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A Consumer Advocate On Medicaid Managed Care

Medicaid managed care may offer the last, best chance to provide integrated health care for the nation’s poor—but only if states learn from past problems.

BY GERALDINE DALLEK

MEDICAID PROMISED TO END dual-class medical care in the United States. Unfortunately, this promise was never realized. Inadequate funding, low physician payment rates, and the increasing costs of long-term care resulted in continued access problems for the Medicaid population, especially poor mothers and children. As early as 1975 two Medicaid authorities noted that “in some areas of the nation, an orthopedist or periodontist willing to accept Medicaid patients was as rare as a tropical bird in Alaska.” Indeed, for an example, one need only look at access problems for pregnant Medicaid beneficiaries. One study found that by 1986 pregnant women in twelve California counties could not find a single obstetrician willing to accept Medi-Cal’s (California Medicaid’s) payment of $518 for all prenatal care, delivery, and postpartum care. More than 140,000 Medi-Cal-eligible women of childbearing age lived in counties without even minimal access to obstetrical care.

Medicaid managed care, with its “guarantee” of access to medical care and emphasis on primary and preventive care, promises to correct these deficiencies. Indeed, Medicaid managed care may offer the last, best opportunity to provide integrated health care for the nation’s poor. However, this opportunity will be wasted if states do not learn from their own and other states’ experiences how to make managed care fill the promises made by Medicaid so many years ago.

Marsha Gold and her coauthors provide a valuable blueprint for states as they pursue Medicaid managed care as the solution to their Medicaid ills. For advocates working to ensure health care for the poor, the paper provides reason for hope as well as for caution as we transform health care for the nations most vulnerable populations.

CAN STATES LEARN THE LESSONS OF THE PAST?

The nation’s governors recently proposed a massive Medicaid overhaul, promising that, in return for unfettered authority over the program and its dollars, the states—unshackled from the chains of federal authority—would provide a higher-quality, more responsive health care program for the poor. The Oregon and Minnesota case studies cited by Gold and colleagues lend credence to these assertions. These states implemented managed care programs in ways that minimized disruptions in care and expanded access for enrolled populations. Even Tennessee’s TennCare program, with all of its massive enrollment problems, greatly expanded care for the poor and provides evidence that, when given authority, states will pursue an integrated health care system for their low-income residents.

However, for every successful state effort,
legal services and community groups advocating on behalf of the Medicaid population can point to one or more cases in which states have failed disarmally to protect vulnerable populations. Establishing a thoughtful Medicaid managed care program that minimizes the possibility of marketing fraud and abuse, provides a responsive education and enrollment process, ensures continued access to specialty providers, and requires internal and external quality-of-care protections is not rocket science. Nevertheless, time after time states implement Medicaid managed care programs that are rife with egregious marketing violations, are ill prepared to educate and enroll large populations of poor persons, and lack any system to monitor the quality of care provided. The history of Medicaid managed care in Florida, Ohio, and California illustrates these shortcomings.

**Florida.** From 1990 to 1995 Florida moved some 360,000 poor mothers and children into managed care plans. Reports by the Ft. Lauderdale Sun-Sentinel found the following problems in the plans: poor quality of care; mass marketing fraud; ownership of or involvement in some Medicaid health maintenance organizations (HMOS) by persons who had been involved in previous HMO scandals; the siphoning of up to 50 percent of state Medicaid payments for “administrative costs, including luxury car leases and perks for owners and executives;” and state officials’ inability or unwillingness to address these problems.

**Ohio.** The findings of Sun-Sentinel reporters were similar to those of Cleveland Plain Dealer reporters ten years earlier. In 1984 Ohio contracted with Health Power to provide Medicaid HMO services, although the state had developed no quality assurance standards and several of Health Power’s owners and providers previously had been implicated in Medicaid fraud. A subsequent audit of Health Power found serious quality problems. The audit teams medical director concluded that “the program was chaos, total unadulterated chaos… There was no quality assurance there that I could find.” Despite these findings, the state gave Health Power a grant to expand operations to other Ohio cities.

Unfortunately, past scandals have not led to discernible improvements in Medicaid managed care in Ohio. Studies and investigations of the state’s mandatory managed care program in Montgomery County in 1991-1995 found that (1) the state failed to provide any meaningful oversight of the county’s three managed care plans; (2) the state did not check the accuracy of data reported to it by these plans, which made evaluation of the program in the early years impossible; (3) 39-45 percent of women in the three HMOs who gave birth in 1993 had inadequate prenatal care or none at all; (4) access to primary care physicians declined, while emergency room visits increased at least threefold from 1989 to 1995; and (5) about 40 percent of the 3,000 preschool children enrolled in Montgomery County’s Head Start programs lacked all or some of the required medical exams.

