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THE IMPACT OF MANAGED CARE PAYER CONTRACTS ON THE SUBSPECIALTY MEDICAL PROVIDER: POLICY IMPLICATIONS THAT IMPACT ON THE CARE OF DISABLED CHILDREN

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INTRODUCTION

While it is evident that the remodeling of America's health care industry¹ into a third-party payer system² continues to evolve in

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1. The "health care industry" is the business enterprise concerned with supplying services and equipment for the maintenance or restoration of health. WEBSTER'S COLLEGE DICTIONARY 599, 666 (2d ed. 1997).

2. The health care industry has been transformed into a "managed care model" with "managed care plans" that focus on managing health care so that costs of providing medical services can be decreased. In this type of health care delivery system, a third party (a party other than the physician or the patient) determines the type, nature and extent of medical care that will be paid for so as to decrease costs. Characteristics of such systems include arrangements with selected "providers" (physicians, dentists, etc.), who are chosen by the managed care plan to "participate" because they provide a less expensive "package deal" for medical services offered to patients enrolled in the plan (the "enrollees"). There are arrangements by which the providers share in the risk incurred in providing health care to select groups of enrollees, e.g., by agreeing to a set fee in advance for caring for a certain number of enrollees, and then providing whatever health care needs arise subsequently at no additional cost to the plan. The plans often include financial or program coverage incentives or penalties to enrollees who do not use selected providers. The plans institute so-called "quality assurance" measures to insure that health care is delivered in a cost-efficient fashion and conduct "utilization review" measures, by which providers are monitored to see if they, in fact, practice efficiently or appropriately within the rubric of "medically necessary" care. Physicians are placed under tight contractual control with provisions that may violate public policy. Reimbursements made for physician services are decreased by the plan, which issues fee schedules (a list of fees charged for each medical procedure or service performed) with previously agreed upon fees that usually are below what the physician ordinarily would charge, but which the physician accepts in exchange for an increased number of patients. Managed care plans can refuse to pay for the medically unnecessary use of hospital facilities and other ancillary services, and they can decrease reimbursements allowed for diagnostic testing procedures as well. Managed care organizations, therefore, are engaged in practices that have a

dramatic fashion, it is unclear just how the government and private industry plan to finance effective³ health care delivery systems to high-risk communities, and in particular, to poor,⁴ developmentally disabled⁵ children with surgical problems.⁶ Uniform application of preventive health measures to health care in general ignores the needs of populations requiring acute care for health problems that cannot be predicted or prevented.⁷ Surgeons (for example, pediatric neurosurgeons) deliver highly specialized services to proportionately small populations with major disabilities, making these practitioners less attractive to managed care organizations.⁸

direct impact on the practice of medicine. For the neurosurgeon, these cost-cutting measures are being implemented at a time when the costs of neurosurgical treatments have not been fully evaluated. See John A. Kusske, *Managed Care – the Growth of Cost Containment and the Impact on Neurosurgical Practice*, in *NEUROSURGERY IN TRANSITION: THE SOCIOECONOMIC TRANSFORMATION OF NEUROLOGICAL SURGERY* 3, 3 (James R. Bean ed., 1998) [hereinafter Kusske, *Managed Care*]; see also Richard A. Roski, *Changing Reimbursement for Neurosurgery*, in *NEUROSURGERY IN TRANSITION: THE SOCIOECONOMIC TRANSFORMATION OF NEUROLOGICAL SURGERY* 61, 66 (James R. Bean ed., 1998). See generally Peter R. Kongstvedt, *THE ESSENTIALS OF MANAGED CARE HEALTH* (1995).

3. "Effective" health-care delivery systems actually accomplish the intended result of providing health care to designated populations. See WEBSTER'S COLLEGE DICTIONARY 416 (2d ed. 1997).

4. "Poor" refers to those families and their dependents who fall under the federal poverty level. However, the states determine family eligibility for financial aid. Until 1996, the Aid to Families with Dependent Children ("AFDC") program assured federal funds to match state funds for certain categories of low-income people: the aged, blind, totally disabled, and dependent children. The state determines eligibility requirements and payment guidelines. This program was subsequently repealed by the Welfare Personal Responsibility and Reform Act of 1996. Pub. L. No. 104-93, Stat. 2105 (1996). Welfare status now is used to determine eligibility. RAND E. ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 412 (1997).

5. A "developmentally disabled" child is one who has a physical incapacity caused by a physical defect or infirmity, or a bodily imperfection, or who has mental weakness affecting his physical or mental development. BLACK'S LAW DICTIONARY 461-62 (6th ed. 1991).

6. Surgical problems include structural or anatomical abnormalities children may be born with, brain and spinal cord tumors, or trauma.

7. Preventative health care measures cannot eliminate acute surgical conditions such as appendicitis (inflammation of the appendix) or traumatic injuries, nor predict surgical conditions requiring emergency care with which a child may be born, such as brain tumors, hydrocephalus (excessive accumulation of fluid causing pressure inside the brain), intracerebral hemorrhage or spina bifida (a defect in the spinal column through which the spinal cord protrudes).

8. The development of managed care affects those providers caring for the poor by excluding them from health care networks because it is assumed that the care they provide is expensive, and that they attract sick, uninsured patients. See Sara Rosenbaum, *Beyond the Freedom to Choose: Medicaid, Managed Care and the Family Planning Freedom of Choice Requirement*, 163 W. J. MED., SUPP; Sept. 1995, at 33; Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 754 (1997) [hereinafter *Medicaid Managed Care*].

A critical challenge facing managed health care programs today is the creation of subsidized, workable health delivery programs for disenfranchised⁹ and medically fragile groups, especially poor, developmentally disabled children. The private sector, thus far, is not committed to assuring competent, accessible health care to the uninsured¹⁰ or lower income patient, the ethnic minority populations, and other ill communities who often require significant medical attention.¹¹ There is no evidence to date that health maintenance organizations ("HMOs")¹² even have considered financing effective health care delivery systems to high-risk communities.

9. "Disenfranchised" here refers to being deprived of a right or a privilege. See WEBSTER'S COLLEGE DICTIONARY 375 (2d ed. 1997). However, the term "disenfranchised," as applied to health care consumers was utilized by Trubek and Hoffman in their article on health care reform as synonymous with "marginalized," "subordinated" and "disadvantaged." See Louis G. Trubek & Elizabeth A. Hoffman, *Searching for a Balance in Universal Health Care Reform: Protection for the Disenfranchised Consumer*, 43 DEPAUL L. REV. 1081, 1081 (1994).

10. In 1992, 17.4% of the non-elderly population (38.5 million people) had no health insurance and did not receive publicly financed health assistance. Only 52% of the non-elderly with incomes below the poverty line, as defined within 42 U.S.C. § 1396(a)(10)(A)(i), were covered by a public plan, 50% by Medicaid. Most of the uninsured were working adults (56.7%). The rest were children (25.4%) and non-working adults (17.8%). See ROSENBLATT, *supra* note 4, at 597-98. By 1996, there were 41.5 million non-elderly Americans without health insurance. See Medicaid Managed Care, *supra* note 8, at 731. The number of people in the United States without health insurance increased by 15% over the last five years. See The Business Council of New York State, Inc. INSIDE THE BUSINESS COUNCIL (May 1998) [hereinafter "BCNYS"]. In New York, from 1991 to 1996, the proportion of New Yorkers without insurance rose 34 % so that health care providers are shouldering a greater proportion of the financial burden inherent in caring for an uninsured population incapable of caring for its health care. See BCNYS; The Public Policy Institute of New York State, Inc., *Managing with Care*, § 2 (June 1998).

11. See Vernellia R. Randall, *Does Clinton's Health Care Reform Proposal Ensure (E)qual(ity) of Health Care for Ethnic Americans and the Poor?*, 60 BROOK. L. REV. 167, 190 (1994).

12. In New York, a comprehensive system of authorization and regulation of HMOs was developed to assure that health services of "good quality" be provided to all citizens who choose to take advantage of that alternative to meet their health care needs. "Good quality" was not defined. See N.Y. PUB. HEALTH L. § 4400 (McKinney 1999). The "health maintenance organization" encompasses any person, natural or corporate, or any group of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plan which proposed to provide or offer, or which do provide or offer, a comprehensive health services plan, in which comprehensive health services are provided to each member of an enrolled population in consideration for a basic or periodic charge. See *id.* § 4401(1)-(2). "Comprehensive health services" means all those health services that an enrolled population might require in order to be maintained in good health, and includes physician services, inpatient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiology services, and emergency and preventive health services. See *id.* § 4401(3). In essence, an HMO is a licensed state entity, licensed by the Department of Justice and the Department of Health, which provides medical care through a sys-

This Note explores the impact of current managed care contractual practices on the subspecialty¹³ provider's ability to deliver health care to chronically ill and disabled children. Part I sets forth the historical events giving rise to the development of health care reform. Part II details the evolution of health contracts and the resulting changes in reimbursements for subspecialty medical services. Various physician agreements with several managed care organizations ("MCOs")¹⁴ in the New York metropolitan area will be reviewed to see how contract conditions¹⁵ affect compensation¹⁶ for pediatric neurosurgical services.

Part III details the impact of managed care on the management of the chronic health problems experienced by children with neurological disabilities. Because chronically disabled children are often medically indigent,¹⁷ they are forced to resort to Medicaid¹⁸ in or-

tem of prepaid physician-providers. Medical care is controlled through a primary-care gatekeeper physician who determines what care is necessary, and participants are required to seek treatment only from approved physicians. Though many HMOs are federally qualified, this qualification is not required for operation under state law. See Health Maintenance Organization Act, 42 U.S.C. § 300e (2000).

13. "Specialization" refers to a physician's "confining [his] attention to a single disease, region of the body, age, or sex of a patient for study, research, and treatment." *STEDMAN'S MED. DICTIONARY* 1308 (Williams & Wilkins 24th ed. 1982) [hereinafter *STEDMAN'S*].

14. A "managed care organization" (MCO) is defined as a reimbursement framework along with a health care delivery system that is combined into a single entity responsible for integrating and coordinating the financing and delivery of services. These services traditionally were divided between physicians and patient-payers. Two examples of MCOs are HMO and preferred provider organizations ("PPOs"). PPOs consist of groups of providers who agree to provide care to patient populations for discounted fee-for-service rates. Patients who choose to go "out of plan" to non-preferred providers pay higher cost-sharing, and are therefore steered to preferred providers. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 799 (1997) [hereinafter *FURROW, HEALTH LAW*].

15. Calamari and Perillo have defined a contract as "a condition [that] is an act or event, other than a lapse of time, which, unless the condition is excused, must occur before a duty to perform a promise in the agreement arises (condition precedent), or which discharges a duty of performance that has already arisen (condition subsequent). See JOHN D. CALAMARI & JOSEPH M. PERILLO, *CONTRACTS* 438 (3d ed. 1987).

16. "Compensation" is the term used by managed care plans to refer to reimbursement or payment for services rendered.

17. "Medically indigent" is used here to refer to one who is in need of medical treatment and needs financial assistance to pay for it. The medically indigent are those whose incomes are slightly above welfare levels—thereby making them ineligible for welfare—but are unable to afford high medical bills.

18. Under Title XIX of the Social Security Act, Medicaid created a statutory entitlement to healthcare—through cooperative state and federal programs—for low income people who are aged, blind, or disabled, or who are eligible for AFDC assistance. 42 U.S.C. § 1396 3.4(b). Medicaid must cover "categorically needy" per-

der to access health care. The conditions imposed by managed care contracts on the pediatric neurosurgical health care provider will be compared to current Medicaid agreements. Reimbursements by different health care plans for the same neurosurgical procedure will be reviewed. The effect of these fee schedules on costs incurred in delivering pediatric neurosurgical care to this particular population will be explored. The data will be analyzed in an effort to evaluate what long-term health care policy considerations may arise affecting the care of chronically disabled children with special medical care needs.

Part IV proposes alternative solutions for affordable health care delivery systems for poor, medically fragile groups with complex health problems. This Note concludes that, notwithstanding the efforts of the health care industry to reorganize health care into affordable delivery systems, the industry has not succeeded in integrating the medically disenfranchised consumer into the health care system.

I. GENESIS OF HEALTH CARE REFORM

A. Goals of Managed Health Care

While the first exercise in prepaid group practice dates back to 1910, when the Western Clinic in Tacoma, Washington was developed,¹⁹ managed care, as it is known today, evolved as a response to skyrocketing health care costs.²⁰ As early as 1972, when na-

sons, including AFDC recipients; children, pregnant and postpartum women with incomes below certain federal poverty guideline standards; aged, blind or disabled individuals receiving federal Supplemental Social Security Income ("SSI"); and Medicare beneficiaries whose income is less than certain federal poverty guideline standards. SSA § 1902(a)(10)(A); 42 C.F.R. §§ 435.1-435.170, 436.1-436.128. States also have the option of covering "medically needy" people under Medicaid with federal financial participation ("FFP"). Medically needy persons are those who, but for slightly higher incomes, would otherwise qualify as "categorically needy." SSA § (a)(10)(C); 42 C.F.R. § 435.300. Hospitals and physicians participating in the Medicaid program cannot refuse needed treatment to Medicaid patients, must accept Medicaid payments as payment in full for covered services rendered to Medicaid recipients, and cannot seek additional payments from individuals. See 42 U.S.C. § 1396.

