



February 2014

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### Recommended Citation

Nancy A. Burke, *Medicaid-HMOs: A Device for Delivering Health-Care Service to the Poor*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 281 (1988).

Available at: <http://scholarship.law.nd.edu/ndjlepp/vol3/iss2/7>

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# MEDICAID-HMOs: A DEVICE FOR DELIVERING HEALTH-CARE SERVICE TO THE POOR?

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## INTRODUCTION

Judeo Christian ethics call each individual to be a healing force to others both literally and symbolically.<sup>1</sup> The rising cost of medical care, however, diminishes this ability.<sup>2</sup> Recently, health care costs have risen at an annual rate of 13.2 percent in excess of the general inflation rate.<sup>3</sup> These increases have prompted the health care industry and the largest purchaser of medical services, the government, to re-examine who has a right to health care, who has an obligation to finance care and what means should be used to provide care.<sup>4</sup>

Private, charitable and government doctors share in the ethical obligation to ensure that adequate, quality health care be made available to all who need it, but cannot afford it.<sup>5</sup> Because of the practical limitations of scarce resources, such care must be provided in a cost-effective manner.

Government has responded to the medical needs of indigents principally through the Medicaid program.<sup>6</sup> This pro-

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1. Carney, *Justice and Health Care: A Theological Review*, in JUSTICE AND HEALTH CARE 37 (E. Shelp ed. 1981). See also Brody, *Health Care for the Haves and Have-Nots: Toward a Just Basis of Distribution* in JUSTICE AND HEALTH CARE 154 (E. Shelp ed. 1981); R. McCORMICK, HEALTH AND MEDICINE IN THE CATHOLIC TRADITION (1984).

2. Trends in national health expenditures have shown dramatic increases. National health expenditures in 1965-1983 were \$42 billion and \$355 billion, respectively. The projected national health expenditure for 1990 is \$660 billion. Arnett, Cowell & Davidoff, *Health Spending Trends in the 1980's: Adjusting to Financial Incentives*, 6 HEALTH CARE FIN. REV. 1 (Spring 1985). [hereinafter Arnett].

3. *Id.* at 1.

4. DesHarnais, *Enrollment in and Disenrollment from Health Maintenance Organizations by Medicaid Recipients*, 6 HEALTH CARE FIN. REV. 39 (Spring 1985).

5. Meeting the health care needs of the poor demands that a variety of social institutions offer assistance either through separate programs or through coordinated efforts.

6. 42 U.S.C. § 1396 (1982).

gram, a joint federal-state effort, subsidizes the health expenditures for a segment of the nation's poor who meet income and categorical criteria. The adequacy of Medicaid, however, is jeopardized by increasing administrative costs coupled with the rising cost of health care. In an attempt to contain costs, efforts are underway to integrate health maintenance organizations (HMOs) into the Medicaid program through the use of state-HMO contracts. HMOs provide comprehensive health care for a prepaid, fixed amount. Because the combination of these programs presents a potentially cost-effective means of providing quality medical services to the poor, this article explores how Medicaid might be restructured to promote the development of Medicaid-HMOs.

## I. CURRENT RESPONSES TO THE HEALTH CARE NEEDS OF THE POOR

### A. *Medicaid*

Medicaid was enacted in 1965 pursuant to title XIX of the Social Security Act.<sup>7</sup> It is a joint federal-state welfare program that provides public assistance for the health care expenditures of the poor who both apply and meet income and categorical criteria.<sup>8</sup> Medicaid seeks to ensure the poor "mainstream" medical assistance by eliminating the financial restraints that prevent the poor from having access to quality health care.<sup>9</sup>

Medicaid attempts to achieve quality service for lower income individuals through freedom of choice and the reimbursement of costs. Eligible Medicaid recipients are free to choose medical services from any provider, including an institution, individual practitioner or prepaid plan which satisfies state standards.<sup>10</sup> The federal government, through the state's Medicaid agency, reimburses the provider of ser-

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7. Distinguish Medicare, enacted in conjunction with Medicaid in 1965. Medicare is an insurance program for the elderly, who have contributed to the fund. Medicaid is a welfare program. With the enactment of both Medicare and Medicaid, the government became the nation's largest, single purchaser of health care in the country.

8. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, Pub. No. (PHS) 81-50168, *Medicaid Beneficiaries in Health Maintenance Organizations*, 1 (1980) [hereinafter *Medicaid Beneficiaries*].

9. *Id.*

10. 42 U.S.C. § 1396(a)(23) (1982).

vices.<sup>11</sup> Despite admirable objectives, both the access to and quality and administration of the Medicaid program have not always met expectations.<sup>12</sup>

Medicaid patients have limited access to care, in part, because few primary physicians locate in areas with high concentration of low income families.<sup>13</sup> Even those that do locate in these areas are reluctant to serve Medicaid recipients because of low Medicaid reimbursement rates, as well as an administration bureaucracy which delays reimbursement. Transportation to providers outside the low income areas is generally unavailable.<sup>14</sup> Because access to care in low income areas is limited, many Medicaid recipients seek other, usually more expensive, sources of primary health care in hospital outpatient rooms, including emergency rooms.<sup>15</sup> This also suggests that Medicaid recipients receive medical assistance only for their immediate health needs, rather than maintenance or preventive care. This problem of inaccessibility has prompted some states to question the wisdom of freedom of choice.<sup>16</sup> For example, it is sometimes argued by state Medicaid agencies that they could make more efficient use of the program's limited dollars by channeling Medicaid recipients to accessible, lower cost facilities, where the quality of care administered could be monitored.<sup>17</sup>

The quality of care available to the Medicaid recipient may also be substandard. Some have found that the Medicaid provider market has been dominated by less qualified physicians, many of whom are non-board certified graduates of foreign medical schools.<sup>18</sup> "Medicaid doctors" may also take

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11. *Id.* at § 1396(a)(13) (1982).

12. E. NEUSCHLER AND K. SQUARRELL, PREPAID AND MANAGED CARE UNDER MEDICAID: OVERVIEW OF CURRENT INITIATIVES 1 (1985) [hereinafter Neuschler].

13. *Medicaid Beneficiaries*, *supra* note 8, at 7.

14. *Id.* See also *infra* note 50 and accompanying text.

15. Neuschler, *supra* note 12, at 1.

16. These states do not seek to limit the options of the poor for administrative simplicity, but instead hope to assure the Medicaid recipient has access to providers that will give prompt, well-coordinated care when needed. *Id.* at 14.

17. *Medicaid Freedom of Choice Waiver Activities: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 2 Sess. (March 30, 1984). See also, STAFF OF SENATE COMM. ON FINANCE, 98th Cong., 2 Sess., NEW APPROACHES TO PROVIDING HEALTH CARE TO THE POOR: MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES (Comm. Print 1984).

18. Mitchell & Cromwell, *Medicaid Mills: Fact or Fiction?*, 2 HEALTH CARE FIN. REV. 37, 43 (Summer 1980).

on high case loads and provide minimum services. Such activities have led to the creation of "Medicaid Mills," where patients wait hours to receive any type of care.<sup>19</sup> This system fails to attend to either the health needs or dignity of the patient. Medicaid is also plagued by lax claim processing and an insufficient monitoring system to protect against fraud by Medicaid recipients and health care providers. A federal study determined that participating doctors frequently boost fees and over-serve Medicaid recipients.<sup>20</sup>

Despite these shortcomings, Medicaid continues to provide basic medical service to the nation's poor. Medicaid's operational problems coupled with the rising cost of health care, however, jeopardize the continued existence of any type of government subsidized health program. One possible means for containing health care costs has been the development of health maintenance organizations. Before exploring the use of HMOs for Medicaid recipients, they are briefly described.

