Policing Medicaid and Medicare Managed Care: The Role of Courts and Administrative Agencies

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Abstract The much-publicized 2000 case of *Frew v. Gilbert*, in which a federal judge castigated the State of Texas for deficiencies in its Medicaid program, brought renewed attention to the issue of regulating the quality of care in Medicaid and Medicare HMOs. *Frew* and other recent cases highlight both the promise and the pitfalls of relying on courts to correct deficiencies in public managed care programs. This article argues that while litigation over inadequacies in Medicare and Medicaid managed care can serve an important signaling function in alerting agencies and legislatures about the need for reform, the role of the courts in policing public managed care is circumscribed by several constraints. Barriers to class action litigation and differences in the institutional capacities of courts and administrative agencies mean that litigation is best viewed as a supplement, not an alternative, to a renewed commitment to strong quality monitoring on the part of Centers for Medicare and Medicaid Services and state Medicaid agencies.

In August 2000, a federal district court judge delivered an opinion lambasting the State of Texas for failing to provide adequate health care to impoverished children through its Medicaid program. Judge William Wayne Justice's 175-page opinion in the case of *Frew v. Gilbert* (109 F. Supp. 2d 579 [E.D. Tex. 2000]) recited a laundry list of problems with Texas's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children, placing particular emphasis on deficiencies in the care provided by Medicaid managed care organizations. Among his find-

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ings were that only 10 percent of eligible children were receiving immunizations, that over a million were going without dental care, that well-child checkups given in Medicaid HMOs were "grossly inadequate and incomplete," that case management services were deplorably inaccessible, and that the state had failed to adequately inform beneficiaries of their eligibility for services. Reporters pounced on then-governor George W. Bush upon learning of the ruling, creating an opportunity for the Gore campaign to drive home its message that Bush did not share voters' concern about health care.

In fact, *Frew* is not so much a landmark decision as the flurry of media reports would suggest: There have been numerous cases in which beneficiaries have successfully challenged the adequacy of Medicaid services, including lawsuits against twenty-eight states specifically addressing the EPSDT program and the provision of care by Medicaid HMOs (GAO 2001: 28–29). But in politics, as in comedy, timing is everything. Issued during the peak of the candidates' battle for dominance in the health care arena, the decision was seized upon as "a sweeping indictment" of Bush's Medicaid program (Meckler 2000: A6). Whether or not that characterization is fair, the publicity attending the decision did elevate the visibility of concerns about the quality of care in Medicaid and Medicare HMOs.

The case raises important questions about the respective roles of administrative agencies and courts in regulating public managed care programs. This article explores the strengths and weaknesses of reliance on each of these regulatory options and concludes that while litigation can play an important role, ultimately strong and reliable oversight requires a heightened commitment to program monitoring on the part of state and federal agencies. For several reasons, agencies are better situated than courts to manage complex programs effectively. However, litigation can contribute in important ways to a regulatory strategy centered on administrative agencies.

The first part of this article highlights the gaps that currently exist in agencies' policing of Medicare and Medicaid managed care, which have allowed many abuses to go unchecked. The second part proposes possible structural explanations for the shortcomings in agency monitoring. The following part describes the limitations of the judiciary as a program manager, including problems of institutional expertise, institutional legitimacy, and available regulatory tools. The next section details several barriers to bringing class action litigation concerning deficiencies in Medicare and Medicaid managed care, some of which stem from the

recent Supreme Court decision in the case of *Grijalva v. Shalala* (152 F.3d 1115 [9th Cir. 1998], *vacated and remanded*, 526 U.S. 1096 [1999], *remanded*, 185 F.3d 1075 [1999]). Finally, the conclusion argues that, notwithstanding these limitations, litigation has a meaningful role to play in the policing of public managed care programs. Litigation may contribute to a larger regulatory regime by serving a signaling function vis-à-vis agencies and legislatures. By detecting and publicizing problems in public managed care programs, it can serve as a catalyst for intervention by other regulators who are better situated to rectify policy problems.

