MISSION AND MARKETS IN HEALTH CARE: PROTECTING ESSENTIAL COMMUNITY PROVIDERS FOR THE POOR

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Does mission matter? To some, medicine is a profession: while money changes hands, professional conduct is a thing apart from commerce.[1] To others, health care delivery is the exchange of services for payment, a form of economic exchange that varies from other market transactions only in minor, largely correctable ways.[2] On health care *financing*, most in both camps agree: access to health care is sufficiently important, the causes of illness are sufficiently beyond the control of the ill, that market forces should not deny the poor access to "at least a basic ration of critically needed health care."[3]

But what of *service delivery*—or is it *caregiving*? Does the care provided by mission-driven providers differ significantly from that provided by economically driven providers? This question is central to the future of Medicaid,[4] the federal-state health care program that is undergoing a dramatic conversion to managed care.[5] A decade ago, entrepreneurs saw

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1. *See* Edmund D. Pellegrino, *Contempo 1996: Ethics*, 275 JAMA 1807 (1996); Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323 (1995); MARC A. RODWIN, MEDICINE, MONEY, AND MORALS 152-54 (1993); BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE 4-5 (1991); *see also* Peter T. Kilborn, *Doctors Organize to Fight Corporate Intrusion*, N.Y. TIMES, July 1, 1997, at A12.

2. *See* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 1-3 (1995); Richard Kronick, *Managed Competition—Why We Don't Have It and How We Can Get It*, *in* AMERICAN HEALTH POLICY 44, 48-49 (Robert B. Helms, ed., 1993); RITA RICARDO-CAMPBELL, THE ECONOMICS AND POLITICS OF HEALTH 328-30 (1982).

3. Uwe E. Reinhardt, *Turning Our Gaze From Bread and Circus Games*, HEALTH AFF., SPRING 1995, at 33; *see* Uwe E. Reinhardt, *Reflections on the Meaning of* Efficiency: *Can Efficiency Be Separated from Equity*, 10 YALE L. & POL'Y REV. 302 (1992); Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 J. HEALTH POL. POL'Y & L. 227, 235-36 (1988). *But see* RICHARD A. EPSTEIN, MORTAL PERIL, 43-58 (1997).

4. Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396-1396v (1994).

5. *See* Joel D. Ferber, *Auto-Assignment and Enrollment in Medicaid Managed Care Programs*,

Medicaid services, particularly in primary or comprehensive care, as providing insufficient remunerative benefits to be worthwhile. As a result, Medicaid beneficiaries had very limited access to appropriate care.[6] Out of religious[7] or social[8] mission, however, a cadre of community health centers and community-oriented hospitals provided high-quality, culturally sensitive care to these underserved communities.[9] But mission-driven providers were few in number, and care unquestionably suffered. Costs continued to rise although the program increasingly was regarded as failing to provide adequate health care to the poor.[10]

More recently, states, with federal acquiescence, have encouraged commercial managed-care organizations to take on the care of the poor as a profit-making venture.[11] For the states, Medicaid managed care[12] permits the

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24 J.L. MED. & ETHICS 99, 99-100 (1996); John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, HEALTH AFF., Spring 1995, at 199, 208. The percentage of the Medicaid population in managed care has increased from 9.53% in 1991 to 40.10% in 1996. *See* Health Care Financing Administration, *National Summary of Medicaid Managed Care Programs and Enrollment* (last modified Feb. 26, 1997) <http://www.hcfa.gov/medicaid/trends1.html>.

6. *See* PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REP. TO CONGRESS 341-42 (1996); Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED., 191, 192-93 (1995); PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REP. TO CONGRESS 350-51 (1994); KAREN ERDMAN & SIDNEY M. WOLFE, PUB. CITIZEN HEALTH RESEARCH GROUP, POOR HEALTH CARE FOR POOR AMERICANS: A RANKING OF STATE MEDICAID PROGRAMS 73-74 (1988).

7. *See* Robert Heuer, *Preserving the Mission*, AM. MED. NEWS, Nov. 27, 1995, at 19.

8. *See* Howard Larkin, *Community Care Gets Competitive*, AM. MED. NEWS, Feb. 17, 1997, at 7.

9. *See* Helen Halpin Schauffler & Jessica Wolin, *Community Health Clinics under Managed Competition: Navigating Uncharted Waters*, 21 J. HEALTH POL. POL'Y & L. 461, 462-65 (1996); STUART H. ALTMAN ET AL., COMPETITION AND COMPASSION: CONFLICTING ROLES FOR PUBLIC HOSPITALS 202-203 (1989); LARRY S. GAGE ET AL., NATIONAL ASS'N OF PUB. HOSPS., AMERICA'S URBAN HEALTH SAFETY NET: PRESERVING ACCESS IN THE ERA OF REFORM 64 (1994); Andrew Bindman, *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 JAMA 2899 (1990); Heuer, *supra* note 7; Larkin, *supra* note 8; Kenneth E. Thorpe, *Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?*, 12 J. HEALTH POL. POL'Y & L. 313 (1987).

These institutions do not always act completely selflessly, of course, as evidenced by fierce struggles over provisions in the Medicaid statute which provide for "reasonable and adequate" hospital rates, 42 U.S.C. § 1396a(a)(13)(A) (1994), and full-cost reimbursement to community health centers, 42 U.S.C. § 1396a(a)(13)(E). *See, e.g.*, Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990). These institutions have suffered a setback in this regard. The Balanced Budget Act of 1997 repealed these rate protections, granting states new "flexibility in payment methods." Pub. L. No. 105-33, 111 Stat. 251, §§ 4711-12 (to be codified at 42 U.S.C. § 1396(a) note (1997)).

10. *See* Robert J. Blendon et al., *Data Watch: Medicaid Beneficiaries and Health Reform*, HEALTH AFF., Spring 1993, at 132, 138-41; *see also* Watson, *supra* note 6.

11. *See* Michael S. Sparer, *Medicaid Managed Care and the Health Reform Debate: Lessons from New York and California*, 21 J. HEALTH POL. POL'Y & L. 433 (1996); Trish Riley, *State Health Reform and the Role of 1115 Waivers*, HEALTH CARE FIN. REV., Spring 1995, at 139; Deborah A. Freund & Robert E. Hurley, *Medicaid Managed Care: Contribution to Issues of Health Reform*, 16 ANN. REV. PUB. HEALTH 473 (1995).

"privatization" of network maintenance and much of the quality control responsibilities of Medicaid. States convert from Medicaid provider to payor: they bid out contracts to provide health services to the poor.

States and, at least for the time being, federal regulators[13] are inventing Medicaid managed care on the fly. They must decide how, if at all, mission-driven providers will relate to the entrepreneurial enterprises in the new networks. The states experience considerable tension between controlling costs and maintaining caring, culturally sensitive provider networks. In addition, there is tension between the urge to "mainstream" Medicaid beneficiaries into the commercial health care delivery system, thereby breaking down a historically two-tiered health care system, and the urge to support historic "essential community providers"[14] that target the particular needs of economically disadvantaged patients, needs that are *different* from the mainstream.

State and federal regulators have struggled with the place of essential community providers in Medicaid managed care. Federal law provides little protection to Medicaid's historic providers in waivered Medicaid managed care systems. Some states' statutes or regulations, meanwhile, require that Medicaid-participating managed care organizations include essential community providers in their networks.[15] Most of the regulatory activity in this area, however, is informal, as federal officials cajole states to preserve access to historic Medicaid providers for Medicaid managed care

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12. Prior to the passage of the Balanced Budget Act of 1997, state movement of Medicaid beneficiaries to managed care required a federal waiver from generally applicable Medicaid principles. HCFA was empowered to grant "programmatic" waivers under § 1915(b) of the Social Security Act, 42 U.S.C. § 1396n (1994), or "demonstration" waivers under § 1115 of the Social Security Act, 42 U.S.C. § 1315 (1994). *See* Freund & Hurley, *supra* note 11, at 476-77. In recent years, the Health Care Financing Administration has granted § 1115 "demonstration waivers" with increasing frequency, permitting states to experiment with broad reconfigurations of their Medicaid programs, centered around a shift to managed care. *See* John Holahan et al., *supra* note 5; Bruce C. Vladeck, *Medicaid 1115 Demonstrations: Progress Through Partnership*, HEALTH AFF., Spring 1995, at 217. With the passage of the Balanced Budget Act of 1997, states are permitted to shift most Medicaid beneficiaries to managed care without obtaining a federal waiver. *See* Pub. L. No. 105-33, 111 Stat. 251, §§ 4701-02 (to be codified at § 42 U.S.C. § 1396(u)(2) (1997)). These amendments to Medicaid obviate the need for "programmatic" waivers, although "demonstration" waivers remain necessary for more extensive modifications of a state's Medicaid plan.

13. The Balanced Budget Act of 1997 eliminated some, but not all, federal oversight of states' shift to Medicaid managed care. *See supra* note 12.

14. The term "essential community provider" is variously defined in statute and regulation. *See infra* Part II. For purposes of this article, "essential community provider" is used broadly to mean organizations, such as community health centers and public and community nonprofit hospitals, that serve a high proportion of Medicaid and uninsured patients and are devoted to the service of medically underserved communities. *Cf.* LA. REV. STAT. ANN. §§ 40:2241-2242 (West 1996).

15. *See infra* text accompanying notes 110-16, 131-36.

beneficiaries,[16] and state officials in turn encourage or require that participating managed care organizations make a place in their networks for these essential community providers.[17]

Should government protect mission-driven providers in the shift to Medicaid managed care? In part, the answer to this question turns on the statutory purposes of Medicaid as both a vehicle for providing an opportunity for the poor to enter the medical mainstream, and as a program to provide medical care in a setting that includes a wide variety of culturally appropriate social services. The answer also turns in part on an economic and public policy analysis of the performance of these mission-driven providers in comparison with their for-profit counterparts. Part I of this article will describe the complex mission of Medicaid, as a program that on the one hand integrates the poor into the mainstream of health care, and on the other hand provides enhanced, supplementary or remedial care to a population with different and greater needs. Part I concludes that legislative intent is insufficiently clear to determine the fate of mission-driven providers. Rather, their fate must depend on economic and public policy analysis of their effect on Medicaid beneficiaries' health care. Part II will describe the developing Medicaid managed care system, and the complex, largely informal mechanisms by which essential community providers achieve some limited insulation from competitive forces. Part III will argue that regulatorily mandated inclusion of essential community providers in Medicaid managed care networks is appropriate for three reasons. First, mission-driven providers have in the past and are likely in the future to be willing and able to cost-shift, providing necessary care to the poor uninsured. Second, information asymmetries that plague the Medicaid managed-care market can be ameliorated to some extent by affording special status to historic Medicaid providers. Third, the nonprofit essential community providers' reliance on debt financing and donations renders their capital less mobile than that of their for-profits competitors, who normally rely on equity markets. This capital immobility lends stability to the provider network for the vulnerable Medicaid population in the inevitable event of significant funding contraction.

I. MEDICAID GOALS: MAINSTREAMING OR DECENT MINIMUM

Congress created Medicaid[18] in 1965 as a medical insurance program for

16. *See infra* text accompanying notes 117-31.
17. *See infra* text accompanying notes 117-31.
18. Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at Title XIX of the Social Security Act

the poor. The United States had missed the movement among Western European countries, which afforded their citizens nearly universal access to health care by adopting broad social insurance legislation.[19] As a result, a large class of Americans emerged without insurance or the means otherwise to purchase health care, and who became dependent upon a system of poor clinics and charity hospitals.[20] The poor and non-poor, then, came to rely on distinct health care systems, and America produced a "dual track" system of health services: one for those with means, and another, lesser system for those reliant on a patchwork of private charity or state and local governmental largess.[21]

Medicaid is a joint federal-state program created to "provide a more effective medical assistance program for welfare recipients and to extend medical assistance to additional persons with low-income."[22] Nationally, Medicaid is the major payor for health care services for the poor and disabled. By 1996, over thirty-three million persons were enrolled in Medicaid, well over ten percent of the population.[23]

Almost from the beginning, Medicaid experienced two problems. First, the program experienced higher than expected costs due to states' manipulation of "disproportionate share hospital" payments,[24] increases in the number of people eligible for coverage, and increased per-beneficiary costs.[25] Second, even with the increases in program costs, Medicaid beneficiaries remained outside the medical mainstream, and continued to be treated by caregivers dedicated to caring for the poor.[26] In recent years, the

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of 1965, 42 U.S.C. §§ 1396-1396v (1994))

19. *See* WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS 5-6 (1991); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237-38 (1982).

20. *See* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 16 (1974); RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 411-13 (1997).

21. *See* Rand E. Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643, 645 (1975) (book review).

22. Laurens H. Silver & Mark Edelstein, *Medicaid: Title XIX of the Social Security Act—A Review and Analysis—Part I*, 4 CLEARINGHOUSE REV. 239 (1970) (footnote omitted) (citing DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, Supp. D, § 1000).

23. *See* Health Care Financing Administration, *supra* note 5; DIANE ROWLAND ET AL., KAISER COMM'N ON THE FUTURE OF MEDICAID, MEDICAID AT THE CROSSROADS 5-7 (1992).

24. *See infra* notes 158-59 and accompanying text.

25. *See* DAVID LISKA ET AL., KAISER COMM'N ON THE FUTURE OF MEDICAID, MEDICAID EXPENDITURES AND BENEFICIARIES: NATIONAL AND STATE PROFILES AND TRENDS, 1984-1993 83-84 (1995); Freund & Hurley, *supra* note 11; JUDITH FEDER ET AL., KAISER COMM'N ON THE FUTURE OF MEDICAID, THE MEDICAID COST EXPLOSION: CAUSES AND CONSEQUENCES 7-8 (1993).

26. *See surpa* note 6 and accompanying text.

nearly universal response of federal and state officials to the dual concerns of increasing costs and cramped access to medical care has been to move toward Medicaid managed care.[27] This transformation must be undertaken, however, in a manner that is consistent with Medicaid's purpose. In particular, it must interfere with Medicaid beneficiaries' access to essential community providers only to the extent that such interference comports with the statutory mission of Medicaid.[28]

But what is the statutory mission of Medicaid? It is clear that the "general aim" of Medicaid is to provide a "package of health care services" to eligible persons and to assure that "individuals will receive necessary medical care,"[29] although the statutory goal clearly falls short of requiring states to provide *all* necessary care.[30] It is remedial legislation, intended to improve the second-class system of health care for the poor.[31]

Yet such aims do not establish the proper treatment of the "dual system" of American health care, nor the fate of essential community providers. Does the statute intend to remedy both the substandard nature of the care *and* the segregation of the poor in the delivery of health care, or does a "separate but adequate" system of health care meet the statutory mandate?[32] In other

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27. *See* Colleen M. Grogan, *The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns*, 22 J. HEALTH POL. POL'Y & L. 815, 818-19 (1997); John K. Iglehart, *Health Policy Report: Medicaid and Managed Care*, 332 NEW ENG. J. MED. 1727 (1995); DIANE ROWLAND ET AL., KAISER COMM'N ON THE FUTURE OF MEDICAID, MEDICAID AND MANAGED CARE: LESSONS FROM THE LITERATURE 1 (1995); Freund & Hurley, *supra* note 11, at 474.