19. See Kusske, *Managed Care*, *supra* note 2, at 6.

20. National expenditures on health care increased from \$12.7 billion in 1950 to \$41.9 billion in 1965 to \$647 billion in 1990. Since much of the growth in absolute expenditures reflects inflation, the increases in the cost of medical care should be compared to consumer prices or should be measured as a proportion of the gross national product (GNP). Between 1980 and 1988, the medical care component of the consumer price index increased 85% compared to a general increase in inflation of 43%. The proportion of the GNP devoted to medical care has risen from 4.4% in 1950 to 12% in 1990. In 1967, the federal government spent \$12 billion on health care, and state and local governments spent \$7 billion. In 1990, the federal govern-

tional health expenditures were ninety-four million dollars, annual health care costs already were said to have reached "crisis" proportions.²¹ Yet, during the following decade, health care costs rose 12.2%, and costs now amount to more than \$1 trillion spent per year on health care.²²

Under traditional indemnity plans, patients had no incentive to choose economically efficient²³ providers or procedures, nor did physicians try to control the number of services rendered.²⁴ Advances in health care technology and the development of new medical and surgical procedures encouraged patient demand for the "latest" in health care, a desire not discouraged by the health care profession. Not only did physician consultations increase in frequency and volume, but physician fees escalated as well.²⁵ Managed care developed as a response to these spiraling health care

ment spent \$196 billion, and state and local governments spent \$73 billion. See BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 325 (1991)[hereinafter FURROW, FINANCE]. In New York alone, hospital services, physician services and prescription drug costs tripled between 1980 and 1993. Hospital costs rose \$24 billion a year. All three increases were greater than the overall inflation rate during that same 13-year period, which was reported to be about 75% or almost 5.8% per year. See BCNYS, *supra* note 10, at § 2.

21. The enactment of Medicare and Medicaid coincided with a dramatic escalation in national health care spending. See Kenneth W. Wing, *American Health Policy in the 1980s*, 36 CASE W. RES. L. REV. 608, 620 (1986).

22. BCNYS, *supra* note 10, at § 1.

23. An "economically efficient" provider might consider the financial cost of the health care provided in making a medical decision. However, if a doctor complies with his non-delegable fiduciary duty to his patients, he must act with the patients' interests in mind. Providing incentives to the physician to disregard this duty may constitute criminal bribery under state and federal law. Costs may not be of any consequence to the patient primarily because a third party (such as the employer) is footing his health care bill. The patient may expect all medical care that is of any conceivable benefit to him, or may not understand the financial impact of her treatment decisions. From an ethical point of view, if costs are not of consequence to the patient, then they should not factor into the doctor's treatment decisions. This conflict between medical ethical obligations to patients, and patients' desire to receive the "best" care possible without cost considerations by either party, presents the need for some kind of overseer. This role has been left to employers and insurers, both private and government. See MARK A. HALL & IRA MARK ELLMAN, *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 8-13 (1990).

24. Cost-based payment systems, based on "customary, usual and reasonable" charges, suggested that the more government and private insurers would pay the hospital or provider, the higher the costs for health care services because of guaranteed reimbursements. This trend resulted in overutilization of expensive technology and new equipment, highly trained support staff, in-hospital care and surgical procedures, and prestigious physicians, with no controls on volume of services billed. See E.H. Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987).

25. See ROSENBLATT, *supra* note 4, at 18.

costs by emphasizing preventive health care in an effort to avert costly health problems.²⁶ MCOs offered financial incentives and management controls to deter patients from consulting physicians unnecessarily²⁷ and to prevent health care providers from abusing the system.²⁸ It was a direct response to overutilization of health care services by implementing quality assurance controls,²⁹ utilization management,³⁰ and concurrent³¹ and prospective³² review of health care provisions and expenditures.

26. Examples of preventive health care with respect to newborns include pre-natal care, emphasis on proper nutrition, and avoiding illicit drug use and smoking during pregnancy. Correction of elevated blood pressure by the use of medications may prevent life-threatening heart attacks or strokes.

27. Minor ailments such as ear infections could be diagnosed and treated during regularly scheduled medical appointments, rather than requiring an additional examination out-of-hours or a visit to the emergency room.

28. Cost containment methods implemented by the MCO decrease unnecessary and costly procedures or treatments that a physician might recommend in several ways. A "gate-keeper" physician could review a provider's recommendations and determine whether the care was medically necessary before authorizing the procedure for payment and allocating funds for it. Another party within the HMO system could review the procedure, either at the time it was implemented or afterwards, to determine whether it should be paid for. Reimbursement fees for the actual procedures could be determined by the MCO itself without any provider participation. See Daniel R. Sullivan & Perry Oxley, *Managed Care Organizations*, in *THE PHYSICIAN'S PERSPECTIVE ON MEDICAL LAW* 355 (Howard H. Kaufman & Jeff L. Lewin, eds. 1997).

29. "The ultimate goal [of quality assurance] is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves." HEW Supplement D § D-5140. In *Corcoran v. United Health-Care, Inc.*, the court noted that the health care plan's "Quality Care Program" (its quality assurance program) promised the plan's subscribers that professionally-qualified reviewers, "together with your doctor . . . work to assure you and your covered family members receive the most appropriate medical care." 965 F.2d 1321 (5th Cir. 1992).

30. Insurance companies, MCOs and other health benefit plans hire or contract services from physicians, nurses or special companies to perform "utilization review," an assessment of the "medical necessity" of services for which claims are made. There is, however, no consensus as to the meaning of the term "medical necessity." It has been variably defined as "efficacious and safe" by the HMO in *Dallis v. Aetna Life Ins. Co.*, 574 F. Supp. 547 (N.D. Ga. 1983), *aff'd*, 768 F.2d 1303 (11th Cir. 1985). The plaintiff argued that the term applied to "necessary for the treatment" of a diagnosis. Other courts have interpreted the term to mean "appropriate," or "consistent with community medical standards," as in *Hughes v. Blue Cross of N. Cal.*, 263 Cal. Rptr. 850 (Ct. App. 1989). In *Siegal v. Health Care Serv. Corp.*, the court determined that "medical necessity" is an issue of fact to be decided by the jury because of the ambiguity of the term. 401 N.E.2d 1037 (Ill. App. Ct. 1980). However, whatever the term "medical necessity" means, it is a medical judgment and should be subject to the appropriate standards. See *MANAGED CARE HANDBOOK FOR NEUROLOGICAL SURGEONS* 97 (John A. Kusske et al. eds., 1994) [hereinafter Kusske, *HANDBOOK*].

31. As the service is provided, managed care organization nurses examine patient records. "Concurrent review" is the analysis of treatment costs at the time the treat-

The MCO is distinguished from earlier health care systems by its maintaining tight control over its health care delivery system.³³ Today's MCOs are based upon a series of contracts among independent entities offered by insurers or other companies merging medical care with health insurance,³⁴ selling health care from the plan's providers to enrollees who purchase this combined product for a pre-negotiated fee.

Cost containment stems from the member's obligation to receive his health care from a restricted list of designated network providers as a condition of coverage. To keep patient-enrollees' fees low, the MCO negotiates lower compensation rates with the physicians who participate in the plan. These participating providers function as independent contractors under written contractual or employment agreements, and their selection and authority to furnish covered benefits is controlled by the managed care company.³⁵ Financial inducements are offered to employers via lower-cost health care "premiums,"³⁶ encouraging them to participate in these plans.

ment is being administered so as to determine whether or not those costs will be covered by the health care plan, as opposed to pre-certification and pre-authorization.

32. "Prospective review" analyzes potential costs of prospective treatment, so as to determine whether a health care plan will "cover" or pay for them.

33. Patient incentives are inducements for enrollees to use health care providers participating in the plan. Provider reimbursement incentives are enticements for participating providers to be cost efficient in their use of health care services. Utilization management is a series of procedural reviews used to contain the number and type of services rendered so as to contain costs. Quality assurance programs ensure the care provided is considered "appropriate" in order to reduce cost and volume of the service rendered, even though incentives already are placed on both the provider and the patient to be cost-effective. Primary care physicians act as "gatekeepers," regulating the utilization of specialty services, ancillary services including outpatient mental health, home health care and pharmacy, and hospital services. See Sullivan, *supra* note 28, at 355.

34. Traditionally, the medical community opposed mergers between medical care providers (physicians) and third-party payer insurance plans because of the perceived threat to physician autonomy and control over medical practice and income. This opposition culminated in *Group Health Ass'n of Wash., D.C. v. AMA v. United States*, in which the AMA was indicted on charges of violating the Sherman Act in trying to prevent the operation of a pre-paid group health plan. 130 F.2d 233 (D.C. Cir. 1942). Subsequently, prepaid health care plans served as the conceptual payment basis for the HMO in the federal 1973 HMO Act (based upon President Nixon's initiatives on behalf of HMOs). These initiatives, in turn, developed into today's managed care scenario, in which the original issues of physician autonomy and income have returned to the forefront. See ROSENBLATT, *supra* note 4, at 547-48.

35. *Id.* at 552.

36. An example of such an incentive is CSEA plan's coverage for mental health and substance abuse, which has no deductible and no annual or lifetime benefit maximum, on the condition that participants receive treatment from a network provider.

MCOs offer financial incentives to health care providers whose practice styles are less costly.³⁷ Physicians who comply with the plan's cost-cutting goals by accepting decreased reimbursements for their services constitute this restricted group of providers. The financial incentive for the physician to accept lower compensation rates from the MCO stems from one of two circumstances. The physician might make a profit because of the increased volume of patients that are referred to him because he is a preferred provider. Alternatively, the physician might opt to participate in a given health care plan because many of his patients become enrolled in that plan, and he might otherwise lose a significant portion of his practice.³⁸

Strict physician credentialing requirements include an analysis of physician practice patterns in an effort to identify those physicians who use health services more efficiently.³⁹ There are variably de-

If the participant uses an out-of-network provider, the participant has an annual deductible of \$500 for outpatient care and \$2000 for inpatient treatment, as well as limits on what the plan will pay for over the participant's lifetime. For mental health treatment, medically necessary care is unlimited when provided within the plan. A 30-day limit applies each year if participants use an out-of-network provider. *See* BCNYS, *supra* note 10, at Section 2.

37. A common component of some MCO agreements is the "withhold," whereby the health care plan retains a portion of the provider's reimbursement presumably as a reserve to cover unexpected expenses. If utilization of services does not exceed projections, and if plan costs are within the MCO's budget, some or all of the withhold is returned to the physician. It is possible that the withhold may be construed as a "bribe," and therefore subject to criminal penalties. A slightly different version of this withhold is the "variant-risk withhold" system in which a physician who does an above-average job of managing health care utilization receives the full withhold in addition to a bonus payment. Both systems encourage the provider to implement fewer services, thereby fostering underutilization, also referred to "reverse" fraud and abuse. More money remains in the pool of funds withheld initially, thereby assuring the efficient provider a larger withhold at the end of the term. Kusske, *HANDBOOK*, *supra* note 30, at 103.

38. Joseph A. Snoe, *Selected Managed Care Provider Issues*, in *AMERICAN HEALTH CARE DELIVERY SYSTEMS* 456, 456 (1998). It is unclear whether the implicit threat to physicians of completely losing their medical practices if they do not participate in health care agreements forces them into adhesion contracts with the managed care company. Such contracts are standardized and offered on a "take it or leave it" basis without the ability to bargain. BLACK'S, *supra* note 5, at 40; *see also Medicaid Managed Care*, *supra* note 8, at 754; John F. Little, Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 *RUTGERS L. REV.* 1397 (1997).

39. "Physician profiling" is a network selection process, which examines physicians' billing and claims records in an effort to determine the physician's utilization of health services. Generally, it does not take into account the characteristics of the population for which the physician provides services. If the population is one with a poorer health status requiring more health services, the physician's profile suffers in comparison to that of other physicians caring for healthier patients who consume

finer quality assurance criteria used by primary care "gatekeepers"⁴⁰ who screen and limit the use of specialized, costlier treatments.⁴¹ However, uniformly applied cost containment programs based upon preventive health measures ignore the needs of those patients with acute, unpredictable problems.

B. The Goal of Medicaid

While Medicaid ostensibly was created to provide medically indigent patients equal access to health care, it has not succeeded yet in fulfilling its original promise to bring them into the mainstream⁴² of medicine.⁴³ The original goal of the program was to afford the poor a floor of basic medical services. The poor were to be integrated into middle-class patterns of health care. This was to be accomplished by providing eligible patients with health insurance

fewer health services. As such, plans may bypass the physician caring for the sicker patient in favor of enlisting onto its provider roster the physician caring for healthier populations. ROSENBLATT, *supra* note 4, at 560.

40. A "gatekeeper" is a medical professional assigned responsibility for managing health care within an MCO on a prospective and concurrent basis. The gatekeeper is responsible for approving referrals and services prior to delivery, if full benefits are to be paid. Gatekeepers for neurosurgical services are typically primary care physicians, such as pediatricians, internists or family practitioners. Kusske, *HANDBOOK*, *supra* note 30, at 210.

41. For example, U.S. Healthcare requires that the primary provider approve diagnostic procedures, such as MRI scans, requested by a specialist evaluating a patient. Theoretically, if the primary provider does not approve the procedure, the scan will not be paid for by the health plan. See *Healthcare Provider Manual*, U.S. Healthcare-Aetna.

42. The dominant movement in health care today is toward third-party payer systems that pay for health care. This pattern characterizes the trend, if not the norm, in health care today. The original vision of Medicaid was that it would provide "mainstream" care for its recipients. However, what may be termed "mainstream" medicine may be a *de minimus* program as opposed to an optimal one. FURROW, *HEALTH LAW*, *supra* note 14, at 877.

