, planned, collective organization at odds with the individualistic rhetoric (and monopolistic reality) of organized medicine. See, e.g., Note, *The Role of Pre-*

effective force of market competition.⁷⁹ The goal of this perspective is not simply to reduce health care expenditures, but rather to give "reasonable individuals what they want *and only what they want*, in the sense that, understanding the alternatives, they would purchase it for themselves assuming their income was not below a certain level, perhaps the median in the population."⁸⁰ Under this model, competitive "intermediaries" or "gatekeepers," such as health plans, insurance companies, or doctors at financial risk, decide through a market with consumers which types of health care are worth their cost.⁸¹ The primary protection for patients against unreasonable underservice is said to be market competition.⁸² In practice, middle-class HMO consumers have relied on a complex mix of protective devices, including individual market freedom (i.e., disenrollment), collective bargaining and influence through employers and unions, internal grievance mechanisms and quality assurance programs, federal⁸³ and state⁸⁴ regulation, malpractice law,⁸⁵ and a culture of professional norms and consumer expectations that work to deter unethical and exploitative behavior. These competitive and regulatory mechanisms, together with the fruits of geographic vari-

paid Group Practice in Relieving the Medical Care Crisis, 84 HARV. L. REV. 887, 902-18 (1971).

79. See, e.g., A. ENTHOVEN, *supra* note 1, at 93-113; Havighurst, *supra* note 16, at 739-59.

80. Havighurst & Blumstein, *supra* note 24, at 15-16.

81. For analysis of and references to these proposals, see Rosenblatt, *supra* note 70, at 1074-78.

82. Thus, according to Enthoven, if "every family has a free and fair choice among competing health plans, organizations that make a practice of underserving their members will not last long." A. ENTHOVEN, *supra* note 1, at 69.

83. See Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914, codified at 42 U.S.C. §§ 300e *et seq.*; 42 C.F.R. § 110 (1985).

84. See, e.g., 40 PA. CONS. STAT. ANN. §§ 1551-1567 (Purdon Supp. 1986); N.J. STAT. ANN. tit. 26, § 2J-1 *et seq.* (West Supp. 1986); Schneider, *Model Consumer Health Maintenance Organization Act and Commentary*, 6 RUT.-CAM. L.J. 266, 267-70 (1974).

85. On the general issue of applying malpractice law to HMOs, see Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375. However, the impact of malpractice law may be diminished by HMO policies, notably in California, requiring binding arbitration as a condition of enrollment. See Note, *Medical Malpractice Arbitration: Time for a Model Act*, 33 RUTGERS L. REV. 454, 466 (1981); Madden v. Kaiser Found. Hosp., 17 Cal.3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976) (en banc) (enforcing agreement to arbitrate medical malpractice claims entered into between state retirement board on behalf of state employees and prepaid health care provider); Stevens, *Medical Malpractice: Some Implications of Contract and Arbitration in HMOs*, in HEALTH MAINTENANCE ORGANIZATIONS: MILLBANK READER 5, at 414 (J. McKinlay ed. 1981) [hereinafter cited as HEALTH MAINTENANCE ORGANIZATIONS]. In addition to malpractice law, HMOs may become subject to the doctrine of "bad faith breach of contract" traditionally applied to insurance companies. See Stern, *Will Tort of Bad Faith Breach of Contract Be Extended to Health Maintenance Organizations?*, 11 LAW MED. & HEALTH CARE 12 (1983).

ations research and other data, could constitute a new and expanded "patient-centered ideal."⁸⁶

Achieving Enthoven's version of this ideal would still require substantial government action, particularly for the poor. The key step in Enthoven's strategy is the government's supplying low-income persons with an income-related subsidy "large enough to enable them to purchase membership in a good quality comprehensive health care plan"⁸⁷ In addition, the government would try to assure actual availability of plans to low-income and high-risk patients by regulating the scope of services covered, premiums, out-of-pocket expenses, information disclosure, and open-enrollment periods.⁸⁸ Starting in the mid-1970's, Congress and the Health Care Financing Administration (HCFA), the federal Medicaid agency, attempted a version of this strategy by urging the states to contract with mainstream, federally certified HMOs that also served middle-class patients and to encourage Medicaid recipients to enroll in those HMOs.⁸⁹ Such HMOs are widely thought to deliver better and less costly care than that provided by fee-for-service doctors, particularly those who serve Medicaid patients. However, progress remains slow in most states, primarily because many HMOs consider the capitation rates offered by Medicaid inadequate in light of the anticipated costs of marketing, Medicaid eligibility turnover, and treatment of patients often regarded as "high risk."⁹⁰

86. See Lohr, in this Symposium. For discussion of reasons why the market competition approach may be incapable of achieving this ideal, see Rosenblatt, *supra* note 70; Arras, *The Neoconservative Health Strategy*, in *IN SEARCH OF EQUITY* 125 (R. Bayer, A. Caplan & N. Daniels eds. 1983) and *ETHICAL ISSUES IN MODERN MEDICINE* 532 (J. Arras & R. Hunt eds. 2d ed. 1983).

87. A. ENTHOVEN, *supra* note 1, at 81.

88. See *id.* at 126-30. The extent of these suggested regulations indicates the inventiveness of prepaid plans in avoiding patients who are perceived to be bad financial risks. Required and "government-supervised" annual open enrollment periods are necessary to give low-income and high-risk patients a realistic enrollment opportunity. Enthoven does not address, however, the most effective HMO exclusionary policy—filling existing capacity with desired patients and declining to expand, particularly into areas accessible to low-income patients.

Community rating—charging the same premium to persons in the same "actuarial category" based on gross characteristics such as age and family size—is needed to avoid pricing high-risk patients out of the market. Service coverage must be regulated to prevent inadequate undercoverage, deceptive advertising, and exclusionary overcoverage, i.e. offering only a very expensive benefit package to deter lower-income patients. Information disclosure and other marketing practices must be regulated to generate understandable contracts and to avoid deceptive practices.

89. See, e.g., Luft, *Assessing the Evidence on HMO Performance*, in *HEALTH MAINTENANCE ORGANIZATIONS*, *supra* note 85, at 212, 233; H. LUFT, *supra* note 7, at 323-28.

90. See, e.g., Luft, *supra* note 89, at 234; H. LUFT, *supra* note 7, at 323-41; Veit, *Health*

Compared with the well-funded and highly visible market competition approach, the concept of democratic participation presently has a quasi-fugitive existence in the world of health policy. Nevertheless, it has made major contributions to the patient-centered ideal. The basic premise of this approach is that patients or consumers of health care should be directly represented in the institutions that make health policy and particularly in the institutions engaged in health care cost containment. Indeed, federal and state laws and regulations currently require such representation on local and state health planning boards,⁹¹ Medicaid advisory committees,⁹² and the boards of directors of Blue Cross/Blue Shield⁹³ and HMOs.⁹⁴ Such representation has often been co-opted and ineffective, because few social resources have been devoted to building and sustaining an independent consumer presence in the arena of health policy.⁹⁵ However, the few existing resources—organized senior citizens, consumer advocates such as the Health Research Group founded by Ralph Nader, public interest law firms, legal services programs, welfare rights groups, and other advocates in the field of social services—have supported important contributions to health policy in general and to PCCM policy in particular.⁹⁶ Indeed, ana-

Maintenance Organizations and Medicaid, in *AMBULATORY CARE: PROBLEMS OF COST AND ACCESS* 147 (S. Altman, J. Lion & J. Williams eds. 1983). The initial reluctance of established HMOs to participate in the Arizona AHCCCS project, *infra* notes 165-80, was reportedly based on similar concerns. See J. CHRISTIANSON & D. HILLMAN, *HEALTH CARE FOR THE INDIGENT AND COMPETITIVE CONTRACTS: THE ARIZONA EXPERIENCE* 116 (1986) (noting that established HMO facilities were geographically located so as to be attractive to employed groups; a commitment to serve large numbers of indigents would require investment in new facilities and staff, and "could reduce their attractiveness to private employed groups.").

91. See 42 U.S.C. § 3001-(b)(3)(C)(i) (1982) *discussed in* Rosenblatt, *supra* note 64, at 304-30.

92. See 42 C.F.R. § 431.12 (1985), *discussed (under prior numbering) in* Rosenblatt, *supra* note 64, at 290-98.

93. See, e.g., N.J. STAT. ANN. tit. 17 § 48-5 (West 1985); S. LAW, *supra* note 78, at 26-30, 171-73.

94. See, e.g., 40 PA. CONS. STAT. ANN. § 1557 (Purdon Supp. 1986).

95. See Rosenblatt, *supra* note 64, at 297, 304-36; S. LAW, *supra* note 78, at 26-30, 171-73; Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1 (1981) [hereinafter cited as Sparer, *Gordian Knots*]. On the more general relationship of law and movements for social change, see Sparer, *Fundamental Human Rights, Legal Entitlements, and the Social Struggle: A Friendly Critique of the Critical Legal Studies Movement*, 36 STAN. L. REV. 509, 560-74 (1984).

96. On the contributions made by legal services programs, public interest law firms, and organized low-income consumers to health care policy in the Hill-Burton, Medicaid, and health planning programs, see Rosenblatt, *supra* note 64; on the contributions of such groups and advocates to Medicaid PCCM, see *infra* text accompanying notes 219-33. (For a contrary argument, with which I disagree, on why such efforts were not a "contribution" to the

lysts of the PCCM experience at the local level tend to agree that constructive involvement of Medicaid recipients and their advocates in policymaking and implementation is essential to program success.

E. *Three Themes of the Patient-Centered Ideal*

Three themes common to the diverse sources discussed above are particularly relevant. First, all the versions of the patient-centered ideal profess that the patient's well-being and autonomy should be a central, perhaps preeminent factor in the doctor-patient relationship and in the making of health policy. Second, all the versions of the patient-centered ideal recognize a connection between reimbursement and coverage decisions and the dynamics of the doctor-patient relationship. Third, all the versions seek to "operationalize" the patient-centered ideal, either by saying what that ideal requires in different contexts (as do medical ethics and malpractice law) or by establishing a process through which patients and their representatives can give concrete meaning to the ideal (as do market competition and democratic participation). All of these versions and their competing sub-versions can be criticized in conception and implementation. But their shared virtues become clearer when they are confronted with a perspective denying their common premises.

II. MEDICAID PRIMARY CARE CASE MANAGEMENT AND THE THREAT TO THE PATIENT-CENTERED IDEAL

The general tension between PCCM and patient-centered health care for all patients is magnified with respect to the poor. The protective factors upon which middle-class HMO patients rely—such as purchasing power, freedom to disenroll, capacity to press grievances, access to malpractice law, and a culture of non-exploitative norms and expectations—operate much less effectively for Medicaid patients.⁹⁷ Moreover, the dependence of the poor on government action has led to additional political and administrative threats to the patient-centered ideal.

Hill-Burton program, see Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227, 1231-38 (1984)). On the contributions of organized senior citizens and other consumer groups to the market approach to health care, see Lohr, *supra* note 86, in this Symposium.

97. See, e.g., Dallek, *supra* note 2, in this Symposium; Arras, *supra* note 86, at 541; Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401, 1412-16 (1981).