28. *See* Gregg S. Meyer & David Blumenthal, *TennCare and Academic Medical Centers: The Lessons from Tennessee*, 276 JAMA 672 (1996) (citing National Ass'n of Health Ctrs. v. Shalala, No. 1:94CV01238 (D.D.C. filed June 7, 1994)) (challenging the grant of waivers from Medicaid requirements for reimbursement of and access to community health centers) (complaint dismissed by plaintiffs); David Burda, *Community health group quietly drops Medicaid suit*, MODERN HEALTHCARE, Nov. 18, 1996, at 20; Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 550-51 (1995); Suzanne Rotwein et al., *Medicaid and State Health Care Reform: Process, Programs, and Policy Options*, 16 HEALTH CARE FIN. REV. 105, 118-20 (1995).

29. Alexander v. Choate, 469 U.S. 287, 303 (1985).

30. *See id.* (upholding a 14-day annual limit on any beneficiary's hospital inpatient services); Charleston Mem'l Hosp. v. Conrad, 693 F.2d 324, 329-30 (4th Cir. 1982) (upholding a 12-day annual limit on any beneficiary's hospital inpatient services).

31. *See* STARR, *supra* note 19, at 373.

32. This is a difficult question in other areas as well. In crafting remedial legislation addressing disability discrimination, Congress has required not only nondiscrimination and reasonable accommodation in access to public accommodations and services for persons with disabilities, 42 U.S.C. § 12182(b)(1)(A)(ii) (1994), but also that the accommodations and services not be "different or separate from that provided to other individuals. . . ." 42 U.S.C. § 12182(b)(1)(A)(iii) (1994). And over forty years ago the Supreme Court held that racially segregated "separate but equal" public education necessarily violated the Equal Protection Clause of the Fourteenth Amendment. *See* Brown v. Board of Educ., 347 U.S. 483, 493 (1954). *But see* Alex M. Johnson, Jr., *Bid Whist, Tonk, and United States v. Fordice: Why Integrationism Fails African-Americans Again*, 81 CAL. L. REV. 1401

words, is the integration of the poor into the medical mainstream a distinct goal of Medicaid, or is integration merely one of several strategies available for improving health care access for the poor?[33] If it is the former, essential community providers are largely unprotected by statute, and may even be a hindrance to the full achievement of a unitary health care system. If it is the latter, essential community providers are protected to the extent they can argue successfully that they advance the health of the poor.

The statutory language contains no reference to mainstreaming or integrating the care of Medicaid beneficiaries. The most straight-forward statement of goals in the statute[34] is its mandate that participating states "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interest of recipients."[35] The original legislation also required that states demonstrate progress toward the goal of providing "comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."[36] The effective date for achieving this second goal, however, was first postponed;[37] then in 1972 the provision was repealed altogether.[38]

Medicaid's very general language provides no definitive indication that its general goal of enhancing the poor's access to health care carries an implicit codicil encouraging an end to the dual-track health care system. Medicaid has evolved over time, and it may be that its focus has shifted.[39]

(1993).

33. *See* Charles J. Dougherty, *Ethical Values at Stake in Health Care Reform*, 268 JAMA 2409, 2409 (1992) (distinguishing between values that are of "intrinsic importance" and those that are "instrumental to the attainment of what is intrinsically important.")

34. If, indeed, anything about Medicaid could be said to be straight-forward. *See How I Learned to Stop Worrying and Love The Medicaid Statute, in* REPRESENTING OLDER PERSONS: AN ADVOCATE MANUAL 23 (National Senior Citizen Law Center, 1985), *excerpted in* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 598 (2d Ed. 1991); *see also* Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 856-57 (1990).

35. 42 U.S.C. § 1396a(a)(19) (1994).

36. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 1903(e), 79 Stat. 286, 350 (codified as amended in Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (1994)).

37. *See* Social Security Amendments of 1969, Pub. L. No. 91-56, § 2(a), 83 Stat. 99 (1969). *See* Rosenblatt, *supra* note 21, at 643, 651 n.39.

38. *See* Social Security Amendments of 1972, Pub. L. No. 92-603 § 230, 86 Stat. 1329, 1410 (1972). *See* Rosenblatt, *supra* note 21, at 651 n.39.

39. *See* Freund & Hurley, *supra* note 11, at 474 (stating Medicaid "was developed first with a consuming concern for access and later with cost containment objectives") (footnotes omitted). By suggesting that the statutory focus has shifted, I mean only that Congress has repeatedly passed

With respect to the question of mainstreaming, however, amendments to the statute are no more illuminating than was the original language. For example, in an amendment that could be construed as suggesting an emphasis on mainstreaming, Congress in 1989 required that states "assure that payments [to providers] are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[40] This language appears to envision a congruity between the network of health care providers available to Medicaid beneficiaries and the non-poor, privately insured population. In the same Act, however, Congress mandated enhanced Medicaid reimbursement for, and guaranteed beneficiary access to, Federally Qualified Health Centers and Rural Health Centers, which by design and practice create a separate system of health care for the poor.[41] Yet even if these amendments more clearly expressed a coherent vision of Medicaid's mission that expression would be of minimal instructive value, as they are among the provisions that can be waived in a section 1115 Medicaid managed care program.[42]

The principle of mainstreaming runs chimerically through discussions of Medicaid's mission. A major theme of the discussion is that breaking down the barriers between America's separate health systems is integral to the program's mission. Rand Rosenblatt, for example, has described the purpose of the Medicaid statute as directed at mainstreaming:

> The ultimate goal of the legislation, stated explicitly in the "comprehensive care" section [§ 1903(e), repealed in 1972] and implicitly in other sections, was nothing less than the elimination of traditional dual track health care for the poor, and the incorporation of the poor into the "mainstream" or middle-class patterns of hospital and medical care.[43]

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amendatory statutes, *see, e.g.*, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 § 6402(a), 103 Stat. 2106, 2260 (codified as amended at 42 U.S.C. § 1396a(30)(A) (1994)) (adding mandatory language regarding the availability of providers); *see also* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 § 131(a), 96 Stat. 324, 367 (codified as amended at 42 U.S.C. § 13960 (1994)) (modifying cost-sharing provisions), and not that the meaning of the original statute has been somehow dynamically interpreted by non-legislators, either "beyond" or "against" its original meaning. *Cf.* WILLIAM N. ESKRIDGE, JR., DYNAMIC STATUTORY INTERPRETATION 49 (1994).

40. Omnibus Budget Reconciliation Act of 1989, § 6402(a). *See* Watson, *supra* note 6, at 198-99.

41. *See* Omnibus Budget Reconciliation Act of 1989, § 6402(c)(2) (codified at 42 U.S.C. § 1396 a(a)(13)(E) (1994)).

42. *See* 42 U.S.C. § 1315(a)(1) (1994). Interview with Michael Fiore, Acting Deputy Director, Division of Integrated Health Systems, HCFA, June 25, 1997 and July 26, 1997.

43. Rosenblatt, *supra* note 21, at 649.

Sidney D. Watson similarly describes the purpose of the statute as directed at eradicating dual-track care, arguing that "Medicaid promised to end this dual class delivery system by providing poor people with health insurance they could use to purchase private medical care."[44]

This mainstreaming vision of Medicaid was embraced by courts and regulators early in the program's life. In 1975, Judge Jack Weinstein granted a preliminary injunction against a New York City plan to contract selectively with clinical laboratories, ruling that such limitations on beneficiary choice would violate "[t]he acknowledged purpose of the Medicaid program [which] was to bring the poor into the mainstream of American medical services."[45] Judge Weinstein cited several provisions of the Medicaid statute to support his characterization of its purpose:

> Congress required that the program be in effect in all parts of the participating state (42 U.S.C. § 1396a(a)(1)); that services be made available promptly (42 U.S.C. § 1396a(a)(8); that services for which the state pays be comparable for covered groups (42 U.S.C. § 1396a(a)(10)(B)); and that the program be administered in the "best interests of the recipients" (42 U.S.C. § 1396a(a)(19)). In 1968, Congress added provisions establishing a system of reviewing use and quality of care. 42 U.S.C. § 1396a(a)(30)-(31). It permitted Medicaid recipients to choose health care providers according to their own preference. 42 U.S.C. § 1396a(a)(23). Section 1396(a)(23) is commonly referred to as the "freedom of choice" provision.[46]

The Department of Health, Education and Welfare, later renamed the Department of Health and Human Services, expressed a similar vision in its regulatory material:

> A basic concept of [Medicaid] is that of equality of medical and remedial care and services. Its purpose is to erase the differences in the various categories in regard to care and services. What this means in

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44. Watson, *supra* note 6, at 192.

45. Bay Ridge Diagnostic Lab., Inc. v. Dumpson, 400 F. Supp. 1104, 1106 (E.D.N.Y. 1975) (citing *Hearings Before the Subcommittee on Medicaid and Medicare of the Senate Finance Committee*, 91st Cong. 57 [(1970)]. The Senate hearing record cited by Judge Weinstein included the following description of Medicaid's purpose: "The whole purpose of the 1965 act was to provide 'mainstream medical care' for all the people of this country. The objective was great, and I think during the transition, we are bound to have problems." *Medicare and Medicaid: Hearings Before the Senate Comm. on Fin.*, 91st Cong. 57 (statement of John G. Veneman, Under Secretary, Dept. of Health, Educ. and Welfare) (1970).

46. *Bay Ridge*, 400 F. Supp. at 1106.

> actual operation is that AFDC children will be treated the same as all other recipients.[47]

Furthermore, the Agency by regulation had required that states set provider fees at a level "sufficient to enlist enough providers so that services under the plan are available [to Medicaid beneficiaries] at least to the extent that those services are available to the general population,"[48] long before Congress amended the statute to ratify that aspect of the Agency's interpretation.[49]

To the extent that courts, commentators, and regulators suggest that mainstreaming advances and is consistent with the statutory purposes of Medicaid, their argument is compelling. The poor have long been subjected to lesser medical care than the non-poor,[50] and bringing them *up* to the mainstream of course advances "the best interests of the [Medicaid] recipients."[51] The goal of "moving to the mainstream" is within the broad statutory goal of improving services for the poor, and is a rhetorically effective and easily-grasped articulation of a strategy for achieving such improvement.

But nothing in the statutory language or legislative history supports elevating the ideal of mainstreaming from programmatic vehicle to destination. Few would disagree that providing the poor with care substantially identical to that of fully insured members of the middle class would discharge the program's duty to provide "necessary medical care"[52] in the "best interest of the recipients."[53] But it would go beyond the evidence of Congress's intent to suggest that, in constructing Medicaid managed care programs, state and federal officials are required to embrace mainstreaming as anything beyond an instrument, a means to an end.

A minor theme of the mainstreaming discussion is contrapuntal to the major theme, and supports the existence of essential community providers in the Medicaid managed care system. Many have observed that the poor have *different* needs due to historical neglect of their health and general economic disadvantage.[54] The poor therefore require some health services beyond those

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47. UNITED STATES DEPARTMENT OF HEALTH, EDUC. AND WELFARE ADMIN., HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, Supp. D, Medical Assistance Program, § D-5143 (Washington, D.C., December 1, 1966), *quoted in* Rosenblatt, *supra* note 21, at 648 n.23.

48. 42 C.F.R. § 447.204 (1994).

49. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 § 6402(a), 103 Stat. 2106, 2260 (1989) (codified as amended at 42 U.S.C. § 1396a(a)(30) (1994)).

50. *See* Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1649 (1993); STARR, *supra* note 19, at 151-53; STEVENS & STEVENS, *supra* note 20, at 16.

51. 42 U.S.C. § 1396a(a)(19) (1994).

52. Alexander v. Choate, 469 U.S. 287, 303 (1985).

53. 42 U.S.C. § 1396a(a)(19).

54. In 1996 interviews with Medicaid "policy elites" in Connecticut, researchers determined that

provided to more economically advantaged populations through commercial health insurance.[55] Medicaid beneficiaries' historical (and continuing[56]) lack of access to health care providers, and lack of resources with which to supplement insurance benefits in the purchase of services, has driven the program to support the development of specialized community health clinics through directing grants, mandating access to the clinics for Medicaid beneficiaries, and requiring enhanced reimbursement levels;[57] to develop highly structured preventive care programs;[58] and to create substantial links with other social service systems.[59] Prior to the emergence of managed care, Medicaid evolved into a program intended to go beyond "simply giving eligible recipients a Medicaid 'credit card' and leaving them to find their own way in a fragmented and inadequate health care system."[60] Rather, the special needs of the poor were recognized by assisting them in finding providers willing to serve them,[61] and by integrating their health care with other social support and service systems.[62]

> About half of the respondents articulated a strong belief that AFDC recipients should be treated just like anyone else in society; if given the opportunity, they will be able to negotiate the managed care system like anyone else. . . . However, many other respondents—particularly those representing recipients—believe AFDC-Medicaid recipients should be treated differently because on average they have greater health needs.

Grogan, *supra* note 27, at 834.

55. *See* Note, *The Impact of Managed Care on Doctors who Serve Poor and Minority Patients*, 108 HARV. L. REV. 1625, 1635 (1995).

56. *See* Watson, *supra* note 6.

57. *See* 42 U.S.C. § 1396a(a)(13)(E) (1994) (requiring 100% reasonable cost reimbursement of federally qualified health centers and rural health clinics).

58. *See* 42 U.S.C. § 1396d(r) (1994) (Early and periodic screening, diagnosis, and treatment services).

59. *See* Freund & Hurley, *supra* note 11, at 486-87.

60. Rosenblatt, *supra* note 21, at 656.

61. *See id.*

62. *See* UNITED STATES DEPARTMENT OF HEALTH, EDUC. AND WELFARE ADMIN., *supra* note 47, at §§ D-1000 & 5140, *quoted in* STEVENS & STEVENS, *supra* note 20, at 80:

> In seeking to put Title XIX into effect, States are expected to approach the provision of such health services with the aim of making them readily available to all eligible persons. The States are expected, furthermore, to set standards that will be appropriate to insure that the services will be of high quality and to adopt methods of administration designed to assure that the services are furnished in a sympathetic and dignified manner. The emphasis will be focused on medical care as part of a comprehensive plan for services, not just on payment of the medical bill. . . .
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> . . . .
>
> The passage of Title XIX marks the beginning of a new era in medical care for low income families. The potential of this new title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose, will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.

There is an air of anachronism about any attempt to read the effort to mainstream beneficiaries' medical care as the statutory mission of Medicaid. Early in its history, Medicaid bore with it the promise of a full, rich, compassionately administered program that would wipe out America's legacy of unequal health care for the poor.[63] Within a few years of its creation, however, Congress was chipping away at this promise.[64] By 1971, a mere six years after Medicaid's enactment, Elliot Richardson, President Nixon's Secretary of Health, Education and Welfare, drove a stake in the heart of the hope that the passage of Medicaid would lead to a truly integrated health care system.[65] Since that time, the focus of state Medicaid policy has been as much on cost containment as on providing adequate health services to the poor.[66] Increasing cost pressures have limited states' ability and will to maintain reimbursement levels for health care providers that are sufficient to draw the providers into the program or to add optional services that would have fulfilled the vision of the program's early years.[67]

A program whose goals were vague from the beginning,[68] Medicaid evolved away from coherence toward an increasingly complex amalgam of statutory provisions cobbled together through piecemeal amendment.[69] The lack of internal coherence and clear legislative mandates makes it impossible to determine, from the statute's text or the legislative record, whether any

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See also Silver & Edelstein, *supra* note 22.

63. *See* STEVENS & STEVENS, *supra* note 20, at 51-52.

64. *See id.* at 143-45.

65. Secretary Richardson testified to Congress as follows:

> [S]ince the 1930's the Nation has evolved a basic division of public and private health care roles. Over the last 35 years government has taken responsibility in health care for the poor, the disabled, and the aged, while the private sector has provided ever-increasing protection for those in the labor force through diversity, free choice and competition. We firmly believe that this fundamental division of responsibilities between the two sectors is desirable, workable, and can serve as a basis for improvement.