43. There are several examples of discrepancies and problems within the Medicaid program that affect its coverage system. Because federal law does not require providers to participate in Medicaid programs, many poor patients cannot find providers willing to treat them and accept Medicaid payment. Patricia A. Butler, *Legal Problems in Medicaid*, in *LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS* 215, 222 (Ruth Roemer & George McKray, eds., 1980). Physicians and dentists who treat Medicaid patients must enter into participating provider agreements with state Medicaid agencies. These agreements prohibit providers from charging beneficiaries whatever amount they choose. ROSENBLATT, *supra* note 4, at 222, 526. Medicaid covered medical services for 35.1 million people in 1994, excluding 42% of those living in poverty. Medicaid coverage varies among the states—eligibility requirements, funding levels and benefits differ. See *Medicaid Managed Care*, *supra* note 8, at 753. In some states, especially in the South, Medicaid covers only minimum services, whereas New York and California provide almost comprehensive coverage. See Butler, *supra*, at 221.

that would enable them to purchase health care services in the private sector.⁴⁴

Medicaid is supposed to cover and pay for multiple but basic services, many of these at discounted prices, for the categorically needy.⁴⁵ Included are in-hospital costs;⁴⁶ out-patient services;⁴⁷ physician services; rural clinic services; radiology and laboratory testing; skilled nursing facilities⁴⁸ for patients over twenty-one years of age; home health care services⁴⁹ for patients eligible to be in nursing homes; family planning services; and screening for children's health defects.⁵⁰

However, Medicaid finances health care services rather than providing health care per se, and depends upon voluntary provider participation. There are no controls over the composition of Medicaid provider networks.⁵¹ Medicaid's emphasis on reimbursement

44. Medicaid's goal was to eliminate the stratification of two-tier health care (which resulted in inferior care for the poor) and to integrate the poor into middle-class patterns of hospital and medical care, considered to be superior. Prior to the enactment of Medicaid in 1965, health care services for the poor were subject to state discretion, including budgets allocated for whatever kind of care was considered appropriate for low-income patients. A hierarchical health care system developed, stratified on the basis of economic class, race and ethnicity, still evident (even after Medicaid's enactment). Poor patients were admitted to wards and cared for primarily by doctors-in-training (interns and residents), occasionally with senior physician (attending) supervision. These "clinic" patients received inferior care provided by less experienced health care providers compared to middle-income and upper-income patients, who had private or semi-private rooms and care administered by fully-trained physicians, rather than doctors-in-training. See ROSENBLATT, *supra* note 4, at 415.

45. See *supra* text accompanying note 18.

46. In-patient services include those medical treatments or diagnostic tests performed while a patient is in the hospital, such as blood work, radiology, nursing, medications, ventilators, intensive care, food, laundry and housekeeping services. It excludes doctors' fees.

47. Such services may include blood work, radiological procedures, nursing and medical treatments administered in a dispensary or a clinic. It usually includes doctors' fees.

48. A "skilled nursing facility" is a private institution, other than a hospital, or a distinct part of an institution (such as a convalescent wing), licensed by the State, which provides personal care, sheltered care or skilled nursing and related services or rehabilitation services. Generally the care is similar to that provided in a hospital, but with lower staffing ratios and less intensive care than that provided in an acute care hospital. See DOUGLAS A. HASTINGS ET AL., *FUNDAMENTALS OF HEALTH LAW* 3 (1995).

49. "Home health care services" are intermittent skilled nursing services or physical, speech or occupational therapy provided by a licensed public agency or private organization for a patient confined to his home. FURROW, *FINANCE*, *supra* note 20, at 75; SSA § 1814(a)(2)(C).

50. See Butler, *supra* note 44, at 215.

51. There are no uniform state controls over the composition of provider networks, though the Office of the Inspector General has been designated to oversee

for even costly and arguably inappropriate institutional services⁵² may have contributed to its limited funding and its failure to bring conventional and uniform medical coverage to poor populations.⁵³

State Medicaid funds allocated to the care of the disabled are growing more rapidly than any other segment of the Medicaid budget.⁵⁴ Average annual health care costs for this group are six

Medicaid physician panels. The government enforces compliance by these providers with federal fraud and abuse laws through the Fraud and Abuse Control Program. Among those regulations which make up the backbone of recent enforcement activity are: (1) the Civil False Claims Act, 31 U.S.C. § 3729 (2000), which makes it illegal to submit a false claim for payment to the government or to a payer who receives federal funds; (2) the Criminal False Claims Act, 18 U.S.C. § 287 (2000), which makes it a felony for anyone to present a false claim to any U.S. civil, military or naval officer; (3) the Federal Medicare/Medicaid False Claims and Anti-Kickback Statute, 42 U.S.C. §§ 1320a-7b (2000), which makes it a felony to make false statements in connection with a claim for payment under the Medicare or Medicaid programs and prohibits offering, receiving or soliciting illegal remuneration; (4) the Federal (Stark) Physician Self-Referral Law, 42 U.S.C. § 1395nn (2000), which prohibits a physician from making a referral to an entity for the furnishing of designated health services, for which payment otherwise may be made under Medicare/Medicaid, where the physician has an immediate family member or financial relationship with the entity; (5) the Federal Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961-1968 (2000), whereby several acts of false claims constituting a pattern may give rise to a civil or criminal RICO action; (6) the Federal False Statements Statute, 18 U.S.C. § 1001 (2000), which prohibits anyone from knowingly falsifying material facts, statements or documents; as well as (7) the Federal Mail and Wire Fraud Statute, 18 U.S.C. § 1343 (2000), which prohibits the use of the mails or wires to advance a scheme of fraud. New York State Fraud and Abuse Regulation covers (1) New York State's Anti-Kickback Law, N.Y. PUB. HEALTH L. § 238(a-c) (McKinney 1999), which makes it illegal to make a referral for medically related services to another provider, where that provider is an immediate family member or has a financial relationship with the referring provider; (2) New York State's Clinical Laboratory Law, N.Y. PUB. HEALTH L. §§ 585-588 (McKinney 1999), which makes it illegal for any clinical lab to receive any kickback in exchange for referrals for clinical lab services; and (3) the Unacceptable Practices under the Medical Assistance Program, N.Y. COMP. CODES R. & REGS. tit. 18, § 515.2 (1999), which describes kickbacks, improper record keeping, unnecessary services and other practices, which, if committed under the Medicaid program would constitute an administrative violation. Ari J. Markenson, *Compliance Programs in the Health Care Industry*, 3(3) HEALTH L. J. (NYSBA) 3, 4-5 (1998).

52. The U.S. Senate Committee on Finance had conducted hearings during which witnesses testified that a significant proportion of the health services provided under Medicare and Medicaid were probably not medically necessary. The Supreme Court stated that, in addition to the economic impact of this situation, the committee was concerned about the effects of overutilization on health care, observing that "[u]nnecessary hospitalization and unnecessary surgery are not consistent with proper health care." *Association of Am. Physicians and Surgeons v. Weinberger*, 395 F. Supp. 125 (N.D. Ill.), *aff'd*, 423 U.S. 975 (1975).

53. See Butler, *supra* note 44, at 215.

54. In 1990, the Supreme Court expanded the Federal Supplemental Security Income Program (SSI) coverage for children in *Sullivan v. Zebley* 493 U.S. 521 (1990). This program increased Medicaid coverage for disabled children, since SSI recipients generally are eligible for Medicaid. It should be noted that, in 1972, the federal SSI

times greater than health care costs for poor, non-disabled children, and three times greater than health care costs for poor, non-disabled adults.⁵⁵ Yet, there are no risk-adjusting methods to account for the higher utilization of health services by this disabled population, making it financially difficult for traditional providers who have served Medicaid beneficiaries in the past to continue doing so.⁵⁶ Provider reimbursements for necessary subspecialty care⁵⁷ are low in comparison to managed care payments,⁵⁸ and do not cover the subspecialists' costs for providing health care to this

program replaced preexisting state Aid to the Aged, Blind and Disabled (AABD), the primary welfare program for adults. Prior to that time, states tied Medicaid eligibility to AABD financial eligibility levels. Once SSI replaced AABD, Medicaid recipients became eligible for SSI. See ROSENBLATT, *supra* note 4, at 865 n.3. Furthermore, while dependent children and their families make up over three-quarters of Medicaid recipients, they are only responsible for about a third of Medicaid expenses. However, Medicaid covers programs for the disabled, including severely disabled children of middle-class families. Although the disabled make up about 14% of Medicaid recipients, they consume some 73% of Medicaid expenditures. See FURROW, *HEALTH LAW*, *supra* note 14, at 864-67.

55. See Furrow, *Health Law*, *supra* note 14, at 864-67.

56. Issues that affect the enrollment of disabled populations in managed health care plans include the MCOs lack of experience with this type of patient; the lack of controls over provider networks; and most importantly, the absence of methods for "risk adjusting" premium payments to health plans to account for the increased use of services by the disabled. See ROSENBLATT, *supra* note 4, at 596.

57. An example of "necessary subspecialty care" is surgery for a brain tumor. A child who comes to an emergency room with a brain tumor (the second most common cancer in children, following leukemia, a malignant proliferation of abnormal white blood cells) and increased pressure in the head requires urgent or emergency surgery to remove it, a life-saving procedure. STEDMAN'S, *supra* note 13, at 775; see also WALDO E. NELSON, ET. AL., *NELSON TEXTBOOK OF PEDIATRICS* 1777 (11th ed. 1979). Another common diagnosis among neurologically impaired children is cerebral palsy, a defect of motor power, coordination and, often, mental retardation, due to brain damage secondary to a loss of oxygen. See STEDMAN'S, *supra* note 13, at 1019. This condition is often associated with hydrocephalus (accumulation of cerebrospinal fluid inside the brain due to an obstruction in the normal pathways by which this fluid is recycled and reabsorbed, causing life-threatening increased intracranial pressure if not corrected immediately), for which a shunt is needed. The shunt (which acts to bypass the block and siphon off the fluid into a different area in the body, where the excess can be absorbed or eliminated), upon which the child is dependent to control the pressure in his head, can malfunction precipitously, requiring emergency surgery. See Carolyn M. Carey et. al., *Hydrocephalus: Etiology, Pathologic Effects, Diagnosis and Natural History*, in William R. Cheek et al., *PEDIATRIC NEUROSURGERY: SURGERY OF THE DEVELOPING NERVOUS SYSTEM* 185, 189 (3rd ed. 1994).

58. An example of this disparity in reimbursements is Medicaid's payment for surgery for brain tumor. Medicaid pays between \$500 and \$600 for this surgery, no matter how complicated or long the procedure may be. Private insurance pays anywhere from \$4,000 to \$11,000 for exactly the same procedure, depending upon the health care plan. See Tables 1 and 2.

population.⁵⁹ It is difficult to reconcile these specific issues with Medicaid's commitment to free access to providers.⁶⁰ Medicaid expects physicians to provide poorly compensated⁶¹ health care to Medicaid recipients despite the financial constraints imposed upon the physician by the poor reimbursement rates.⁶² Notwithstanding Medicaid's original promise to finance some minimum level of

59. The largest component in the subspecialist's costs in providing health care is malpractice insurance coverage. In New York, annual malpractice fees calculated for "Premium Class 1," i.e., full-time neurosurgery and pediatric neurosurgery, range from \$114,804 to \$129,694 for occurrence policies (covering claims arising from professional services rendered during the policy period regardless of when the claim is reported) to \$120,543 to \$136,185 for claims-made rates after the eighth practice year (covering claims arising from one's professional services rendered while the policy is in effect that are first reported while the policy is in effect or during an extended reporting endorsement period). These rates apply to New York City, and the Hudson Valley area, including Westchester, Orange, Rockland and Sullivan counties. Professional Liability Insurance Premium Rate Schedules for Physicians and Surgeons, Medical Liability Mutual Insurance Company, effective July 1, 1998. Current Medicaid reimbursement fees in New York hardly cover this expense. See *supra* text accompanying note 59.

60. The court reviewed the "equal access requirement" for health care for Medicaid recipients in *Clark v. Kizer*, stating that "equal access" means that health care is available to recipients at least to the extent that those services are available to the general population. It noted that the State failed in its statutory duty to ensure equal access to dental care because reimbursement rates were so low that the State could not enlist enough providers to make care available under the plan to the extent that it was required to. 758 F. Supp. 572 (E.D. Cal. 1990). See also Roski *supra* note 2, at 63; Sullivan, *supra* note 28, at 359; Sandra A. Price, *Health Insurance, Medicare and Medicaid*, in *THE PHYSICIAN'S PERSPECTIVE ON MEDICAL LAW* 373 (Howard H. Kaufman & Jeff L. Lewin, eds., 1997).

61. Most states use fee schedules that are well below the fees paid by Medicare or private insurance, making physician participation in Medicaid historically low. States have sought to limit payments to physicians for services provided to older disabled patients who are covered by both Medicare and Medicaid. States argue that these patients are Medicaid recipients, so that their physicians are entitled to payment at the lower Medicaid rates. Medicare pays physicians 80% of the federally determined Medicare fee, and the state pays the 20% deductible. Many states refuse to pay the 20% deductible if 80% of the Medicare fee is more than 100% of the Medicaid fee. Because Medicaid fees are so low, 80% of Medicare is almost always more than 100% of Medicaid, so physicians are denied the fee to which they would be entitled under Medicare. If physician participation in Medicaid is low because of poor reimbursement rates, this low reimbursement violates federal Medicaid regulations requiring that "payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." See 42 C.F.R. § 447.204 (1994).

62. Participation in Medicaid per se is voluntary. However, physicians who treat Medicaid patients must accept the state's reimbursement fee, which has been reported to range as low as 21% of charges in some states. See ROSENBLATT, *supra* note 4, at 526. For pediatric neurosurgical (for necessary surgical subspecialty procedures), the reimbursement rate ranges from five to 15%. See *supra* note 61. Additionally, network providers who have contracted to serve individuals enrolled in health care plans also must furnish care to the Medicaid recipients enrolled in that

health care for poor and disabled populations, the program has failed to secure affordable access to the subspecialty care many of the disabled need primarily because it does not adequately pay for the costly treatments that some patients require.⁶³ This discourages subspecialists from providing anything more than emergency health care to Medicaid patients.

II. CONTRACTING AND REIMBURSEMENT

A. Changes in Health Care Contracting

Because participation in managed care provider networks is not automatic, physicians must apply to be included in health care plans as preferred or "participating providers."⁶⁴ The incentive to participate often stems from a lack of choice,⁶⁵ because physician income has decreased in recent years, largely due to managed health care.⁶⁶ Non-participating physicians whose patients become enrolled in managed care plans stand to lose a significant portion of their practice.⁶⁷ Managed care organizations have the sophistication and incentive to bargain with providers for low prices⁶⁸ since the physician theoretically will accept decreased compensation rates in exchange for an increased patient base.⁶⁹

The physician's medical judgment may be directed by HMO payment decisions, especially payer denials for care. Utilization review practices curtailing services that physicians judge to be appropriate for patients may force providers into medical decisions

plan, even though they are reimbursed at Medicaid rates. See *Woolfolk v. Duncan*, 872 F. Supp. 1381 (E.D. Pa. 1995).