### B. HMOs

The concept of the prepaid health care system has been heralded as the solution to contain medical costs since the 1920s.<sup>21</sup> Only within the past eighteen years, however, have prepaid health systems come to the forefront in the form of health maintenance organizations.<sup>22</sup> Health maintenance organizations provide comprehensive health care services to an enrolled population for a fixed sum of money, paid in advance of the rendering of medical services.<sup>23</sup> HMOs administer services through a "package of benefits" that is available

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19. *Id.* at 43-44.

20. *Medicaid Beneficiaries*, *supra* note 8, at 2.

21. Spitz, *When a Solution Is Not a Solution: Medicaid and Health Maintenance Organizations*, 3 J. HEALTH POL., POL'Y & L. 497, 500 (1979).

22. In 1971 there were thirty-one HMOs in existence in the country. In 1982 there were over 250 HMOs and a 1990 projection of 450 operational HMO plans. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PUB. NO. H-79, HOSPITALS AND HMOs: AN OVERVIEW OF HOSPITAL SPONSORSHIP OF HEALTH MAINTENANCE ORGANIZATIONS 2 (1982).

23. HMOs are essentially corporate entities which provide a system of health care through one of four organizational formalities: (1) Staff models; (2) Group models; (3) Individual practice associations (IPAs); and (4) Network models. For a detailed discussion of the structure and operation of each of these models, see DEPARTMENT OF HEALTH AND HUMAN SERVICES, *HMO: Technical Assistance Monograph Guide for Fee-for-Service Medical Groups on Affiliation with HMOs* (1982).

24 hours a day.<sup>24</sup> Notably, the package of benefits may exempt extraordinary services, such as cancer treatments, or may require the enrollee to pay an additional price for services outside the package.<sup>25</sup>

HMOs have several advantages which make the concept particularly attractive to the health care industry and the Medicaid program.<sup>26</sup> The prepayment of a fixed sum each month encourages health providers to serve patients in the most cost-efficient manner, since profit is not dependent on the volume or type of services rendered.<sup>27</sup> The centralized system is also more administratively effective than a reimbursement process. Records need not be duplicated; referral services are readily available; and paper work, such as billing, decreases.<sup>28</sup> Consumers have greater access to a wide range of medical assistance within one structure.<sup>29</sup> Particularly important to Medicaid, budgeting medical expenditures is more exact with the use of a prospective payment system.<sup>30</sup>

Despite their many advantages, HMOs also have several inherent disadvantages, which limit their effectiveness in the Medicaid program.<sup>31</sup> Enrollees must use only the HMO's services.<sup>32</sup> A fixed allocation of facilities and personnel minimize the locations to which enrollees have access.<sup>33</sup> Thus, enrollees may have to relinquish established doctor-patient relationships in order to partake in the more cost-effective HMO system.<sup>34</sup> Even once enrolled in an HMO, the patient rarely has one particular physician.

Prepayment may also be an incentive to cut back on the amount and quality of care provided, so the patient is underserved.<sup>35</sup> Benefit packages may exclude many health services, particularly for catastrophic illnesses, which require lengthy

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24. *Id.* at 3.

25. *Id.*

26. *Medicaid Beneficiaries*, *supra* note 8, at 4-6.

27. *Id.*

28. *Id.* at 5.

29. *Id.*

30. The use of a reimbursement payment system instead of a prospective payment system has resulted in Medicaid being considered an "uncontrollable" program whose expenditures are not subject to the Congressional appropriation process. *Id.* at 2.

31. DEPT. OF HEALTH AND HUMAN SERVICES, *Monograph Guide for Fee-for-Service Medical Groups*, *supra* note 23, at 4-7.

32. *Id.*

33. *Id.*

34. *Id.* See also DesHarnais, *supra* note 4, at 41.