Hearings Before the House Comm. on Ways and Means on the Subject of National Health Insurance Proposals, 92d Cong., 6 (1971), *quoted in* Rosenblatt, *supra* note 21, at 661. The current state of the "ever-increasing protection for those in the labor force" is a subject for another day. *Id.* Suffice it to say, the rosy picture described by Secretary Richardson in 1971 is today decidedly mixed. *See* Kenneth E. Thorpe, *The Health System in Transition: Care, Cost and Coverage*, 22 J. HEALTH POL. POL'Y & L. 339, 351-55 (1997); JOEL S. WEISSMANN & ARNOLD M. EPSTEIN, FALLING THROUGH THE SAFETY NET: INSURANCE STATUS AND ACCESS TO HEALTH CARE 18-22 (1994).

66. *See* STEVENS & STEVENS, *supra* note 20, at 318-19.

67. *See* Watson, *supra* note 6, at 196-98; Rand E. Rosenblatt, *Medicaid Primary Care Case Management, The Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915, 931-32 (1986); Margaret McManus et al., *The Adequacy of Physician Reimbursement for Pediatric Care Under Medicaid*, 87 PEDIATRICS 909 (1991).

68. *See* Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1, 9-10 (1983).

69. *See* STEVENS & STEVENS, *supra* note 20, at 316-19; *see also* Robert L. Schwartz, *Medicaid Reform Through Setting Health Care Priorities*, 35 ST. LOUIS U. L.J. 837, 837-38 (1991).

particular approach to providing necessary care to Medicaid beneficiaries is more consistent with its overall plan than any other approach. The poor remain dramatically ill-served by our health care system.[70] Changes in the program, to the extent that they are within the remarkably permissive section 1115 waiver limits, are appropriate if they are in the "best interests of the recipients."[71] The next section demonstrates that state and federal officials overwhelmingly favor a wholesale shift to managed care as the best means to advance the interests of Medicaid beneficiaries, sometimes apparently by mainstreaming beneficiaries' health care, and sometimes by improving their care, but always by saving money. The statute is clear, however, that neither managed care nor mainstreaming are ends in themselves, but can be parts of strategies to eliminate the second-class level of health care experienced by the poor.[72]

II. MEDICAID MANAGED CARE AND PROTECTION OF THE SAFETY NET

Medicaid managed care represents the outer reaches of states' experimentation with mechanisms to attain their goals of providing appropriate care to beneficiaries while reining in the exploding costs of the program. Medicaid, like the other social welfare programs of the Social Security Act, is a joint federal-state venture, with the two levels of government sharing both cost and governance. Although states have substantial flexibility in the design of their Medicaid programs, federal requirements cabin that discretion.[73] The limitation in the states' ability to shape their programs has been blamed for their experiencing increasing Medicaid expenditures in the last decade or more.[74] However, since 1962—three years before Medicaid was enacted—the federal government has permitted states to employ section 1115 waivers to undertake "demonstration" projects in welfare programs (including, since 1965, Medicaid). The waivers excuse compliance with a wide range of otherwise-

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70. There are limits to the pessimism regarding the Medicaid program. Although the program has certainly not created a unitary, comprehensive system of health care, there is no doubt that the poor have received better access to care, particularly primary care, thanks to the Medicaid program. *See* Robert F. St. Peter et al., *Access to Care for Poor Children: Separate and Unequal?*, 267 JAMA 2760 (1992); Paul W. Newacheck & Neal Halfon, *Preventive Care Use by School-Aged Children: Differences by Socioeconomic Status*, 82 PEDIATRICS 462 (1988).

71. 42 U.S.C. § 1396a(a)(19) (1994).

72. *See* Freund & Hurley, *supra* note 11, at 494 ("[M]anaged care does not address Medicaid's severe financial problems, which are likely to persist so long as financing of programs and services for the poor are segregated from financing for other beneficiary groups.")

73. *See* 42 U.S.C. § 1396a (1994); 45 C.F.R. § 302.0 - 302.85 (1995).

74. *See* PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REP. TO CONGRESS 422-24 (1997) [hereinafter 1997 PPRC REPORT]; Rosenberg & Zaring, *supra* note 28, at 546-47.

applicable federal program requirements.[75] Since 1981, states have been permitted to employ section 1915 waivers to undertake longer term but more targeted projects varying from the generally applicable federal requirements.[76] With the passage of the Balanced Budget Act of 1997, the limited goal of moving Medicaid beneficiaries to managed care may be achieved without a waiver.[77]

The use of waivers for Medicaid managed care suffered a false start in California in the early 1970s, in a program rife with fraud, poor service, and mismanagement at the state and provider levels.[78] Beginning in 1981, states began to pursue limited waivers to pursue managed care projects "to control the growth and improve the predictability of expenditure increases."[79] Since 1993, there has been an explosion of growth in Medicaid managed care, as the federal review process to which states are subject has become simpler, even inviting.[80] The "demonstration" aspect of section 1115 waivers has effectively fallen away, as similar programs are approved in several states, for longer periods of time, and with relaxed standards of budget neutrality.[81] Although states have created many types of managed care programs, utilizing a wide variety of managed care organizations, the trend has been toward broad programs mandating the enrollment of large segments of the Medicaid population in managed care, and toward contracting with health maintenance organizations ("HMOs") to provide a comprehensive array of services in return for a capitated payment.[82] The rise of managed care waiver programs, and particularly of section 1115 waiver programs, reflects the growing adoption by state and federal officials of new health management

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75. *See* Public Welfare Amendments of 1962, Pub. L. No. 87-543, tit. I, § 1115 76 Stat. 172, 192 (codified as amended at 42 U.S.C. § 1315 (1994)).

76. *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 2161, 95 Stat. 357 (codified as amended at 42 U.S.C. § 1396n(b),(c) (1994)).

77. *See* ROWLAND ET AL., *supra* note 27, at 7; Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (to be codified at 42 U.S.C. § 1396(a) note (1997).

78. *See* Iglehart, *supra* note 27, at 1730; ROWLAND ET AL., *supra* note 27, at 6; Freund & Hurley, *supra* note 11, at 476; David F. Chavkin & Anne Treseder, *California's Prepaid Health Plan Program: Can the Patient Be Saved?*, 28 HASTINGS L.J. 685, 686 (1977).

79. Freund & Hurley, *supra* note 11, at 474.

80. *See* 59 Fed. Reg. 49,249 (1994) (discussing relaxed criteria for managed care waivers); *see also* ROWLAND ET AL., *supra* note 27, at 8-9; Iglehart, *supra* note 27, at 1728; Ferber, *supra* note 5, at 99-100.

81. *See* Rosenberg & Zaring, *supra* note 28, at 549-51. *But see* Beno v. Shalala, 30 F.3d 1057, 1076 (9th Cir. 1994) (remanding § 1115 waiver of cash-benefit welfare program requirements for more study on the scope of waiver and its effect on recipients).

82. *See* 1997 PPRC REPORT, *supra* note 74, at 425-31; UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAID: SPENDING PRESSURES DRIVE STATES TOWARD PROGRAM REINVENTION GAO/HEHS-95-122 (April 1995) [hereinafter U.S. GAO, MEDICAID].

techniques for restraining and regularizing health care costs.[83]

The increase in the number of Medicaid beneficiaries shifted to managed care in recent years has been spectacular. In the five years from 1991 to 1996, the number of Medicaid beneficiaries enrolled in managed care shot from 2,696,397 (9.53% of the Medicaid population) to 13,330,119 (40.10% of the Medicaid population).[84] This shift to managed care has "alarmed" historical providers of care to Medicaid beneficiaries, who "find their positions threatened as managed care plans compete to enroll these patients and channel them to their own provider networks."[85]

Policymakers reacting to this alarm are faced with a difficult problem. At its heart, Medicaid managed care is the "privatization" of the network formation and provider reimbursement aspects of the Medicaid program. States contract with managed care organizations to provide comprehensive care to a segment of the Medicaid population, often paying them a flat, capitated fee for that care. In return, the managed care organizations take responsibility for matching the population with an accessible, appropriate array of health care providers.[86] Privatization is touted for encouraging efficiencies through competition, and for reducing regulatory restraints in

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83. *See* Grogan, *supra* note 27, at 818-19; Rotwein et al., *supra* note 28, at 120.

84. *See* Health Care Financing Administration, *supra* note 5; *see also* 1997 PPRC REPORT, *supra* note 74, at 424; 1 SARA ROSENBAUM ET AL., CENTER FOR HEALTH POLICY RESEARCH, GEO. WASH. U. MEDICAL CENTER, NEGOTIATING THE NEW HEALTH CARE SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS, iv-x (1997); Holahan et al., supra note 5, at 208.

85. Iglehart, *supra* note 27, at 1727; *see also* Debra J. Lipson, *Medicaid Managed Care and Community Providers: New Partnerships*, HEALTH AFF., July-Aug. 1997, at 91, 93; Schauffler & Wolin, *supra* note 9, at 461.

Some traditional providers of Medicaid care have banded together to form managed care organizations of their own, and in this guise continue to control their own destinies in the evolving Medicaid system. *See* Michelle M. Casey et al., *Rural Health Network Development: Public Policy Issues and State Initiatives*, 22 J. HEALTH POL. POL'Y & L. 23 (1997); Sparer, *supra* note 11, at 433; Heuer, *supra* note 7. Commercial HMOs increasingly dominate the Medicaid managed care marketplace, however, as states seek to move quickly to integrate Medicaid populations into mainstream health care. *See* Diane Rowland & Kristina Hanson, *Medicaid: Moving to Managed Care*, HEALTH AFF., Fall 1996, at 150, 150-51; Marsha Gold et al., *Medicaid Managed Care: Lessons From Five States*, HEALTH AFF., Fall 1996, at 153, 159-162. For-profit ownership is increasingly dominant among managed care organizations generally, and for-profit plans (particularly large, multi-state plans) are growing more rapidly than non-profits. *See* Janet M. Corrigan et al., *Trends Toward a National Health Care Marketplace*, 34 INQUIRY 11 (1997). In contrast, the number of hospital beds in non-profit ownership has remained at about 70%, with 20% in public hospitals and only about 10% in for-profit ownership. *See* Gary Claxton et al., *Public Policy Issues in Nonprofit Conversions: An Overview*, HEALTH AFF., Mar.-Apr. 1997, at 9 (1997). The effect of shifts in ownership of health care firms from nonprofit to for-profit is a separate but closely-related controversy. *See id.; see also* Mark Schlesinger et al., *Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System*, 21 J. HEALTH POL. POL'Y & L. 697 (1996).

86. *See* DIANE ROWLAND ET AL., *supra* note 27, at 10-11.

management and employment matters.[87] In cost terms, privatization efforts by state and local governments have been broadly successful.[88] States' movement to managed care as a privatization of management and financing services in Medicaid programs is, then, an extension of a trend in the relationship among government, nonprofits, and markets. Thus, an inclination to permit the contracting managed care organizations to manage their own networks—their subcontractors—is to be expected.

For state and federal officials, Medicaid managed care shifts a nettlesome administrative burden to private contractors and offers some moderation of Medicaid's financial pressures.[89] But to carry through on the "privatization" of the network formation aspects of this arrangement, state and federal officials would at least risk the continuing viability of traditional Medicaid providers, which rely on Medicaid reimbursement and would have no guarantee of survival in the private competitive world of network formation under a purely privatized system. That is, there is no guarantee that commercial managed care organizations will select traditional Medicaid providers for membership in their provider networks. Indeed, there is reason to believe that they will be inclined not to include them. Managed care organizations place great stock in their ability to select, limit, and control their network of providers.[90] In evaluating providers for network membership, managed care organizations value efficiency, practice methods that reduce utilization of high-cost modalities of care, well-developed quality measurement systems, and integration with broad delivery systems.[91] Many traditional Medicaid providers are perceived to score poorly on these criteria.[92] In addition, these providers often care for patients who are vulnerable in terms of health needs, socioeconomic status, and cultural and language barriers.[93] Managed care organizations "may assume that all

87. *See* DONALD F. KETTL, SHARING POWER: PUBLIC GOVERNANCE AND PRIVATE MARKETS 160-63 (1993); Marc Benedick, Jr., *Privatizing the Delivery of Social Welfare Services: An Idea to be Taken Seriously*, *in* PRIVATIZATION AND THE WELFARE STATE 97, 107 (Shelia B. Kamerman & Alfred J. Kahn eds., 1989).

88. *See* KETTL, *supra* note 87, at 160; Benedick, *supra* note 87, at 107.

89. Some controversy exists regarding the extent to which Medicaid managed care provides genuine financial benefits to the states. *See* Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 755-57 (1997); William Alvarado Rivera, *A Future for Medicaid Managed Care: The Lessons of California's San Mateo County*, 7 STAN. L. & POL'Y REV. 105, 116 (1996); ROWLAND ET AL., *supra* note 27, at 19-20. The resolution of that question is beyond the scope of this article.

90. *See infra* text accompanying note 139.

91. *See* Raymond J. Baxter & Robert E. Mechanic, *The Status of Local Health Safety Nets*, HEALTH AFF., July-Aug. 1997, at 7, 19.

92. *See id.*

93. *See* Lipson, *supra* note 85, at 94.

community-based providers serve high-risk, sicker populations, which would increase the risk of adverse selection for [managed care organizations] that have community-based providers in their provider network."[94] The exclusion of community-based providers from managed-care networks in states with comprehensive Medicaid managed care programs can interfere with these community-based providers' relationship with Medicaid patients, and the revenue stream on which these providers rely to provide care to Medicaid and uninsured patients.[95]

For a variety of reasons which are evaluated in Part III below, officials have equivocated when faced with this dilemma, and have attempted to accommodate both the impulse to move to market systems and the desire to maintain essential community providers. They have done so by formally or informally creating essential community provider provisions that limit market forces, thereby allowing some historical providers of health care to the poor preferred entry into essentially private managed care networks.[96]

Essential community provider provisions gained prominence as part of President Clinton's proposed Health Security Act.[97] The proposal would have required all "health plans" (the name given participating insurers and managed care entities under the proposal[98]) either to include essential community providers in their networks on terms "at least as favorable as those that are applicable to other providers participating in the health plan," or to contract with them for compensation pursuant to a regulatorily-created fee schedule.[99] The term "essential community provider" was broadly

94. *Id.*

95. *See id.* at 93.

96. The thrust of the protections offered by states to essential community providers is limited to assured or assisted entry into managed care networks. The essential community providers would then be subject to intra-plan competition and the possibility that they would lose market share to other network providers that may be new to Medicaid. Thus, the essential community provider provisions can be seen as a necessary but not sufficient measure in these providers' efforts to survive in a competitive Medicaid marketplace. To survive, essential community providers must not only participate in Medicaid managed care networks, but do so successfully. *See* Gold et al., *supra* note 85, at 163; Schauffler & Wolin, *supra* note 9, at 471-73.

97. H.R. 3600, 103d Cong. (1993). A description of the proposed Health Security Act is beyond the scope of this paper. For a concise description of the intended functioning of the plan, *see* Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, HEALTH AFF., Spring (I) 1994, at 9; THE WHITE HOUSE DOMESTIC POLICY COUNCIL, THE CLINTON BLUEPRINT: THE PRESIDENT'S HEALTH SECURITY PLAN (1993). For perspectives on the reform effort's resounding defeat, *see, e.g.*, THEDA SKOCPOL, BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996); Hugh Heclo, *The Clinton Health Plan: Historical Perspective*, HEALTH AFF., Spring 1995, at 86.