A. *The Politics of Medicaid Cost Containment*

Medicaid cutbacks before 1981 had restricted but not eliminated the fundamental principle of open-ended entitlement. Under that principle, Medicaid recipients are entitled to defined services for which the federal and state governments will pay allowed costs without any fixed upper limit on overall expenditures.⁹⁸ The Reagan administration arrived in Washington in 1981 with more ambitious plans and a more far-reaching philosophy. At the most fundamental level, the administration sought not simply to restrict domestic expenditures or to improve program efficiency, but further to eliminate or to reduce sharply major welfare and redistributive functions of the federal government, particularly those embodied in the most politically vulnerable open-ended entitlement programs such as Medicaid.⁹⁹ The most radical strategy for accomplishing this goal, embodied in the 1980 Gephardt-Stockman bill, was to repeal the Medicaid program and most health regulatory programs entirely and to give low-income persons vouchers to purchase health insurance through private insurers.¹⁰⁰ Although by no

98. See *supra* text accompanying note 67.

99. See, e.g., Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1 (1984); Omenn, *supra* note 12, at 2-1; Gorham, *Overview*, in THE SOCIAL CONTRACT REVISITED 1, 5-6 (D. Bawden ed. 1984). Former Office of Management and Budget (OMB) Director David Stockman's appreciative description of then-Congressman Phil Gramm captures the spirit of some of the officials involved in making Medicaid policy:

Gramm understood fully that high marginal tax rates were but one manifestation of the welfare state problem. Down in the briar patch of the budget and regulatory agencies, hundreds of similar policy errors demanded correction. He could rip through the alleged facts and mythical rationalizations which support little sink-holes of waste such as physicians' training subsidies or big ones like open-ended Medicaid reimbursement In his mind, as in mine, the first principles of the anti-statist revolution were complementary. They required an enormous shrinkage of the vast expenditures that the Congress pumped into illicit and inappropriate functions of the state. That permitted lower taxes. Capitalist dynamism also required lower taxes. That necessitated far less spending.

D. STOCKMAN, THE TRIUMPH OF POLITICS 52 (1986). Stockman is correct that "open-ended Medicaid reimbursement," particularly cost-based reimbursement for hospitals, is inflationary and wasteful. However, he does not explain why solutions less harmful to vulnerable patients (such as changing the hospital reimbursement system) are not available, nor why the poor should be among the first to bear the burden of cost containment, when the bulk of health care cost inflation is caused by cost-based reimbursement from Medicare and private insurance. See *supra* note 63. More fundamentally, Stockman does not attempt to justify his apparent assertion that financing medical care for the poor is an "illicit and inappropriate function" of the federal government (and perhaps of any government).

100. See H.R. 7527, 96th Cong., 2d Sess. (1980), also introduced as H.R. 850, 97th Cong., 1st Sess. (1981). For discussion of this bill and of David Stockman's views on health policy, see Iglehart, *supra* note 20.

means relinquishing this policy goal,¹⁰¹ the administration also proposed in 1981 a fixed limit or "cap" on federal Medicaid spending increases of five percent for FY 1982, to be adjusted thereafter by the rate of inflation as measured by the gross national product (GNP) deflator.¹⁰² Such a change in the basic structure of Medicaid would have two profound and intended effects. First, it would eliminate health needs—however inadequately measured—as the policy and budgetary center of the program and would substitute a budgetary ceiling determined by general budgetary politics, including the demands of budget balancing and the military.¹⁰³ Second, because the federal cap was set to rise much more slowly than the projected fifteen percent per year increase in Medicaid expenditures, the states would have received much less federal money than under the existing system, estimated at \$1.2 billion less in FY 1982 and \$5 billion less by FY 1984.¹⁰⁴ In return, the states were to be given unprecedented discretion to limit the kind or scope of services offered, to restrict eligibility, and to alter the terms and amount of reimbursement.¹⁰⁵ Since most of the states were themselves pressed by economic recession, budgetary deficits, and strong taxpayer resistance, it was likely that the Medicaid program would have been reduced in ways that seriously threatened any pretense of patient-centered medical care for the poor.

Federal officials who adopt this perspective typically continue to refer to access and quality as program ideals¹⁰⁶ but simultaneously

101. See Pear, *White House Urges Cash Welfare Aid*, N.Y. Times, Aug. 10, 1986, at 1, col. 1 (White House officials "quietly encouraging state welfare officials to make proposals" that would "consolidat[e] social welfare programs and substitut[e] a single monthly cash payment or check for food, medical and housing assistance, day care, employment and training programs and other social services.").

102. See Omenn, *supra* note 12, at 2-2; Wing, *supra* note 99, at 40.

103. See Wing, *supra* note 99, at 29-34, 37-42. On more general proposals of this sort, see Rosenblatt, *Rationing "Normal" Health Care Through Market Mechanisms: A Response to Professor Blumstein*, 60 TEX. L. REV. 919, 922 (1982).

104. See Wing, *supra* note 99, at 40. Depending on various estimates of the gap between actual Medicaid expenditures and the federal budget inflation factor, Wing states that the administration's proposal might have resulted in "a 30% to 40% reduction in the Medicaid program funding by 1985." *Id.* at 40-41. Even if the state governments had managed to resist reductions of this magnitude, there seems little doubt that the administration's proposed cap would have "vastly increased pressures on states to cut their programs," while at the same time giving them wide discretion to do so. See R. BOVBERG & J. HOLAHAN, *supra* note 6, at 8, 63.

105. See Wing, *supra* note 99, at 40; R. BOVBERG & J. HOLAHAN, *supra* note 6, at 63.

106. See, e.g., Anderson, *The Objectives of the Reagan Administration's Social Welfare Policy*, in *THE SOCIAL CONTRACT REVISITED*, *supra* note 99, at 15 (on the Reagan domestic program generally); S. 1377, § 724(a), 97th Cong., 1st Sess. (1981), *discussed infra* text accompanying notes 135-40; Health Care Financing Administration (HCFA) testimony regard-

insist on fast budget savings and minimally regulated state and private administration of Medicaid.¹⁰⁷ Achieving these latter two goals—quick budget savings and unregulated administration—would usually be inhibited by serious attention to access and quality. The Reagan administration's approach thus also implies a jurisprudence: a lack of enforceable federal duties concerning access and quality on the part of federal and state agency officials and health care providers, and a lack of rights and remedies for patients.¹⁰⁸

On the issue of the federal cap the administration suffered one of its few budget defeats at the hands of a coalition composed of Congressional liberals, the National Governors' Association, counties, mayors, and groups working for the interests of children, senior citizens, women, the institutionalized, and public and teaching hospitals.¹⁰⁹ Pressed by these advocates and interests, Congress rejected the Medicaid cap in favor of a more complex system of federal reductions that the states could recover if they met stated cost-containment goals.¹¹⁰ On the issue of federal program requirements, a compromise emerged which in principle rejected the administration's proposal for virtually unregulated state administration and which retained a significant federal administrative role.¹¹¹ But despite these two legislative setbacks, the administration neither changed its policy goals nor lost its opportunities to further them through executive action.¹¹²

ing the Arizona Health Care Cost Containment System (AHCCCS), *infra* text accompanying note 166. For similar expressions of benign intentions during earlier periods of cost cutting, see Rosenblatt, *supra* note 64, at 294 & n.230 (quoting 1972 views of Senate Finance Committee and its then-chairman, Senator Long).

107. See, e.g., Eizenstat, *Comments* (on Anderson, *supra* note 106), in *THE SOCIAL CONTRACT REVISITED*, *supra* note 99, at 28 (on the Reagan domestic program generally); discussion of Reagan administration's 1981 proposals regarding Medicaid, *supra* text accompanying notes 98-105; discussion of HCFA implementation of Medicaid PCCM and the AHCCCS program, *infra* text accompanying notes 150-203; Dallek, *supra* note 2 in this Symposium.

108. For discussion of why certain statutory provisions regarding access and quality passed by the Senate would probably have been unenforceable, see *infra* text accompanying notes 135-40. For an effort to justify lack of enforceable rights and duties in terms of market theory and judicial doctrine, see Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 *TEX. L. REV.* 1345, 1354-85 (1981); for a similar argument based on legislative history and statutory interpretation, see Blumstein, *supra* note 96, at 1227. For a critique of these arguments, see Rosenblatt, *supra* note 97, at 1417; Rosenblatt, *supra* note 103, at 920; Rosenblatt, *supra* note 64.

109. See Omenn, *supra* note 12, at 2-21.

110. See Wing, *supra* note 99, at 49-50. A detailed account of the legislative politics is provided in Omenn, *supra* note 12, at 2-19 to 2-36.

111. See *infra* text accompanying notes 113-49.

112. On the administration's continuing commitment to radical restructuring of Medi-

B. *The Statutory Basis of PCCM*

Prior to 1981, states wishing to implement PCCM or other at-risk health care faced two major restrictions in the federal Medicaid statute. The first were restrictions on state Medicaid contracts with "at-risk" providers such as HMOs, embodied in section 1903(m) of the Social Security Act.¹¹³ Under this provision, states were permitted to enroll Medicaid recipients in prepaid, capitated health plans only if Medicare and Medicaid enrollment did not exceed fifty percent of the total enrollment and if the plans were federally qualified HMOs or were based at federally funded community health centers.¹¹⁴ The HMO restrictions had been developed in response to unregulated Medicaid contracting with prepaid health plans in

caid through vouchers or cash benefits, see Pear, *supra* note 101. For examples of continued legislative and executive struggle over Medicaid policy, see the discussion of waiver administration, at-risk contracting, and health insuring organizations (HIOs) *infra* text accompanying notes 150-203. In addition to the obvious avenues of influence through formal executive department policies and appointments, the White House and the Office of Management and Budget (OMB) have apparently played a role in particular health policy issues such as the Medicaid waiver program in Arizona, discussed *infra* text accompanying notes 165-80. See *Medicaid Issues: Management of Arizona Medicaid Waiver: Hearing Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce* [hereinafter cited as *Medicaid Issues*], 98th Cong., 2d Sess. 203-04 (1984) (testimony of Michael Zimmerman, Assoc. Dir., Human Resources Div., United States General Accounting Office (GAO)) [hereinafter cited as Zimmerman/GAO testimony] (acknowledging White House policy support for "testing competition and market force in the health area" but denying any "political interference" or "compromise" of the Health Care Financing Administration's (HCFA) "professional judgment"); *id.* at 234-41 (colloquy between Congressman Sikorski and Patrice Feinstein, HCFA Assoc. Admr. for Policy, regarding OMB role in HCFA decisions regarding Medicaid waivers). See also J. CHRISTIANSON & D. HILLMAN, *supra* note 90, at 70, 71 (discussing OMB and White House role in approval of AHCCCS waiver); *Health Financing: Medicaid Community Care Waiver: Hearing Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 99th Cong. 1st Sess. 65, 65-67, 202-310 (1985) (detailing OMB involvement in Medicaid waivers under Pub. L. No. 97-35, § 2176, 95 Stat. 812 (1981), adding § 1915(c) to the Social Security Act, codified at 42 U.S.C. § 1396n(c) (1982)).

113. Social Security Act § 1903(m), 42 U.S.C. § 1396b(m) (1980), added to the Social Security Act by the Health Maintenance Organization Amendments of 1976, Pub. L. 94-460, § 202(a), 90 Stat. 1957 (1976).