63. See ROSENBLATT, *supra* note 4, at 522.

64. PHYSICIANS HEALTH SERVICES OF NEW YORK, INC. PHYSICIAN AGREEMENT, Art. I, Definitions § 1.12 (1997).

65. HMOs require their enrollees to consult only their in-plan providers. The HMO can negotiate discounts from individual providers theoretically by guaranteeing them an exclusive right to a certain volume of patients. In exchange for these exclusive contracts, providers may be willing to offer significant discounts below traditional fee-for-service reimbursements. However, the implicit threat is that, if the provider does not offer a discount, the plan will shift its enrollees to another provider. See *Medicaid Managed Care*, *supra* note 8, at 754; see also Little, *supra* note 39, at 1422.

66. See ROSENBLATT, *supra* note 4, at 517.

67. In *Kartell v. Blue Shield of Mass., Inc.*, the Court recognized the district court's finding that "because of the large number of subscribers, doctors are under 'heavy economic pressure' to take them as patients and to agree to Blue Shield's system for charging the cost of their care." 749 F.2d 922, 924 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) (quoting *Kartell v. Blue Shield*, 582 F. Supp. 734 (D.C. Mass. 1984). See Little, *supra* note 39, at 1427.

68. See FURROW, *HEALTH LAW*, *supra* note 14, at 735.

69. See Snoe, *supra* note 39, at 456.

they would not otherwise make.⁷⁰ This outcome can have a detrimental impact on reimbursement to the physician for services provided. The MCO can enforce its cost-containment decisions under the guise of "quality assurance" by penalizing a provider or terminating a provider's participation with the plan without explaining why.⁷¹ HMOs may discriminate⁷² against doctors because of their costlier treatment practices⁷³ by simply not credentialing them,⁷⁴ or

70. In *Varol v. Blue Cross and Blue Shield of Mich.*, the plaintiff argued that utilization review practices and associated financial incentives would adversely affect the provider's clinical judgment. 708 F. Supp. 826 (E.D. Mich. 1989). In *Wilson v. Blue Cross of S. Cal.*, a patient was discharged from a psychiatric hospital because his insurance company would not pay for the hospitalization. Shortly thereafter, the patient committed suicide. The court held that summary judgment in favor of the insurance company could not be granted since there was a triable issue as to whether the conduct of the patient's insurance company and doctor was a substantial factor in causing the patient's death. 271 Cal. Rptr. 876 (Cal. App. 1990). In *Wickline v. California*, the court held that a physician is still liable even if he complies with an MCO decision to deny care that he believes is medically necessary. 239 Cal. Rptr. 810, 819 (Cal. App. 1986) *petition for review dismissed*, 741 P.2d 613 (Cal. 1987). The court stated that "[T]he physician who compli[ed] without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour." The physician has a non-delegable fiduciary duty to do what is in his patient's best interest.

71. Managed care plans can oversee health care costs by determining contract terms that control the relationship between the health care plan and the providers. The provision giving either party the right to terminate the agreement without cause can be implemented by the MCO should the provider not comply with its cost containment measures. Since physicians have been terminated in the past for insisting upon MCO authorization of medically necessary treatment, the threat of termination can discourage them from advocating on behalf of patients. See ROSENBLATT, *supra* note 4, at 513, 517; see also Little, *supra* note 39, at 1446, 1456.

72. In this scenario, the transformation to managed care (regulated by the Department of Health and Human Services, the Health Care Finance Administration, etc.) might cause cost-conscious HMOs to disfavor the work of doctors in poor communities, exposing them to different types of discrimination, including racial and economic. Lack of available services in the community may force the poor patient to seek health care at larger medical centers, where it is costlier. See Note, *The Impact of Managed Care on Doctors who Serve Poor and Minority Patients*, 108 HARV. L. REV. 1625, 1626 (1995) [hereinafter *Impact of Managed Care*].

73. A physician caring for neurologically impaired children who cannot communicate may need to order frequent magnetic resonance imaging (MRI) of the brain in order to see if there are any anatomical changes that correlate with a change in the child's clinical status. This radiological study produces detailed images of the body regardless of intervening bone by means of a strong magnetic field and low-energy radio waves. More specifically, if a neurologically impaired child with a congenital abnormality of the brain becomes lethargic or unusually irritable, or develops epileptic seizures, an MRI is usually ordered to rule out any condition requiring emergency surgical intervention. Sometimes several sequential studies are needed within short periods of time if the anatomical changes are small and difficult to perceive visually.

by "deselecting" them⁷⁵ from their provider plans. Those physicians with consistent patterns of overutilization of ancillary services, low patient volume, or no observable commitment⁷⁶ to managed care objectives may be least likely to find their contracts renewed.⁷⁷

In addition to physicians' apprehensions of sudden termination by the MCO, there are other concerns. Major contract issues for most physicians, and for neurosurgeons in particular, include: professional liability transactions;⁷⁸ indemnity clauses;⁷⁹ scope of ser-

In the New York metropolitan area, fees for one MRI may range between \$800 and \$1,000. See Personal Communication, MRI Diagnostics of Westchester, Valhalla, New York.

74. In *Harper v. Healthsource N.H., Inc.*, the HMO re-enrolled the surgeon-plaintiff as a primary care physician, rather than credentialing him as a surgeon. In this case, the "termination without cause" provision of the physician's contract was implemented in order to terminate his employment without having to explain why, even though the termination was not related to quality reasons. In turn, the physician also could leave the plan without giving any reason. 674 A.2d 962 (N.H. 1996). Provider membership decisions are unilateral decisions made by the MCO. Due process is not always required, though the standards used theoretically have a rational relationship to the MCO's business. See *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 293 (1985).

75. If providers do not meet the plan's standards (e.g., if their practice styles are costly or they do not meet "quality" standards), they may be screened out of the provider network. See Kusske, *HANDBOOK*, *supra* note 30, at 26; see also *Impact of Managed Care*, *supra* note 73, at 1629.

76. The MCO may claim that a physician's use of health services is excessive without determining whether patient costs were medically justified, and claim that the physician's style of medical practice is too costly and not in keeping with the cost-containment methods of the particular MCO.

77. See C. S. Rowe, *The Impact of Managed Care on Specialty Practices*, 41 *MED. GROUP MGMT ASS'N* 36 (1994).

78. The issue arises when a managed care organization supervises and influences either directly or indirectly a health care provider's decisions in the interest of cost-containment, but the provider is still held liable. In *Wickline v. California*, the state Medicaid agency (Medi-Cal) applied prospective cost constraints to inpatient hospital care and major surgery. 239 Cal. Rptr. 810, 819 (Cal. App. 1986). In this case, a patient suffered medical complications arising from her early hospital discharge before full recovery after surgery. The physician had discharged her when the insurance plan refused to pay for her continued hospitalization. While the court held that "[t]hird party payers of health care services can be held legally accountable when medically inappropriate decisions result from . . . implementation of cost containment," it also decided that the treating physician remains legally responsible for quality of care.

79. Contract language by which the physician is required to indemnify the health care plan may subject him to litigation risks for actions of other physicians or actions and policies of the plan that directly affect how the physician is allowed to manage the patient's care. Since malpractice does not protect the physician who indemnifies, he may be assuming an uninsured risk. See Kusske, *HANDBOOK*, *supra* note 30, at 97.

vices covered;⁸⁰ term renewal and termination of contracts;⁸¹ gag rules;⁸² and mode of compensation for services provided. The payment structure of the contract is the most important provision for both the provider and the managed health care plan. Most commonly, managed care contracts involve modified fee-for-service⁸³ arrangements for specialists or capitation fees⁸⁴ for primary care

80. Unless specifically stated in the agreement, the physician assumes that he is obligated to perform all services relevant to his specialty, though investigatory protocols and unusually complex, subspecialized procedures are excluded. One significant issue that arises in this context is whether the physician, in delivering the usual services, runs the risk of bankrupting his practice. *See id.* at 94.

81. While termination with or without cause theoretically is the right of either party, some health plans include termination clauses that are not equally fair to both parties. For example, Westchester Prepaid Health Services Plan (Healthsource) Participating Specialty Physician Agreement § 7 Term and Termination stipulates that "This Agreement may be terminated a) by WPHSP at any time with or without cause upon thirty (30) days written notice; and b) by Physician at any time with or without cause upon ninety (90) days advance written notice." This provision allows the plan to dispense quickly with a physician, disrupting his cash flow abruptly, as opposed to the plan's far longer (90-day) allowance which may allow the provider to adjust to the economic change. However, the physician still has obligations post termination for continuity of care of panel member patients until transition of their care to another provider.

82. Some contractual arrangements do not allow physicians to discuss treatment options that are not covered by the particular managed care plan with their patients. Paul Gray, *Gagging the Doctors: Critics Charge That Some HMO's Require Physicians To Withhold Vital Information From Their Patients*, *TIME*, Jan. 8, 1996. In 1995, U.S. Healthcare's "gag clause" providing that "Physician shall agree not to take any action or make any communication which undermines the confidence of enrollees . . ." was exposed. *See ROSENBLATT, supra* note 4, at 565, 645. In 1996, federal and individual state legislation was proposed, outlawing the use of gag clauses. The measure, which would have prohibited any managed care organization from restricting any communication between physician and patient with respect to the patient's physical or mental condition or treatment options, was defeated. *See id.*

83. In fee-for-service systems, the provider is reimbursed for each service provided. The specialist sends in a claim and the plan pays it. A variation is the discounted fee-for-service, which can either be a straight discount on charges, or a discount based on volume or a sliding scale. Other variations on fee-for-service include global, flat, or case rates. The flat rate is a single fee paid for a procedure regardless of how much or how little time and effort the surgeon spends doing the procedure. A global fee is a flat rate encompassing more than a single type of service. For example, pre- and postoperative care as well as follow-up office visits are included in the surgical reimbursement fee. Case rates are single reimbursements that combine both institutional and professional charges into one lump sum. This last system is not often implemented in neurosurgery. Most commonly used is the relative value scale, such as the resource-based relative value scale ("RBRVS"), or a fee allowance schedule. In the relative value scale, each procedure is assigned a relative value, which is multiplied by a conversion factor so as to arrive at a payment value. In a fee allowance schedule, the fees are explicitly defined in the contract. *See Kusske, Managed Care, supra* note 2, at 23.

84. Capitation is a method by which the risk of providing health care is distributed away from payers to providers. Capitation refers to a fixed payment that an MCO

physicians.⁸⁵ Most specialists are involved in modified fee-for-service contracts.⁸⁶

Managed care plans often select those physicians who care for generally healthy⁸⁷ populations unlikely to require costly medical attention. With managed care emphasis on improved disease management, MCOs encourage primary care fields that emphasize prevention of health problems, such as pediatrics, internal medicine and family practice.⁸⁸ Doctors are considered cost-effective if they perform fewer procedures,⁸⁹ hospitalize fewer HMO subscriber patients, order fewer diagnostic tests, write drug prescriptions in an effort to avoid hospitalization, and minimize referrals to more costly specialists. This strategy effectively eliminates surgeons from this group, especially those who care for children with complicated surgical problems requiring multiple procedures and subspecialty care.⁹⁰

pays a physician to cover a specified set of services, regardless of the actual number of services provided to each patient. If patient costs exceed the capitation amount, the physician must absorb these additional costs. If costs are below the capitation, the physician may keep the additional money. There are two types of risk involved. In the "upside risk," the provider is paid an additional amount if he realizes savings from practicing in an efficient manner. By comparison, in the "downside risk," a portion of the provider's fee is withheld and is returned to the provider only if costs are kept below a stated target. See ROSENBLATT, *supra* note 4, at 563; see also HASTINGS, *supra* note 49, at 269.

85. Primary care physicians are internists, family practitioners and pediatricians. See Kusske, *HANDBOOK*, *supra* note 30, at 210.

86. See Linda O. Prager, *Fee-for-service Plans Tops Among Doctors in Most Markets*, AM. MED. NEWS, Oct. 12, 1998, at 15.

87. When an employer buys coverage from an MCO that contracts to furnish health care for a pre-set fee (i.e., on a financial risk basis), the MCO insures the employees and provides medical care for that pre-set fee. If the employee does not need health care services because he is healthy, then the MCO makes money since it expends relatively little on that employee's health care. On the other hand, if an employee is sick and requires a lot of health care services, the MCO must provide those services for the same pre-set fee, thereby losing money if the employee's care amounts to more than the pre-set fee. See ROSENBLATT, *supra* note 4, at 553.

88. See Polly Miller, *Doctors' Incomes: Who's Up, Who's Down*, MED. ECON., Oct. 1998, at 45.

89. MCOs cut costs by avoiding unnecessary medical treatments or duplicative services, with the least costly provider rendering services. See Snoe, *supra* note 39, at 457. Alternatively, MCO contracts may require primary care physicians to perform specialty procedures (such as setting fractures, excising large skin lesions and suturing wounds) since they receive the same reimbursement rate regardless of what procedures they perform, in comparison to the specialist, who is paid by each procedure he performs. See Little, *supra* note 39, at 1412.