98. *See* H.R. 3600, 103d Cong. § 1400 (1993).

99. *See id.* § 1431.

defined in the Act.[100] Some categories of providers were to be automatically designated as essential community providers, including statutorily defined federally qualified health centers, rural health centers, family planning clinics, and service units of the Indian Health Service.[101] In addition, "qualified community practice networks"—consortia created to provide services to a "medically underserved population"[102]—were to be so designated.[103] Finally, public hospitals and nonprofit community hospitals, health professionals, and other public and nonprofit organizations located in "health professional shortage areas" and serving a "medically underserved population" were to be permitted to apply to the Secretary of Health and Human Services for designation as essential community providers.[104] This essential community provider provision would have accommodated the conflict between market freedom and protection of favored providers by requiring that essential community providers participate in health plan networks, but not otherwise requiring health plans to accord them any significant special status.[105]

Current federal Medicaid law requires that states provide beneficiaries access to services offered by some community health centers, (although the enhanced payments diminish over time),[106] and also enhanced payments to "disproportionate share hospitals."[107] Even prior to the Balanced Budget Act, Medicaid managed care waivers permitted states, with federal approval, to

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100. *See id.* §§ 1581-1584.

101. *See id.* § 1582(a).

102. A "qualified community practice network" was to be a "public or nonprofit" entity whose mission was to provide services "in one or more health professional shortage areas or to provide such items and services to a significant number of individuals who are members of a medically underserved population." *Id.* § 3421(b), (c). The entity had to be a consortium of providers listed in the statute, including public health agencies and community health clinics. *See id.* § 3421(c), (d).

103. *See id.* § 1582(a)(11).

104. *See id.* § 1583. The definition of "essential community provider" was to be part of a study of essential community providers undertaken by the Secretary of Health and Human Services in preparation of a report to Congress on possible amendments to the Act's provisions in this regard. *See id.* § 1431(b), (c).

105. The wild card in this regard would have been the fee schedules created for compensation of essential community providers that did not elect to enter into a provider agreement. If the fees in the schedule were set sufficiently low, this "opt-out" provision would have provided little protection, while high fees would have provided substantial advantage for essential community providers over other providers. As the Act was never adopted, we will of course never know how the opt-out provision would have functioned.

106. *See* 42 U.S.C. § 1396a(a)(13)(E) (1994) (providing for reimbursement of rural health centers and federally-qualified health centers); *id.* § 1396d(a)(xi)(2) (specifying rural health centers and federally-qualified health centers services for which state Medicaid plans must pay); 42 C.F.R. § 440.20(b) (1994) (listing rural health center and federally-qualified health center services that must be accessible to Medicaid beneficiaries); Pub. L. No. 105-33, § 4712, 111 Stat. 508-09 (codified as amended 42 U.S.C. § 1396a note (1994)) (phasing out enhanced payments).

107. *See infra* notes 158-59 and accompanying text.

gain partial or total relief from those provisions.[108] No federal law, then, *mandates* protection of essential community providers, although as is discussed below,[109] federal regulators retain and use the discretionary authority to condition the grant of section 1115 waivers on favorable treatment of essential community providers.

A few states have enacted statutes granting varying degrees of special status to some essential community providers. Louisiana, for example, mandates that benefit plans providing services pursuant to a Medicaid managed care waiver[110] include essential community providers, including community health centers and "[p]hysicians who have historically served Medicaid and indigent patients" in their networks.[111] South Carolina designates a much more limited class of providers—Federally Qualified Health Centers and Rural Health Clinics—as essential community providers, and mandates their inclusion in "any formulation of the state health care system."[112] Maine[113] and Minnesota[114] go further, requiring in the former case that all HMOs agree to include essential community providers in their networks, and in the latter that most health plans include them.[115] Minnesota has the most detailed definition of essential community provider, allowing an

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108. *See* 42 U.S.C. §§ 1315(a), 1396n(b) (1994); *see* Memorandum from Acting Director, Medicaid Managed Care Team to All Associate Regional Administrators, Division of Medicaid (Feb. 8, 1996) (on file with the author); interview with Michael Fiore, *supra* note 42; interview with Matthew Barry, Office of Managed Care, Health Care Financing Administration (Mar. 20, 1997). *See generally* Debra J. Lipson & Naomi Naierman, *Effects of Health System Changes on Safety-Net Providers*, HEALTH AFF., Summer 1996, at 33; Suzanne Rotwein et al., *supra* note 28.

109. *See infra* text accompanying note 117.

110. Louisiana has applied for, but has not yet received approval for, a § 1115 waiver. *See* Health Care Financing Administration, *Louisiana Statewide Health Reform Demonstration Fact Sheet* (last modified May 13, 1997) <http://www.hcfa.gov/medicaid/lafact.html>.

111. LA. REV. STAT. ANN. § 40:2241-2242 (West 1997). "Essential community providers are defined as:

> health care providers who have historically served medically needy or indigent patients, including each of the following:
>
> (1) Federally qualified health centers.
>
> (2) Rural health clinics.
>
> (3) Hospitals owned and operated by the state and the Louisiana Health Care Authority.
>
> (4) Community health centers.
>
> (5) Small rural and service district hospitals.
>
> (6) Physicians who have historically served Medicaid and indigent patients.
>
> (7) Children's hospital as defined by 42 CFR 412.23(d).

Id. § 2241(A).

112. S.C. CODE ANN. § 44-6-910 (Law Co-op. 1996).

113. ME. REV. STAT. ANN. tit. 24-A, § 4204(2)(M) (West 1996).

114. MINN. STAT. § 62Q.19 (1997).

115. Ironically, Minnesota excludes from this requirement health plans "with fewer than 50,000 enrollees, all of whose enrollees are covered under medical assistance, general assistance medical care, or MinnesotaCare." *Id.* § 62Q.19, subd. 2a.

entity to be designated as such if it meets the following criteria:

> (1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations . . . , underserved, and other special needs populations; and
> (2) a commitment to serve low-income and underserved populations by meeting the following requirements:
> (i) has nonprofit status [under state law];
> (ii) has tax exempt status in accordance with Internal Revenue Service Code, section 501(c)(3) [endnote omitted];
> (iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and
> (iv) does not restrict access or services because of a client's financial limitation; or
> (3) status as a local government unit . . . , an Indian tribal government, an Indian health service unit, or community health board . . . .[116]

Most states, however, have made no such provisions by law or regulation.

The absence of state or federal law *requiring* essential community provider provisions in Medicaid managed care or other programs does not, however, end the analysis. Using their substantial discretion to shape and review section 1115 waiver applications and contracts between states and participating managed care organizations, regulatory officials have created a patchwork of essential community provider provisions through an informal negotiation process that occurs at two levels. First, state officials negotiate with the HCFA during the process of applying for and obtaining a section 1115 waiver. The Social Security Act grants the Secretary of Health and Human Services broad latitude in determining whether to grant a waiver.[117] Outer limits provide some restraint on the Secretary's ability to override the general Medicaid requirements in granting a section 1115 waiver,[118] but within these broad limits, the secretary has a great deal of room

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116. *Id.* § 62Q.19, subd. 1.

117. The section of the Act authorizing § 1115 waivers permits the Secretary to approve a state's application "to the extent and for the period he finds necessary to enable such State or States to carry out such project . . . ." 42 U.S.C. § 1315(a)(1) (1994). Section 1915(b) waivers may be approved "to the extent [the Secretary] finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter." 42 U.S.C. § 1396n(b) (1994).

118. *See* Beno v. Shalala, 30 F.3d 1057, 1068-69 (9th Cir. 1994):

> The legislative scheme, with its mandatory language and detailed requirements, evidences a clear Congressional intent to take certain decisions away from state officials. In granting a § 1315(a) waiver, the Secretary allows the state to deviate from the minimum requirements which Congress has determined are necessary prerequisites to federal funding.

within which to exercise discretion, and therefore to prevail upon state applicants to modify their proposals to more nearly comport with her judgment on public policy matters.[119] Current Secretary Donna Shalala has served public notice that she intends to exercise that discretionary authority in reviewing section 1115 Medicaid managed care waivers.[120] She has also indicated the Department of Health and Human Services will "[w]ork with States to develop research and demonstrations in areas consistent with the Department's policy goals," but it "may disapprove or limit proposals on policy grounds."[121]

In other words, states must be prepared for a fair amount of give and take in the waiver approval process. And they must expect that any section 1115 waiver will be granted subject to very specific "terms and conditions" of the waiver, against which states will be measured during evaluative reviews.[122] The modifications and conditions "suggested" by federal officials during the review process can be specific and detailed. When approving waivers of reimbursement or access guarantees related to Federally Qualified Health Centers or Rural Health Clinics,[123] federal reviewers have routinely imposed specific terms and conditions calculated to ensure beneficiary access to community health centers' services, and to demonstrate how culturally sensitive services will be provided in the waivered system.[124]

In a broader sense, this negotiation process permits federal officials to "encourage" states to include measures protecting essential community providers. Following a state's initial application for a waiver, it is required to submit an "operational protocol," a massive document that details the projected implementation of the waiver.[125] In preparing a "readiness assessment" of the state program, the federal officials then undertake an investigation, including in-state visits. During this investigation they seek to

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> While § 1315(a) obviously represents a congressional judgment that, in certain circumstances, such an override is appropriate, we doubt that Congress would enact such comprehensive regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute allowing states to evade these requirements with little or no federal agency review.

Id. (citations ommitted). The court concluded that the Secretary is required to consider objections and comments on proposed waivers in light of the contextual statutory purpose. *See id.* at 1076.

119. *See* Aguayo v. Richardson, 473 F.2d 1090, 1103 (2d Cir. 1973).

120. *See* 59 Fed. Reg. 49,249 (1994) (public notice describing Secretary's review process).

121. *Id.*

122. *See id.* at 49,251.

123. Approximately two-thirds of the 14 or 15 § 1115 Medicaid managed care waivers that have been granted have included waivers of these community health clinics' 100% cost reimbursement or access requirements, or both. *See* Interview with Michael Fiore, *supra* note 42.

124. *See id.*

125. *See id.*

identify the current and historical providers of Medicaid services and ask for assurances that no falloff of appropriate services will result from a grant of the waiver application.[126] In the course of seeking such assurances, federal officials "strongly encourage" the continuing participation of essential community providers.[127]

But this attempt to maintain the viability of the historic providers of Medicaid services is tempered by a desire to be flexible, and to allow states to improve access to services by bringing expanded networks of commercial health care providers into the Medicaid system.[128] The federal reviewers of state waiver applications therefore attempt to strike a delicate balance by allowing states to employ the tools of competitive commercial managed care organizations and commercial health care providers in order to expand access and constrain costs, while preserving the historic infrastructure of traditional Medicaid providers.[129] The process is by its nature ad hoc, and the effectiveness of the attempts to balance disparate social goals can only be judged over time.

Not by mere coincidence, the second level of informal negotiation in the section 1115 waiver process closely tracks the first. In the first, federal officials negotiate with state officials over terms and conditions that will, among other things, provide some protection to essential community providers. In the second level, states negotiate with managed care organizations over the terms of the contract that will define the latters' obligations, in their construction of provider networks, to provide, among other things, for some special accommodation of essential community providers. No doubt spurred in part by the urgings of federal officials, state officials are

> actively engaged in the complex task of developing [with managed care plans] service agreements which seek to address complex questions regarding: how covered care and services should be delivered; how accessible health care should be; the settings in which care should be furnished; the types of health care professionals and institutions that should be part of managed care networks; and how they expect plans to document and demonstrate the quality of their care.[130]

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126. *See id.*
127. *See id.*
128. *See id.*
129. *See id.*
130. 1 ROSENBAUM ET AL., *supra* note 84, at 16-17.

Preliminary examinations of the contracts between states and the managed care plans reveal varying forms of essential community provider provisions, most of them concentrating on Federally Qualified Health Centers and Rural Health Clinics, which enjoy some limited protection under Medicaid law.[131] Some state contracts require managed care organizations to contract with Federally Qualified Health Centers and Rural Health Centers, and to pay them on terms no less favorable than the rate enjoyed by other providers.[132] Others require that these community health clinics, *if* they are members of the network, receive payment at a rate no less favorable than that paid other contractors.[133] Some states' contracts require that managed care organizations reimburse community health clinics at 100% full cost unless the community health clinic agrees to an alternative arrangement, for example, capitation.[134] Still other states provide that community health clinics that agree to participate in Medicaid managed care networks must be paid "fair" reimbursement by the managed care organization, that is, no less than that paid to other participating providers, and the state Medicaid agency will make up the difference to bring the community health clinic's total reimbursement up to 100% full cost.[135]

States, then, have employed an array of provisions, mostly through

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131. *See supra* text accompanying notes 110-16; *see also* 1 ROSENBAUM ET AL., *supra* note 84, at 33 (suggesting that if access to these community health clinics is not provided through managed care contracts, then state Medicaid agencies "must pay for [it] as a residual service."). Notwithstanding the special statutory position of these community health clinics, the Health Care Financing Agency regards itself as empowered by 42 U.S.C. § 1315 to waive broad aspects of both the cost and access protections of the clinics. *See* 42 U.S.C. § 1315 (1994). As of this writing, the Agency has approved only waivers that incorporate a purpose of involving essential community providers in the waivered Medicaid program. Personal Interview with Michael Fiore, *supra* note 42. Continuation of this solicitous attitude is of central importance to essential community providers. If they were to be excluded from the managed care provider networks, they would be largely separated from their historic patient base even if beneficiaries retain a formal entitlement of access to their services.

132. *See, e.g.*, Delaware RFP at II.44, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-81, 7-82; Montana Contract at 1-17, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-97, 7-98; Minnesota Contract at 17-18, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-92, 7-93.

133. *See, e.g.*, Rhode Island Contract at 26, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-108 to 7-111; Vermont RFP at 2-31, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-115 to 7-117.

134. *See, e.g.*, Colorado Contract at 29, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-81; District of Columbia Contract at 12, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-82; Illinois Contract at 28, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-87; Kansas Contract at 64, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-88, 7-89; Maryland Contract at 32-33, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-89, 7-90; Pennsylvania RFP at 90, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-107, 7-108.

135. *See, e.g.*, Michigan Contract at 8, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-91, 7-92; New Jersey Contract at 22, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-100, 7-101; New York RFP at 66-67, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-101, 7-102; Texas Contract at 15, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 7-112, 7-113.

contracts with managed care providers, to provide some protections to some traditional Medicaid providers.[136] There is no indication yet that such measures damage states' ability to move to a competitive Medicaid managed care system. But the essential community provider provisions vary, and the uncertainty plagues historical Medicaid providers as they anticipate increasing Medicaid managed care activity.

III. ESSENTIAL COMMUNITY PROVIDER PROVISIONS: JUSTIFIED INTERFERENCE IN MARKETS

As the previous section describes, some states have provided a measure of preferred status to essential community providers in the structure of Medicaid managed care networks by statute, regulation or, most commonly, by the terms of the states' contracts with Medicaid-participating HMOs.[137] The nature of this preferred status varies, and is sometimes ill-defined. What is clear is that the states have split regarding whether essential community providers should receive special status in Medicaid managed care.