114. See Social Security Act §§ 1903(m)(2)(A)(iii), (1)(A)(iii), and (2)(B) (1976), 42 U.S.C. § 1396b(m)(2)(A)(iii), (1)(A)(iii), and (2)(B) (1976) (embodying the 50% rule, the federal qualification requirement, and the exceptions for federally funded community health centers and certain other entities respectively). The numerous requirements for "federal qualification" of HMOs, set out in 42 U.S.C. § 300e (1976), include restrictions on sub-contracting, requirement of consumer representation on the policymaking board, availability of a grievance procedure, maintenance of community rating, and provision of health education and health maintenance information to each member. See Mullen & Schneider, *The Health Maintenance Organization Amendments of 1976: Implications for the Poor*, HEALTH L. PROJECT LIB. BULL., Jan. 1977, at 1, 6; see also SQUARRELL/NGA, *supra* note 13, at 3 (discussing the pre-1981 provisions of § 1903(m)).

California in the early 1970's, under then-Governor Reagan, which had resulted in serious underservice, misrepresentation, and profiteering.¹¹⁵ The second was the Medicaid recipient's right to freedom of choice of any qualified provider who agreed to supply services, embodied in section 1902(a)(23) of the Social Security Act.¹¹⁶ The Secretary of Health and Human Services (HHS) had (and continues to have) authority under section 1115 of the Social Security Act¹¹⁷ to waive these requirements to enable the states to carry out demonstration projects. Relatively few states had pursued such projects before 1981, perhaps because they required a formal research design and evaluation.¹¹⁸ Taken together, the provisions on at-risk contracting and freedom of choice insured that Medicaid recipients could only be offered voluntary enrollment in plans that also served privately insured patients and that met federal regulatory standards.¹¹⁹

The Omnibus Budget Reconciliation Act of 1981 (OBRA)¹²⁰ involved a complex legislative struggle over at-risk contracting, freedom of choice, and the extent of the federal administrative role. The Republican-controlled Senate, supporting much but not all of the administration's proposals,¹²¹ passed a bill repealing section

115. See, e.g., S. REP. NO. 749, 95th Cong., 2d Sess. 37-38 & *passim* (1978); *Prepaid Health Plans: Hearings Before the Permanent Subcomm. on Investigations of the Sen. Comm. on Government Operations*, 94th Cong., 2d Sess. 335 & *passim* (1976) (testimony of Mr. David Vienna); Mullen & Schneider, *supra* note 114, at 5. For additional discussion of the problems with unregulated Medicaid at-risk contracting in California, and analysis of the relevant pre-1976 provisions of federal and state law, see Schneider & Stern, *supra* note 17.

116. Social Security Act § 1902(a)(23), 42 U.S.C. § 1396(a)(23) (1982), discussed *supra* note 60.

117. 42 U.S.C. § 1315 (1982).

118. Section 1115(a), 42 U.S.C. § 1315(a) (1982) authorizes the Secretary of HHS to waive "[a]ny of the requirements of section . . . 1396a" and to include as expenditures costs otherwise excludable under § 1396b, including the at-risk contracting requirements. According to a House Committee Report, waivers under § 1115 can be granted only in order to test a "unique" approach to delivery and financing of Medicaid services, combined with a detailed research methodology and comprehensive evaluation. See H.R. REP. NO. 158, 97th Cong., 1st Sess. 307 (1981); cf. 45 C.F.R. § 282.41 (1985) (requiring evaluation of demonstration projects); SQUARRELL/NGA, *supra* note 13, at 2; but see *Crane v. Matthews*, 417 F. Supp. 532 (N.D. Ga. 1976) (holding that Secretary of HHS has broad discretion to grant waivers under § 1115). Extensive discussion of and materials concerning HHS's standards and procedures with respect to § 1115 waivers can be found in *Medicaid Issues*, *supra* note 112.

119. However, relatively few such plans were interested in participation. See *supra* text accompanying note 90.

120. Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981).

121. See Omenn, *supra* note 12, at 2-19 to 2-20 (noting that the Republican Senate supported the administration proposal for a firm limit on federal Medicaid expenditures and for nearly unfettered discretion at the state level, but raised the five percent cap to nine percent, included some protections for pregnant women and children, and sought significant budget

1903(m), which would have given the states unregulated discretion to engage in at-risk contracting, including establishment of Medicaid-only at-risk health plans.¹²² In contrast, the Democratic-controlled House of Representatives' bill amended section 1903(m) to give the states somewhat greater flexibility by raising the Medicare/Medicaid enrollment ceiling from fifty to seventy-five percent¹²³ and to increase protections for patients by adding provisions regarding financial solvency, nondiscrimination on the basis of health status, and voluntary disenrollment by patients.¹²⁴ The Conference Committee rejected the Senate's attempt to repeal section 1903(m) and accepted the House bill with one major modification. This modification allowed the states to contract with plans that were not federally qualified HMOs if they met certain requirements as to accessibility of services and financial solvency.¹²⁵

However, the struggle over at-risk contracting occurred not only on the logical battleground of section 1903(m), but also around the freedom-of-choice provision, section 1902(a)(23). Here, too, the Senate bill in effect provided for total repeal,¹²⁶ while the House bill authorized the Secretary of HHS to waive the freedom-of-choice (and certain other) provisions (but *not* the at-risk contracting requirements of section 1903(m)), to enable the states to establish case management systems.¹²⁷ Again, the Conference Committee rejected the Senate bill and appeared to adopt the House approach with minor modifications.¹²⁸ However, the text of the law as enacted—known as section 1915(b) of the Social Security Act¹²⁹—authorized the Secretary to waive the requirements of *both* section

savings from Medicare, despite the fact that the administration had exempted Medicare from budget cuts).

122. S. 1377, § 724(b), 97th Cong., 1st Sess. (1981); *see also* S. REP. NO. 139, 97th Cong., 1st Sess. 476-77, *reprinted in* 1981 U.S. CODE CONG. & AD. NEWS 396, 743.

123. *See* H.R. 3982, § 6330(a)(2), 97th Cong., 1st Sess. 127 CONG. REC. 14,356, 14,413 (1981).

124. H.R. 3982, § 6330(a), 97th Cong., 1st Sess., 127 CONG. REC. 14,356, 14,413 (1981).

125. *See* HOUSE CONF. REP. NO. 208, 97th Cong., 1st Sess. 968-69 (1981), *reprinted in* 1981 U.S. CODE CONG. & AD. NEWS 1010, 1330-31.

126. The Senate bill would have permitted the states to restrict recipients' choice of health care providers as long as the restrictive arrangements were cost-effective, based upon reasonable payments, and assured that recipients had "reasonable access to services" through providers who met "all applicable [state] standards." S. 1377, § 724(a), 97th Cong., 1st Sess. (1981); *see also* S. REP. NO. 139, 97th Cong. 1st Sess. 476-77, *reprinted in* 1981 U.S. CODE CONG. & AD. NEWS 396, 742-43. For discussion of why the apparent protections for patients were unlikely to be effective, *see infra* text accompanying notes 135-40.

127. H.R. 3982, § 6326(a), 97th Cong., 1st Sess., 127 CONG. REC. 14,356, 14,411 (1981).

128. *See* HOUSE CONF. REP. NO. 208, 97th Cong., 1st Sess. 964 (1981), *reprinted in* 1981 U.S. CODE CONG. & AD. NEWS 1010, 1326.

129. 42 U.S.C. § 1396n(b) (1982).

1902 (which includes the freedom-of-choice provision) *and* section 1903(m) (the HMO contracting provision) as may be necessary to implement a case management system.¹³⁰ The Secretary now had the authority to accomplish by waiver what the Senate had attempted to achieve by statutory amendment: a grant of authority to the states to mandatorily assign Medicaid recipients to at-risk health plans without the protections of section 1903(m). In the next session's Tax Equity and Fiscal Responsibility Act of 1982¹³¹ (TEFRA), Congress quickly deleted the Secretary's authority to waive the provisions of section 1903(m),¹³² explaining that it had been "an erroneous statutory reference."¹³³ However, HHS continued to circumvent the section 1903(m) requirements until 1986 through the concept of a "health insuring organization" (HIO).¹³⁴

The struggle between the Senate and the House concerning the degree of federal control over state Medicaid programs involved not only substantive requirements, but also differing conceptions of the federal administrative role. The Senate bill repealing patient freedom of choice, for example, required state programs restricting choice to assure that Medicaid recipients "have reasonable access to services [through providers] which meet all applicable standards under the State plan . . ."¹³⁵ Enforcing this provision, however, would have been very difficult. Aside from the discretionary na-

130. OBRA, Pub. L. No. 97-35, § 2175(b), 95 Stat. 357, 810, *adding* § 1915(b) to the Social Security Act. This section also permitted waivers of federal requirements to allow a locality to act as a "central broker" in assisting recipients in selecting among competing health plans, to share with recipients cost savings from more cost-effective care through provision of additional services, and to restrict recipients to particular cost-effective providers. Other subsections of § 1915 permit, *inter alia*, the states to engage in competitive bidding for laboratory services, § 1915(a)(1)(B); to restrict recipients who have abused the program through unnecessary use to particular providers, § 1915(a)(2)(A); and to suspend providers who have abused the program by providing unnecessary services or below-quality care, § 1915(a)(2)(B).

131. Pub. L. No. 97-248, 96 Stat. 324 (1982).

132. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(19)(A), 96 Stat. 324, 380. Thus, after August 1982, the Secretary of HHS could waive only the freedom-of-choice requirement and certain other provisions of § 1902 to enable states to establish case management programs.

133. H.R. REP. NO. 757, 97th Cong., 2d Sess. 15 (1982). The report of the House Committee on Energy and Commerce further stated that "[i]t was never the intent of the [1981] Conference to authorize" the waiver of the at-risk contracting requirements. *Id.* at 16. The Conference Report accepted the House position on § 1903(m), subject to "grandfathering in" those waivers that were in effect prior to August 10, 1982. HOUSE CONF. REP. NO. 760, 97th Cong., 2d Sess. 440, *reprinted in* 1982 U.S. CODE CONG. & AD. NEWS 781, 1220.

134. *See infra* text accompanying notes 181-99.

135. S. 1377, § 724(a), 97th Cong., 1st Sess. (1981).

ture¹³⁶ and inadequate remedies¹³⁷ of federal administrative enforcement, the Senate bill did not require the Secretary of HHS to develop any operational standards, or to gather any data, concerning "reasonable access" to care through PCCM and other cost-containment programs.¹³⁸ Thus even an HHS Secretary inclined to enforce these requirements—or a Medicaid recipient seeking judicial enforcement directly against a state agency¹³⁹—would have faced great difficulties in defining the applicable legal standard and proving a violation.¹⁴⁰

Unlike the Senate bill, which permitted states to implement mandatory cost-containment programs and put the burden of monitoring and challenging them on providers and recipients, the House bill, as explained by the House Subcommittee on Health and the Environment,¹⁴¹ required the states "to document the cost-effectiveness and program impact of their desired changes" to HHS *before* implementing their programs.¹⁴² In considering state waiver requests, the House Committee intended the Secretary's broadened waiver authority "only [to] be used to approve waivers that assure that access to care is maintained or improved for Medicaid benefi-

136. See *Arthur C. Logan Memorial Hosp. v. Toia*, 441 F. Supp. 26 (S.D.N.Y. 1977).

137. See *id.* at 27 ("The Secretary can withhold payment or he can negotiate with a State. He cannot compel compliance [with federal law].").