The Need for Policing

While reasonable persons may disagree about the relative degrees of participation that the courts and executive agencies should have in the regulation of managed care organizations, there is a broad consensus that improved policing in some form or another is needed. The available evidence indicates that two types of problems—one substantive, one procedural—occur in Medicaid and Medicare HMOs on a widespread basis. First, substantive deficiencies have been identified in the quantity and quality of care that the HMOs provide. The *Frew* opinion details a litany of examples. Cataloged according to Avedis Donabedian's (1988) classic framework, they are problems of structure (a shortage of case managers and clinical providers, an inadequate medical transportation system), process (hastily conducted checkups, misuse of primary care gatekeepers), and outcome (low uptake of services, high prevalence of easily preventable conditions). These problems are by no means confined to the Texas Medicaid system. All nine of the HMOs in Maryland's Medicaid program, for instance, failed their first external evaluation in 1998 (Goldstein 1999), and only two of eight plans in California's program were determined to be delivering adequate care to at least 50 percent of their enrollees (Legislative Analyst's Office, State of California 1998).

Second, there are widespread procedural violations by HMOs relating to beneficiaries' rights to file a grievance and appeal of a health plan's decision to deny coverage for a particular service. Two national surveys have revealed a pattern of appeal procedures in Medicaid HMOs that "exist on paper, but [are] nonfunctional in practice" (Perkins et al. 1996: 55; Dallek, Jimenez, and Schwartz 1995; Bonnyman and Johnson 1998: 374). They found that state fair hearings were infrequently used to challenge denials and terminations of services, largely because beneficiaries were not given timely and substantively adequate notice of denials and

the right to a fair hearing (Perkins and Olson 2000). Such violations of grievance and appeal rights have led to class action lawsuits against Medicaid HMOs and state Medicaid agencies in Connecticut, Tennessee, and Pennsylvania (see Karen L. v. Physicians Health Servs., Inc., No. 3:99CV 002244[CFD] [D. Conn. filed Nov. 17, 1999]; Daniels v. Wadley, 926 F. Supp. 1305 [M.D. Tenn. 1996]; Metts v. Houstoun, 1997 WL 688804 [E.D. Pa. Oct. 24, 1997]).

Studies by the General Accounting Office (GAO) (1995a, 1999) have found widespread violations of statutory due process obligations by Medicare contractors as well. In 1997, the Health Care Financing Administration (HCFA)[1] conducted ninety monitoring visits to health plans and cited 13 percent of the plans for failing to issue denial notices and nearly a quarter of the plans for issuing denial notices that did not adequately explain beneficiaries' appeal rights (GAO 1999).

Existing oversight efforts by the federal and state agencies that administer Medicare and Medicaid, while undertaken in good faith, have not proven adequate to meet the challenge presented by these continuing abuses. With respect to Medicare managed care, GAO evaluations have identified several shortcomings in HCFA's monitoring scheme: HCFA's quality assurance reviews have not been comprehensive or accompanied by adequate follow-up monitoring, HCFA has been reluctant to employ the sanctions at its disposal, implementation of the new expedited appeals process enacted as part of the Balanced Budget Act of 1997 (BBA) has been incomplete, and HCFA has exercised little or no oversight over coverage decisions that HMOs have delegated to provider groups (GAO 1995a, 1999). With regard to Medicaid HMOs, the GAO found that HCFA oversight of plans' provision of EPSDT services has been quite limited (GAO 2001:20–21). Rather than perform direct oversight duties such as helping states identify and correct specific problems, HCFA's involvement has focused largely on improving state reporting of service uptake, which is still inadequate.

State monitoring of Medicaid managed care contractors, too, is limited. A 1995 study of monitoring of Medicaid HMOs in California found that the state conducted only a "minimal" review of plans' provider financial incentives and did little monitoring to ensure that EPSDT services were actually provided (GAO 1995b). A later study of the Arizona, Penn-

1. HCFA changed its name to the Centers for Medicare and Medicaid Services (CMS) in June 2001. I use the name HCFA when referring to past actions of the agency and CMS to refer to present and future circumstances.

sylvania, Tennessee, and Wisconsin Medicaid programs also identified several methodological problems with the states' monitoring schemes, including a failure to apply meaningful measures of quality (GAO 1997).