35. See DesHarnais, *supra* note 4, at 41.

and expensive treatments.<sup>36</sup> Finally, the only control mechanism monitoring the quality of HMO services on a continuous basis may be the state's Medicaid agency's Medical Care Advisory Committee (MCAC). Yet, such advisory committees seem ill-suited to this task.<sup>37</sup> These disadvantages aside, the HMO is increasingly suggested as a vehicle for delivery of medical services to Medicaid recipients.

### C. Medicaid-HMOs: The Current Framework

The Department of Health and Human Services (HHS) through the offices of Health Care Financing Administration (HCFA), which oversees Medicaid, and the Office of Health Maintenance Organizations, which oversees HMOs, regulates the relationship between Medicaid and HMOs.<sup>38</sup> Both offices act pursuant to title XIX of the Social Security Act.<sup>39</sup>

Title XIX authorizes state Medicaid agencies to enter into contracts with HMOs.<sup>40</sup> Medicaid recipients have the opportunity to enroll in an HMO in contractual privity with the state. The state pays the HMO a fixed amount based on the number of Medicaid recipients enrolled and the average cost of health care.<sup>41</sup> From 1977 to 1981 states were allowed to

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36. See *supra* note 23.

37. See the discussion *infra* accompanying footnotes 51-53. These committees are discussed at 42 C.F.R. 431.12(a) (1986); see generally, Davidson, Harold & Simon, *The Medical Care Advisory Committee for State Medicaid Programs: Current Status and Trends*, 5 HEALTH CARE FIN. REV. 89 (Spring 1984) [hereinafter Davidson].

38. Both offices act pursuant to federal statutes: Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1982) and The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (1982).

39. 42 U.S.C. § 1396 (1982).

40. See 42 C.F.R. § 434.20 (1986) for guidelines on State Medicaid Agency Contracts with HMOs. See also Office of Health Maintenance Organizations of the Department of Health and Human Services Model HMO-State Medicaid Agency Contract (May 1984).

41. Contracts can be either risk or nonrisk. Both define an upper limit on the amount of payment the state Medicaid agency will be required to forward. With risk contracts the HMO bears the risk of changing medical costs since the state agency never pays more than the agreed prepayment. Nonrisk contracts, however, may require the state Medicaid agency at the end of the contract period to make limited retroactive payments for the actual costs of services rendered in excess of prepaid amount, subject to an upper limitation. Most HMO-Medicaid contracts are at-risk contracts. Still, since both are bound by an upper limit, which is always less than the comparable fee-for-service costs, practically risk and nonrisk contracts have the cost-effectiveness advantage. Still, savings with the risk contracts may be more than savings with comparable nonrisk contracts. See 42 C.F.R.

enroll Medicaid recipients only in federally qualified HMOs,<sup>42</sup> that did not have more than 50 percent Medicare and Medicaid enrollment. In 1981, however, the Omnibus Budget Reconciliation Act (OBRA) amended title XIX of the Social Security Act. Since 1981, the state may establish its own qualification standards for HMOs serving Medicaid patients, and HMOs contracting with Medicaid may have up to 75 percent Medicare and Medicaid enrollment.<sup>43</sup> Today most Medicaid recipients may choose to enroll in an HMO in privity with the state, remain with the traditional fee-for-service provider reimbursement system, or enroll in an alternative state prepaid health plan.<sup>44</sup>

Although states have flexibility in contracting with health maintenance organizations, HHS suggests a model contract which is used by most Medicaid agencies with some modification. Use of the model contract ensures compliance with federal regulation. For example, the model contract requires that the HMO offer particular minimum services and establish an in-house procedure for hearing complaints.<sup>45</sup> While federal and state regulations offer the general framework for the Medicaid-HMO program, success has been moderate.<sup>46</sup> The remainder of this comment explores changes in the structure of both Medicaid and HMOs which might improve the performance of this device.