138. The Senate bill also addressed quality and access by requiring state programs limiting recipient freedom of choice to provide for "reasonable payment based upon comparison of costs at which services of proper quality may be obtained and are actually available . . ." S. 1377, § 724(a). Again, however, HHS was not required to develop standards or data to make enforcement feasible. Moreover, the bill provided that recipients be assured reasonable access to "providers which meet all applicable standards under the State plan . . ." *Id.* This provision in effect delegated the quality issue to the states themselves.

139. See, e.g., *Bass v. Rockefeller*, 331 F. Supp. 945 (S.D.N.Y. 1971), discussed in Rosenblatt, *supra* note 64, at 290-91.

140. For analogous problems encountered by low-income patients seeking to enforce the Hill-Burton Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946), codified at 42 U.S.C. §§ 291-291o (1982), see *Perry v. Greater Southeast Community Hosp. Found.*, No. 725-71, slip op. (D.D.C. June 28, 1972), discussed in Rosenblatt, *supra* note 64, at 273-76.

141. The Medicaid program, and most other federal health financing and services programs except the hospitalization part (Part A) of Medicare, are under the substantive jurisdiction of the House Committee on Energy and Commerce, chaired by John Dingell of Michigan, and its Subcommittee on Health and the Environment, chaired by Henry Waxman of California. Omenn, *supra* note 12, at 2-19. Under the congressional budget process, the House Budget Committee sets overall spending goals but permits the substantive committees and subcommittees to allocate the specified amounts within programs and to draft the relevant budget legislation and reports. See HOUSE COMM. ON THE BUDGET, THE CONGRESSIONAL BUDGET PROCESS: A GENERAL EXPLANATION 15 (Comm. Print 1986).

142. H.R. REP. NO. 158, 97th Cong., 1st Sess. 308 (1981). The House bill did "streamline" the pre-1981 waiver process. *Id.* For discussion of waiver standards under Social Security Act § 1115, 42 U.S.C. § 1315 (1982), see *supra* note 118.

ciaries."¹⁴³ The House bill, particularly in light of the House Committee Report accompanying it, thus relied significantly on federal administrative enforcement to reconcile cost containment with the access and quality goals of patient-centered care.

The waiver provision as finally enacted—section 1915(b) of the Social Security Act—was in most respects a strengthened version of the House bill. The House Committee's emphasis on maintaining access to and quality of care was transferred from the committee report to the statute itself, so that in reviewing waivers the Secretary was now to consider not only whether care was cost-effective and efficient,¹⁴⁴ but also whether the waiver proposal would "substantially impair access to . . . [medical] services of adequate quality where medically necessary."¹⁴⁵ Moreover, the Secretary was directed to "monitor the implementation of waivers . . . to assure that the requirements . . . are being met . . ."¹⁴⁶ Congress's legislative intent, as expressed in the statute and legislative history, was thus reasonably clear: the Secretary of HHS was to play a significant role in protecting the goals of access and quality. At the same time, the long history of federal nonenforcement of Medicaid requirements on behalf of recipients¹⁴⁷ and the preferred policies of the Reagan administration¹⁴⁸ suggested that the waiver authority could and would pose a significant threat to the patient-centered ideal.¹⁴⁹

143. H.R. REP. NO. 158, 97th Cong., 1st Sess. 308 (1981). The House Committee Report also stated that "while the Committee appreciates the need for States to realize economies in their Medicaid programs and desires, through waivers . . . to accord States with the flexibility to make such economies, the Committee is greatly concerned that such waivers are not to be used to substantially impair access to care for all recipients. Access to quality health care services that are sufficient in amount to meet genuine needs of all recipients should be maintained and services should be available from providers that are sufficient in number and location so as to be reasonably accessible to all recipients." *Id.* at 311.

144. Social Security Act § 1915(b), 42 U.S.C. § 1396n(b) (1982). Under this section, the Secretary must also find the waiver to be "not inconsistent with the purposes of this subchapter [the Medicaid statute]." *Id.* For judicial interpretation of a similar statutory provision granting the Secretary broad discretion, see California Welfare Rights Org. v. Richardson, 348 F. Supp. 491 (N.D. Cal. 1972).

145. Social Security Act § 1915(b)(1), 42 U.S.C. § 1396n(b)(1) (1982).

146. Social Security Act § 1915(e)(1), 42 U.S.C. § 1396n(e)(1) (1982).

147. See, e.g., Rosenblatt, *supra* note 64, at 286-303; R. STEVENS & R. STEVENS, *supra* note 6.

148. See *supra* text accompanying notes 99-112.

149. In this context, one can distinguish between legislative intent as to what should occur, embodied in the text and legislative history of the statute, and political expectations about what is likely to occur. According to Gilbert Omenn, Dean of the University of Washington School of Public Health & Community Medicine, and a close analyst of OBRA's legislative history, Congressman Henry Waxman, the Chairman of the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, proposed the waiver provision "to bring . . . state changes into the open, to buy time for assessment of

C. *The Administration of Medicaid Waivers for PCCM*

Federal regulation of the waiver process depends on the meaning given to the key terms in section 1915(b): "cost-effective and efficient"¹⁵⁰ and "substantially impair access" to services of "adequate quality."¹⁵¹ These terms were virtually undefined in the statute or legislative history,¹⁵² thereby placing great responsibilities on the Secretary of HHS, the Health Care Financing Administration (HCFA) (the component of HHS responsible for Medicaid) and the state Medicaid agencies. Given the history of at-risk contracting in Medicaid,¹⁵³ the innovative nature of the enterprise, and the general tension between PCCM's financial incentives and the patient-centered ideal,¹⁵⁴ protection of access and quality depends on careful definition of the crucial regulatory terms and on clear operational standards for implementing them. Similar issues arise in HCFA's administration of demonstration project waivers under section 1115, which contains even less guidance in its statutory text and legislative history.¹⁵⁵

With respect to section 1915(b), HCFA issued "interim final regulations" in October 1981¹⁵⁶ and final regulations in May 1983.¹⁵⁷ The agency stated its general approach to its waiver-approval role as trying

to afford States the greatest possible flexibility and opportunity

proposals in the affected states as well as by the Health Care Financing Administration, and to build a record from which state actions could be evaluated later." Omenn, *supra* note 12, at 2-29.

150. Social Security Act § 1915(b), 42 U.S.C. § 1396n(b) (1982).

151. *Id.* at § 1396n(b)(1).

152. The one partial exception is "access." The Senate bill referred to "reasonable access to services (taking into account geographic location and reasonable traveltime) . . ." S. 1377, 97th Cong., 1st Sess. § 724(a) (1981). The House Committee Report referred to "the availability of services during reasonable time periods and within reasonable geographic distance of the residence of the Medicaid beneficiaries." H.R. REP. NO. 158, 97th Cong. 1st Sess. 308 (1981).

153. See *supra* text accompanying notes 114-15; Dallek, *supra* note 2, in this Symposium.

154. See *supra* text accompanying notes 69-71.

155. Section 1115(a), 42 U.S.C. § 1315(a) gives the Secretary authority to waive any requirement of § 1396a "to the extent and for the period he finds necessary to enable" a state to carry out a "demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid statute]." This provision was enacted by the Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 122, 76 Stat. 172, 192 (1962), before the enactment of Medicaid itself. Its legislative history simply repeats the statutory terms. See S. REP. NO. 1589, 87th Cong., 2d Sess., reprinted in 1962 U.S. CODE CONG. & AD. NEWS 1943, 1961-62. The references to the Medicaid statute were added by the Social Security Amendments of 1965, Pub. L. No. 87-97, § 121(c)(3), 79 Stat. 286, 352 (1965).

156. See 46 Fed. Reg. 48,524 (1981).

157. See 48 Fed. Reg. 23,212 (1983) (codified at 42 C.F.R. § 431).

for innovation . . . consistent with the statutory requirements. We have therefore decided to minimize federal prescription of definitions and procedures . . . [and] do not intend . . . to compel [states] to meet unnecessary burdensome regulatory requirements Instead, we will permit each State to determine its own program content and administration, consistent with the law. We will impose no requirements or criteria for waiver approval or compliance beyond those specified in the statute.¹⁵⁸

At first glance, these statements may appear to be reasonable administrative implementation of a Congressional compromise about the degree of state discretion. The text of the regulations reveal, however, that what HCFA means is that many of its regulations will simply repeat verbatim the literal statutory terms.¹⁵⁹ The regulations do require a state agency seeking a waiver to "document in the waiver request and maintain data regarding [cost effectiveness, the] effect on recipients regarding access to care and quality of services, [and] the projected impact of the program."¹⁶⁰ "Cost effectiveness" and "efficiency" are defined simply as "reducing costs or slowing the rate of increase and maximizing outputs or outcomes per unit of cost,"¹⁶¹ while "substantially impair access" and "adequate quality" are not defined at all, despite public requests for clarification.¹⁶² HCFA thus left itself free to decide on a case-by-case basis, without clear standards, whether a state waiver request was "consistent with the statutory requirements."¹⁶³ HCFA pursued a similar policy with respect to section 1115 waivers by issuing no Medicaid regulations.¹⁶⁴

158. 46 Fed. Reg. 48,524 (1981).

159. Thus both the interim and final rules simply repeat the statutory clause that a Medicaid recipient's choice of provider may be restricted under a PCCM waiver "provided that [those] restrictions do not substantially impair access to [medical care] services of adequate quality where medically necessary." 42 C.F.R. § 431.55(c), *reprinted in* 46 Fed. Reg. 48,528 (1981) and 48 Fed. Reg. 23,222 (1983). Indeed, HCFA itself noted that the "regulations merely restate the statute . . ." 48 Fed. Reg. 23,215 (1983).

160. 42 C.F.R. § 431.55(b)(2) (1985).

161. *See* 42 C.F.R. § 431.55(f)(2) (1985).

162. *See* 48 Fed. Reg. 23,215, 23,218 (1983) (refusal by HHS, in response to public comments on interim final regulations, to provide more detailed guidance and definitions, to promulgate performance standards, or to regulate the qualifications of case managers).

163. 46 Fed. Reg. 38,524 (1981); 48 Fed. Reg. 23,212 (1983). *See also* 48 Fed. Reg. 23,215 (1983) (refusal by HHS to promulgate performance standards); UNITED STATES DEPT. OF HHS, HEALTH CARE FIN. ADM'N. (HCFA), STATE MEDICAID MANUAL § 2108 (1985) [hereinafter cited as STATE MEDICAL MANUAL] (noting that HCFA "evaluates waiver requests on a State-by-State basis. . .").