A large and growing proportion of Medicaid and Medicare beneficiaries receive their care through managed care plans. All but two states now have Medicaid beneficiaries in managed care plans, and the percentage of Medicaid beneficiaries who receive their care through such arrangements has risen from 10 percent in 1991 to 56 percent in 1999 (GAO 2001: 7). The percentage of Medicare beneficiaries in managed care reached nearly 18 percent in 1999 (Kramarow et al. 1999) before dipping slightly in 2000. Unchecked abuses and shortcomings in public managed care programs potentially affect millions of beneficiaries and represent a significant policy problem.

Agencies As Monitors

Federal and state agencies' failure to detect and rectify problems in Medicare and Medicaid HMOs may be attributable to several structural factors. Perhaps most significantly, agencies do not operate in a political vacuum. "Enmeshed in politics" (Aberbach and Rockman 2000: 4), they are subject to a number of political constraints stemming from their codependence on the legislature, the executive branch, and the private actors that participate in the programs they administer.

Agencies rely on the legislature for their funding and mandates. In the case of HCFA (now the Centers for Medicare and Medicaid Services or CMS), this poses a particular problem since Congress has not treated the agency well. While members of Congress have placed considerable blame on HCFA for poor administration, Congress has a long tradition of underfunding the agency. In 1999, leaders from fourteen leading research organizations and universities published an open letter alleging that the problems facing HCFA "stem from an unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment" (Butler et al. 1999: 8). They noted that HCFA has been downsized during an era in which its oversight responsibilities "have increased geometrically" (ibid.: 9). Among the direct consequences of the lack of monetary support for HCFA's mission have been severe staff shortages and continued reliance on an outdated and inadequate information system (Scanlon 2001: 8–11), both of which constrain the agency's ability to engage in effective monitoring of managed care contractors.

The resources and mission of federal agencies are also influenced heavily by the White House and are subject to disruptions with each change of administration (Moe 1982). The president may exert considerable control over agency budgets through his proposed budget submitted to Congress, by playing an agenda-setting role for congressional deliberations on agency appropriations, and through Office of Management and Budget (OMB) monitoring of expenditures of appropriated funds (Hammond and Knott 1996: 124; Wildavsky 1964; Kiewiet and McCubbins 1991; Waterman 1989: 37–39; Moe 1982). Presidents also exert control over agencies through the strategies of politicization and centralization. They politicize by using their appointment power to put ideologically compatible officials in positions of power in the executive departments and OMB (Moe and Wilson 1994: 17–18). They centralize by imposing managerial rules and structures that shift the locus of bureaucratic decision making upward, toward these loyal political appointees (ibid.: 18–19; Waterman 1989: 40; Hill 1995: 325–326).

Further, presidents empower agency administrators to a greater or lesser degree by contributing or withholding political support for their activities. The president will attempt to ensure that agency behavior is consistent with his own political priorities. Where it is not, he will impose additional structural constraints on administrators' ability to function (Moe 1989: 285). Norton Long (1949) has commented that the power of administrative agencies is largely a product of the clarity of signals sent to administrators by political principals. To the extent that the president does not vocally support an aggressive regulatory role for the agency, administrators may not feel they have the political mandate to monitor federal programs closely.

The last several presidential administrations have engaged in reform efforts that have had the effect of creating a weaker bureaucracy. The dedication of the Reagan and Bush administrations to the ideas of small government and devolution of control over programs from the federal government to states and municipalities led to a more circumscribed role for federal agencies. Reagan's system of rigorous regulatory review, which has become a standard part of the executive process, significantly hampered the rule-making activities of many agencies, including the Environmental Protection Agency and the Occupational Health and Safety Administration (Moe and Wilson 1994: 37–42; Wilson 1989: 264). More recently, the Clinton administration's campaign to "reinvent government" may also have weakened agency regulation by emphasizing responsiveness, cost cutting, and efficiency of operations over the achieve-

ment of substantive regulatory goals. Among the key strategies of the movement to reinvent government have been cutting programs, contracting out government functions, and relying on markets (Aberbach and Rockman 2000:142), all of which clash with the notion of tighter HCFA monitoring of public managed care programs. The new Bush administration has sent a signal that stronger federal oversight of public managed care programs is not on its agenda by first delaying and then watering down a plan formulated by the Clinton administration to provide new substantive and procedural protections for Medicaid managed care enrollees (Goldstein 2001). Bush's appointment of Tommy Thompson, a longtime governor who resented federal control (ibid.), as secretary of Health and Human Services also bespeaks a desire for a reduced federal regulatory role in health care. Thus, one reason HCFA/CMS may be failing as a managed care regulator is that it has not received sufficient political capital from the White House.