## II. MEDICAID-HMOs: PROBLEMS AND SOLUTIONS

### A. Accessibility

For HMOs to be accessible to Medicaid recipients, the HMOs must be located in or near low income neighborhoods. Such locations, however, discourage non-Medicaid recipients from enrolling in the HMO.<sup>47</sup> Because HMOs earn a profit by enrolling low risk consumers, and because non-

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§ 434.20 (1986); 42 C.F.R. §§ 447.361-362 (1986).

42. 42 C.F.R. § 434.20 (1986). A federally-qualified HMO is one that satisfies the requirements of The Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e (1982). The Act offers qualified HMOs grants, contracts and loan guarantees to be used for the formation and operation of HMOs. *Id.* at §§ 300e-3, 300e-4.

43. Neuschler, *supra* note 12, at 3.

44. *Id.*

45. *See supra* note 40. *See also* 42 C.F.R. § 434.32 (1986).

46. *See generally* DesHarnais, *supra* note 4; *Medicaid Beneficiaries*, *supra* note 9.

47. Spitz, *supra* note 21, at 510.



Medicaid recipients traditionally are generally a lower health care risk than Medicaid recipients,<sup>48</sup> HMOs need to locate where they can attract both the non-Medicaid and Medicaid consumer. Despite federal provisions offering additional monetary subsidies for HMOs locating in low income areas, HMOs continue to locate in middle class areas.<sup>49</sup>

To foster accessibility of HMOs to Medicaid recipients, two plans should be considered. First, federal assistance should be geared to subsidize the development of HMOs in "middle ground areas" where the HMO could draw both from a middle and upper income and Medicaid population. Second, if such a middle ground area is nonexistent and HMOs are located outside areas of ready access to Medicaid recipients, either the HMO or local Medicaid agency could provide transportation to transport Medicaid recipients from their residences to the HMO.<sup>50</sup>

### B. Quality Controls

Not only must HMOs be accessible to Medicaid recipients, but the care provided must be quality care, sufficient to meet the recipient's needs. Aside from the initial state or federal quality standards HMOs must meet to be able to contract with state Medicaid agencies, no effective on-going monitoring systems or inherent incentives exist to ensure that Medicaid recipients receive quality care adequate for their needs.

Federal law requires each state Medicaid agency to establish a Medical Care Advisory Committee to present an "opportunity for participation in policy development."<sup>51</sup> Medical providers, consumers and government representatives compose the MCAC. The Committee's purpose is to examine any deficiencies in the delivery of medical assistance to Medicaid recipients and to propose changes to best meet the demands

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48. See generally DesHarnais, *supra* note 4, at 48. Medicaid recipients are documented to be higher-risk users, requiring more frequent health care. *Id.*

49. The Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-2(e), 300e-3(f) (1982). The Act also gives special consideration to grant and loan applications for HMOs which will serve medically underserved populations. *Id.* at §§ 300e-2(c), 300e-3(d), 300e-4(f).

50. This proposal had been suggested by former HHS Secretary Margaret Heckler. The plan, however, has never been tested. For other proposals offered by Heckler, see Demkovich, *Margaret Heckler Shows Fighting Style, Proving She Came to Stay at HHS*, 16 NAT'L J. (1984).

51. 42 C.F.R. § 431.12(e) (1986). See also Davidson, *supra* note 37, at 96.

of the recipients. In fact, the MCAC is often superficial by nature. When the Committee does meet, much of the Committee's discussion focuses on MCAC's "own role and function."<sup>52</sup> Only 16 percent of all state MCACs have established procedures to investigate the workings of the state Medicaid program.<sup>53</sup> Despite these shortcomings, the MCAC might be reformulated to monitor more closely the quality of care provided Medicaid recipients and to investigate complaints of both the HMO and Medicaid recipient. For example, federal law might require that states outline the scope of the MCAC as an investigative and monitoring body, detail procedures for investigation of Medicaid-HMO problems, require regular meetings, and provide an informal mechanism by which both HMOs and Medicaid recipients could present complaints to the Committee.