164. *See Medicaid Issues*, *supra* note 112, at 245 (letter from Patrice Feinstein, Associate Administrator for Policy, HCFA, to Congressman Henry Waxman (Aug. 10, 1984), stating that "[t]here are no regulations which govern the section 1115 waiver review and approval process."); for internal HCFA materials on § 1115 waivers, see *id.* at 325-47. The only HHS

HCFA's conception of its regulatory role under the waiver statutes is most clearly documented with respect to one of the largest and most ambitious projects, the Arizona Health Care Cost Containment System (AHCCCS). Before 1982, Arizona was the only state to have no Medicaid program at all, relying on "free care" public hospitals and clinics with many of the characteristics of the traditional dual-track system to provide health care to 380,000 residents with incomes below the poverty line.¹⁶⁵ Seeking, in the words of a HCFA associate administrator, "to avoid the perverse incentives [of an open-ended fee-for-service system] . . . and provide high quality care to the poor in a cost-effective manner," Arizona received a section 1115 waiver in July 1982 to establish a statewide prepaid PCCM system in which providers would competitively bid for local contracts under the administration of a for-profit contractor.¹⁶⁶ Beginning operations in October 1982, by March of 1984 AHCCCS had enrolled about 85,000 Medicaid recipients, 16,000 federally-covered Indians, and 60,000 low-income patients financed entirely by the state, at a projected total cost through September 1984 of \$284.2 million, of which the federal share was \$176.3 million.¹⁶⁷

To implement this massive and, in the words of Governor Babbitt, "radical experiment,"¹⁶⁸ both Arizona and HCFA turned to

regulations on § 1115 waivers concern demonstration projects for recipients under the AFDC program. See 45 C.F.R. § 282 (1985).

165. The pre-1982 Arizona system included seven state and county acute care general hospitals, 20 state and county primary care clinics, and 39 non-profit community hospitals that together provided uncompensated care worth approximately \$55 million. See Blendon, *supra* note 65, at 1161. Blendon and his colleagues report that Arizona's pre-1982 system was characterized by significant underservice and financial barriers to care; for example, low-income Arizona children had 40% fewer visits to a physician than low-income children in the rest of the United States, even though the health status of the two groups was comparable. Similarly, low-income Arizona residents were twice as likely to report refusal of care for financial reasons than their counterparts in other states. See *id.* at 1162-63. County residence requirements for free hospital care, another characteristic of the traditional dual-track system, were declared unconstitutional in *Memorial Hosp. v. Maricopa County*, 415 U.S. 250 (1974). Additional material on the pre-1982 Arizona system can be found in J. CHRISTIANSON & D. HILLMAN, *supra* note 90, at 14-23.

166. *Medicaid Issues*, *supra* note 112, at 222-24 (testimony of Patrice Feinstein, Associate Administrator for Policy, HCFA) [hereinafter cited as Feinstein/HCFA testimony]. Descriptions and analyses of the AHCCCS program can be found in J. CHRISTIANSON & D. HILLMAN, *supra* note 90; Brecher, *Medicaid Comes to Arizona: A First Year Report on AHCCCS*, 9 J. HEALTH POL., POL'Y & L. 411, 415 (1984); Babbitt & Rose, *Building A Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243, 263 (1986).

167. *Id.* at 161-62 (background information prepared by subcommittee staff).

168. *Id.* at 165 (statement of Governor Bruce Babbitt) [hereinafter cited as Babbitt testimony].

the private sector with a strong belief in the capacity of competitive bidding and for-profit management to achieve access, quality, and cost-containment goals.¹⁶⁹ The state and HCFA sought what Governor Babbitt termed a "turnkey contract to the private sector,"¹⁷⁰ i.e., a contract with a private, for-profit entity that would enable the state to simply "turn the key" and walk away from the Medicaid program. The result was, in Governor Babbitt's words, a managerial "nightmare," and the state resumed administration of the program in May 1984.¹⁷¹ Governor Babbitt's June 1984 testimony to the House Subcommittee on Health and the Environment was that "my advice to this committee, to HCFA, . . . lesson No. 1" is to move slowly and incrementally in setting up demonstrations, and avoid "turnkey contracts" with the private sector.¹⁷²

HCFA's administration of the access and quality components of the AHCCCS project are of particular interest. According to the General Accounting Office (GAO) investigation, "[d]elivering quality and appropriate care" was a "primary objective" of the project, and HCFA required that contracting providers develop written quality assurance plans, that the state check and analyze detailed utilization data, that the state and providers establish beneficiary grievance procedures, and that the state conduct medical audits.¹⁷³ Yet by May 1984—twenty months after startup of the project—virtually none of these quality assurance mechanisms were functioning properly. The GAO concluded that "neither HCFA nor the State has adequate information to be assured that quality and appropriate care is being provided."¹⁷⁴

Despite the absence of utilization data, HCFA and Arizona maintained, on the basis of a consumer satisfaction survey and a medical review carried out in late 1983, that AHCCCS patients "were receiving care at least as good as that received by private patients in the same plans."¹⁷⁵ But the GAO reported that one of HCFA's own medical advisors, who evaluated the medical review process relied on by HCFA and the state, found that the quality of care reflected in the medical records was "generally substan-

169. *See id.* at 181 (Babbitt testimony); Dallek, *supra* note 2, in this Symposium; Brecher, *supra* note 166, at 415, 420; Babbitt & Rose, *supra* note 166, at 263; J. CHRISTIANSON & D. HILLMAN, *supra* note 90, at 33.

170. *Medicaid Issues*, *supra* note 112, at 181, 166 (Babbitt testimony).

171. *Id.* at 163 (staff background), 166 (Babbitt testimony).

172. *Id.* at 181 (Babbitt testimony).

173. *See id.* at 187 (Zimmerman/GAO testimony).

174. *Id.* at 187 (Zimmerman/GAO testimony); *see also id.* at 199-219.

175. *Id.* at 228 (Feinstein/HCFA testimony), 175 (Babbitt testimony).

dard;"¹⁷⁶ that the reviewing physicians were inclined to understate their findings, in part because the reviewing physicians believed that "these are less desirable places to practice medicine and it is not realistic to expect top practitioners to reside there;"¹⁷⁷ that the reviewing physicians had been allowed only one-eighth of the time normally spent for medical review of less problematic providers;¹⁷⁸ and that the review criteria were very general, not quantified, and did not evaluate the reasonableness or correctness of diagnosis.¹⁷⁹ For all of these reasons, the quality and appropriateness of care under AHCCCS remained a sharply disputed question. A second medical audit, carried out in August and September 1984, improved the systematic quality of the review and led to "the correction of several areas of deficiency on a program-wide basis."¹⁸⁰

Against this background, it is remarkable that one of HCFA's major policy initiatives in the Medicaid waiver area between 1982 and 1986 involved encouraging the states to turn over large parts of their Medicaid administration to private, at-risk contractors under programs designed to exempt them from what the House Subcommittee termed the "minimal" at-risk contracting protections of section 1903(m).¹⁸¹ Although Congress had twice indicated its intent to maintain those protections—once during the 1981 passage of OBRA and again in the 1982 enactment of TEFRA¹⁸²—HCFA began actively to promote the concept of the "Health Insuring Organization" (HIO) as a way to avoid them. As originally conceived, an HIO is like a fiscal intermediary—such as Blue Cross or a commercial insurance company—that contracts with a state Medicaid agency to process and pay providers' bills under the fee-for-service system. Unlike an intermediary, however, the HIO is paid on an at-risk capitation basis. It receives a fee for each enrollee and takes a

176. Problems noted by the HCFA Chief Medical Advisor included "numerous [medical history] notes lacking *any* physical examination;" lack of continuity of care (e.g., diagnostic tests ordered in one visit ignored in the next); and "reluctance to refer to specialists when patients failed to respond to treatment (e.g., a ten month old infant who had more than eight sequential ear infections, a body weight of 14 pounds and *no referral* for specialist pediatric evaluation)." Memorandum from Arnold Milstein, M.D., Chief Medical Advisor, HCFA, to John O'Hara, Associate Regional Administrator, Program Operations (Oct. 19, 1983), reprinted in *Medicaid Issues*, *supra* note 112, at 218 (emphasis in original).

177. *Id.* at 218. The reviewing physicians also stated that "attenuation of critical comments was essential to gaining necessary provider cooperation . . ." *Id.*

178. *See id.* at 218.

179. *See id.* at 219.

180. Bostrom & Rafferty, *Quality of Care Under AHCCCS*, 143 WEST. J. MED. 6, 7 (Supp. 1985).

181. H.R. REP. NO. 757, 97th Cong., 2d Sess. 16 (1982).

182. *See supra* text accompanying notes 127-34.

risk of loss or gain depending on the level of provider costs.¹⁸³ Because under this model an HIO does not “provide” medical care, but only “pays” for it, HCFA took the position that HIOs were exempt from all the contracting and patient protection requirements of section 1903(m).¹⁸⁴ After Congress eliminated the Secretary’s authority under section 1915(b) to waive the section 1903(m) protections,¹⁸⁵ HCFA invited the states to structure their section 1915(b) waiver requests in the form of HIOs and thereby achieve the same result of largely unregulated at-risk contracting between the state and the HIO, as well as less internal control by the HIO of its subcontracting providers.¹⁸⁶

Although HCFA claimed that this strategy was “consistent with the law and the intent of Congress,”¹⁸⁷ this claim is open to the strong objection that the HIOs being approved in Louisville, Kentucky, and Philadelphia, Pennsylvania, were functioning almost identically to HMOs. As with HMOs, the HIO primary care providers were at financial risk under standards designed by the HIO, with complex reimbursement arrangements that “skirt[ed] along the edges of the TEFRA prohibition.”¹⁸⁸ TEFRA had limited non-

183. See 42 C.F.R. § 434.2 (1985) (defining health insuring organization); U.S. GENERAL ACCOUNTING OFFICE, MEDICAID REQUIREMENTS: HEALTH INSURING ORGANIZATIONS 1 (1985) [hereinafter cited as U.S. GENERAL ACCOUNTING OFFICE]; Dallek & Wulsin, *supra* note 12, at 283.

184. See STATE MEDICAID MANUAL, *supra* note 163, at § 2102(F); U.S. GENERAL ACCOUNTING OFFICE, *supra* note 183, at 1. HCFA’s position is based on the wording of § 1903(m)(2)(A), 42 U.S.C. § 1396(m)(2)(A), which prohibits federal matching funds to be used for at-risk payment for services “provided by any entity which is responsible for the provision” of a range of services (emphasis supplied).

185. See *supra* note 132.

186. HCFA’s invitation was published in the Federal Register. Immediately after explaining that, because of TEFRA, the Secretary no longer had authority under § 1915(b) to waive the provisions of § 1903(m), HCFA stated that “[a]lternative arrangements to section 1903(m) waivers may be available to States that would largely meet their objectives consistent with the law and the intent of Congress. HCFA is prepared to assist States in developing alternative arrangements.” 48 Fed. Reg. 23,214 (1983). As an example of this policy, HCFA apparently took an active role in encouraging Pennsylvania to structure the HealthPASS proposal as an HIO. See Roche, *State Launches a New Health System for Poor*, Philadelphia Inquirer, Mar. 3, 1986, at 1-B, col. 6, 3-B (reporting that HHS officials told Pennsylvania officials that “an HIO . . . was like an HMO and could be used exclusively for welfare recipients, according to the law”). The relative lack of required internal control between an HIO and its providers occurs because, in theory, the HIO is not “providing” care, but only “paying” for it; in HCFA’s view the HIO “may [not] assume a medical responsibility for services.” STATE MEDICAID MANUAL, *supra* note 163, § 2102(F).

187. 48 Fed. Reg. 23,214 (1983), discussed in *supra* note 186.

188. Dallek & Wulsin, *supra* note 12, at 283. Indeed, according to a report in the Philadelphia Inquirer, Health and Human Services (i.e., HCFA) officials told Pennsylvania officials that an HIO “was like an HMO and could be used exclusively for welfare recipients, according to the law.” Roche, *supra* note 186, at 3-B.