90. Surgeons often must hospitalize their patients for operations that are considered "major," such as procedures requiring long hours of work, having risks of blood loss or other medical complications, or involving major internal organs such as brain and spinal cord, abdominal viscera, lungs, heart and some orthopedic surgeries for

Managed care plans continue to make increasing demands upon the health care professional to improve health care delivery by providing care more efficiently and cheaply. Specialists are asked to assume a portion of the economic responsibility of caring for certain populations⁹¹ by furnishing services on a discounted fee-for-service basis, like network doctors, or in a capitated agreement with an MCO, an arrangement they may not be able to afford.⁹² Health care organizations may decide to implement decreased reimbursement rates for particular procedures, possibly to discourage their implementation by medical providers unwilling to undertake liability risks⁹³ without further compensation. Health care plans cannot limit enrollees on the basis of particular characteristics such as the present status of their health, anticipated need

bone abnormalities. Such surgeries require, at the very least, anesthesia, critical care nursing, prolonged hospitalizations with multiple medications and ancillary procedures, such as radiology, all of which are costly services.

91. Physicians assume the risk of financial loss due to provision of inefficient health care services because the HMO reimburses them most commonly on a capitation basis, rather than fee-for-service. See *Medicaid Managed Care*, *supra* note 8, at 754. Managed care contracts can demand that providers partly subsidize their Medicaid benefits plans. Amendment to the Agreement between Independent Health Association, Inc. (Hudson Valley), paragraph (d) states, "Member Physician authorizes IHA to withhold from any fees payable to the Member Physician such amounts as are deemed necessary by IHA to allow Member Physician to share the risk of costs and utilization in the Medicaid Health Benefit Plan. Member Physician acknowledges that withheld fees will be deposited in a risk pool which is separate and distinct from IHA's other businesses and that the determination of whether some or all of the withhold will be returned is exclusively at the discretion of the IHA Board of Directors." *Id.*

92. Costs for the emergency care of one patient can mount to the entire amount received for caring for a patient group on a capitated basis. See Howard Kim, *Medi-Cal Tells Physicians to Shape Up*, AM. MED. NEWS, Aug. 24/31, 1998, at 5.

93. A physician may be unwilling to continue performing sophisticated procedures that are considered high-risk, especially for liability (malpractice) purposes. Furthermore, if it seems unlikely that an HMO can be liable for a malpractice action, a physician may be concerned that he will be held liable for the consequences of medical decisions shaped by cost-effective concerns of the HMO. The consequences for the physician can be significant. If a physician loses a malpractice case, the payment made on his behalf as part of the settlement is reported and permanently documented in the National Practitioner Data Bank ("NPDB"), established by the Health and Human Services Department under the umbrella of the Health Care Quality Improvement Act ("HCQIA") of 1986, 42 U.S.C.A. §§ 11101-11152 (1999). The Data Bank is a registry for information about medical malpractice or professional misconduct by health care practitioners. Licensure boards have access to the Data Bank. The information also may be used by hospitals in evaluating applicants to, or members of, its medical staff. Though the general public does not have access to this information, there have been several proposals to allow increased access, most recently in Massachusetts. See FURROW, *HEALTH LAW*, *supra* note 14, at 86.

for health care or age.⁹⁴ However, with state approval, health care plans may limit their patient enrollment because of their presumed inability to deliver services or to maintain financial stability.⁹⁵

B. Practice Cost Analysis and the Impact of Managed Care Contracts

This Note reviews representative physician agreements⁹⁶ to see how contract conditions⁹⁷ affected compensation for specialized physician services. The ability of the physician to modify reimbursement amounts or contract requirements was analyzed. In all eight contracts reviewed, the managed care plan retained complete control over reimbursement rates, payment adjustments and determination of the medical necessity of all services provided prior to forwarding payment to the enrolled provider. The relevant wording in these clauses was similar from one contract to the next.

The specialist physician's compensation for services is to be made in accordance with the current HMO "reasonable" fee

94. See H.R. 3600, 103rd Cong. § 1402(1) (1993).

95. Plans may decrease or eliminate benefits to such a degree that enrollees may have to seek coverage elsewhere. In *Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees*, 740 F.2d 454 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109 (1985), the court held that ERISA created tax incentives to encourage voluntary employer action regarding retirement plans, and that "courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the market place and, when appropriate, by federal legislation." *Id.* at 456. See also H.R. 3600, 103rd Cong. § 1402(a) (1993).

96. The eight contracts chosen for review are representative of those agreements offered to specialist physicians (pediatric neurosurgeons) in the New York metropolitan area. These included agreements with Aetna-U.S. Healthcare; Anthem Blue Cross and Blue Shield ("Anthem BC&BS"); Cigna; Westchester Prepaid Health Services Plan ("WPHSP"); Independent Health Association, Inc.; Oxford Health Plans (NY), Inc.; Physician Health Services of New York, Inc. ("PHS"); and Wellcare of New York, Inc. See U.S. Healthcare Specialist Physician Agreement; Anthem Blue Cross and Blue Shield of Connecticut Participating Provider Agreement; Westchester Prepaid Health Services Plan ("Healthsource"), Participating Specialty Physician Agreement; (1996) Independent Health Association Inc., Participating Physician Agreement; Oxford Health Plans (NY), Inc. Consultant Physician Agreement; (March 31, 1998) Physicians Health Services of New York, Inc. Physician Agreement; (Apr. 15, 1997) Wellcare of New York, Inc. Agreement Between Wellcare of New York, Inc., and Consulting Specialist.

97. Contract analysis was limited to four factors. First, the ability of the physician to modify reimbursement amounts or contract requirements was analyzed. Next, requirements for provision of services were reviewed. Third, the physicians' financial responsibility for providing malpractice coverage was noted. Finally, fee schedules offered by the different managed care plans were compared to each other and to Medicaid's current New York rates.

schedule.⁹⁸ The HMO can unilaterally adjust rates as it sees fit⁹⁹ or can include in a single reimbursement for the primary procedure all of those services that it determines are part of that primary procedure.¹⁰⁰ The HMO can decide at any time whether it will consider a service "medically necessary," as well as determine the criteria necessary for reimbursement to the provider of this service. The HMO maintains the final authority to do either.¹⁰¹

Next, requirements for provision of services were reviewed. All of the contracts reviewed stipulated that the physician provider was obligated to care for any member enrolled in the plan. The health care provider must accept whatever reimbursement rate the HMO designates as appropriate,¹⁰² including care for Medicaid recipients enrolled in the HMO, whose care is paid for at Medicaid rates and not according to the HMO fee schedule.¹⁰³

Third, the physician's financial responsibility in providing his own malpractice coverage was noted. No HMO or managed care plan offered any financial assistance to the physician toward obligatory malpractice insurance.¹⁰⁴ All plans reviewed required that the physician purchase his own policy, stating specifically that the physician must obtain and maintain malpractice insurance at his own expense.¹⁰⁵ Furthermore, the contracts stipulated that the physician is solely liable for any treatment decisions he makes¹⁰⁶

98. U.S. Healthcare Specialist Physician Agreement § 2 Compensation (A) specifies this type of provider reimbursement, though no definition of "reasonable" or "equitable" is provided. See U.S. Healthcare, *supra* note 97, at § 2. See Westchester Prepaid Health Services Plan (Healthsource) Participating Specialty Physician Agreement § 2(a) where compensation is almost identical.

99. See Oxford Health Plans (NY), Inc. Consultant Physician Agreement §§ 2-3 Reimbursement Rates; Payment/Hold Harmless. July 9, 1998.

100. See Healthsource, *supra* note 97, at § 2 Compensation (B).

101. See Wellcare of New York, Inc. Agreement with Consulting Physician § 1(A) Services. See also Healthsource, *supra* note 99, at § 1 Services (B).

102. MCOs have threatened to terminate physicians for not accepting lower reimbursement rates. See *Maltz v. Aetna Health Plans of N.Y.*, 114 F.3d 9 (2d Cir. 1997). If a physician has signed a contract accepting the fees and conditions that the MCO stipulates, then the physician is obligated to accept whatever fee the MCO pays him. He has contracted to provide health care, which he is obligated to do, no matter what the reimbursement may be. See Little, *supra* note 39, at 1460.

103. See U.S. Healthcare, *supra* note 97, at § 6 Other Program Participation.

104. Since the physician is viewed by the HMO as an independent contractor, it is the physician's obligation to obtain malpractice insurance.

105. See e.g., Oxford Health Plans (NY), Inc., Consultant Physician Agreement § 8 Insurance (Mar. 31, 1998). "Consultant Physician shall provide and maintain . . . (malpractice) insurance . . . subject to the approval of Oxford, and shall not be less than \$1,000,000 per claim and \$3,000,000 per year." *Id.*

106. See U.S. Healthcare, *supra* note 99, at § 5 Insurance. "Specialist Physician at his or her sole cost and expense shall procure and maintain such policies of general

independent of whether the decisions are made in accordance with MCO requirements or guidelines, so that the MCO itself cannot be held liable.¹⁰⁷ In effect, the physician is paying for malpractice insurance coverage for the HMO as well as for himself. These clauses were similarly worded in all the contracts reviewed.

Finally, fee schedules offered by different managed care plans were compared to each other and to Medicaid's current New York rates.¹⁰⁸ Fee schedules from five health care plans in the New York metropolitan area were compared to each other according to their CPT codes.¹⁰⁹ Among the five plans, most of the reimbursement rates were comparable.¹¹⁰ However, in comparing the New York Medicaid reimbursement rates to the MCO reimbursement rates for the same CPT codes, the Medicaid fees were calculated to be, at best, only twelve to fourteen percent of the "reasonable" reimbursement rates allowed by the managed care companies.¹¹¹

and professional liability and other insurance as shall be necessary to insure it and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of services hereunder in connection with this Agreement." *Id.*

107. In *Howard v. Sasson*, Civil Action No. 95-0068, 1995 WL 581960 (E.D. Pa., Oct. 3, 1995), a primary care physician (acting as "gatekeeper" for the MCO) refused to authorize an infant's emergency room visit on the basis of a telephone conversation with the mother wherein she described the child's symptoms. The child died shortly after arriving in the emergency room. The court remanded the negligence claim to state court, holding that ERISA preemption of claims against health care providers does not exist without allegations that the organization refused to pay for, or authorize, treatment. In *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996), authorization of a patient's transfer to another hospital for specialty care was refused by a physician acting as a utilization reviewer for the HMO. The court noted that the negligence claim was based upon a delay in medical care occasioned by a cost containment protocol set by a for-profit organization.

108. See BCNYS, *Managing With Care*, *supra* note 10, at § 2 (stating that New York's Medicaid program is the most generous in the nation by far). The disparity between the average reimbursement rates for managed care plans, considered "reasonable," and the inexplicably low rates that Medicaid pays, is significant. Whereas private insurance plans pay between \$4,000 and \$11,000 for brain tumor surgery, Medicaid pays between \$500 and \$600 for the exact same procedure. Table 2.

109. See AMERICAN MEDICAL ASSOCIATION, *PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY* (1997) [hereinafter "CPT"].

110. See *infra* Table 2.

111. Generally, the so-called "high quality" care, such as that provided in the private health care system, is too expensive for Medicaid to subsidize. Medicaid fees range from 30% to 75% of private market prices, the upper range of more generous reimbursements going to less expensive primary care services such as pediatrics and family practice. See ROSENBLATT, *supra* note 4, at 418. Rates of reimbursement vary from state to state and between specialties. The most costly care is the least reimbursed, such as neurosurgery. The reimbursements for neurosurgery hardly cover the subspecialist's expenses in maintaining a medical practice. If he cares for an increasing number of Medicaid patients, his overall income will decrease because of the de-

Federal Medicaid law suggests that payment rates should be "consistent with efficiency, economy, and quality of care and . . . sufficient to enlist enough providers so that care and services are available to the general population in the geographic area."¹¹² With such low reimbursement fees, it is unclear how the Medicaid program can expect providers to offer medical services voluntarily, because many private practitioners will not be able to keep their practices solvent if obligated to do so under these circumstances.¹¹³ Though the Supreme Court upheld the right of providers to sue states over the adequacy of Medicaid payments,¹¹⁴ it is unclear if a provider denied payment actually could recover damages against the state.¹¹⁵ Generally, providers still accept Medicaid payments as payment in full for their services¹¹⁶ despite low reimbursements because of their non-delegable duty to care for patients in general.¹¹⁷ The manner in which Medicaid pretends to enlist "enough providers" to accomplish its stated goal is unclear under the circum-

creased compensation he receives. If he cannot pay his overhead, malpractice, etc., then he cannot maintain his medical practice.

112. 42 U.S.C.A. § 1396a(a)(30) (2000); 42 C.F.R. §§ 447.200, 447.204 (2000).

113. In *Clark v. Kizer*, the court recognized that the State had failed in its statutory duty to endure equal access to dental care. Denti-Cal (California Medicaid coverage of dental care) reimbursements were so low as to be insufficient to attract and enlist enough providers to secure dental care for the poor to the same extent as that available to the general public. 758 F. Supp. 572 (E.D. Cal. 1990). After that case, California was required to increase rates from 55% to 80% of dentists' customary charges. See *Clark v. Coye*, No. 92-16852, 1993 U.S. App. LEXIS 26615, at *2 (9th Cir. October 5, 1993) (finding no abuse of discretion by magistrate in imposing the increased rate).

114. In *Temple Univ. v. White*, 941 F.2d 201 (3d Cir.1991), cert. denied, 502 U.S. 1032 (1992), state Medicaid rates were found to be inadequate under federal standards. Pennsylvania Medicaid hospital rates were held to be inadequate to meet the costs incurred by efficiently and economically operated hospitals, by failing to take into account that the hospitals served a disproportionate number of low-income patients with special needs. See also *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990); *Methodist Hosps., Inc. v. Indiana Family & Soc. Servs. Admin.*, 860 F. Supp. 1309 (N.D. Ind. 1994); *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).

115. See *Edelman v. Jordan*, 415 U.S. 651 (1974).

116. After the passage of the Boren Amendment, requiring states to pay facilities rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws regulations" (SSA § 1902(a)(13)), there were numerous cases litigated by providers challenging the adequacy of Medicaid payment rates. Among these were *AMISUB (PSL), Inc. v. Colorado Dep't of Soc. Servs.*, 879 F.2d 789 (10th Cir. 1989); *Folden v. Washington State Dep't of Soc. and Health Serv.*, 981 F.2d 1054 (9th Cir. 1992). However, providers have been less successful in arguing these cases in recent years. See HASTINGS, *supra* note 49, at 237.