**California.** California, like Florida and Ohio, has failed to learn the lessons of the past. In response to Medi-Cal managed care scandals in the late 1960s California has passed some of the strongest (and most detailed) Medicaid managed care protections of any state in the nation. However, laws are meaningful only if they are enforced. Legal protections in California have not prevented Medicaid managed care plans from improperly marketing plans or providing poor-quality care to enrollees.

Although the state has had almost thirty years of experience with Medicaid managed care marketing problems, as recently as 1995 marketing agents from one of the state’s largest Medicaid HMOs stationed themselves at a Los Angeles check-cashing outlet and illegally paid Medicaid recipients, many of whom were in their last trimester of pregnancy, up to $50 to enroll in their plan. Furthermore, findings of serious quality-of-care problems in the state’s yearly medical quality assurance audits had no discernible impact on the subsequent care provided by the plans. In some cases, the state found that care had actually worsened in
the years following the audits. In recent reviews of Medi-Cal’s managed care program, both the Health Care Financing Administration (HCFA) and the U.S. General Accounting Office (GAO) found that the state’s monitoring and oversight were inadequate to ensure the provision of high-quality care to the Medicaid population.

The history of Medicaid managed care tells us what works and what does not work. What remains questionable is whether states can and will learn from this history.

**MEDICAID MANAGED CARE: SEPARATE AND UNEQUAL?**

One lesson that states should take to heart is that the move to Medicaid managed care could facilitate the integration of America’s health care system. For the first time, mainstream commercial HMOs are bidding to serve the Medicaid population. As Gold and colleagues note, some states are making it advantageous for plans to participate in Medicaid, while states such as Tennessee require providers to care for the poor as a condition of participating in the state’s employee plan.

Unfortunately, the move to Medicaid managed care also could result in the institutionalization of a separate and unequal system of care for Medicaid beneficiaries. Entrepreneurs in Florida established new managed care plans to serve Medicaid beneficiaries. The state neither required these plans to serve a mix of Medicaid and privately insured patients nor required the Medicaid HMOs to meet the same standards that HMOs serving the privately insured had to meet. Ten states now permit Medicaid-only HMOs to provide care to their Aid to Families with Dependent Children (AFDC) populations.

A second protection for Medicaid managed care enrollees is choice. If Medicaid enrollees are unable to “vote with their feet,” they could find that managed care is a far worse option than fee-for-service care. Political exigencies could result in the Medicaid populations losing all choice of providers or having their choices so circumscribed as to be meaningless.

For Medicaid managed care to work, it must entitle the poor, not the providers that serve them. At the same time, states face an enormous challenge to ensure that the nation’s health care safety net—its public hospitals, community and rural clinics, school clinics, and inner-city minority providers—receives help to compete effectively in the new marketplace. Increased price competition, heightened by managed care, may limit hospitals’ ability to shift costs to finance care for the uninsured. Public hospitals in Los Angeles, Memphis, and New York, to name a few, are being buffeted by changes over which they have no control and by challenges that they are ill equipped to meet.

In the long run, managed care may or may not improve health care for Medicaid and other low-income populations. However, unless states use any promised savings in these systems to expand coverage for the uninsured, as happened in Tennessee and Oregon, and unless we can find a new way to subsidize our nation’s health care safety net, managed competition will lead to a decline in care for America’s uninsured.

**A ROLE FOR THE FEDERAL GOVERNMENT?**

The enormity of the challenge to build a decent health care system for the nation’s poor and the inconsistent record of states’ managed care programs argue for a continued role for the federal government in Medicaid. States have always played a pivotal role as the nation’s laboratories for innovative health care and welfare reform. However, the federal government serves an equally pivotal role in ensuring minimum national standards and curbing the worst excesses of state neglect and
poor oversight. Although states complain about the bureaucratic hurdles in obtaining federal waivers to implement Medicaid managed care programs, the waiver process has been streamlined. It also has resulted in increased protections in states’ managed care programs and has given Medicaid advocates a forum in which to advance the interests of the poor who are served by these programs.16

Thus, as we move toward a new system of care for the nation’s vulnerable populations, we need to learn from the states that are leading the way, and at the same time use the resources of the federal government to provide minimum protections for all Medicaid managed care enrollees.

NOTES
9. California Welfare and Institutions, sec. 14200 et seq.
13. Health Care Financing Administration, Region IX. Review of California’s Administration of Its Managed Care Program (San Francisco: HCFA, 1993); and GAO, Medicaid Managed Care: More Competition and Oversight Would Improve California’s Expansion Plan, GAO/HEHS-95-87 (Washington: GAO, April 1995).