HMO risk contracts to those that covered only inpatient hospital care or to any two of the other five mandated Medicaid services (such as physicians' services and laboratory/X-ray services).¹⁸⁹ Put simply, an HIO could insulate its subcontracts with physicians from the requirements of section 1903(m) only if the physicians' capitated rate included no more than physicians' services and one other, such as laboratory/X-ray. HIOs such as CitiCare in Louisville and HealthPASS in Philadelphia (both designed by Health America, Inc., to serve 40,000 and 100,000 patients respectively) comply with this limitation as a matter of form but then create two other funds—for specialist referrals and hospitalization—and give physician case managers a share of any accumulated surplus.¹⁹⁰ The result is to create a kind of physician financial risk for hospitalization that is arguably beyond the limits of section 1903(m).

In addition to accepting this strong financial incentive against specialist referrals and hospitalization, HCFA also ran into similar quality assurance and access problems in the CitiCare HIO that characterized the AHCCCS program. According to health policy analyst Bruce Spitz,

[CitiCare's utilization review] plan was never submitted and never developed. Two CitiCare committees set up to address quality of care, and particularly to hear patient complaints, never issued guidelines or sanctioned any providers. No protocol was developed for CitiCare. There were no routine client reviews. The Health America information system that was to assist in the monitoring of quality of care did not become operational until February 1984, eight months after the program had begun enrolling clients The state had abdicated its role to monitor and assure compliance [with quality assurance standards].¹⁹¹

The lack of quality assurance data made it difficult to understand a major statistical anomaly in the CitiCare experience. Although most HMOs achieve reductions in hospitalization compared to the fee-for-service system by reducing hospital admission rates, CitiCare's hospital admission rate per 1,000 clients actually in-

189. TEFRA accomplished this by eliminating the Secretary's authority to waive the at-risk contracting provisions of § 1903(m). See TEFRA, Pub. L. No. 97-248, § 137(b)(19), 96 Stat. 380 (1982). Section 1903(m)(2)(A) itself, 42 U.S.C. § 1396b(m)(2)(A) (1982 & Supp. II 1984) limits federal financial participation in non-HMO at-risk contracts to inpatient hospital care or any two of the other five mandated Medicaid services.

190. See Spitz, *supra* note 12, at 17-18 (discussing CitiCare); HealthPASS, Schedule "B": Payments for Enrollees, Enrollee Limitations (n.d.); cf. Somers, *supra* note 12, at 307-08 (describing a similar physician reimbursement system used by HMO of New Jersey).

191. Spitz, *supra* note 12, at 18.

creased.¹⁹² On the other hand, CitiCare achieved a spectacular reduction in hospital length-of-stay, from an average of 7.9 days before the program began to an average of 3.8 days in the first six months of the program,¹⁹³ thereby raising serious concerns about underservice. According to Spitz,

[i]f clients were not underserved, then three things had to have happened. First, CitiCare was dealing with hospitals that had provided one inappropriate day of care for every necessary hospital day. Second, CitiCare was able to identify that inappropriate care, and third, it was able to eliminate this care within six months.¹⁹⁴

These underservice concerns were highlighted by a federal lawsuit by CitiCare patients against CitiCare and the state alleging violations of the statutory guarantees of access to quality care, as well as the requirements regarding cost effectiveness and efficiency.¹⁹⁵ The suit was dismissed as moot after Kentucky terminated the CitiCare program in June 1984.¹⁹⁶

At the request of the House Subcommittee on Health and the Environment, the GAO investigated HCFA's HIO regulations and reported in November 1985 that they did not specify minimum qualifications for HIOs, quality assurance methods, access assurance standards, the amount of retained profit, utilization and financial reports, or financial and ownership information.¹⁹⁷ Congress then amended section 1903(m) in April 1986 to make clear that an HIO "that does more than simply act as a fiscal agent to review and process claims for payment, but actually arranges with other providers (through subcontract or otherwise) for the delivery of [Medicaid] services" is subject to all the regulatory requirements governing HMOs and other prepaid entities under section 1903(m).¹⁹⁸ Although this provision remedied an important poten-

192. *See id.*

193. *Id.*

194. *Id.*

195. *See Kinley v. CitiCare*, No. C 83-0984 (W.D. Ky., Mar. 6, 1984) (memorandum opinion and judgment dismissing state and individual defendants and causes of action based on federal and state cost-effectiveness provisions, but denying motion to dismiss causes of action based on federal statutory guarantees of access to quality care and constitutional grounds).

196. *See* NHeLP, *Medicaid Primary Care Case Management Systems: What We've Learned*, 18 CLEARINGHOUSE REV. 270, 272 n.12 (1984).

197. *See* U.S. GENERAL ACCOUNTING OFFICE, *supra* note 183, *discussed in* HOUSE CONF. REP. NO. 453, 99th Cong., 1st Sess. 551 (1985).

198. *See* HOUSE CONF. REP. NO. 453, 99th Cong., 1st Sess. 551 (1985); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 9517(c)(1), 100 Stat. 82, 216 (1986).

tial threat to patient-centered care, its "grandfather" clauses left in place several previously-approved HIOs designed to enroll over 100,000 recipients.¹⁹⁹ This is not to suggest that all HIOs will necessarily provide inadequate access and low quality care, but rather that the relative lack of internal and regulatory oversight increases the risk that these problems will occur.

In its regulations and administration under section 1915(b), its HIO policy, and its administration of section 1115 waivers, HCFA has followed a policy of minimal regulation of Medicaid PCCM. Major failures such as the Arizona AHCCCS program between 1982 and 1984 have led to greater intervention in particular cases, but there has been no explicit commitment to change the agency's basic policy orientation. For example, HCFA largely acknowledged at the June 1984 House hearing that it had been unable to monitor access to and quality of care in the AHCCCS program because of the failure of the state to collect relevant information from providers.²⁰⁰ Both the GAO and Governor Babbitt attributed the lack of data at least in part to physician prepayment. Unlike the fee-for-service system, which requires submission of claims in order to obtain payment, the prepaid capitation system contains no such incentive.²⁰¹ In response, HCFA stated that its waiver renewal for AHCCCS would require the state to include in its contracts with providers "a penalty clause to reduce payments to those providers who do not provide accurate, timely encounter data."²⁰² But although lack of quality assurance data because of prepayment is a widespread problem in PCCM systems, HCFA apparently did not incorporate the contract penalty provision into general policy. For example, such penalties were not included in HCFA's waiver guide-

199. HIOs that became operational prior to January 1, 1986, were exempted from the change, and those that had received a § 1915(b) waiver prior to January 1, 1986, were exempted from the 75% ceiling and disenrollment requirements of 1903(m) for the duration of the waiver. See COBRA, Pub. L. No. 99-272, § 9517(c)(2), 100 Stat. 82, 216 (1986). The Secretary of HHS was also authorized to expand and/or reinstate waivers granted under § 1915(b) to two named projects in Oregon and Wisconsin. See COBRA, Pub. L. No. 99-272, §§ 9522, 9524, 100 Stat. 82, 217, 218 (1986). Despite this second round of legislative clarification, the House Budget Committee (and the relevant substantive committees, see *supra* note 141) believe that HCFA is continuing to promote its preference for HIOs in violation of federal law, by granting Philadelphia's HealthPASS and two other HIOs the broader exemptions for pre-1986 "operational" HIOs, when they should qualify (in the House's view) only for the more limited exemptions granted to HIOs that became operational after January 1, 1986. See H.R. REP. NO. 727, 99th Cong., 2d Sess. 124-25 (1986).

200. See *Medicaid Issues*, *supra* note 112, at 187 (Zimmerman/GAO testimony); 227, 229-30 (Feinstein/HCFA testimony).

201. See *id.* at 203 (Zimmerman/GAO testimony), 168 (Babbitt testimony).

202. *Id.* at 227 (Feinstein/HCFA testimony).

lines issued in August 1985.²⁰³

D. *The Consequences of Federal PCCM Policy for the Patient-Centered Ideal*

HCFA's Medicaid PCCM policies have undercut the patient-centered ideal of health care in at least three major ways. First, HCFA (along with some state agencies) has made no effort to apply the statutory goals of access and quality to the structure of the financial incentives themselves. Nothing in sections 1915(b) or 1115 requires HCFA to accept any particular financial incentive designed by a health plan or proposed by a state agency. On the contrary, the widespread recognition of reimbursement systems' influence on physician decisions suggests that "treatment neutral" reimbursement²⁰⁴ and positive financial incentives to achieve access and quality goals should be built into the reimbursement system. Surely the most obvious lesson of the open-ended, fee- and cost-based reimbursement era is the futility of designing strong financial incentives in one direction, and then attempting to counteract them with regulations such as utilization review and health planning. That lesson has been consistently confirmed in early Medicaid PCCM projects such as AHCCCS and CitiCare. Strong financial incentives to deny care—and even information about care—have often overwhelmed efforts to "monitor" and "evaluate" the system months and even years after the risks have occurred.

A second, related threat to the patient-centered ideal has been the weakness of mechanisms to assure access to and quality of care. Aside from restructuring financial incentives, there will likely always be a need for other safeguards, such as protocols, data analysis, peer review, grievance systems, and monitoring by advocates and recipients. Here, too, HCFA could have taken the lead by giving waiver priority and perhaps extra financial support to programs that made serious efforts to develop technically sophisticated and client-responsive systems. Instead, it has been congressional committees and the GAO, together with a small number of state agencies, providers, recipients and their advocates and allies, who have made the major contributions in this area.

203. See STATE MEDICAID MANUAL, *supra* note 163 at §§ 2100-2110. According to an undated memorandum issued by the Pennsylvania state Medicaid agency, providers participating in the Philadelphia HIO (HealthPASS) who fail to submit encounter forms will have their entire monthly capitation allotment withheld. See Pennsylvania Dept. of Public Welfare, Office of Medical Assistance, Quality of Care in HealthPASS, at 3.

204. See Berenson, *supra* note 23.

A third problem has been the new PCCM systems' difficulty in coordinating their activities with providers who specialize in health and social services for the poor. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid, programs for maternal and child health and nutrition, family planning programs, and drug, alcohol, and mental health treatment programs are prominent examples. Many of these programs are funded by HCFA itself or by other divisions within HHS. Yet HCFA has done little to promote coordination among these systems, sometimes with tragic results.²⁰⁵

III. RESPONDING TO THE THREAT TO THE PATIENT-CENTERED IDEAL: TOWARD AN ETHICAL SYSTEM OF MEDICAID PRIMARY CARE CASE MANAGEMENT

Low-income patients have almost always received health care under conditions that undermine the patient-centered ideal.²⁰⁶ Contemporary cost-containment measures such as PCCM could worsen this inferiority by reducing reimbursement, codifying through contracts the separateness of poor people's health care systems, building negative financial incentives into the heart of the doctor-patient relationship, and dismantling countervailing traditions of medical ethics, law, and public policy. The most effective response to this threat—a political reorientation at the national level that would yield universal coverage for adequate health benefits—is not likely to occur during the short term. Nevertheless, political efforts to defend the patient-centered ideal at the national level remain important, as the congressional experience with HIOs and other quality of care issues demonstrates.²⁰⁷

A second possible avenue of response—federal litigation to enforce statutory guarantees of access to and quality of care—is un-

205. A detailed examination of coordination problems in Wisconsin is presented in CENTER FOR PUBLIC REPRESENTATION/COMMUNITY BASED MATERNAL AND CHILD HEALTH PROJECT, *MEDICAID, HMO'S, AND MATERNAL AND CHILD HEALTH* (1986) [hereinafter cited as *MEDICAID, HMO'S, AND MATERNAL AND CHILD HEALTH*]. For an account of a patient death possibly related to an HMO refusal to authorize treatment for drug addiction, see Jones, *HMOs Squeeze the Health Care Dollar*, *Milwaukee J. Mag.*, Apr. 6, 1986.