After considering arguments for both viewpoints, this section describes reasons supporting granting essential community providers some special protections. Granting essential community providers special status may seem contrary to the basic principles driving Medicaid managed care. States pursue Medicaid managed care in order to privatize Medicaid, to become purchasers of health insurance for the poor rather than purchasers of (or providers of) health care for the poor. States are increasingly pursuing this privatization because they believe—on the basis of some evidence—that managers of commercial HMOs have extracted substantial savings in the non-governmental health insurance arena, at least in the short term.[138] Further,

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136. The provisions described in the text are by no means exhaustive. In a recent article, Debra J. Lipson describes six categories of state action regarding participation of traditional Medicaid providers in managed-care groups. These six actions are: (1) California created a program in which plans "developed by county governments and traditional [Medicaid] providers" were one of two plans from which beneficiaries in densely populated counties could choose; (2) some states required plans to contract with traditional Medicaid providers as a condition of program participation; (3) some states in a bidding process favored plans including traditional Medicaid providers; (4) some states assigned more beneficiaries to plans including traditional Medicaid providers; (5) some states set "performance standards" that would be met more easily with the participation of traditional Medicaid providers; and (6) some states directed "transitional payments" or "enhanced reimbursement" to traditional Medicaid providers. *See* Lipson, *supra* note 85, at 102-04.

137. *See supra* text accompanying notes 96-136.

138. *See* 1 ROSENBAUM ET AL., *supra* note 84, at 8-9.

> In the long term, it may be possible [for managed care organizations] to realize savings through greater use of certain types of care, such as preventive services. In the short term, however, managed care organizations realize immediate savings (and therefore, profitability) by curbing utilization of health care or substituting less costly forms of treatment for more costly health

these savings are often attributed not to HMOs' fabled ability to manage their members' care, thereby keeping them well, but to HMOs' ability to manage, through selection, close oversight, and creative incentives, their network of providers.[139] This faith in the power of network management runs deep in health administration circles, and has become an article of faith in government at all levels.[140]

States' strong interest in cost containment is a substantial argument against granting essential community providers preferred entry into Medicaid managed care networks. Any special status granted essential community providers would interfere with HMOs' ability to manage their networks of providers independently. If independent management of provider networks is a substantial factor in the success of HMOs in restraining the rate of health care inflation, interference with that management threatens to undermine the effectiveness of the waiver programs. States arguably would be attempting to have it both ways: to gain the financial benefit of turning over the management of Medicaid to commercial actors, while retaining in the public sector some of the management prerogatives allegedly central to the success of managed care.

To counter this argument against inclusion, the reasons supporting

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services....

Because of its basic structure, Medicaid may be more amenable to short-term, rather than long-term, savings.

Id.; see also John F. Sheils & Randall A. Haught, *Managed Care Savings for Employers and Households: 1990 through 2000*, at 16, 37 (visited Feb. 3, 1998) <http://ww.aahp.org/menus/index.cfm> (estimating private health insurance savings attributable to managed care in 1996 at between $23.8 and $37.4 billion, and projecting private health insurance savings attributable to managed care from 1997 through 2000 at between $125 and $202 billion).

139. *See* Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 915-16 (1995); Christine C. Dodd, Comment, *The Exclusion of Non-Physician Health Care Providers from Integrated Delivery Systems: Group Boycott or Legitimate Business Practice?*, 64 U. CIN. L. REV. 983, 989 (1996); Gary A. Francesconi, *ERISA Preemption of "Any Willing Provider" Laws—An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227, 231 (1995).

140. *See* Iglehart, *supra* note 27, at 1727:

> The sharp divide between Democrats and Republicans on most major health policy issues largely disappears when the subject turns to how federal and state governments should provide medical care to the vulnerable populations that are eligible for Medicaid coverage. Figures as politically disparate as President Bill Clinton and House Speaker Newt Gingrich (R-Ga.), as well as most of the nation's governors, have concluded that states should have the flexibility to enroll many of Medicaid's more than 32 million beneficiaries in managed care plans. They believe such plans hold the greatest potential for stemming the rapid growth of Medicaid expenditures and for expanding coverage to uninsured people with low incomes.

Id.; *see also Managed Care May Save Money, But Hard To Say How Much*, 1995 CONG. Q. 2905 (September 23, 1995); Freund & Hurley, *supra* note 11, at 474; Rosenberg & Zaring, *supra* note 28, at 549-51; Rivera, *supra* note 89, at 106.

essential community provider provisions must go beyond a sense of gratitude to essential community providers for their mission-driven service to the poor when profit-driven institutions were uninterested and instead hew closely to the statutory purposes of Medicaid. Further, they may not be premised on an ideological dislike of for-profit institutions if, as I argue above, corporate structure is of only instrumental, not essential, importance to the goal of providing care for the medically indigent.[141] It is also not sensible to force the inclusion of traditional Medicaid providers on the basis of their alleged lower historical costs, although there is some evidence that nonprofit providers have lower costs than for-profits.[142] The movement to Medicaid managed care is premised on the competitive abilities of commercial managed care organizations. If these competitive abilities have any value, they must encompass price discrimination. It would therefore seem anomalous to embrace privatization of network formation, only to retain in the states the power to determine which network providers are least costly. A slightly more appealing, but similarly unpersuasive argument is that society has invested in public and nonprofit facilities, and that investment should not be "wasted."[143]

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141. *See supra* text accompanying notes 29-38. The instrumental nature of business activities in the effort to provide care to the needy was captured recently by Sister Jean deBlois, vice president for Mission Services of the Catholic Health Association:

> [R]aising the red flag of the supposed dichotomy between business and ministry blinds people to the reality that business, because it is a human endeavor, can be a graced activity. "Doing business" should not be seen as the nemesis of "doing ministry." Rather, business should be understood as an instrumental value that enables us to do what ministry requires. This means, of course, that the manner in which we conduct the business of health ministry must be informed and driven by the values and commitments that flow from the MISSION [sic] imperative.

Sr. Jean deBlois, *The MISSION Imperative: Our Foundation and Market Advantage*, HEALTH PROGRESS, Mar.-Apr. 1997, at 24, 27.

An argument for an absolute ban on for-profit institutions in Medicaid managed care now seems somewhat quaint. It would depend on assumptions that informed consumer choice combined with appropriate legal protections is *never* able to discriminate among profit-seeking and nonprofit providers, that the participation of for-profit institutions in the market has *no* beneficial effect on the responsive actions of nonprofits, and that there is sufficient capacity in the nonprofit sector to meet the demand for services. *See* Henry Hansmann, *Economic Theories of Nonprofit Organization*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 27, 40-41 (Walter W. Powell, ed., 1987).

142. *See* William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 439-40 (1995); Larkin, *supra* note 9; Schauffler & Wolin, *supra* note 9; *see also* Steffie Woolhandler & David U. Himmelstein, *Costs of Care and Administration at For-Profit and Other Hospitals in the United States*, 336 NEW ENG. J. MED. 769, 772 (1997); Stuart H. Altman & David Shactman, *Should We Worry about Hospitals' High Administrative Costs?*, 336 NEW ENG. J. MED. 798 (1997).

143. Reduced (perhaps unfairly) to its essence, this argument is that the very existence of expensive public and nonprofit facilities is sufficient justification for their current protection. At this level, the argument is a variant of the "because it's there" explanation, attributed to George Leigh Mallory (mountaineer), *see* OXFORD DICTIONARY OF QUOTATIONS 443 (4th ed. 1992), or the "because that's where the money is" explanation, attributed to Willie Sutton (bank robber).

The mere fact of past investment in infrastructure, however, cannot support future investment, unless future investment can be justified on its own merits.[144]

An argument that prior public or nonprofit investment should be protected from competitive pressure because the institutions relied on regulators' explicit or implicit promises of continuing reimbursement streams is similar to that made by for-profit electric utility firms in the face of deregulation. There, investors in for-profit firms argue that they have "stranded costs, which can be defined as those costs that the utilities currently are permitted to recover through their rates but whose recovery may be impeded or prevented by the advent of competition in the industry."[145] These costs were incurred by the utilities during years of heavy regulation, often to advance public purposes (such as encouraging alternative fuel sources, temporarily ameliorating rate pressure, or allowing access to services for the poor), which purposes were often imposed on the firms by regulators.[146]

Deregulation of electric utility services without some allowance for recovery of these costs is arguably a regulatory taking, and is arguably unwise, as it would impair otherwise vigorous market participants from competing on a level playing field.[147] Yet even in the for-profit utility firm setting, the arguments for recognition of stranded costs are controversial.[148]

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144. It may be true that society would not have engaged in the historical level of expenditures on some public and nonprofit facilities had it been known that they would become uneconomic. But to continue to fund such facilities, *if* it is true that less current funding could purchase like services elsewhere, would be financially wasteful and an example of the common phenomenon of overvaluing past, irreversible expenditures in present decision-making, sometimes known as the "sunk cost fallacy." *See* DONALD RUTHERFORD, ED., DICTIONARY OF ECONOMICS 445 (1992) (defining "sunk cost fallacy" as "[t]he mistaken view that a firm should take into account the fixed costs it has incurred when deciding whether to continue with production.") In some circumstances, such wasteful spending is not irrational, but merely uneconomic, as it serves the interests of some decision-makers to advance their interests for "prestige, credibility, and the desire for personal vindication." 3 JOHN EATWELL ET AL., THE NEW PALGRAVE: A DICTIONARY OF ECONOMICS 950 (1987). Advancement of such interests, however, seem to be beyond the statutory purposes of Medicaid. *See supra* text accompanying notes 34-38.

145. William J. Baumol & J. Gregory Sidak, *Stranded Costs*, 18 HARV. J.L. & PUB. POL'Y, 835, 835 (1995); *see also Chopping Up America's Power: Deregulating the Power Industry*, THE ECONOMIST, May 3, 1997, at 21 ("Stranded costs are those investments made by utilities which are expected to become uneconomic when competition is introduced and rates begin to fall. They include nuclear plants (there are now much cheaper ways of generating electricity), and long-term contracts with various alternative energy suppliers.").

146. *See* Baumol & Sidak, *supra* note 145, at 835.

147. *See* J. Gregory Sidak & Daniel F. Spulber, *Deregulatory Takings and Breach of the Regulatory Contract*, 71 N.Y.U. L. REV. 851, 866-69 (1996).

148. *See* Stephen F. Williams, *Deregulatory Takings and Breach of the Regulatory Contract: A Comment*, 71 N.Y.U. L. REV. 1000 (1996); Oliver E. Williamson, *Deregulatory Takings and Breach of the Regulatory Contract: Some Precautions*, 71 N.Y.U. L. REV. 1007 (1996); Ruth K. Kretschmer & Robert Garcia, *Recovering Stranded Costs: Not "If," but "How"*, FORTNIGHTLY, Jan. 15, 1997, at

In the case of nonprofit or public health care institutions, however, the argument falls flat. First, mission-driven providers are concerned with service, not profit, and they should not object to a shift that improves services for their clients and patients, even if that shift harms their own institution. Investors in firms, on the other hand, disclaim any interest in social mission, and are interested only in return on their investment. Second, the investors arguably stand to lose something tangible if regulatory decisions bankrupt their firm—they will lose their investment. In the public or nonprofit setting, however, government is making decisions affecting either public or quasi-public institutions, incorporated to serve a public function; therefore, government may have a substantial claim of authority as to the continuing use or disposition of these institutions' assets.[149] Ultimately, the managers of neither public nor nonprofit facilities appear to have standing to object to a shift in governmental policy that is beneficial to the facilities' patients or clients, but is harmful to the facilities themselves.

In sum, supporters of essential community provider provisions must advance the goal of current and future services to the medically indigent. The purposes of Medicaid[150] may have been well served in the past by mission-driven essential community providers. However, any claim that they are literally "essential" to fulfilling Medicaid's statutory mission should not be taken on faith, but should be supported by persuasive argument. Those arguments must take seriously the economic value to states in protecting the managerial autonomy of Medicaid-participating HMOs. For whatever reason,[151] the historical Medicaid system dominated by fee for service reimbursement and mission-driven providers has failed.[152] It too often provided poor care at high prices.[153] States, then, have some basis for moving

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149. *See* Donald Shriber, *State Experience in Regulating a Changing Health Care System*, HEALTH AFF., Mar.-Apr. 1997, at 48; Patricia Butler, *State Policy Issues in Nonprofit Conversions*, HEALTH AFF., Mar.-Apr. 1997, at 69; Eleanor Hamburger et al., *The Pot of Gold: Monitoring Health Care Conversions Can Yield Billions of Dollars for Health Care*, 29 CLEARINGHOUSE REV. 473, 474 (1995); Rob Atkinson, *Reforming Cy Pres Reform*, 44 HASTINGS L.J. 1111, 1120 (1993); *see also* Tamar Lewin & Martin Gottlieb, *In Hospital Sales, an Overlooked Side Effect*, N.Y. TIMES, Apr. 27, 1997, at A1.

150. *See supra* text accompanying notes 18-72.

151. To a certain extent, the fee-for-service Medicaid system was sandbagged, as the states simply failed to maintain provider reimbursement levels (particularly for primary care physicians) at levels sufficient to maintain a suitable network. *See* Blendon et al., *supra* note 10, at 138-41; Watson, *supra* note 6; *see also* ERDMAN & WOLFE, *supra* note 6; CONGRESSIONAL RESEARCH SERVICE, 103d CONG., 1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) 343-54 (Comm. Print 1993).

152. *See* Blendon et al., *supra* note 10, at 138-41; Watson, *supra* note 6.

153. *See* Rivera, *supra* note 89, at 106; *see also* Cynthia G. Tudor, *Medicaid Expenditures and State Responses*, HEALTH CARE FIN. REV., Spring 1995, at 1; U.S. GAO, MEDICAID; *supra* note 81;

to privatize the management and financial oversight of Medicaid by "contracting out" these management and oversight duties in Medicaid managed care programs.

There are three compelling reasons to support essential community provider provisions within the framework of Medicaid managed care: (1) the willingness and ability of essential community providers to cost-shift for the benefit of the medically indigent not covered by Medicaid; (2) the ability of essential community providers to soften the harmful effects of information asymmetries that plague consumers in the Medicaid managed care market; and (3) the sluggishness of essential community providers' capital and the market stability they therefore offer in changing economic times.

A. Cost-Shifting to Serve the Uninsured Poor

Arguments about the role of mission in modern health care often focus on the willingness of firms to shift revenue from insured patients to finance treatment for the uninsured. Medicaid covers only slightly more than half of America's poor.[154] The plight of the uninsured has worsened in recent years as competitive pressures limit community providers' ability to cost-shift. Consequently, "the percentage of uninsured persons who lacked a usual source of care, a traditional measure of access that facilitates entry into the system, increased from 27.7 percent in 1977 to 35.9 percent in 1993."[155] As described below, cost-shifting for the benefit of the uninsured poor is an appropriate statutory goal of a Medicaid program, and many nonprofits have a history of and propensity for cost shifting. Although more efficient means of providing care to the poor could easily be adopted, practical and political constraints lead governments to fall back on the accepted method of cost-shifting.

As described above, statutory, regulatory or contractual provisions granting special preferences to essential community providers in Medicaid managed care must be consistent with Medicaid's statutory purposes.[156] At first blush, it might seem that cost-shifting to cover the care of the poor who are not eligible for Medicaid coverage, while a socially appropriate goal, is

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Note, *supra* note 89.

154. *See* KAISER COMMISSION ON THE FUTURE OF MEDICAID, MEDICAID FACTS 1 (February 1995) ("Although Medicaid has increasingly been used to expand coverage to the low-income population, it covers only 58 percent of poor Americans.").

155. Peter J. Cunningham & Ha T. Tu, *A Changing Picture of Uncompensated Care*, HEALTH AFF., July-Aug. 1997, at 167, 172.