Monitoring action by HCFA/CMS and state Medicaid agencies is further constrained by the agencies' codependence with the private actors who participate in their programs. Medicare and Medicaid managed care programs cannot succeed without the support and participation of private health plans. Agencies have a structural conflict of interest in trying to keep down health expenditures that militates squarely against enforcing regulations against managed care contractors. This conflict of interest is a weak form of the phenomenon of agency capture in which agencies are dominated by the interests of the regulated industry (Wilson 1989). The last several years have seen the exodus of large numbers of plans from Medicaid and Medicare managed care: Of 309 plans serving Medicare beneficiaries at the end of 1999, 99 terminated their contracts or reduced their service areas for the 2000 contract year, and 118 terminated their contracts or reduced their service areas for 2001 (GAO 2000: 4). These market exits cause serious dislocations, and the agencies likely have been willing to accept substandard performance from some HMOs in order to avoid such shocks. Pressures to turn a blind eye may be especially severe in particular states whose political traditions are hostile to vigorous enforcement of government contracts.

A final explanation for bureaucratic failure relates to the structural design of administrative agencies. Terry Moe (1989, 1990) argues that agencies are deliberately designed to be technically deficient. The political group in power when the agency is created knows that it may not always be politically dominant. Thus, it is in the group's interest to "design its creations so that they have the capacity to pursue its policy goals in a

world in which its enemies may achieve the right to govern" (Moe 1990: 136). Through a variety of means, the group insulates the agency from political control. One protective strategy is to place statutory constraints on the agency's mandate. Another is to impose complex requirements for agency decision making and in particular to judicialize decision making and make decisions appealable to the courts (ibid.: 137). A third is to minimize congressional oversight. These strategies come at the price of a loss of technical rationality, efficiency, and flexibility: the bureaucracy is "designed to fail" (ibid.: 148). In Moe's view, even agencies that receive strong support from particular presidential administrations and Congresses may be ineffectual program monitors because of inherent structural weaknesses.

Judges As Managers

Given the failure of state and federal agencies to ensure quality of care in Medicare and Medicaid HMOs, it is unsurprising that some beneficiaries have turned to the courts for relief. But this avenue of relief, too, is beset with problems. The potential impact of litigation as a regulatory strategy for Medicaid and Medicare managed care is constrained by the inherent limitations of the judiciary as an institution.

One problem is that judges lack the management expertise that agencies possess. They rarely have proven adept at designing and administering specific measures to redress substantive violations like those at issue in *Frew*. Although courts generally shy away from rectifying constitutional violations with sweeping remedial orders, they have done so in several areas of law where the violations were particularly appalling and state regulators particularly remiss. The most prominent examples of such efforts at institutional reform are cases from the 1970s dealing with prison administration and school busing to enforce desegregation orders (Horowitz 1977: 11–12).

Judge Justice, the architect of the *Frew* opinion, has consistently been in the vanguard of the institutional reform movement. In the 1980 case of *Ruiz v. Estelle* (503 F. Supp. 1265 [1980]), for example, he famously held that Texas maintained unconstitutional conditions in its prisons, including severe overcrowding, inadequate security, and arbitrary and harsh discipline. The judge ordered relief that has been described as "more comprehensive and specific than any other prison order ever issued by a federal court" (Kemerer 1991). Further, he has retained jurisdiction over the case to the present day in order to ensure compliance,

notwithstanding Texas's subsequent expenditure of over $2 billion to rectify the violations (Shannon 2000). The *Frew* decision is but the most recent instance of the judge's commitment to active monitoring of state programs. While acknowledging that "litigation is a poor alternative to capable and caring performance by the state officials in the first instance" (Justice 1992: 11), Judge Justice has unapologetically defended his activism by invoking Judge Richard Posner's famous statement that "we on the bench are not potted plants" (Justice 1992: 10; Tagatz v. Marquette Univ., 861 F.2d 1040, 1045 [7th Cir. 1988]).