206. See *supra* text accompanying notes 2-8.

207. On congressional response to HCFA's HIO policy, see *supra* text accompanying notes 181-99. On related congressional initiatives to protect access to and quality of care in the context of cost containment, see COBRA, Pub. L. No. 99-272, §§ 9211 (shortening required effective period for Medicare patients to disenroll in HMOs); 9405 (subjecting HMO services to Medicare patients to Peer Review Organization (PRO) quality of care review); 9403 (authorizing PROs to deny Medicare reimbursement for substandard care).

likely to provide significant protection for patients, at least under current statutory provisions. To be sure, cases involving particular statutory requirements may have merit and even produce victories for patients,²⁰⁸ and litigation that does not yield a victory may still buy valuable time, publicity, and opportunity for negotiation.²⁰⁹ But even at the height of the political and legal movement to legalize welfare rights in the late 1960's and early 1970's, the federal courts were reluctant to review the "substantive adequacy of welfare efforts."²¹⁰ That reluctance has increased in the 1980's.²¹¹ When one adds to this general point the likelihood of great judicial deference to the Secretary's discretion in granting waivers,²¹² the lack of mandatory congressional directions regarding access and quality in section 1915(b) and in section 1115, and the Supreme Court's extremely restrictive approach to enforcing federal statutory provisions perceived as impositions on state budgets,²¹³ the prospects for vigorous federal judicial enforcement of the current access and quality protections appear rather dim. One exception to this prognosis may lie in the enforcement of contracts between states and providers by patients as third-party beneficiaries, because these contracts are often more specific than the federal statute and regulations, or are less exclusively linked to administrative enforcement.²¹⁴

A third area of response lies in the development and application of malpractice law to complex cost-containment systems such as

208. See *Estate of Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984) (Secretary of HHS has a statutory duty to establish an information and enforcement system to ensure that Medicaid-funded nursing homes actually provide high quality medical care).

209. See, e.g., Rosenblatt, *supra* note 64, at 298, 303.

210. Simon, *Rights and Redistribution in the Welfare System*, 38 STAN. L. REV. 1431, 1490 (1986) (citation omitted); see also Rosenblatt, *Legal Entitlement and Welfare Benefits*, in *THE POLITICS OF LAW* 262 (D. Kairys ed. 1982).

211. See, e.g., *Alexander v. Choate*, 105 S. Ct. 712 (1985) (unanimous Supreme Court upholds Tennessee's refusal to pay for more than 14 days of hospitalization under the Medicaid program against challenge that such limit discriminates against the handicapped under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794); *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981) (holding that the "bill of rights" contained in the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6010, does not create enforceable rights and obligations).

212. See *Crane v. Mathews*, 417 F. Supp. 532 (N.D. Ga. 1976); *California Welfare Rights Org. v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972).

213. See *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981).

214. See, e.g., *Fuzie v. Manor Care, Inc.*, 461 F. Supp. 689 (N. D. Ohio 1977) (although a resident of a Medicaid-funded nursing home has no federal cause of action to enforce federal regulations regarding patient transfer against the nursing home, there is a state-law cause of action as a third-party beneficiary because the federal regulations are incorporated into the contract between the state agency and the nursing home).

PCCM, particularly in the light of the detailed contracts between state agencies and providers and among providers themselves. Malpractice law has yet to play a significant role in policing cost containment, particularly for the poor.²¹⁵ On the other hand, one can easily imagine the development of doctrines that enforce primary care physicians' ethical and legal duties to their patients and that also impose a duty of care on physicians and nurses engaged in utilization review and quality assurance to exercise reasonable care on behalf of the patients affected by their actions.²¹⁶

A fourth avenue of response holds out significant promise and is in fact taking place: the development through experience and advocacy of the operational elements of what might be called an "ethical cost-containment system." As a matter of general theory, ethical cost containment represents an effort to take seriously and to reconcile both the need for cost containment and the values of access, quality, and patient-centeredness that form our ideals of health care. Given the history of Medicaid PCCM, three implications are apparent for Medicaid policy: (1) to end, as much as possible, the separation of Medicaid patients from mainstream health institutions, (2) to structure financial incentives and quality assurance programs so as to avoid financially motivated denial of beneficial care, and (3) to promote the values of patient-centered care through patient and provider education and involvement. This involvement might include grievance mechanisms, monitoring programs, and appropriate connections with other providers of health and human services.

These general policies can be translated into operational components of an ethical Medicaid-PCCM system. First, as the National Health Law Program pointed out in Senate testimony, "careful planning is essential for an effective program One would not expect a \$180 million business with 150,000 customers to set up shop in 4 months, but that is exactly what Arizona did [with the

215. See Rosenblatt, *supra* note 97, at 1414-19; S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 19-20 (1978); cf. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, in this Symposium.

216. One case raising these issues was recently decided by a California appellate court. See *Wickline v. State of California*, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986) (reversing a jury award of \$500,000 to a Medicaid patient for loss of a leg allegedly caused by premature hospital discharge, itself said to be caused by the negligent failure of a consulting physician and nurse reviewer working for the state Medicaid utilization review program to authorize the necessary extended hospital stay). For an argument that the legal standard of care should be *diminished* for certain physicians practicing under cost constraints, see Morreim, in this Symposium.

AHCCCS program]."²¹⁷ Crucial planning tasks include setting the capitation rate and other financial incentives and establishing mechanisms for patient enrollment and education, provider enrollment and education, financial disclosure and auditing of providers, data collection, quality assurance, grievance procedures, participation by interested parties in policy development, and coordination with other health and social service systems. These steps may appear to be "obvious," but they have been repeatedly ignored or inadequately handled in many of the Medicaid PCCM programs.²¹⁸

Of particular interest is the role of recipient and advocate participation in the process of planning, implementing, and monitoring PCCM. Analysts of Medicaid PCCM generally agree that "community support appears very important to the success of such programs, especially during implementation."²¹⁹ Yet many programs have been "planned by a small group of responsible individuals from state government who had little time to consider the concerns expressed by certain constituencies . . ."²²⁰ The result in Louisville was a "poor relationship between CitiCare, the local medical society and legal aid and welfare rights organizations . . . with select welfare rights organizers charging CitiCare with lack of cooperation and inadequate health care delivery."²²¹ According to Spitz, this poor relationship was instrumental in the state's ultimate decision to terminate the project.²²² Similarly, the effort to establish a major PCCM project in Boston was blocked at least in part by recipient opposition.²²³

In contrast, the experience of other states—notably Wisconsin

217. *Medicaid Freedom of Choice Waiver Activities: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 2d Sess. 107 (1984) (statement of Judith G. Waxman, J.D., NHeLP, Washington, D.C.) [hereinafter cited as NHeLP testimony], reprinted in NHeLP, *supra* note 196.

218. See, e.g., *supra* text accompanying notes 165-80 (discussion of AHCCS program); NHeLP testimony, *supra* note 217; Spitz, *supra* note 12, at 17-19; Dallek, *supra* note 2, in this Symposium; Center for Public Representation, *Health for Mothers and Children: Options, Problems and Recommendations* (July 1985) (evaluating Wisconsin's Preferred Enrollment Initiative (PEI) as of 1985); Brief in Opposition to the Granting of a Waiver to Pennsylvania's Case Management Proposal, Before the Secretary of Health and Human Services (n.d.); Brief in Opposition to the Supplement of Pennsylvania's Application for a Waiver Under the Social Security Act, Before the Secretary of Health and Human Services (Nov. 12, 1985).

219. D. FREUND, *supra* note 16, at 8; see also Spitz, *supra* note 12, at 17-19.

220. D. FREUND, *supra* note 16, at 8.

221. Spitz, *supra* note 12, at 18.

222. *Id.*

223. See *Medicaid Freedom of Choice Waiver Hearing*, *supra* note 217, at 125 (testimony of Rina K. Spence, former Project Director, Commonwealth Health Care Corp., Boston, Mass.).

and Michigan— demonstrates the positive contributions that can be made by active involvement of Medicaid recipients and their advocates and allies in PCCM programs. In Wisconsin, a coalition of public interest advocates, legal-services attorneys, nurses, county human-services departments, and groups concerned with hunger, nutrition, birth defects, children's health, and family planning have made impressive efforts to monitor the operation of the state's program requiring AFDC recipients to enroll in HMOs and to suggest constructive improvements.²²⁴ In the wake of a tragic death of a five month-old child covered by Medicaid in December 1985, apparently caused by confusion about HMO coverage of emergency care, and the extensive press coverage of this and similar incidents,²²⁵ Wisconsin agreed to significant changes in its HMO contracts for Medicaid patients proposed by consumers and their advocates.²²⁶ These changes included clearer explanations for consumers of emergency care, HMO liability for all subsequent care related to telephone calls to which the HMO fails to respond in thirty minutes, and HMO payment for appropriate diagnostic tests needed to determine if an emergency exists. These changes also include extensive provisions dealing with confidential family planning for adolescents, services for disabled persons, and early and periodic screening for children.²²⁷

Michigan represents what is probably the most serious large-scale effort to reconcile PCCM with the ideals of patient-centered care through financial incentives and recipient and advocate participation. First, rather than impose the strong negative financial incentive of capitation on all providers, Michigan has a carefully

224. See MEDICAID, HMO'S, AND MATERNAL AND CHILD HEALTH, *supra* note 205; Memoranda from Catherine L. Gaylord (Apr. 10 and Mar. 21, 1986) (summarizing advocacy activities during Spring 1986, including detailed suggestions for program evaluation); Memorandum from Carol Huber, Center for Public Interest Representation (Feb. 14, 1986) (listing participants in the coalition).

225. See Manning, *Mother says Infant Died after HMO Refused Care*, Milwaukee Sentinel, Dec. 12, 1985 at 1 col. 1; Manning, *HMO Rule Faulted in Tot's Death*, Milwaukee Sentinel, Feb. 7, 1986, at 1; Jones, *supra* note 205; Jones, *Bitter Pill*, Milwaukee J., Apr. 13, 1986; see also Dallek, *supra* note 2, in this Symposium.

226. See MEDICAID, HMO'S, AND MATERNAL AND CHILD HEALTH, *supra* note 205, at 23-29; Memorandum from Catherine L. Gaylord, Attorney, Center for Public Interest Representation, (Apr. 22, 1986) [hereinafter cited as Gaylord Apr. 22, 1986 Memorandum] (giving detailed summary of changes to protect consumers embodied in the contract between the Wisconsin Dept. of Health and Social Services and HMOs signed Feb. 1, 1986).