117. Under professional and ethical standards, a physician cannot withhold necessary medical care from a patient. To do so would constitute malpractice. See ROSENBLATT, *supra* note 4, at 560; see also Little, *supra* note 39, at 1448.

stances because federal constraints somewhat limit state discretion in setting physicians' fees.¹¹⁸

III. IMPACT ON DISABLED CHILDREN: POLICY IMPLICATIONS

If the objective of a health plan is to maximize the health of the population it serves,¹¹⁹ it is nothing less than institutionalized (though not unlawful) discrimination to provide affordable health care to some populations and not others. Yet this discrimination is prevalent in today's managed care environment.

Though managed care organizations are highly lucrative players in today's health care market and are traded on the stock exchange, there is evidence that they are now beginning to lose money.¹²⁰ Since the motives and interests of managed care corporations are driven by profit, there is little initiative outside of the Medicaid or Medicare¹²¹ systems to provide health care to poor and ill communities.¹²² These patients often require more expensive medical treatments when their health status deteriorates be-

118. The Medicaid statute does not explicitly guarantee beneficiaries a "right" to services, nor does it give providers a "right" to judicial review of state agency actions, though "fair hearings" for applications denied assistance are required. While federal Health and Human Services ("HHS") provisions can require that Medicaid pay qualified providers, HHS has limited power to enforce this, since the ultimate sanction, cutting off federal funds, is unavailable as a remedy. See ROSENBLATT, *supra* note 4, at 421-22.

119. David M. Eddy, *Rationing Resources While Improving Quality: How to Get More for Less*, 272 JAMA 817, 823 (1994). Dr. Eddy supports a population-based concept of quality for the health plan shared by the physician. He writes, "we [physicians among others] will need to change from focusing on individuals to focusing on populations"

120. While HMOs kept prices down to attract customers, two thirds of them now are losing money and raising their premiums. Michael Meyer, *Oh No, Here We Go Again*, NEWSWEEK, Dec. 14, 1998, at 46, 47. A look at the local stock listings shows that in the past year, Oxford went from a high of 22-1/2 to a low of 5-13/16. Stock listings, WALL ST. J. & N.Y. TIMES, Dec. 9, 1998.

121. Congress enacted Medicare as part of the Social Security Amendments in 1965. SSA Title XVIII. The program established a national health insurance system for aged Americans. Part A covers hospital services and is an entitlement program (anyone meeting the eligibility criteria is entitled to the benefits). Part B is a voluntary program (monthly premiums must be paid) covering physician services. See Hastings, *supra* note 49, at 191-93.

122. In October 1998, at least three New York-based HMO's (Oxford, United Healthcare and Vytra Health Care) announced that they would no longer serve seniors enrolled in their Medicare programs effective January 1, 1999. Oxford Health Plans narrowed its fourth-quarter loss to \$19 million from \$285 million a year by quitting several "unprofitable" Medicaid markets. *5 O'clock News* (NBC television broadcast, Dec. 8, 1998); see also Leah Rae, *HMO's, Seniors Meet Today*, JOURNAL NEWS, Dec. 9, 1998, at 1B.

cause they are less likely to receive consistent preventive health care.

Thus far, when the private health care industry wished to maximize its revenues, it could resort to whatever policy was necessary to do so, even if restricting certain groups' access to health care was the only way to accomplish this goal. The easiest target is, of course, the most vulnerable population: the disenfranchised ill, including disabled children, the aged and ethnic Americans.¹²³ While managed care plans may exploit Medicaid enrollments when it is a lucrative proposition, health plans leave the Medicaid system when they no longer have the financial capacity to serve those disenfranchised communities.¹²⁴ Given the poor health status of chronically disabled children and their need for costly services, it is likely that for-profit health care plans will exclude this population.¹²⁵

The proper management of the chronic health problems that a disabled, neurologically impaired patient has often requires ongoing care and monitoring by a subspecialist. The absence of such care can exacerbate a particular condition and may precipitate secondary health complications. Pediatric neurosurgical diagnoses, in particular, may appear to be completely "cured" after successful surgery without the apparent need for further medical evaluation.¹²⁶ However, most of the chronic medical conditions requiring

123. See Randall, *supra* note 11.

124. HMOs have no obligation to provide care for the uninsured under many Medicaid reform plans. When HMOs pull out of Medicaid programs because a disproportionate amount of the funding is directed toward the costly care of the disabled, local hospitals will have less revenue to subsidize charity care. See *Medicaid Managed Care*, *supra* note 8, at 763. See also *Ethnic Americans*, *supra* note 125, at 189-90.

125. Stephen J. Pearson, *Health Care for Uninsured and Underinsured Children: Letter to the editor*, 145 AM. J. DISABLED CHILD 1985 (1991).

126. For example, a child born with spina bifida, a defect where the spinal cord is exposed without any protective covering such as skin, muscle or bone, is at risk of meningitis and death if the lesion is not surgically repaired immediately. After successful surgery, the skin abnormality is no longer evident. However, the diagnosis may be associated with severe neurologic impairment and abnormalities of the spinal cord, as well as associated deficits such as paralysis of the extremities; loss of sensation below the level of the lesion; bladder and bowel abnormalities, including constipation and the inability to void without medication and intermittent urinary catheterizations; hydrocephalus, an abnormal accumulation of spinal fluid in the brain, requiring surgery to prevent lethal increased intracranial pressure; other abnormalities of brain development associated with mental retardation, seizures and difficulty breathing; scoliosis, clubfeet and hip dislocations; and genitourinary abnormalities including malrotation of the kidneys, hydrocele, undescended testes and hydronephrosis, among other problems. The syndrome places the child at constant risk of infection, meningitis, progressive weakness and even death if symptoms of neurologic deterioration are not recognized and corrected. As a significant number

pediatric neurosurgical care are life-long issues, including, but not limited to, spina bifida and other life-threatening diagnoses, such as obstructive hydrocephalus, cerebral palsy,¹²⁷ epilepsy¹²⁸ and recurrent brain and spinal cord tumors. These severe medical and surgical conditions often fluctuate over the years.¹²⁹ Subtle clinical signs, if not immediately attended to, often herald catastrophic outcomes.¹³⁰ Each disability varies with each patient and over time. Such details are easily recognizable to the subspecialist who is equipped to respond instantly and rectify the condition, suggesting that patients with such conditions need continuing subspecialty care¹³¹ even when their surgical conditions appear to be cured. Yet under the current health care system, once a person is deemed

of these children grow, they develop secondary problems referable to their original condition, such as a tethered spinal cord, a scarring of the neural elements, which subsequently causes scoliosis, a curvature of the spine, and further weakness leading possibly to complete paralysis and loss of all neurological function. This disastrous consequence may present itself subtly as mild back pain, for which an untrained general medical practitioner may simply prescribe analgesics, warm soaks or physical therapy, relatively inexpensive medical management, when compared to potential surgery. If ignored for too long, subtle pain may progress to the irreversible neurological problems described above, all of which can be prevented if attended to in timely fashion by an experienced practitioner. See Donald H. Reigel & Deborah Rotenstein, *Spina Bifida*, in *PEDIATRIC NEUROSURGERY: SURGERY OF THE DEVELOPING NERVOUS SYSTEM* 51, 52-56 (William R. Cheek et al. eds., 3d ed. 1994).

127. For definitions of hydrocephalus and cerebral palsy, see Carey, *supra* note 58, and accompanying text.

128. "Epilepsy" is a chronic disorder characterized by paroxysmal attacks of brain dysfunction usually associated with alterations in levels of consciousness and seizure activity or convulsions. There are multiple etiologies, among them brain tumors, head injury, strokes, infections and meningitis, and congenital abnormalities of the brain. See *STEDMAN'S*, *supra* note 13, at 472.

129. For example, a child with epilepsy may require different dosages of anticonvulsant medications, or different medications altogether, as his body grows, which requires frequent neurological evaluations and blood tests, among other diagnostic studies. Occasionally, such children may require surgery to remove portions of the brain that cause the seizure activity when medications are no longer beneficial. *Id.*

130. For example, the child with obstructive hydrocephalus who is dependent upon a shunt may exhibit symptoms of a potentially catastrophic malfunction of the apparatus, which may go unrecognized by the non-specialist in neurosurgery. Such symptoms may include clinical findings as subtle as mild personality changes or subtle changes in school performance.

131. The U.S. Court of Appeals for the 4th Circuit reconfirmed the importance of continuity of care in *Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634 (4th Cir. 1995). However, the long-term relationship that a physician develops with his patient appears to be less important. In *Maltz v. Aetna Health Plans of N.Y.*, the plaintiff argued that terminating a pediatrician's contract because he would not accept the lower reimbursement rates imposed by the health care plan would jeopardize the physician-patient relationship. While the court recognized the value of such a relationship, it ruled in favor of Aetna. 114 F.3d 9 (2d Cir. 1997).

"medically recovered," the otherwise disabled person often becomes ineligible for medical and surgical benefits.¹³²

HMOs are more likely to evaluate physicians based on the cost-effectiveness of their decisions, rather than on how they addressed the health status of their patients.¹³³ For poor people, and especially for children, this practice can be disastrous. Neurologically impaired and chronically disabled children demand more expensive specialized services, an unattractive option for the cost-conscious managed care business. Even when families resort to Medicaid, the benefits offered through this plan do not adequately cover the costs of the subspecialized medical and surgical work¹³⁴ that neurologically disabled children require. Physician reimbursements are so low that the physician's costs to deliver care, especially appropriate liability coverage, the costliest item that physicians are obligated to provide out of their own pockets,¹³⁵ cannot be met. Without liability protection, physicians are unable and unwilling to undertake the risk of caring for such high-risk patients. At the same time, managed care's decreasing reimbursements to the medical provider¹³⁶ make it difficult if not impossible,

132. Not only do the disabled require medical intervention for the disability itself, but they often have other special care needs that must be met in order to live in their own homes, rather than in a chronic care facility, including rehabilitation, personal assistance, home care and other equipment. These services are not always well covered by managed health care programs. See Trubek, *supra* note 9, at 1088-89 & n.29. However, both § 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. § 794 (2000), and Title III of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C.A. §§ 12101-12213 (2000), specifically prohibit discrimination against people with disabilities in many areas, including patient access to health care.

133. See Trubek, *supra* note 9, at 1628-34 & nn16-19; see also Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 BROOK. L. REV. 35, 37 (1992). Health care organizations evaluate patients by using practice profiles, which present data about the physician's cost of services. This data, concerning a physician's economic performance, is then utilized in the MCO's decision whether to contract with the physician. These profiles generally do not account for variations in the health of different doctors' patients.

134. See Carey, *supra* note 58 and accompanying text.

135. While malpractice costs generally account for one percent of health care expenses, the costs are borne disproportionately by physicians in particular specialties and geographic areas. See FURROW, *HEALTH LAW*, *supra* note 14, at 725. Neurosurgical malpractice costs, in particular, are among the highest in the country. Physicians spend \$9 billion annually on malpractice insurance. Neurosurgeons pay an average of \$44,000 for "claims made" coverage (ranging from \$17,000 to \$74,000 depending upon location, with maximums reaching \$150,000). See American Association of Neurological Surgeons and Congress of Neurological Surgeons, 1992 Comprehensive Practice Survey (1993). For sample estimates of neurosurgical malpractice costs in the New York metropolitan area, see also *supra* note 60.

136. MCO reimbursements for pediatric neurosurgery now range approximately 40-50% of the surgical fees usually reimbursed just five or six years ago.

for the physician to cross-subsidize the care of this needy, vulnerable population.¹³⁷

Competition for affordable health care relegates high-risk patients, such as developmentally disabled children, into specific groups identifiable by virtue of the high cost of care they require that may be so exorbitant as to be unaffordable without financial support.¹³⁸ Because of the chronic nature of pediatric neurosurgi-

137. In the past, hospitals were able to use revenues from full-paying patients to subsidize the Medicare and Medicaid patients. Mark Schlesinger & Richard W. Smithey, *Nonprofit Organizations and Health Care*, in UNDERSTANDING HEALTH CARE REFORM 48, 66-68 (Theodore R. Marmor ed. 1994). Similarly, many private physicians had, in the past, been able to cross-subsidize uncompensated or poorly-compensated care for the uninsured or Medicaid patients by relying on reimbursements from commercially insured patients to cover the costs incurred in maintaining a medical practice. While MCO reimbursements for pediatric neurosurgery have decreased, malpractice costs have remained the same or increased. See *supra* notes 59-60 & *infra* note 138.