Judge Justice's efforts notwithstanding, there has been a pronounced judicial retreat from remedial activism since the mid-1970s (Gilles 2000: 1393–1395). The Supreme Court and federal appellate courts issued a number of important decisions in the late 1970s and 1980s restricting the circumstances in which federal courts may engage in institutional reform (Gormley 1996: 166–167; Youngberg v. Romeo, 457 U.S. 307 [1982]; Wilson v. Seiter, 501 U.S. 294 [1991]), and the breadth of remedies that courts may impose (Milliken v. Bradley, 418 U.S. 717 [1974]; Pasadena City Bd. of Educ. v. Spangler, 427 U.S. 424 [1976]; Newman v. Alabama, 559 F.2d 283 [5th Cir. 1977]; Ruiz v. Estelle, 679 F.2d 1115 [5th Cir. 1982]). The demise of the institutional reform movement was attributable to several factors. First, the appointment of a huge number of conservative judges, including five Supreme Court justices, during three Republican administrations in the 1980–1992 period fundamentally reoriented the courts away from judicial activism (Gilles 2000: 1394; Rudenstine 1986: 452). Second, public sentiment began to turn against sweeping judicial remedies, particularly where implementation of those remedies necessitated a tax increase (Gilles 2000: 1393).

Third, even those judges whose ideology did not preclude judicial activism per se came to appreciate the enormous burdens involved in reforming public institutions. Aside from the administrative burden involved in monitoring the implementation of judicial orders, courts' attempts at reforming public programs raise concerns about institutional competence and institutional legitimacy. Unlike officials in administrative agencies, judges generally lack the training, experience, and resources with which to evaluate public programs and craft sweeping policy solutions (Mishkin 1978). Judges are generalists and have difficulty processing specialized information (Horowitz 1977: 25–30). In contrast, administrators have highly specialized expertise and are better able to understand where and why a particular program has taken a wrong turn and to choose wisely from among a range of alternative remedies.

Leaving the management of complex public programs to judges is particularly problematic given the difficulty of reversing an unsatisfactory judicial order. The legislature can overturn judicial decisions only by passing a new statute, and legislators cannot easily lobby judges to reverse their position. Members of Congress can make life difficult for agency administrators in a number of ways, but judges are structurally insulated from such pressures (Melnick 1994: 270–271). Judges, for their part, are reluctant to reverse themselves because of their fidelity to the principle of stare decisis.

Because judges' competence as managers is open to question, judicial activism in the area of institutional reform may negatively impact public views of the courts. It creates a perception that unelected, unaccountable, and perhaps unskilled judges are overstepping their bounds and acting as a sort of superlegislature. As Paul Mishkin has explained, the institutional reform movement came to be viewed as the takeover of government institutions by "federally-appointed lawyers neither chosen by nor responsive to an electorate, neither charged with nor even assuming responsibility for the ultimate directional thrust or effectiveness of the institutions of state or local government" (Mishkin 1978: 971). Judges who impose broad remedial orders place the judiciary's institutional legitimacy in peril (Jacobson and Warner 1999: 796).

With respect to the regulation of HMOs, it is wise to heed the lessons of courts' experience with institutional reform, for the challenges of administering the Medicare and Medicaid managed care programs are certainly no less daunting than those presented by schools and prisons. Indeed, the Supreme Court has signaled its belief that it is imprudent for the judiciary to engage in evaluations of the particular mechanisms employed by managed care organizations to reduce costs and ration care, which is an important part of quality monitoring. In *Pegram v. Herdrich* (530 U.S. 211, 212 [2000]), Justice David H. Souter opined that "Any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk. . . . But such complicated fact-finding and such a debatable social judgment are not wisely required of courts."