156. Some extend their essential community provider provisions beyond Medicaid. Minnesota's provision applies to all managed care organizations. *See* MINN. STAT. ANN. § 62Q.19 (West 1997).

one beyond the statutory reach of Medicaid.[157] Unlike commercial insurance plans, however, Medicaid has long been structured to provide reimbursement not only for its own insureds, but also for a related group of low-income uninsureds. Since 1981 Medicaid has provided, through the "disproportionate share hospital" program, for enhanced reimbursement to fund hospitals' service to non-Medicaid, uninsured patients.[158] Disproportionate share payments are intended to "help hospitals, such as public and non-profit hospitals, that serve needy patients. Because these facilities have high Medicaid and uninsured caseloads, they are less able than other hospitals to shift the costs of uncompensated care to privately insured patients."[159]

Extending care to the poor, whether or not they are eligible for Medicaid, is therefore a long-standing purpose of Medicaid. More particularly, providing access to the uninsured poor is one of the driving forces behind Medicaid managed care. A key component of many section 1115 waiver programs is their extension of insurance coverage for the previously uninsured poor and near-poor, although states' reach in this regard has largely exceeded their grasp.[160] States may be confronted with a large residual uninsured population, and a diminished safety net of providers damaged by their exclusion from selective HMO networks.[161] Essential community provider provisions in Medicaid managed care would help minimize that danger.

There is evidence that nonprofit hospitals provide more charity care than do for-profit hospitals.[162] The same holds true for nonprofits in other areas of

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157. *See supra* note 29 and accompanying text.

158. *See* 42 U.S.C. § 1396r-4 (1994); *see also* Linda E. Fishman & James D. Bentley, *The Evolution of Support for Safety-Net Hospitals*, HEALTH AFF., July-Aug. 1997, at 30, 35-37; CONGRESSIONAL RESEARCH SERVICE, 103d Cong., 1st Sess., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) 319-22 (Comm. Print 1993). The Balanced Budget Act of 1997 preserved Medicaid funding of the disproportionate share hospital program, although at modestly reduced levels. *See* Pub. L. No. 105-33, 111 Stat. 251, 444, 4721 (to be codified at 42 U.S.C. § 1396L (1997)).

159. Leighton Ku & Teresa A. Coughlin, *Medicaid Disproportionate Share and Other Special Financing Programs*, HEALTH CARE FIN. REV., Spring 1995, at 27, 29; *see also* Fishman & Bentley, *supra* note 157, at 36-37; Sparer, *supra* note 11, at 446-47. Gail R. Wilensky, *Health Care Reform: Is 1994 the Year?*, 46 WASH. U. J. URB. & CONTEMP. L. 13, 26 (1994). In recent years it has become increasingly true that hospitals serving a high proportion of Medicaid patients are shouldering a proportionately larger uncompensated care burden. *See* Joyce M. Mann et al., *A Profile of Uncompensated Hospital Care, 1983-1995*, HEALTH AFF., July-Aug. 1997, at 223, 228-29.

160. *See Medicaid: Spending Trends and the Move to Managed Care*, PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REP. TO CONGRESS 425 (1997); U.S. GAO, *supra* note 81, at 4; Holahan et al., *supra* note 5, at 208; Riley, *supra* note 11, at 144-45.

161. *See* Note, *supra* note 55, at 762-64.

162. *See* Bradford H. Gray, *Conversions of HMOs and Hospitals: What's At Stake?*, HEALTH AFF., Mar.-Apr. 1997, at 29, 39-40 (saying nonprofits provide marginally more charity care, and that the amount of charity care varies from state to state); Altman & Shactman, *supra* note 142, at 798-99;

health care delivery, such as home health care, nursing homes, and psychiatric hospitals.[163] These hospitals and other traditional Medicaid providers will probably continue to cost-shift to provide care for the uninsured for three reasons. First, many public and nonprofit facilities cost-shift to provide care to the uninsured because such activity is within their explicit mission.[164] In addition, nonprofits are barred from distributing

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PROSPECTIVE PAYMENT ASSESSMENT COMM'N, ANNUAL REP. TO CONGRESS 84 (1996); Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 352-53 (1991); Lawrence S. Lewin et al., *Setting the Record Straight: The Provision of Uncompensated Care by Not-For-Profit Hospitals*, 318 NEW ENG. J. MED. 1212, 1213 (1988) (reporting study findings that "the perception that there is 'little or no difference' in the provision of uncompensated care between investor-owned and not-for-profit hospitals is clearly wrong"); *see also* Linda E. Fishman, *What Types of Hospitals Form the Safety Net?* HEALTH AFF., July-Aug. 1997, at 215, 220-21 (finding top uncompensated care hospitals are divided equally between government and nonprofit ownership).

Federal and state governments pay a price for the nonprofit status of these hospitals in the form of taxes foregone. If the excess charity care is provided in nonprofit hospitals *because* they are accorded nonprofit status, and if charity care is the sole or principal social benefit of this nonprofit status, society may well not be driving a very hard bargain. *See* Hall and Colombo, *supra*, at 353-54. *But see* Michael A. Morrisey et al., *Do Nonprofit Hospitals Pay Their Way?*, HEALTH AFF., Winter 1996, at 132, 137 ("On average, the [studied hospitals'] amount of uncompensated care, measured on a cost basis, exceeded the tax subsidies by almost two to one."). As Hall and Colombo recognize, however, there are other possible explanations for the grant of tax exemption. *See* Hall & Columbo, *supra*, at 354. In any event, it is not at all clear that nonprofits provide charity care as a quid pro quo for tax exemption; they may instead provide it out of a sense of mission. In addition, efficiency is not the only measure of a financing system for care for the poor. In the real world we sometimes make do with systems that have social benefit regardless of their cost effectiveness. At any rate, there is very little evidence that the grant or withholding of tax exempt status bears any causal relationship to the mix of nonprofit and for-profit firms in the health care delivery system. *See* Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 882-83 (1980).

A recent study concluded that the conversion of hospitals from nonprofit to for-profit status did not result in a fall-off in the amount of uncompensated care provided. *See* Gary J. Young et al., *Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?*, HEALTH AFF., Jan.-Feb. 1997, at 137-140. Yet the validity of this conclusion was significantly compromised by the fact that post-acquision analysis was limited to a three-year period, and because "[i]n some acquisitions the corporation agrees to maintain uncompensated care at its existing level for a specified period." *Id.* at 141. The study, then, may have measured only whether for-profit successor corporations more or less adhered to the regulatorily imposed requirement that they provide for some limited period the level of uncompensated care provided by their predecessor nonprofits. The authors provided no reason to believe that the levels of uncompensated care will continue beyond the required period.

163. *See* Theodore R. Marmor et al., *Nonprofit Organizations and Health Care*, *in* THE NONPROFIT SECTOR, *supra* note 141, at 230-34.

164. *See* Schauffler & Wolin, *supra* note 9; Bruce Siegel, *Public Hospitals—A Prescription for Survival* (Commonwealth Fund) (last modified Feb. 1998) visited July 30, 1997) <http://www.cmwf.org/minority/siegel.html>; NATIONAL ASS'N OF PUBLIC HOSPITALS, AMERICA'S URBAN HEALTH SAFETY NET, January 1994. Joel Weissman explains this shift as follows:

> The debate may come down to attitude. For-profit hospitals are much more likely to have policies that discourage admission of uninsured or Medicaid patients. When speaking of the for-profit sector, a common sentiment among those in public and religiously affiliated hospitals is that "they do by accident what we do on purpose."

Joel Weissman, *Uncompensated Hospital Care: Will it Be There if We Need It?*, 276 JAMA 823

operating margin to owners or investors in the form of dividends or increased share prices, and are therefore more likely to reinvest excess funds into services, including services for the benefit of the broader community.[165] Finally, the "nonpecuniary rewards" available to nonprofit managers channel their activities to areas by which their organizations' excellence can be measured in terms other than profit, including but not limited to expanded service to the uninsured of the community.[166]

Essential community providers, then, will tend to leverage their membership in Medicaid managed care networks to provide care for the uninsured. Is this a legitimate reason for creating essential community provider provisions in Medicaid managed care? It can be argued that this indirect method of providing public funding for the care of the poor is more clumsy and inefficient than simply creating a direct funding system, or expanding Medicaid eligibility to encompass all of the poor.[167] That is, it may not be sufficient that some subset of nonprofit providers will more readily cost-shift than for-profit institutions. Instead, as Mark Hall and John Colombo have argued in a related context, the legitimacy of essential community provider provisions might depend on whether the manipulation of Medicaid managed care networks "represent[s] the most sensible vehicle for support, that some form of direct grant might not more accurately approximate the optimal level of support, or that direct government provision of the same services is not preferable."[168] It is a fair question: why interfere with management prerogatives of commercial HMOs, why manipulate an insurance program to create an operating surplus for the benefit of the uninsured, when direct payment for care of the currently uninsured would almost certainly be more efficient? The short answer is that cost-shifting is an achievable, politically acceptable method of financing care for America's uninsured millions. There appears to be little political support for new government social welfare programs, or for significant changes in the current

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(1996) (footnote omitted).

165. *See* David Lawrence, *Why We Want to Remain a Nonprofit Health Care Organization*, HEALTH AFF., Mar.-Apr. 1997, at 118, 119-20; Hansmann, *supra* note 162, at 838.

166. *See* Schlesinger, *supra* note 85, at 712-13.

167. This point is distinct from the analysis of whether the value of care nonprofits provide to the uninsured equals the value of the taxes from which nonprofits are excused by virtue of their nonprofit status—a question of some dispute in its own right. *Compare* Morrisey et al., *supra* note 162, at 141 (80% of California's nonprofits provide more value in charity care than they receive in tax benefit) *with* Hall & Colombo, *supra* note 162, at 798-99 (saying "fragmentary evidence" suggests that nonprofits gain more benefit from tax subsidies than they return in charity care); *see also supra*, note 162 and accompanying text.

168. Hall & Colombo, *supra* note 162, at 329.

health financing system.[169] Funding for Medicaid itself is hardly secure, and the program is sure to face increasing fiscal constraints in the future.[170] It is difficult to imagine an interest group less likely to succeed in gaining an extension of health financing than the poor and disabled uninsured who are ineligible for Medicaid.[171] Political leaders are caught in a vise: they face an electorate distrustful of government programs, but have an implicit mandate to ensure some minimal level of care for at least some segments of the poor. In other words, care for the uninsured poor is important, and an indirect system of finance, with a proven track record of service and largely in the hands of a trusted non-profit sector may be the most "sensible vehicle" available at this time.[172]

Essential community provider provisions will advance Medicaid's purpose of financing care for the uninsured poor. Essential community providers, due to their mission, their nonprofit status, or both, are more likely than for-profits to leverage the reimbursement they receive for services to Medicaid-eligibles to finance care for those who are unable to afford care, but are ineligible for Medicaid. This means of providing care for the indigent relies upon flexibility within the Medicaid financing system, by which marginally excessive payments are made for the care of the Medicaid-eligible poor to provide resources to be shifted for the care of the poor who are not Medicaid-eligible. The movement to Medicaid managed care reduces

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169. *See* SKOCPOL, *supra* note 97, at 176-77; Daniel Yankelovich, *The Debate That Wasn't: The Public and the Clinton Plan*, HEALTH AFF., Spring 1995, at 7, 15-17. Advances toward reducing the high levels of uninsurance seem to be limited to children, the most politically appealing population segment. *See* Robert Pear, *G.O.P. Lawmakers Want $16 Billion for Health Plan*, N.Y. TIMES, June 9, 1997, at A1.

170. *See* Charles Tiefer, *"Budgetized" Health Entitlements and the Fiscal Constitution in Congress's 1995-1996 Budget Battle*, 33 HARV. J. ON LEGIS. 411, 421 (1996); Robert Kuttner, *The Either/Or Budget Fallacy*, WASH. POST, Jan. 8, 1997, at A25; Editorial, *Medicaid and the Governors*, WASH. POST, Feb. 9, 1996, at A20. *See generally infra* Part III.C.

171. *See* Karl Kronebusch, *Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making*, 22 J. HEALTH POL. POL'Y & L. 839 (1997). *See generally* Herbert Hovenkamp, *Legislation, Well-Being, and Public Choice*, 57 U. CHI. L. REV. 63, 108 (1990).

172. Moving from the political to the economic realm, this is an example of a "second best problem," in which the admixture of regulated and unregulated, efficient and inefficient systems makes it difficult to predict exactly the effect any isolated attempt to foster small-scale efficiency will have on overall efficiency. *See* Ronald H. Coase, *Economics and Contiguous Disciplines*, 7 J. LEGAL STUD. 201 (1978), *reprinted in* READINGS IN THE ECONOMICS OF LAW AND REGULATION 3, 21 (A.I. Ogus & C.G. Velanovski eds., 1984). Coase writes:

> In an imperfect world where some sectors of the economy persistently and irremediably deviate from efficiency it will no longer be true that fostering efficiency in other sectors will maximize economic efficiency. The constraint imposed by deviant sectors of the economy must be taken into consideration and this will require immensely complex, if not impossible, calculations to determine the optimal policy. This is known as the problem of the "second best."

Id.

this flexibility, perhaps a great deal, as disproportionate share funding is diverted from safety-net hospitals to expand Medicaid eligibility.[173] States show little inclination to muster the funding and political will to create a new program of universal coverage for the poor, and cost-shifting must, in the meantime, remain an important part of the safety net.

B. Information Asymmetries and Trust of Mission-Driven Providers

The ability of essential community providers to counteract the effects of significant market imperfections in the Medicaid managed care system also justifies their inclusion in Medicaid networks.[174] Essential community providers serve two functions in this regard: they provide *safe havens* with traditional Medicaid providers for those beneficiaries troubled by provider change, and they provide *benchmarks* of patient-centered care to improve the effects of intra-plan competition on the development of care appropriate to poor patients.[175] In this way, essential community providers can ameliorate the effects of information asymmetries that prevent Medicaid managed care programs from performing as truly efficient markets.

Economists generally agree that goods and services are efficiently provided in well-functioning markets by for-profit firms, and that nonprofits occupy a significant place in commercial markets[176] as a result of market failures.[177] More particularly,

[W]hen certain conditions are satisfied, profit-seeking firms will

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173. *See* Marsha Gold, *Markets and Public Programs: Insights from Oregon and Tennessee*, 22 J. HEALTH POL. POL'Y & L. 633, 662-63 (1997).

174. *See* Freund & Hurley, *supra* note 11, at 492.

175. *See infra* text accompanying notes 226-27.

176. "Commercial market," a term borrowed from Henry Hansmann, refers to a market in which participating firms receive most or all of their income in exchange for the goods or services they provide. *See* Hansmann, *supra* note 162, at 840-41.

177. As market failures diminish (*i.e.*, when markets "mature"), for-profits should come to dominate. But "commercial" (as opposed to "donative," *see* Hansmann, *supra* note 162, at 840, 862) nonprofits continue to dominate the market for hospital services. *See* Claxton et al., *supra* note 85, at 12. This continued dominance of nonprofits could be attributed to "inertia and tradition," *see* Hansmann, *supra* note 162, at 867; to the market advantage of nonprofits attributable to their "tax subsidy," *see* Michael E. Herbert, *A For-Profit Health Plan's Experience and Strategy*, HEALTH AFF., Mar.-Apr. 1997, at 121, 123; Hall & Colombo, *supra* note 162, at 310-11; or to the continuing presence of market failure in the form of information asymmetries. "Inertia and tradition" are hardly powerful long-term factors in market dynamics, and yet nonprofit hospitals persist. Further, there is no evidence that the tax benefit experienced by nonprofit hospitals outweighs their larger charitable activity, *see* Morrisey et al., *supra* note 162, at least to a degree that the marginal benefit could not be overcome by the presumed efficiency superiority of the for-profit form. It is therefore reasonable to infer continuing market failure in the hospital market and other institutional health care markets characterized by continuing substantial nonprofit presence.