138. For example, a chronically ill, severely impaired child with spina bifida usually requires significant health care and medical support. Among the costly items may be ventilators; special made-to-order wheelchairs to accommodate the child's body as it grows; diapers for urinary or fecal incontinence; intermittent bladder catheterizations with sterile equipment used each time for the child who cannot empty his bladder; round-the-clock specialized nursing care; medications; physical therapy; multiple surgical procedures by different surgical subspecialties such as neurosurgery, orthopedics, and urology to correct ongoing problems that develop as a result of the child's primary diagnosis, in addition to regular medical follow-up by neurologists and pediatricians. For a wheelchair-bound, ventilator-dependent patient, costs for non-physician services are exorbitant. Specialized nursing for 72 hours a week (eight hours a day, Monday through Friday, and 16 hours a day on weekends) is estimated at about \$90,000 a year. Specialized nursing care 24 hours a day, seven days a week throughout the year at \$30/hour costs approximately \$260,000 a year. Ventilator costs (including machine, tracheotomy collar and catheters) are about \$500/month or \$6000 a year. Special electric wheelchairs cost up to \$10,000. Braces, splints or crutches can cost \$1500 a pair each time they are replaced as the child grows. Physical therapy (PT) treatments are approximately \$135/session. If a patient receives PT five days a week, it costs about \$35,000 a year. Barrier-free lifts to transport a paraplegic person up and down stairs costs \$9000 to install. It costs about \$8500 above the cost of a van to modify it for the transport of a disabled person. Diagnostic studies, including X-rays (\$50/individual film), CT scans (\$200/study) and MRI scans (\$600/study) can add up, depending upon how often they are needed. An estimate total of the yearly expenses incurred in caring for such a disabled child, excluding pharmaceutical, laboratory, medical or hospitalization costs, is well over \$300,000/year. If a family makes less than \$18,000-\$20,000/year, they may qualify for Medicaid coverage. If their income is above this, the family may have to pay \$8000-10,000/year for a comprehensive health care plan to cover these costs, above and beyond a deductible for which they are responsible. Families above the poverty or categorically needy range may qualify for a Medicaid waiver program, whereby \$10,000 a month is allotted by Social Services for medically necessary treatments. If the child's care exceeds this amount, then the child is no longer eligible for this program because his care may be less expensively administered in an in-hospital setting. Otherwise, the family is responsible for these added expenses. It should also be noted that, as medical treatments and technologies

cal disabilities, requiring frequent, repeated and long-term medical intervention, some insurance plans "cap" the medical coverage they will provide for disabled children by imposing certain limits that the health care plan itself determines despite the physician's recommendations to the contrary.¹³⁹

Families are often forced to resort to Medicaid,¹⁴⁰ or go into bankruptcy and lose their health care coverage altogether.¹⁴¹ In fact, while the aged and disabled represent only twenty-five percent of Medicaid recipients, they consume nearly seventy-five percent of all Medicaid expenditures, generally accounting for about seventy percent of state Medicaid budgets.¹⁴² However, just like private insurance HMOs, Medicaid managed care programs also try to minimize access to more expensive health care by limiting benefits to enrollees or by adhering to the Medicaid schedule since there is little benefit in providing services for which Medicaid will not compensate.¹⁴³

Physicians excluded from managed care plans may be driven out of the medical profession completely,¹⁴⁴ forcing their own patients

advance, such disabled children live much longer than they had in the past, many now with full-life expectancies. See Personal communication, The Family Connection, Westchester Medical Center, Valhalla, New York.

139. In *Higdon v. Boning*, the court determined that a 42-year-old cerebral palsy patient was entitled to coverage by the local government for physical therapy, assistance with activities of daily living, and medical treatment, under the General Public Assistance Law 296 A.2d 569 (N.J. Juv. & Dom. Rel. Ct.1972). This decision holding local governments statutorily responsible to pay for hospitalization and other services was disapproved in *Sharp v. Department of Human Servs.*, 453 A.2d 890, 893 (N.J. Super. Ct. App. Div. 1982). In *Miller v. Whitburn*, the court held that despite a child's eligibility of Medicaid benefits, Medicaid is allowed to place a "cap" on the benefits it covers and is not required to pay for if a procedure is deemed "experimental" rather than "medically necessary," or if, in the State's discretion, the procedure was not covered in the Medicaid statute. 10 F.3d 1315 (7th Cir. 1993).

140. This gap in the private insurance market was partly addressed in 1965 by the federal enactment of Medicare and Medicaid. See Family Connection, *supra* note 140.

141. See Alain Enthoven & Richard Kronick, *A Consumer Choice Plan for the 1990s*, 320 NEW ENG. J. MED. 29 (1989).

142. See *Medicaid Managed Care*, *supra* note 8, at 757.

143. Section 1115(a) of the Social Security Act allows states to redesign their Medicaid programs as managed care systems. This portion of the Act gives the Secretary of Health authority to change federal Medicaid requirements including reducing beneficiary rights if it "assist[s] in promoting the objectives of" Medicaid. In only two cases has this section been challenged successfully. See ROSENBLATT, *supra* note 4, at 595.

144. As greater numbers of patients enroll in MCOs, physicians may find increasing numbers of patients leaving their care because they are not enrolled with the MCO as a participating provider. If a particular MCO enrolls a substantial portion of a physician's patients, a physician could face economic ruin if he is not enrolled with the plan or is terminated from that plan. Physicians must sign contracts with many MCOs

to seek care elsewhere, perhaps in inconvenient locations or at inconvenient times,¹⁴⁵ possibly from less experienced¹⁴⁶ or less committed physicians.¹⁴⁷ Given this scenario, uninsured or Medicaid patients increasingly are forced to seek care from institutional physicians associated with teaching hospitals, whose Medicaid funds help finance medical education and surgical residency training.¹⁴⁸ In this situation, both Medicaid patients and the uninsured are treated primarily by those still in medical training, with little clinical experience.¹⁴⁹ As such, the Medicaid patient provides the education for the physician in training. This medical staff may be only cursorily supervised by experienced, fully-trained staff physicians and surgeons for whom investing more time in these patients may not be worth the expense.¹⁵⁰ There is rarely any continuity of

because they do not know which MCO will enroll a large number of his patients. See Little, *supra* note 39, at 1427-28.

145. The uninsured may be forced to seek health care through emergency room services for ailments that could have been prevented or at least treated earlier at a lower cost, and may be hospitalized for conditions that might otherwise have been avoided. See ROSENBLATT, *supra* note 4, at 39.

146. The major medical centers where most disabled children access their health care have large emergency rooms often staffed with medical students, interns, and residents, who provide the majority of the health care.

147. Patients may be forced to seek care from managed care plans employing physicians who are under pressure to minimize costs. Physicians who are not experienced with the culture, language and experiences of a particular ethnic group may spend less time with patients who are not fluent in English. See Impact of Managed Care, *supra* note 73, at 1626; see also Randall, *supra* note 11, at 193-94.

148. See ROSENBLATT, *supra* note 4, at 534.

149. An "intern" has an M.D. (medical doctor) degree, but has less than a year's clinical (practical) experience in any medical or surgical field. Furthermore, he has not yet completed the final phase of the National Board of Medical Examiner's test, which ultimately provides him with a license to practice general medicine. A "resident" begins training in a specific medical or surgical field after one year's internship. A "first-year resident" has no more than one-year's experience in general medicine or surgery, and no clinical experience in the specialized field in which he has chosen to train. A "second-year resident" has a year's experience as an intern and a year's experience in the field in which he is specializing. A fully-trained neurosurgeon spends four years in medical school; a year's time in an internship in general surgery, or a combination of medicine and surgery; a four- to seven-year residency in neurological surgery; and, if he desires further training, then a one- to two-year fellowship in a subspecialty, such as pediatric neurosurgery. See American Medical Association: Accreditation Council for Graduate Medical Education, Essentials and Information Items 58-62 (Graduate Medical Education Directory, 1993); see also Julian T. Hoff, *Neurosurgical Education*, in *Philosophy of Neurological Surgery* 137 (Issam A. Awad ed., 1995).

150. Regulations implementing the Social Security Amendments of 1972, which have remained suspended, would have denied fee-for-service payment to physicians who supervised the care of poor patients, or who worked in hospitals that had traditionally provided a large volume of care for which the individual patient was unable to pay. See ROSENBLATT, *supra* note 4, at 538.

care since there is no single practitioner consistently available with whom the patient can develop a long-term patient-physician relationship. Interns and residents serve patients in clinic settings for only a few years until they complete their training and obtain jobs elsewhere. Other critical issues, such as familiarity with the socioeconomic dynamics that affect health,¹⁵¹ or an understanding of cultural differences and potential language barriers which affect communication between patient and doctor,¹⁵² may be completely neglected.

These larger teaching institutions may be at significant distances from patients' homes. This scenario forces patients to travel to those distant facilities, thereby wasting valuable time traveling when they could receive urgent care sooner from a facility that is more conveniently located.¹⁵³ Decreases in convenient health services can lead to fewer visits to physicians, often condemning patients to access tertiary health care centers when they are sicker. This trend usually results in higher health care costs.¹⁵⁴

MCO practices may result in the elimination of skilled physicians interested in providing health care to underprivileged communities. Those physicians—including surgeons—who serve large numbers of poor, chronically ill or disabled children requiring frequent medical vigilance,¹⁵⁵ protracted therapy and intense, costly provision of subspecialty health services, are least attractive to managed care groups because of the very population for which they care. The work of such experienced doctors may be greatly underval-

151. Inferior education and poverty are two such factors. See ROSENBLATT, *supra* note 4, at 592.

152. See *Impact of Managed Care*, *supra* note 73, at 1635; see also Trubek, *supra* note 9, at 1092.

153. See *Impact of Managed Care*, *supra* note 73, at 1635 n.52.

154. See Randall, *supra* note 11, at 209; see also *Impact of Managed Care*, *supra* note 73, at 1636. A child with a minor ear infection that goes untreated with simple medications that can be taken by mouth may develop a serious ear infection requiring intravenous antibiotics and hospitalization. A pediatric neurosurgical example of this problem would be the shunted hydrocephalic patient, whose symptoms of shunt equipment malfunction may be inadvertently ignored for too long, and who may come in to the hospital emergency room, already critically ill and requiring intensive care unit management and supplementary surgical procedures that may have been obviated by more timely consultation for the problem.

155. "Frequent medical vigilance" refers to continuity of care. In *Wheeler v. Dynamic Engineering, Inc.*, the court noted that if an insurance policy insures against illness, coverage for all medical costs arising from a particular illness vests when the illness occurs, arguing in favor of reimbursement for the medical expenses associated with continuity of care. 62 F.3d 634 (4th Cir. 1995).

ued,¹⁵⁶ making these physicians most vulnerable to the cost-containment measures of the managed care insurance companies.

Those physicians who care for the medically poor, who are excluded from managed care, or who are subject to continually decreasing reimbursement rates, may be forced to supplement their income in other ways or may be driven out of the medical profession entirely.¹⁵⁷ Health care providers struggling with such financial constraints may find themselves unable to provide uncompensated health care.

As a result, the quality of health care delivery to the medically poor population, though financially covered by some health care benefits, may not be as stringently supervised as is "privately"¹⁵⁸ insured care delivered directly to the patient by a fully-trained subspecialist who has contracted independently with a managed care plan.¹⁵⁹ Skilled, experienced doctors, efficient in caring for high-risk, ill patients, who are interested in serving poor and ill communities, may be overlooked by MCOs seeking doctors who serve a higher percentage of healthy patients.¹⁶⁰ The pool of available qualified physicians would continue to decrease, resulting in not one, but two, casualties: the physician interested in serving the

156. Since a cost-efficient HMO would not want high-cost patients in its plan, the doctors providing such care are not attractive to the plan because of the expenses they incur to care for that particular group of patients. Because the patients are also sicker, the physicians may have more valuable experience caring for the very ill, which the HMO may ignore when it selects those physicians it puts on its provider panels or rosters. However, it may be illegal to exclude them. Medicare prohibits cherry-picking elderly patients with few or no medical problems for enrollment in its health care plans. See *Impact of Managed Care*, *supra* note 73, at 1629-30.

157. See Lindy Washburn, *The Money Squeeze: Specialists Hit Hardest by HMOs*, THE RECORD, July 14, 1998, at A-1. Because of reduced fees and delays in reimbursements to specialists, many are finding themselves supplementing their incomes in other ways. Some physicians are peddling Amway products, setting up side businesses, earning law degrees, acquiring professorships, testifying in court as expert witnesses, drawing on their pensions or dipping into savings to keep their practices afloat. See *id.*

158. When privately insured patients receive health care, their insurance company or MCO pays the physician directly, usually on a fee-for-service basis, rather than the physician receiving a straight salary from an institution to provide health care for any individual consulting that medical department, with the HMO or insurance plan paying the institution directly.

159. MCO certification requirements permit only fully trained, licensed physicians to participate on their medical provider panels, suggesting that interns and residents do not satisfy their criteria for quality health care providers.

160. See *Impact of Managed Care*, *supra* note 73, at 1634. A biased selection process, such as this one, results in less qualified physicians available in the managed care provider pool.

poor and the Medicaid recipient or the uninsured patient.¹⁶¹ Chronically disabled patients, especially children,¹⁶² who already have difficulty obtaining health care from pre-paid health plans, may suffer further. Without some change in the current health care system, this practice could lead to poorer¹⁶³ health care for destitute families and more burdensome health care costs in the long run.¹⁶⁴

IV. PROPOSALS

The challenge in health care today is to create affordable delivery systems for poor, medically fragile groups. In view of the crisis in American health care costs, managed care cannot be ignored to the detriment of overall health care in the long run. However, it may be difficult to rebut an HMO's allegation that qualified physicians providing costly subspecialty care for the chronically disabled are selected out of their rosters utilizing criteria that are consistent with business necessities.¹⁶⁵

Decreasing reimbursements and unrealistic fee schedules place an unfair burden on subspecialty medical providers, saddling them with the primary responsibility of subsidizing what essentially is charity health care to the medically disenfranchised. Medicaid's reduced reimbursements need to be integrated into key practice

161. See *id.* at 1629 n.19.

162. See Trubek, *supra* note 9, at 1094. Children's health care advocates emphasize preventive care, asserting that dollars spent on prevention recoup their value many times over in terms of dollars not spent on treatment by preventing disease. Preventative health care does not help the child born with a congenital abnormality or disability, which requires chronic subspecialized care. This aspect of the children's health movement continues to discriminate against the chronically disabled child.

163. Lack of health insurance limits access to quality, timely, cost-effective health care since the uninsured use fewer primary care visits than insured individuals, but remain hospitalized longer than their insured counterparts, reflecting a more advanced stage of illness on admission. Lack of coverage results in limited access and deferred care, which in turn leads to increased severity of illness and higher costs when services are used. The uninsured and underinsured experience burdens of economic hardship, ill health and mortality. See BCNYS, *supra* note 10.