In addition to questions of institutional expertise and legitimacy, there are other reasons to prefer agency regulation to monitoring by the courts. While administrative agencies frequently fail in their monitoring duties, the fact remains that the bureaucratic apparatus is far better capable of enforcing compliance with standards and policies than the courts. Agencies outstrip courts in personnel, technical expertise, and information-

gathering mechanisms, such as inspection and audit (Horowitz 1977: 55–56, 265–266). Courts certainly have attempted to monitor the implementation of their decrees, but the anatomy of the judiciary makes this an awkward exercise.

Another structural consideration is that courts are constrained to take a reactive approach to social problems. Unlike agencies, they do not engage in problem detection. They do not act until someone has been harmed and feels moved to protest. This has several uncomfortable implications. One, of course, is that harm has already been done. Another is that it is difficult to know whether the situation of the particular plaintiff at bar is representative of the experience of the broader population of affected persons (Horowitz 1977: 38). A third is that the adjudication of individual claims is necessarily ad hoc, resulting in inconsistency across cases. Seemingly similar cases may be adjudicated differently due to fine legal distinctions drawn by judges. Different courts may reach different conclusions on identical facts. Circuit splits may stand for years before they are resolved by the Supreme Court, as occurred in litigation over the interpretation of statutes creating entitlements to public education and food stamps (Melnick 1994: 253).

Judges' detachment from the political branches of government and the forces that lobby those branches is advantageous in many respects, but also involves trade-offs. This isolation contributes to judges' relative ignorance about the social context surrounding particular policy decisions (Horowitz 1977: 45). Their knowledge about the issue at hand is limited to information provided by litigants and their experts, judges' personal experience, and, occasionally, reports by court-appointed experts. In many cases this body of information will be insufficient to answer questions such as: What will the collateral effects of particular policy choices be? How will the public receive them? By particular communities within the body politic? By the bureaucracy charged with implementing the decision? What needs will remain unmet? Courts may "only dimly perceive" such matters (Bickel and Wellington 1957: 25). Moreover, they do not often consider the budgetary ramifications of their decisions for other programs (Horowitz 1977: 38). Courts cannot and do not explicitly prioritize among programs, and their orders may have unanticipated consequences for spending on other programs that the public may value more highly.

A further consideration is the time and expense involved in rectifying a policy problem through litigation. The *Frew* suit, for example, was initiated in 1993 during the administration of Governor Ann Richards. It

took three years for the plaintiffs to obtain a consent decree and another four to get it enforced. While plaintiffs may seek a preliminary injunction upon filing a lawsuit as a means of obtaining some immediate relief, the standard for courts to award one is extremely stringent.

Litigation may also become highly politicized, and there certainly is no better example of this than *Frew*. Bush was quick to dismiss the decision as the work of an "activist, liberal judge" (Mabin 2000). While it may have been a political necessity to shrug off the ruling, the unfortunate result was that politics prevented the State of Texas from considering more closely the court's findings and the considerable body of research underlying them. The Texas attorney general is now appealing the decision, and the battle lines are becoming more and more deeply entrenched. The confluence of litigation and politics in this case has produced a highly adversarial situation in which the branches of government are pitted against one another rather than working together to resolve what everyone should acknowledge are persistent problems in the Texas Medicaid system. This adversarialism is hardly a model for effective regulation in an age of managed care.

Finally, courts are limited in the actions they may take in response to a policy problem. Courts can only award damages and forbid or require activities through the issuance of an injunction; in contrast, agencies and legislatures may choose from among a broad range of remedies. In addition to sanctions and prohibitions, they may impose taxes, provide subsidies and economic incentives, intervene in the market, create new institutions, and shift responsibilities to or away from private actors (Horowitz 1977: 35). Thus, these arms of government are better able than the judiciary to calibrate the remedy for the wrong.