227. See citations *supra* note 226. Significant advocacy by legal services programs on behalf of Medicaid patients regarding PCCM has taken place in other states, notably Arizona, California, Kentucky, Ohio, and Pennsylvania. See, e.g., NHeLP, *supra* note 196; Dallek, *supra* note 2, in this Symposium.

graduated system, with full risk capitation for all Medicaid services extended only to large HMOs with a sizeable enrollment and administrative capacity. Smaller primary care clinics receive capitation payment for ambulatory services and can share in the state's savings on hospitalization. Under a third program, known as the Primary Physician Sponsor Program (PPSP), individual primary care physicians serve as case managers and control access to referrals and hospitalization. The primary care physicians are not at financial risk and receive a \$3 per client per month case-management fee up to \$3,000 per month.²²⁸ These physicians must practice "within utilization and cost standards jointly established by the state medical societies and the state Thus as organizational capacity decreases and the likelihood of wide statistical variation among the enrolled patients increases, as it does when the enrolled population declines in size, the state moves from strong financial incentives to direct review and control."²²⁹

In addition to carefully designed financial incentives, Michigan relies heavily on recipient, advocate, and provider participation in policymaking and program implementation. After an initial period of exclusion and opposition, welfare rights organizations and clients were given prominent places on the projects' advisory boards.²³⁰ Moreover, an organization representing Medicaid clients, the Michigan League of Human Services, has a contract with the state agency to monitor the implementation of PPSP. Its contract includes marketing, client enrollment, geographic accessibility, twenty-four hour availability of services, referrals and second opinions, and protection of clients' rights.²³¹ The League has produced impressive surveys and reports on these issues. These reports include such seemingly mundane but actually crucial matters as a "busy signal study" of the PPSP patient service telephone line that showed that 3,790 calls in a typical one-week period could not be completed because the telephone lines were tied up.²³² Many of the problems typical of PCCM remain in the PPSP program, but "[b]y sharing decisionmaking and monitoring powers, the state has created a situation where providers and clients have become vested in

228. Spitz, *supra* note 12, at 19-20.

229. *Id.*

230. See D. FREUND, *supra* note 16, at 6-7.

231. See Spitz, *supra* note 12, at 19; McDonald & Fairgrieve, *Michigan's Experiment with Case Management*, 20 CLEARINGHOUSE REV. 423 (1986).

232. See MICHIGAN LEAGUE FOR HUMAN SERVICES, PHYSICIAN PRIMARY SPONSOR PLAN MONITORING PROJECT, ANNUAL REPORT, SEPT. 1984-AUG. 1985, at 4 (Sept. 1985); McDonald & Fairgrieve, *supra* note 231, at 429 & *passim*.

the programs' success."²³³

The contrasting experiences of Wisconsin, Michigan, Arizona, and Kentucky suggest that rigid dichotomies between "public" and participatory administration on the one hand and "market competition" and financial incentives on the other are unnecessary and counterproductive. In Wisconsin an active coalition of consumer and social services groups has made significant contributions to the state's market-oriented HMO initiative. In Michigan a state Medicaid agency working with providers, Medicaid patients, and advocates and using both regulatory and financial incentives has developed programs that can potentially grapple with the ethical and managerial issues of PCCM. The early experiences of Arizona and Kentucky (and other states as well)²³⁴ suggest that these issues cannot be avoided and that unregulated private administration and at-risk contracting are likely to encounter major problems of cost and quality of care.

IV. MEDICAID PRIMARY CARE CASE MANAGEMENT AND THE POLITICS OF PRIVATIZATION

The development of Medicaid PCCM programs can and should be seen as part of a larger debate over the future of the American welfare state. Without this larger context, it is hard to understand the deep commitment of key federal and state officials to unregulated private management of Medicaid in the face of well-known risks of financial irregularity and low quality care.²³⁵ The debate itself has been heavily shaped by advocates of market competition who have argued strenuously that government efforts to supply, fund, and regulate important services have failed and that what have previously been thought of as public functions should be turned over to private, for-profit entities.²³⁶ But the Medicaid PCCM experience suggests that the general concept of "privatization" does not so much resolve questions about redistribution and government role as cast them in a new language for continued controversy. As Paul Starr writes,

Privatization, as a general idea, describes a direction of change, but does not denote a specific origin or destination. Its specific

233. Spitz, *supra* note 12, at 20.

234. See Dallek, *supra* note 2, in this Symposium.

235. See, e.g., *supra* text accompanying notes 153, 217-18; Dallek, *supra* note 2, in this Symposium. See also Rosenblatt, *supra* note 2, at 655-61; R. STEVENS & R. STEVENS, *supra* note 6, at 53 (making analogous point about early years of Medicaid).

236. See, e.g., A. ENTHOVEN, *supra* note 1; P. STARR, *supra* note 2, at 417-19.

uses depend on the point of departure [i.e., the public/private balance in previous institutional arrangements] And it is a critical question whether moving from public to private in the sense of state to non-state entails a movement in the other senses [of public to private]: that is, from open to closed (for example, in rights of access) or from the whole to the part (for example, in the distribution of benefit).²³⁷

The "destinations" of a privatizing strategy can thus vary enormously. They may include the personal and informal sector (e.g., where local self-reliance is expected to replace public provision), the voluntary nonprofit sector (involving complex organizations based on philanthropy and professionalism), the small business sector, and the large corporate sector.²³⁸ Similarly, the purposes of a privatizing strategy can differ sharply. The purposes may range from use of the private sector as a means of realizing governmental goals (such as delivery of health care to the poor) to "radical privatization, [requiring] drastic withdrawal of government" from previous functions such as welfare or environmental regulation.²³⁹ These different purposes have also been described as the "empowerment" side of privatization, in which government funding is used to strengthen private providers of public needs, as opposed to "loadshedding," in which the government withdraws from both service financing and service delivery.²⁴⁰

In the light of these distinctions, the simple dichotomy in Medicaid policy between the "government" and the "private sector" does not hold. In fact, Medicaid has always relied heavily on private doctors and hospitals to deliver services and has been justifiably criticized for being too passive and subservient to their interests.²⁴¹ The Reagan administration's Medicaid policy represents not so much a shift of services from the public to the private sector as a shift of administration from the public to the private for-profit sector, with the immediate goal of "loadshedding" or reduc-

237. Starr, *supra* note 20, at 6.

238. *See id.* at 8.

239. *Id.* at 9-10.

240. *See* Bendick, *Privatizing the Delivery of Social Welfare Services* 203, in PROJECT ON THE FEDERAL SOCIAL ROLE, WORKING PAPER 6: PRIVATIZATION (1985). For a somewhat similar distinction between true health care cost containment, which attempts to reduce the amount of resources employed to produce a given volume of services, and "ersatz cost containment" which, like "loadshedding," seeks only to reduce outlays by a particular payor (and which usually increases expenditures by other payors and even increases unit costs), see Vladeck, *Equity, Access, and the Costs of Health Services*, in 3 SECURING ACCESS TO HEALTH CARE, *supra* note 1, at 3, 5.

241. *See, e.g.,* R. STEVENS & R. STEVENS, *supra* note 6; SECRETARY'S TASK FORCE ON MEDICAID, *supra* note 6, at 26.

ing federal financial commitments. Private Medicaid administration is then expected to reorganize the private sector, essentially incorporating small businesses (physician practices) and voluntary nonprofit hospitals into for-profit models of reimbursement and management characteristic of large corporations. The ultimate ideal under this vision is to eliminate large-scale state contracting with private Medicaid administration and substitute vouchers or cash payments to the poor that would then be turned over to the even more fragmented and private administration of health plans and insurance companies.

As in the Michigan example, a more patient-centered version of PCCM would seek a mix of public and private functions, performed by different types of institutions, to maximize efficient delivery, high quality, and patient responsiveness of care. Under this approach, the authority and competence of *both* governmental and private institutions could grow as the state takes more sophisticated responsibility through contracting and performance standards for assuring that adequate and available care is delivered through private health care organizations that themselves have more responsibility and flexibility for meeting patients' needs. Moreover, other types of "private" organizations—coalitions of advocates, social service providers, and recipients—could be strengthened and play an important and constructive role. Such an approach would necessarily depend on a continued financial commitment by the federal and state governments to avoid loadshedding and to finance needed health care services.

Another difference between radical privatization and the patient-centered approach to PCCM concerns the consciousness of health and health care as individual and social issues. In August 1985, HHS Secretary Margaret Heckler released the Report of the Secretary's Task Force on Black & Minority Health. The Task Force noted that it was "a unique and historic assemblage in its own right . . . [T]he first time that representatives of [Department of HHS] . . . programs were joined in a common effort to . . . investigate the longstanding disparity in the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to the nonminority population."²⁴² The Task Force found, for example, that blacks under the age of forty-five suffered almost 23,000 "excess deaths" per year—that is, deaths that would not have oc-

242. UNITED STATES DEPT. OF HHS, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH, VOLUME ONE: EXECUTIVE SUMMARY 2 (1985).

curred had the black population had the same age and sex-specific death rate as the nonminority population.²⁴³ These excess deaths constituted 47.4 percent of all black's deaths, and included over 6,000 deaths due to infant mortality.²⁴⁴ The Task Force considered these facts a health problem worthy of public notice and response and recommended extensive public programs regarding patient education, improved and innovative health care delivery through Medicaid and other publicly financed programs, and massive improvements in data collection and research.²⁴⁵

One wonders how these concerns would fare in a fully privatized voucher or cash payment system. The dollar value of such vouchers probably would be minimal—well below the higher-than-average costs of health care for the poor.²⁴⁶ The cut-rate for-profit providers who would enter this market probably would not have the capacity or the inclination to mount innovative programs. Even more fundamentally, the voucher system explicitly encourages people to conceive of health care as a private market transaction between an individual patient and a health care provider or insurance company.²⁴⁷ The very capacity of our culture to inform itself about patterns of health and health care and to mount a public response would possibly be lost in the “stark utopia”²⁴⁸ of radical privatization.

243. *Id.* at 5, 3.

244. *Id.* at 5.

245. *See id.* at 9-45.

246. *See* CBO, *An Analysis of the National Health Care Reform Act of 1981 (H.R. 850)*, (Sept. 1981), in *Proposals to Stimulate Competition in the Financing and Delivery of Health Care: Hearings Before the Subcomm. on Health of the House Ways & Means Comm.*, 97th Cong., 1st Sess. 9, 44-45 (1981).

247. *See* Iglehart, *supra* note 20, at 293 (quoting then OMB-Director David Stockman's policy goal of “once again mak[ing] health care an economic good . . . so that we can bring into play those self-regulatory, economizing, efficiency-producing mechanisms that we rely on in all other sectors.”).

248. K. POLANYI, *THE GREAT TRANSFORMATION* 3 (1944, Beacon Press paperback ed. 1957). Polanyi used the phrase “stark utopia” to refer to the advocates of unregulated markets in nineteenth century England. Radical privatization is likely to undermine our cultural capacity to perceive the social patterns of health problems not only as a matter of thought, but also as a practical matter of data collection. *See* Munding, *Health Service Funding Cuts and the Declining Health of the Poor*, 313 *NEW ENG. J. MED.* 44, 45 (1985) (noting that the National Center for Health Statistics has been subjected to a 28% staff reduction between 1981 and 1985, and that in March 1985 the Office of Management and Budget drafted a proposal that would prohibit agency data collection unless an agency could show that the information was essential to its mission, was unlikely to be collected by the private sector, and would yield benefits in excess of its costs).