> supply goods and services at the quantity and price that represent maximum social efficiency. Among the most important of these conditions is that consumers can, without undue cost or effort, (a) make a reasonably accurate comparison of the products and prices of different firms before any purchase is made, (b) reach a clear agreement with the chosen firm concerning the goods or services that the firm is to provide and the price to be paid, and (c) determine subsequently whether the firm complied with the resulting agreement and obtain redress if it did not.[178]

These conditions all concern the availability and use of information. When sufficient information is available to permit consumers to evaluate a service, bargain for it, and evaluate the performance of its provision, consumers can fend for themselves against self-interested and profit-seeking firms. When appropriate information is not available because, for example, it is difficult to define goals and measure results,[179] or when desired performance cannot be tied to explicit contractual specifications,[180] nonprofits serve a positive consumer protection role in the marketplace.[181] Health care markets are "characterized by serious informational asymmetries because of the vulnerabilities of patients and the use of third-party payment."[182] The market for medical care is highly imperfect in two separate but related ways: first, there is a yawning gap of technical knowledge between the sellers of the services and the ultimate consumers,[183] and second, "[t]he importance of these asymmetries is heightened by the emotional associations of life-saving treatment and the traumas of injury and dread disease."[184] The lack of information and oversight of quality is of particular concern in Medicaid managed care systems.[185]

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178. Hansmann, *supra* note 162, at 843 (footnote omitted).

179. *See* KETTL, *supra* note 87, at 37-40.

180. *See* Benedick, *supra* note 87, at 113.

181. *See* HENRY HANSMANN, THE OWNERSHIP OF ENTERPRISE 233-34 (1996); Schlesinger et al., *supra* note 85, at 713. Hansmann, *supra* note 162, at 29, 36.

182. Gray, *supra* note 162, at 29, 36.

183. *See* Ezekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL. POL'Y & L. 147, 157 (1997).

184. Marmor et al., *supra* note 163, at 221, 223.

185. *See* 1997 PPRC REPORT, *supra* note 74, at 439-52; Gold et al., *supra* note 85, at 158-59; Sparer, *supra* note 11, at 456-57; *see also* Freund & Hurley, *supra* note 11, at 492. Freund and Hurley warn:

> The potential for problems [with managed care plans] is intensified for Medicaid. Beneficiaries, by definition, lack the financial means to go "out of network" to obtain desired care. Legitimate concerns exist about the geographical, cultural, and linguistic accessibility of prepaid health plans whose traditional members have not been economically disadvantaged or drawn from ethnic minorities. Finally, the special medical needs of these populations, such as early intervention

It has been argued in the past that physicians acting as "very sophisticated purchasing agent[s]" for consumers ameliorate these information asymmetries.[186] While consumers are unable to compare products, bargain for services, or monitor quality, some believe their physicians, acting as quasi-fiduciary agents, are able and willing to serve that role. Therefore, consumers, through their agents, are fully able to fend for themselves in dealings with self-interested for-profit firms.

Physicians, by virtue of their professionalism, superior knowledge, and relational position of trust, have been seen as leveling the playing field between consumers and health care institutions.[187] Yet if this rosy picture of physician agency was ever true,[188] it is no longer. Modern physicians are entrepreneurs, involved in a wide range of business activities apparently at odds with a vision of detached professional attention to patient welfare.[189] In addition to conflicts arising from physicians' own business activities, their contracts with managed care organizations often include financial incentives that at least appear to conflict with an ethic of fidelity to patient welfare.[190] While managed care financing mechanisms do not invariably interfere with physicians' loyalty to their patients,[191] changing economic relationships at least call into question any reliance on physician agency as a cure to the

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programs for child health or outreach-based prenatal care services, may demand services and practitioners lacking in both new and existing prepaid plans.

Id.

186. Hansmann, *supra* note 162, at 866.

187. The ethical strictures of the medical profession contemplate that physicians will play this agency role for their patients. *See* Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1816 n.18 (1992) (quoting the American Medical Association's *Code of Medical Ethics*, which indicates a "physician has a duty to do all that he or she can for the benefit of the individual patient" COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS 3 op. 2.03 (1992)); GRAY, *supra* note 1, at 166-67 ("Physicians are expected not only to maintain considerable technical competence but also to be faithful to the interests of their patients"). Physicians are required as a matter of common law to be faithful to this quasi-fiduciary duty in disclosing risks of procedures to patients, *see, e.g.*, Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972); Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972), and in avoiding or disclosing financial conflicts of interest. *See, e.g.*, Arato v. Avedon, 858 P.2d 598, 605-07 (Cal. 1993); Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990). *See generally* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984) (arguing that physicians owe broad duties of fidelity to patients).

188. *See* RODWIN, *supra* note 1, at 1-8; GRAY, *supra* note 1, at 172-74; STARR, *supra* note 19, at 21-24.

189. *See* GRAY, *supra* note 1, at 202-03.

190. *See* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 720-22 (1997); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in the Changing Health Care System*, 21 AM. J.L. & MED. 241, 253 (1995); RODWIN, *supra* note 1, at 8-11.

191. *See* Emanuel & Dubler, *supra* note 1, at 326-27; Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 225-26 (1995).

information asymmetries that plague consumers in the health care delivery system.[192]

Improved methods of independent quality assessment also offer some promise in closing this information gap. Paul Ellwood, in his Shattuck lecture in 1988, prescribed improved data gathering, analysis, and distribution as the cure for patient information asymmetries.[193] Others have suggested that developing independent analytic methods will permit direct assessment of the quality of health care, thereby eliminating at least one reason for the continued presence of nonprofits in the health care delivery system.[194]

Developing technologies offer promise, but they will not in the near future permit lay consumers independently to assess the quality of professional care in medical care generally,[195] or in Medicaid managed care systems in particular.[196] Almost a decade after his Shattuck lecture, Paul Ellwood has observed that competitive developments in the health care industry have focused on cost to the exclusion of quality, that consumers have no means to compare the quality of providers or plans, and that as a result, consumers are losing trust in their health care providers.[197]

The unabated information asymmetries in health care delivery systems in general, and in Medicaid managed care in particular,[198] then, explain the continuing importance of nonprofit participation. At a minimum, the prohibition against nonprofits' distribution of operating surplus in the form of profits provides some assurance against their exploitation of their patients' vulnerability.[199] This reduced ability to profit from information superiority is a source of trust in nonprofits.[200] The general trustworthiness of nonprofits

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192. *See* E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 92 (1994); Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 535-38 (1988).

193. Paul M. Ellwood, *Shattuck Lecture—Outcomes Management: A Technology of Patient Experience*, 318 NEW ENG. J. MED. 1549, 1550 (1988).

194. *See* GRAY, *supra* note 1, at 345-47; Pauly, *supra* note 3, at 235.

195. *See* Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J.L. & MED. 37 (1994); *see also* Jacobi, *supra* note 190, at 768-69; Jesse Green, *Problems in the Use of Outcome Statistics to Compare Health Care Providers*, 58 BROOK. L. REV. 55 (1992).

196. *See* John E. Ware, Jr., et al., *Comparison of Health Outcomes at a Health Maintenance Organization with Those of Fee-For-Service Care*, 1986 LANCET 1017 (reporting study results demonstrating better health results for high-income than low income HMO members in a fee-for-services system); *see also* Freund & Hurley, *supra* note 11, at 494; Rosenblatt, *supra* note 67, at 919-20.

197. *See Plans, Providers, Consumers Need Meaningful Data to Help Restore Trust, Ellwood Says*, 3 MANAGED CARE REP. 522 (1997).

198. *See* Lipson, *supra* note 85, at 92.

199. *See* Schlesinger et al., *supra* note 85, at 713; HANSMANN, *supra* note 181, at 234.

200. *See* Schlesinger et al., *supra* note 85, at 715; Hansmann, *supra* note 162, at 862-63; BURTON

emanates from other sources as well. Health care nonprofits may be regarded as trustworthy because they may include community members on their boards,[201] because they may be geographically concentrated and attuned to local concerns,[202] or because their caregivers are more familiar with and sensitive to the language and cultural differences of their community.[203] Further, the corporate mission of the nonprofits may evidence a mission inconsistent with the nonprofits' taking advantage of their clients; that is, if an institution is well-known for its willingness to moderate fees on the basis of a patient's ability to pay, or to affirmatively reach out to serve the health care needs of a poverty population, its motives may be understood to extend beyond profit.[204]

The conditional tone of the above description is intentional: the evidence of the difference between nonprofit and for-profit institutions is suggestive, but hardly conclusive. Three policy responses to the evident difference between entrepreneurial and mission-driven providers are available to states: *requiring* contracting managed care organizations to subcontract *only* with nonprofits and other suitably qualified essential community providers;[205] *permitting* managed care organizations to *decline entirely* to subcontract with essential community providers; or *requiring* managed care organizations to *permit* essential community providers nonexclusive entry into the Medicaid managed care network.

The evidence seems too thin to warrant the first response. To limit managed care organizations to a sharply limited pool of institutional providers would so restrain their ability to contract selectively as to eviscerate the cost-savings potential of Medicaid managed care.[206] Also, the states' motivating force for seeking Medicaid managed care waivers is after all a reduction in program cost.[207] On the other hand, the arguments that there are genuine consumer protection benefits in maintaining a place in the Medicaid marketplace for mission-driven providers seem strong enough to reject the second option, so long as the cost of restricting the managed care organizations' contracting freedom is not too great. The cost of this option is limited, as essential community providers could be included in the networks

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A. WEISBROD, THE NONPROFIT ECONOMY 124 (1988).

201. *See* Lawrence, *supra* note 165, at 199.

202. *See* Benedick, *supra* note 87, at 115.

203. *See* Note, *supra* note 55, at 1635.

204. *See* Larkin, *supra* note 8; Heuer, *supra* note 7.

205. Public hospitals, for example, are governmental and not nonprofit entities, but they fit within most formulations of the term essential community provider. *See supra* note 14.

206. *See supra* note 139.

207. *See supra* text accompanying notes 79, 83.

under the same terms as other providers,[208] and as nonprofits appear to operate at efficiencies similar to that of for-profits in competitive marketplaces.[209]

A sensible policy response to the information asymmetries in Medicaid managed care, then, is to mandate the non-exclusive inclusion of essential community providers in managed care organizations' provider networks. Essential community providers can serve an important function in Medicaid managed care programs by moderating the potential harm posed to patients by the market's imperfections. The market for health care, and in particular, the market for health care provided to Medicaid beneficiaries, simply cannot be relied upon to provide value to patients. The additional trustworthiness possessed by nonprofits and other mission-driven providers, if they are given access to managed care networks through essential community provider provisions, allows them to provide a needed measure of consumer protection by serving a mediating function in Medicaid managed care.[210]

One of the complexities in the market for medical care is the confusion in identifying the "consumer." The functional "consumer" for medical care services, the person or entity who chooses the "products," (including the health care provider, institutions and plans) has been identified variously as the patient, the physician, and the third-party payor. As described above, physicians are now hampered in serving as a consumer proxy by virtue of the entrepreneurial and behavior-shaping activities of the modern health care delivery system.[211] This leaves the patient and the third-party payor—in this context, state Medicaid agencies. The mandated inclusion of essential community providers in Medicaid managed care plans addresses significant information asymmetries from the perspectives of both "consumers." From the perspective of individual Medicaid beneficiaries, essential community providers serve as "safe havens." From the perspective of Medicaid agencies, they serve as "benchmarks."

From the individual beneficiary's perspective, essential community providers serve the classic role of nonprofits in imperfect markets: they

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208. *See supra* text accompanying notes 132-34.

209. *See* HANSMANN, *supra* note 181, at 239 ("[N]onprofit firms often appear to be managed with substantial efficiency when, as is often the case, they operate in a competitive environment."); Paul J. DiMaggio & Helmut K. Anheier, *The Sociology of Nonprofit Organizations and Sectors*, 16 ANN. REV. SOC. 137, 147 (1990) ("Contrary to orthodox economic theory, research on hospitals reports that [nonprofits] are less expensive (in per-diem patient cost) and thus ostensibly more efficient than [for-profits]"). *But see* WEISBROD, *supra* note 200, at 48-53 (suggesting the measurement of cost efficiency of service provision in the nonprofit sector—including hospitals—is difficult to measure and often becomes distorted).

210. *See* Benedick, *supra* note 87, at 115.

211. *See supra* text accompanying notes 188-92.

provide a trustworthy safe haven in a market where the beneficiaries are unable independently to obtain or assess information on the quality or adequacy of provider services.[212] As described above,[213] when Medicaid devolved from a program offering "mainstream" health access to one offering a "decent minimum" of care, a cadre of specialized Medicaid providers developed. This network of specialized providers was not a satisfactory substitute for the full range of health care providers available to privately insured persons,[214] but it did include a large number of extraordinarily dedicated providers particularly skilled at addressing the needs of the poor.[215] In light of the flaws at least potentially present in the marketplace created by Medicaid waiver programs, it is minimally intrusive to maintain some access to those providers with whom Medicaid beneficiaries have direct experience. If the other providers available in the network are unable to establish their trustworthiness, beneficiaries can fall back on the mission-driven, historically dedicated provider.

The second, and perhaps more important role of essential community provider provisions is their ability to create market "benchmarks" for the appropriate provision of services in Medicaid managed care. Managed care waiver programs proceed on the assumption that the Medicaid system can be improved not only by the privatization of financing and network development, but also by the introduction into Medicaid of a broad array of providers previously excluded by inadequacies of the reimbursement structure in the fee-for-service system. That is, Medicaid managed care attempts to restore Medicaid as a "mainstream" program, in which Medicaid beneficiaries have access to the same array of providers available to privately insured patients.[216] Essential community provider provisions ought not frustrate that goal, and there is no reason to believe they will. Rather, essential community provider provisions will correct for market imperfections created by the third-party payor status of Medicaid agencies.

As third-party payors, Medicaid agencies have oversight and quality control responsibilities that place them in the position of consumer proxies.[217] They are, however, separated from the actual provision of services, and therefore have difficulty assessing the adequacy and quality of the actual

212. *See supra* text accompanying notes 199-200.
213. *See supra* text accompanying notes 18-72.
214. *See supra* text accompanying notes 50-56.
215. *See* Note, supra note 55, at 1635.
216. *See supra* text accompanying notes 71-72.
217. *See* Freund & Hurley, *supra* note 11, at 491-92. The Balanced Budget Act of 1997 adds some modest consumer protection elements to the federal requirements for Medicaid managed care. *See* Pub. L. No. 105-33, 111 Stat. 251, § 4707 (to be codified at 42 U.S.C. § 1396u-2 (1997)).

services rendered. Medicaid managed care rejects the traditional method of dealing with the separation of payor and recipient of services—reliance on nonprofit providers[218]—and instead relies on another strategy: managed competition. Managed competition is a mechanism designed to introduce microeconomic principles into the provision of health care so that quality accountability may increase while costs are contained.[219] Managed competition encourages health care plans and providers to compete for market share within a regulatory framework. Although the competition is expected to be fullest at the plan level,[220] the competition among the providers within the plan can also have the salutary effect of providing incentives for physicians and institutions to compete on the basis of quality and patient satisfaction.[221] In this framework, managed care organization members are permitted to "shop" for physicians and institutions within their plan, and can thereby "vote with their feet," patronizing providers within managed care organizations that meet their particular needs.