Quality of care is also affected by the method of compensation provided to medical personnel. Some doctors receive salaries, others receive a fixed percentage, depending on the number of enrollees served. If doctors are paid on a salary basis, they have less incentive to "rush through" patients in order to increase the number attended, thereby increasing their own income. Thus, states should be encouraged to contract with HMOs employing salaried doctors, to avoid sacrificing the quality of care administered in favor of the quantity of patients assisted.

### C. Medicaid Recipient Enrollment

Medicaid recipients will need some encouragement to participate in HMOs simply by reason of lack of familiarity with the HMO structure. This lack of knowledge is partly attributable to the statutorily-required freedom of choice alluded to earlier.<sup>54</sup> In this regard, a state cannot direct Medicaid recipients to more cost-effective providers<sup>55</sup> or even provide recipients with information regarding the benefits of an HMO. Any communication regarding the quality of providers has been construed as influencing the recipient's selection of provider in violation of freedom of choice.<sup>56</sup>

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52. Davidson, *supra* note 37, at 96.

53. *Id.*

54. 42 U.S.C. §§ 1395, 1395a (1982).

55. Staff of Senate Comm. on Finance, 98th Cong., 2 Sess., *New Approaches to Providing Health Care to the Poor: Medicaid Freedom of Choice Waiver Activities*, 3 (Comm. Print, 1984).

56. *See id.* at 5, 7.

Some states have recently been granted a waiver from the freedom of choice provision pursuant to section 1915(b) of the Social Security Act.<sup>57</sup> In these cases, states have been allowed to restrict recipients receiving health care services (other than emergency care) to a given number of efficient and cost-effective providers.<sup>58</sup> States are also permitted to disseminate information detailing the advantages and disadvantages of each of these providers. Unfortunately, the application for and the granting of waivers can be a lengthy and burdensome process.<sup>59</sup> Consideration should be given to amending the freedom of choice provision to allow all states the ability to limit the number of providers available to Medicaid recipients.

#### D. HMO Incentives

HMOs also need incentives to enter into contracts with the state Medicaid agency. Many HMOs have been reluctant to enter into state contracts because Medicaid recipients are high risk medical consumers, requiring more health care than the average consumer.<sup>60</sup> To offset the disparity between the average consumer and the Medicaid consumer, fixed payments to the HMO should not be based on the cost of care for the average consumer, but on the cost of care for the average Medicaid recipient in that area. This allows for a more realistic assessment between the price paid and the cost of services rendered to the recipient.

HMOs are also reluctant to enter into state contracts because of the high disenrollment of Medicaid recipients.<sup>61</sup> Medicaid recipients may terminate enrollment in an HMO at any time.<sup>62</sup> Recipients often enroll in an HMO for one month and disenroll the next.<sup>63</sup> In such cases, the HMO cannot adequately budget for needed services nor anticipated costs. To ensure greater consistency in budgeting and to encourage HMOs to enroll Medicaid recipients, as well as to give the recipient an opportunity to fairly evaluate the HMO, the state should require the recipient to be "locked in" for a minimum of six months.

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57. *Id.* at 1.

58. *Id.* at 6-7.

59. *Id.* at 6.

60. See generally DesHarnais, *supra* note 4, at 40.

61. See *id.* at 48.

62. 42 C.F.R. § 434.27(b)(1) (1986).

63. See generally DesHarnais, *supra* note 4, at 48.

### CONCLUSION

As the present Medicaid program struggles with the rising costs of health care, it is worth considering new systems of health care delivery to the nation's poor. HMOs provide a potentially cost-efficient way to offer quality care. Several changes in Medicaid's existing statutory and regulatory structure have been presented. These somewhat tentative suggestions may help ensure the provision of adequate, quality care to Medicaid recipients at an affordable cost.