164. The cost of uncompensated care (care for which no payment or government subsidy is received) is borne by all payers in the health care delivery system. Health reformers interested only in cost containment are failing to take a "systematic bird's-eye view of society as a whole," to the detriment of health care in the United States. Uwe E. Reinhardt, *Perspective: Spending More through "Cost Control:" Our Obsessive Quest to Gut the Hospital*, HEALTH AFF., Summer 1996, at 145, 146-47, quoted in Rosenbaum, *supra* note 8, at 752. Since Medicaid relies substantially on state funds, states must raise revenues through income, sales and property taxes, which impact more disproportionately on middle- and low-income families. See ROSENBLATT, *supra* note 4, at 417-18.

165. See *Impact of Managed Care*, *supra* note 73, at 1638-39.

management data in order to assess a practice's readiness for managed care and its capacity to participate in Medicaid programs. Among the expense categories that need to be included are costs for delivering services to the different payers or managed care plans, including salaries and benefits for the physician's office staff, cost of equipment, office rent and insurance, malpractice and other miscellaneous direct and indirect costs.¹⁶⁶ A more equitable distribution of costs imposed on physicians by managed care can still protect the patient's health care concerns and abide by the requirements of the managed care paradigm.

The acute care of chronically ill, disabled children requires a different standard of care, one that is not met by standards imposed by the present managed care model. Whereas the managed care payer model emphasizing preventive care through capitated programs and withhold systems may be appropriate for healthy populations, this paradigm is ineffective for the surgical patient requiring acute care.

The type of surgical health care provider required by the chronically ill, disabled child cannot be reimbursed under the same system as a primary care provider, such as a pediatrician or family practitioner. Physicians' services are not fungible. There are qualitative differences between medical fields, based largely upon differences in the complexity of services rendered, the time required to provide them and the costs incurred by the physician in doing so.¹⁶⁷ Federal and state financial incentives, such as tax exemptions or improved physician reimbursements, may encourage more spe-

166. As an independent contractor who contracts with the HMO to provide health care services, the physician pays for his own business expenses. If his business expenses exceed the payments he receives from HMOs, his costs exceed his income and he cannot afford to stay in practice.

167. In *Kartell v. Blue Shield of Mass., Inc.*, plaintiffs argued that Blue Shield's pricing structure banning balance billing eliminated competition among participating physicians. The First Circuit's response was that the choice of what to buy and what to offer to pay was the buyer's. It left the issue of qualitative differences among physicians to be determined by the buyer (in this case, Blue Shield) or by a regulator, but not by the court. It never addressed the qualitative differences between medical fields. 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). In *Ambroze v. Aetna Health Plans of N.Y., Inc.*, the court held that these "qualitative differences" meant that one doctor was more skillful or experienced than another, or that one physician was more aggressive with an HMO for needed care than another. It determined that offering better service and better quality care were the elements critical to competition, and therefore, to physician reimbursement amounts. However, this analysis is logical only when physicians within the same medical field are competing with each other. No analysis of the complexity of different services, such as those of surgical subspecialties, as opposed to less complex medical services, such as pediatrics, was made. No. 95 CIV. 6631 (DLC), 1996 U.S. Dist. LEXIS 7274 (S.D.N.Y. May 28,

cialty providers to enter into contracts with plans covering disabled or underserved populations, as money is the motivating factor in a competition-based approach.¹⁶⁸

Reimbursement for subspecialty services should continue along the lines of fee-for-service. Fee schedules to specialty providers serving disabled, chronically ill patients can be adjusted to account for many different variables including: the child's diagnosis; the time, intensity and complexity of the service provided;¹⁶⁹ the provider's specialty experience; the continuity of the care;¹⁷⁰ and the setting in which the care is given. Reimbursements should be increased for time-consuming, complex subspecialty surgical care. Basic or primary medical services requiring shorter periods of time and less complex levels of care should be reimbursed at lower rates. By balancing these two factors, the overall budget allocated to health care will not be compromised.

Assistance with malpractice costs is another consideration. Malpractice insurers should be induced to decrease the fees they charge the physicians they insure, based upon a case-by-case evaluation of the number of malpractice suits brought against each particular physician. Defense costs for the physician with multiple lawsuits brought against him may be considerable. However, the physician with few suits brought against him incurs minimal, if any, cost for the malpractice company. The insurer should pass those

1996), *vacated and remanded to permit repleading*, No. 96-7778, 1997 U.S. App. LEXIS 1048 (2d Cir. Jan. 24, 1997).

In *United States v. Mercy Health Servs.*, the court analyzed the geographic markets for which two hospitals competed and viewed those two hospitals as entities providing similar services. The court concluded that price consciousness plays a dominant role in the care-seeking patterns of patients. Because the general services provided by the hospitals were similar, they were deemed fungible for the purposes of the court's decision. This case also was not about the differences between medical fields, such as surgical subspecialties as compared to pediatrics, where disparities in complexity of services should play a role in physician reimbursements. The differences in complexity between medical services provided apparently has not been a consideration when Medicaid determines its physician reimbursements for specialized care. 902 F. Supp. 968, (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

168. See Trubek, *supra* note 9, at 1099, 1105.

169. An example of differing complexities may be a visit to the pediatrician for immunizations or throat cultures, as opposed to a neurosurgical operation.

170. In *Wheeler v. Dynamic Engineering, Inc.*, the value of continuity of care for a particular diagnosis was reconfirmed. The court held that a health care plan was required to cover a medical service (cancer treatment) despite the fact that it consisted of a multiple-stage medical procedure (intermittent intravenous chemotherapy in addition to peripheral stem cell rescue) extending over a long period of time. 62 F.3d 634 (4th Cir. 1995).

savings on to the physician consumer paying for the malpractice policy, instead of pocketing the savings as profit.

HMOs should be required to contribute to the purchase of subspecialty malpractice coverage as required for physicians by the terms of the HMO's contract.¹⁷¹ Cost-sharing systems should be integrated into HMO reimbursements to subspecialty providers through government legislation regulating the managed care industry. The paradigm to be used is the payment reform legislation creating the Medicare Fee Schedule. This schedule specifies a relative value scale ("RVS") that indicates the value of each service relative to other services, including a separate component for the costs of malpractice coverage.¹⁷² The idea is to permit a method of allocating malpractice costs that differs from that for other practice costs. Since malpractice premiums are determined primarily on the basis of a physician's specialty, then a separate component for malpractice allows the calculation of this expense according to a physician's specialty in a RVS that does not incorporate other specialty differentials.¹⁷³

HMOs must share the burden of providing health care to the uninsured in a manner that realistically reflects the distribution of delivery costs. Insured patients can pay a specified amount of money into a state fund (in the form of a tax) which can then be distributed by the government to special needs providers on the basis of the charity care they provide.¹⁷⁴ Alternatively, insured patients could pay for premiums on a sliding-scale basis. Those patients who use services disproportionately more than others would bear more of a financial burden than those who need significantly less health care.¹⁷⁵ Medicaid itself requires that state agencies make additional payments to hospitals serving a disproportionate

171. HMO contracts provide health care services to subscribers and may not be immune from antitrust scrutiny under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2000). In *Group Life & Ins. Co. v. Royal Drug Co.*, a drugstore challenged an arrangement in which Blue Shield entered into contracts with participating pharmacies who agreed to provide drugs to Blue Shield subscribers for a fixed price paid by Blue Shield. The Supreme Court held that the primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. The pharmacy agreements in question were considered arrangements for the purchase of services by Blue Shield. As such, they did not involve underwriting or spreading of risk, and were not immune from antitrust scrutiny. Exemption was for "the business of insurance," and not "the business of insurers." 440 U.S. 205, 211, 213 (1979).

172. See FURROW, *HEALTH LAW*, *supra* note 14, at 403.

173. See *id.*

174. See ROSENBLATT, *supra* note 4, at 509.

175. See Schlesinger, *supra* note 139, at 68.

number of low-income patients.¹⁷⁶ Similarly, state agencies should consider additional payments to those providers caring for this underserved population, allocating funds according to complexity of services provided, diagnosis and provider experience.

Congress or state legislatures can pass legislation mandating that federal or state funds be directed to cover more adequately the physician's costs in providing health care to the country's medically indigent. Furthermore, legislation can prevent discriminatory HMO practices that exclude chronically disabled, poor patients from affordable access to quality health care and that devalue the physicians who serve them. Medicaid managed care contracts are worth billions of dollars.¹⁷⁷ Therefore, HMOs that recruit patients from Medicaid pools can be required to hire or add to their existing networks a certain percentage of physicians who serve poor, chronically disabled populations. These providers should be reimbursed at fair rates based upon physician input.¹⁷⁸

A more extreme alternative is a publicly funded, single-payer, government-directed system, such as the National Health Service ("NHS") in the United Kingdom. The NHS has a centrally fixed, tightly controlled budget. Estimates of NHS funding sources find that these consist of taxes (80%), insurance contributions (15%) and patient charges (5%).¹⁷⁹ The NHS purchases health care through sectional District Health Authorities throughout the country. These Authorities are responsible for purchasing services for their populations from hospitals, both for-profit and non-profit, as well as from physicians. All patients have equal access to government-subsidized health care. All general practitioners, who act as gatekeepers for specialty and hospital care, as well as all specialists, are employed by the NHS. Malpractice costs (and awards) are kept to a minimum, compared to malpractice awards in the United States.¹⁸⁰

If the institution of universal health care is truly a concern of the American public (and of the legal profession, which presumes to serve the needs of its clients), then a government-imposed limitation on malpractice awards is a viable solution. This cap would allow for decreased fees for malpractice coverage. The federal government's increasing intrusion into health care delivery already

176. See ROSENBLATT, *supra* note 4, at 510.

177. See Rosenbaum, *supra* note 8, at 768.

178. See *Impact of Managed Care*, *supra* note 73, at 1641.

179. See FURROW, *HEALTH LAW*, *supra* note 14, at 747.

180. See FURROW, *FINANCE*, *supra* note 20, at 749.

comes on the heels of almost one hundred years of experience so that further government action would not be untoward.¹⁸¹

CONCLUSION

The reorganization of health care financing and health care delivery today has jeopardized the quality of subspecialty surgical care for the medically needy, especially for the neurologically impaired child. Managed care has evolved into a two-tier system, which has barred chronically disabled children from accessing mainstream medical care. The concerns of these medically disenfranchised consumers can be integrated into the health care system however, partly by offering financial incentives to mainstream providers to care for these patients, especially since money is an effective stimulant for the competitive provision of health care.¹⁸² Ignoring the health care needs of poor, neurologically impaired, disabled children leaves them in an appalling predicament. This situation will lead to disastrous consequences for the child's health status and for the managed care system as a whole. There will be increased demands on the health care system to provide more medical services as medical technology advances, patient survival and longevity increases, and more serious medical problems arise. If something is not done, insurance plans will continue to limit the medical coverage they will provide for disabled children by imposing restrictions that they determine are appropriate despite physician recommendations to the contrary. Without competent, accessible health care for poor, neurologically impaired children, this population will be forced to suffer not only because of their disabilities, but also because of insufficient government funding and society's apathy toward their problems.

181. Government involvement in health care began with government reporting requirements to prevent the spread of disease, and continued more recently with the Newborns' and Mothers' Protection Act passed by Congress in response to some HMOs' requiring mothers to leave the hospital with their newborn just one day after childbirth. See Snoe, *supra* note 39, at 22, 77.

182. See Trubek, *supra* note 9, at 1105.

TABLE 1
THE MOST FREQUENT PEDIATRIC NEUROSURGICAL
PROCEDURES AND THEIR CPT CODES¹⁸³

CPT Code	Procedures and services
99245	Office consultation for a new or established patient, which requires a comprehensive history; a comprehensive examination; and a medical decision making of high complexity.
99285	Emergency department visit for the evaluation and management of a patient, which requires a comprehensive history; a comprehensive examination; and medical decision making of high complexity.
62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus.
62230	Replacement or revision of CSF shunt, obstructed valve, or distal catheter in shunt system.
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma.
61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull.
61343	Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (e.g., Arnold-Chiari malformation).
61552	Craniectomy for craniosynostosis; multiple cranial sutures.
63200	Laminectomy, with release of tethered spinal cord, lumbar.
62005	Elevation of depressed skull fracture; compound or comminuted, extradural.

183. See CPT, *supra* note 109.

TABLE 2
COMPARATIVE REIMBURSEMENT FOR NEUROSURGERY
IN NY

CPT Code	Sample Fees, 1994	Aetna – US Healthcare	Empire	Ind. Health ¹⁸⁴	Oxford	PHS ¹⁸⁵	Medicaid
99245	\$225.00	\$105.00	\$203.00	\$250.00	\$210.00	\$244.00	\$36.00 ¹⁸⁶
99285	\$250.00	\$105.00	\$137.00	\$188.52		\$194.00	\$36.00 ¹⁸⁷
62223	\$5,500.00	\$1,672.00		\$1,285.03	\$1,938.00	\$1,079.00	\$360.00
62230	\$4,500.00	\$1,062.00	\$1,049.00	\$1,285.03	\$1,938.00	\$1,079.00	\$360.00
61510	\$10,000.00	\$2,600.00		\$3,348.24	\$4,602.75	\$2,937.00	\$500.00
61518	\$10,500.00	\$3219.00		\$4,055.42	\$4,825.01	\$3,510.00	\$600.00
61343	\$9,500.00		\$3,406.00	\$3,806.57	\$5,652.50	\$3,172.00	BR ¹⁸⁸
61552	\$8,500.00			\$2,106.22		\$1,733.00	\$400.00
63200	\$9,500.00			\$2,454.31		\$2,561.00	\$400.00
62005	\$7,500.00		\$2,761.11	\$1,649.19			\$340.00

184. "Ind. Health" denotes Independent Health Association.

185. "PHS" denotes Physician Health Services.

186. This represents the reimbursement rate for "preferred pediatric providers." The reimbursement rate for the same service provided by a physician without that designation is \$7.00.

187. There are slightly higher reimbursement rates for "preferred pediatric providers."

188. "BR" denotes "by report." Medicaid requires that the medical report for the procedure be submitted, at which time it is reviewed and the reimbursement decided at the time of that review, without the medical provider's participation.