This expressed consumer preference mechanism supplements the states' centralized control of provider quality. Medicaid managed care is a privatization of Medicaid financing and network maintenance. The agencies can specify and monitor a great number of contract terms, *e.g.*, credentials of physicians,[222] geographic distribution of providers,[223] and timeliness of

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218. *See* HANSMANN, *supra* note 181, at 229-30.

219. *See* Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24, 29.

220. *See id.*

221. *See* Jacobi, *supra* note 190, at 774-75.

222. Pennsylvania's request for proposal to HMOs requires the primary care physicians in some specialties to be board-certified or board-eligible. *See* Pennsylvania RFP, at 64-66, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-50, 3-51. Missouri's request for proposal to HMOs required that each plan "designate a quality assurance and utilization manager coordinator" who is "board-certified or board-eligible in his or her field of specialty." Missouri RFP, at 35-38, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 5-38.

223. New Jersey's contract with HMOs is very specific in describing the requisite geographic distribution of primary care physicians, clinical nurse practitioners, and clinical nurse specialists:

> Access Standards
>
> 1. 90% of the members must be within 6 miles of 2 [primary care physicians] in an urban setting.
>
> 2. 85% of the members must be within 15 miles of 2 [primary care physicians] in a rural setting.
>
> 3. Covering physicians must be within 15 miles in urban areas and 25 miles in rural areas.
>
> Travel Time Standards
>
> In a mandatory program, the managed care provider must adhere to the 30 minute standard, *i.e.*, enrollees will not live more than 30 minutes away from their [primary care providers or clinical nurse practitioners/clinical nurse specialists]. The following guidelines are to be used in determining travel time.
>
> 1. Normal conditions/primary roads - 20 miles
>
> 2. Rural or mountainous areas/secondary roads - 15 miles

service.[224] It is difficult or impossible, however, for them to specify or monitor the cultural or community sensitivity of the providers, or thoughtful and caring attention to the special needs of a poverty population. Mission-driven providers are likely to bring these attributes to the network. Medicaid beneficiaries are likely to display preferences for providers who demonstrate those attributes.[225] To compete within networks, other providers will be inclined to emulate the attributes of essential community providers that Medicaid beneficiaries find attractive. Essential community provider provisions, therefore, permit Medicaid agencies to encourage, through intra-plan competition, qualities of services that are difficult or impossible to mandate as a matter of contract.

Essential community provider provisions, then, correct for information asymmetries from two different perspectives, corresponding to the two different "consumers" present in Medicaid managed care programs. From the individual Medicaid beneficiary's perspective, they correct for difficulties in judging the quality of providers by providing a "safe haven" with mission-driven providers. From the Medicaid agency's perspective, essential community provider provisions compensate for their remoteness from the actual provision of care, and their inability to specify or monitor by contract important aspects of medical care. Essential community provider provisions permit Medicaid managed care programs to create "benchmarks" for culturally and socially appropriate care that will, through microeconomic pressure, raise the level of treatment throughout the network. Essential community provider provisions, therefore, somewhat paradoxically use

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3. Flat areas or areas connected by interstate highways - 25 miles

4. Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City, - 30 minutes travel time by public transportation OR no more than 2-6 miles from [primary care provider]. . . .

New Jersey Contract, Appendix L, pp. 4-5, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-283, 3-284. The Missouri RFP sets the maximum travel distance for hospitals at 20 miles, but further provides: "The twenty (20) mile distance standard shall not apply in rural areas where the usual and customary is longer. (Usual and customary is access that is equal to the current existing practice for the non-Medicaid population.) The distance standard shall be the usual and customary for the area." Missouri RFP, at 29, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-280. The Nebraska contract with HMOs requires "access to one or more affiliated [primary care providers] within a 20 mile radius or 45 minutes from [the client's] home." Nebraska Contract, at 11, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-281.

224. Vermont's request for proposals to HMOs requires that "[a]ppointments made on referral to specialty medical services shall not exceed 30 days for routine care." Vermont RFP at 2-34, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-266. New Jersey's contract requires scheduling of "regular dental appointments" within three weeks. *See* New Jersey Contract, App. 2, at 5, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-251. Nebraska's contract requires that "[c]lients shall be seen by a physician within three weeks of having a positive pregnancy test and requesting an appointment." Nebraska Contract at 24, *reprinted in* 2 ROSENBAUM ET AL., *supra* note 84, at 3-246.

225. *See* Lipson, *supra* note 84, at 91, 94-95.

competitive market forces to ameliorate the market defects in the Medicaid managed care system.

C. The Value of Stability: Mission, "Capital Lock" and Nonprofit Form

Institutional stability is of great benefit in health care generally and in the delivery of Medicaid services in particular. It is at least disturbing, and can be counter-therapeutic, when patients are forced to change health care providers.[226] Providers that make a commitment to a system, to a community, and to patients are therefore more valuable than providers less likely to maintain continuous relationships. In this regard mission-driven providers offer benefits beyond their entrepreneurial competitors: their provision of services does not depend on a continued favorable assessment of the profitability of such activity, but on an ideological motivation to serve patients or society through health care delivery.[227] For-profit enterprises, on the other hand, will maintain a relationship with a community or group of patients so long as that relationship is economically advantageous. The choice between financial and mission-based motivation in health care delivery makes a difference in terms of commitment to a community.

A commitment to the community sufficient to weather bad times is evident, for example, in the Lawndale Christian Health Center, located on the West Side of Chicago. Lawndale serves about one thousand patients each

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226. Continuity of professional relationships in health care permit caregivers to understand aspects of a patients' health needs better, including "particular reactions to their diseases, their social support systems, their tolerance for pain and disability, the effect of their illness on their work and interests, and their general values and preferences regarding medical care." Ezekiel J. Emanuel & Allan S. Brett, *Managed Competition and the Physician-Patient Relationship,* 329 NEW ENG. J. MED. 879, 880 (1993); *see also* Bryan A. Liang, *Deselection Under* Harper v. Healthsource*: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 855-56 (1997); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship,* 5 HEALTH MATRIX 141, 143 (1995); Dana Gelb Safran et al., *Primary Care Performance in Fee-for-Service and Prepaid Health Care Systems: Results from the Medical Outcomes Study,* 271 JAMA 1579, 1584 (1994); Paula Berg, *Judicial Enforcement of Covenants Not To Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense,* 45 RUTGERS L. REV. 1, 30-36 (1992).

227. This is an important, if perhaps obvious, point. Estelle James and Susan Rose-Ackerman argue that ideological mission is the single most important factor in predicting the success of a nonprofit firm, or of nonprofit firms in an economic sector:

> We believe that a key feature of nonprofit production is ideology. This may stem from religious faith, from a secular vision of a just society, from a belief in a particular theory of education or child development, to a name just a few possible sources. . . . [M]any organizations are nonprofit because their founders have a set of strongly felt beliefs which motivate them more than money alone. The kind of services they chose to produce, the consumers who prefer these services, as well as the [nonprofit organization] fundraising efforts are directly tied to the founders' beliefs.

ESTELLE JAMES & SUSAN ROSE-ACKERMAN, THE NONPROFIT ENTERPRISE IN MARKET ECONOMICS 51 (1986).

week, almost all of whom are either African-American or Mexican-American.[228] About 60% of its patients are on Medicaid, 15% on Medicare, and 25% uninsured, who either pay on a sliding scale or perform labor in return for services.[229] The Center is a project of a church, and has operated in the community for 13 years. The physicians receive sharply below-market salaries, but few have left the practice, except to undertake overseas medical missionary work.[230] The Center has extensive programs for outreach, social work and case management, and has installed a physician's office in a local public aid office.[231] Most of the staff lives in the community.[232]

Religious organizations have no monopoly on such community-centered care providers. The Sixteenth Street Community Health Center has served the near South Side of Milwaukee for twenty-six years, and has developed a reputation for providing high-quality care to the mixed population, which includes English speakers, as well as those who speak only Spanish or Hmong.[233] It serves patients with public, private, and no insurance, provides social services and case management in addition to traditional medical care, and increasingly relies on cost-shifting to cover the expenses of the uninsured.[234]

Those who run for-profit entities are not devoid of humanitarian impulse, but the depth of a for-profit enterprise's commitment to a community can be measured in terms of return on investment. The attraction of institutions such as Lawndale and the Sixteenth Street Community Health Center can be attributed in part to romance, but they are essential community providers because they are genuinely committed to serving the uninsured, and their communities believe in and trust them.[235] But they are essential community providers also because they are dedicated to their communities, and their missions will permit or compel them to find a way to continue to provide services notwithstanding shifts in funding and reimbursement policies. It is simply beyond comprehension that the organizations would shift their resources to a more remunerative venture.

Leaving aside the staying power derived from organizational mission, nonprofit corporate status in itself fosters a stable community presence. This

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228. *See* Heuer, supra note 7.

229. *See id.*

230. *See id.* The physicians are paid $60,000 per year, far below the going rate. They are selected from among residents who rotate through the Center during their medical education. *See id.*

231. *See id.*

232. *See id.*

233. *See* Larkin, supra note 8.

234. *See id.*

235. *See supra* Parts III.A.-B.

stability derives from a circumstance that is otherwise thought to be a drawback to the nonprofit form: its reliance on debt financing, and its inability to gain access to equity markets. Debt financing is less nimble than equity financing, and nonprofit firms are therefore slower to react to shifts in market conditions. Although this inhibits nonprofits' ability to expand rapidly in response to surges in funding and demand, it also permits them—or requires them—to continue in place in slumping markets, when entrepreneurial capital has sought more favorable placements. As Henry Hansmann describes:

> Nonprofit firms, by definition, are incapable of obtaining equity capital. Instead, they must rely upon debt, donations, and retained earnings as sources of capital. These sources are generally less responsive than equity capital to rapid increases in demand. . . .
>
> . . . [W]hen demand declines, nonprofit firms have much less incentive and opportunity than investor-owned firms to reduce their investment in the industry. A nonprofit firm need not—indeed, cannot—pay any return on its net capital (that is, the capital that the firm has acquired over time through donations and retained earnings). Consequently, even in the absence of any direct or indirect subsidies (such as tax exemption), a nonprofit firm can remain in operation at its current scale as long as its revenues are sufficient to cover depreciation—that is, sufficient to earn just a zero net rate of return.[236]

Nonprofit firms, then, weather bad financial times for reasons that go beyond mission. They are able to survive on a minimal or nonexistent operating margin, as they need not satisfy investors with a return on investment. Their debt financing and nonprofit status also inhibit their ability to dispose of assets or shift to another type of business.[237] In contrast, for-profit health care providers can more readily enter or exit a particular business, transfer ownership, and reorganize.[238]

The staying power of essential community providers has important implications in Medicaid managed care. Currently, while managed care organizations and their subcontractors are generally faring well from Medicaid payments, there is competition for a share of the market. As state governments develop experience in managed care contracting in the Medicaid market, and as they become more sophisticated in pricing the services, they will surely apply price pressure to managed care organizations,

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236. *See* HANSMANN, *supra* note 181, at 240.
237. GRAY, *supra* note 1, at 109-10.
238. *See id.* 50-52.

and through them, to the subcontracting health care providers. In some states, the reimbursement level for Medicaid managed care is already far below that for commercially insured members.[239] To ensure that they obtain the best rates, states are increasingly subjecting Medicaid managed care contracting to competitive bidding, thereby driving down the level of payment to managed care plans.[240]

Even as states move more of the Medicaid population to managed care, they will face increasing pressures to reduce costs, and thus to squeeze much of the operating margin out of the program. Recent efforts to move toward a balanced federal budget have directly targeted Medicaid funding.[241] In addition, Congress has moved to broadly modify the "entitlement" nature of some cash benefit programs; similar shifts in the treatment by the appropriations process of Medicaid are on the horizon.[242] As a result, Medicaid funding will not be buffered from the annual budget process. Instead, advocates for Medicaid funding will be forced to compete with interest groups championing their own spending programs in each budget cycle.[243] In that process, Medicaid faces some substantial hurdles. In the interest group battle for funding, Medicaid will be relatively disfavored because, unlike Medicare, it is seen as a "welfare" and not an "insurance" program, and because its beneficiaries—the poor and disabled—are less powerful than the champions of, for example, Medicare, which benefits the middle class elderly.[244]

At the very least, funding for Medicaid will suffer cyclical periods of slashed spending. During those periods, the mission-driven motivations of essential community providers will provide powerful incentives for them to stay the course while less committed providers fold their tents. In addition, the sluggishness of nonprofits' funding—their "capital immobility"[245]—which is a systemic detriment to their ready expansion in boom times, will prove a systemic asset in times of funding downturns. Nonprofits, unable to distribute profits, can operate on zero margin. In addition, terms and conditions on their debt, as well as their managers' interest in maintaining their institutional positions, may incline them to continue to provide services

239. *See* Sparer, *supra* note 11, at 451.

240. *See* 1997 PPRC REPORT, *supra* note 74, at 443-44; *Illinois to Rebid HMO Contracts While Awaiting Federal Approval*, MANAGED CARE REP., Apr. 9, 1997, at 345-46.

241. *See* Robert Cohen, *Congress on Verge of Cutting Medicare: Hospitals Would Lose Reimbursement Funds*, THE STAR-LEDGER, July 21, 1997, at 1.

242. *See* Tiefer, *supra* note 170, at 413-14.

243. *See id.* at 418-20.

244. *See id.* at 420-21.

245. HANSMANN, *supra* note 181, at 240.

even in the face of reduced funding.[246]

The inclusion of mission-driven, capital-locked providers in Medicaid managed care networks, then, will stabilize the provider network over time. These providers will be more likely to remain in the business of providing services to Medicaid managed care beneficiaries even when fiscal pressures would likely drive profit-seeking firms to move their capital to other, more lucrative ventures. The values of continuity of care and maintenance of steady supplies of service providers therefore support the enforcement of essential community provider provisions.

CONCLUSION

Mission does matter in the context of health care for poor people. Funding streams for the poor can be stretched to provide care for the near-poor, and mission-driven providers are more likely to use their marginal revenue to do so than are entrepreneurs. Health care delivery for the poor exists in a highly imperfect marketplace, and the information asymmetries preventing Medicaid beneficiaries from acting as fully-informed consumers can be partially counteracted by giving mission-driven providers a guaranteed place in the managed care network. There, they will serve both as *safe havens*, providing at least some residual source of historical Medicaid care, and as *benchmarks* in culturally appropriate, patient-centered care, that intra-plan competitors must achieve in order to retain market share. Finally, nonprofit providers, due to their debt-financing and their corporate mission, are slower to respond to shifts in financing, and therefore are less likely to abandon the Medicaid marketplace when Medicaid funding is cut back.

States' Medicaid managed care programs are pursued primarily for their promise of cost-savings. But they offer the opportunity to increase the availability of providers—particularly primary care providers—for the program's beneficiaries. Medicaid managed care offers the promise of moving Medicaid in the long-favored direction of "mainstreaming" the poor into America's health care system. Mainstreaming is a worthy goal, but its careless pursuit could jeopardize the too-small but extremely valuable network of mission driven, essential community providers motivated by a long-term commitment to patient-centered care for the poor. Limited protection of essential community providers in Medicaid managed care statutes and contracts strikes the proper mix between cost-savings and care delivery, employing market forces to bring in new caregivers without fatally wounding the old.

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246. *See id.* at 240-41.