Particularly salient is the fact that state and federal agencies' role as health care purchasers gives them regulatory tools that courts do not have. An initial observation is that agencies are better positioned than courts to take advantage of the assistance of private actors in monitoring managed care providers. The government is one purchaser of managed care services among many in a pluralistic health care market and can free ride on quality evaluations performed by private organizations such as the National Committee for Quality Assurance (NCQA) on behalf of employers and other private purchasers (Freeman 2000). Courts may use this information retrospectively to assess the validity of a legal claim regarding the quality of care in Medicare or Medicaid HMOs, but agencies are able to use the data prospectively to choose among potential HMO contractors and to reduce the costs they incur for ongoing monitoring.

In this vein, state and federal agencies, unlike courts, can use "the power of the purse" to proactively force change in managed care organizations (Epstein 1997). Acting as "prudent purchasers" (Fossett et al. 2000), they can set quality standards and refuse to do business with managed care providers who fail to adhere to them. They can also require that the HMOs assume responsibility for collecting and reporting data on key quality indicators, reducing the government's monitoring burden.

Thus, while courts must regulate by judicial decree and legislatures by statute, agencies have an opportunity to regulate HMOs by contract. One advantage of the regime of contract over other forms of regulation is that the parties to a contract can explicitly agree *ex ante* as to what the standards of performance will be, how they will be measured, and what will occur in the case of nonperformance. Making these standards clear at the outset is to everybody's benefit in that it decreases the likelihood of disputes later on and assists HMOs in developing their own quality management programs. It is more difficult to write specific quality and performance requirements into statutes and regulations because they must be broad and flexible enough to apply to a range of actors and situations. The regulations interpreting the federal Medicaid statute are a good illustration: They read simply that the care provided to Medicaid beneficiaries "must be sufficient in amount, duration, and scope to reasonably achieve its purpose" (see 42 C.F.R. Section 440.230[b]). Such a vague mandate invites legal wrangling over interpretation. It is possible to achieve a high degree of specificity as to managed care organizations' obligations in legal injunctions and consent decrees that ensue from litigation. However, as *Frew* illustrates, they may be years in the making, and a great deal of harm may be done to Medicare and Medicaid enrollees in the meantime. Writing these obligations and standards into contracts between managed care organizations and government agencies involves lower transaction costs.

Unfortunately, neither the states nor the HCFA has yet taken full advantage of the power of the purse. A report released this year by the General Accounting Office does suggest that at least one state (Connecticut) has made its Medicaid managed care contract language much more specific with respect to obligations to provide EPSDT services (GAO 2001: 17). However, other studies indicate that most states have not been aggressive enough in writing explicit performance standards into their managed care contracts or in collecting and using performance data (Fossett et al. 2000). The ongoing national survey of Medicaid managed care contractors by researchers at George Washington University

found in 1999 that nearly a quarter of the contracts contained no explicit details regarding the required grievance process and that among those that did contain details, there was significant variation across states with respect to the range of requirements and the level of detail provided for a given element (Rosenbaum et al. 1999). Furthermore, only half of the contracts contained an expedited grievance procedure requirement, even though plans are required to have such a procedure under the BBA 1997 regulations. Earlier reports from the George Washington University researchers indicated that the contracts frequently failed to detail which services the contractors were financially responsible for and which would remain the residual responsibility of the state Medicaid agency (Rosenbaum and Darnell 1997). This posed a significant problem given the legal rule that the burden falls to the drafter of a contract to be clear in its instructions to a supplier. Contractors were able to argue that services not mentioned were not their responsibility (Rosenbaum 1998). The regime of contract cannot be effective unless agencies are careful and foresighted enough to make their contracts with HMOs sufficiently explicit.

A second point of vulnerability in the regime of contract relates to enforcement. The contractual approach hinges on agencies being willing and able to vigorously enforce the terms of their contracts and is ineffectual when they fail to do so. The ways in which HCFA and state agencies have come up short as program monitors have already been discussed. In addition, the agencies have been openly unwilling to utilize the range of available contractual sanctions to force HMOs to comply with their obligations. They have instead relied on cooperative, persuasive strategies to try to encourage quality improvement among their contractors. This approach may make sense for states and contractors who are making their first tentative ventures into Medicaid managed care, but it is less defensible in the case of long-standing programs and repeat-offender contractors.

The foregoing suggests that, due to concerns about judicial expertise, courts' institutional legitimacy, and the range of available regulatory tools, administrative agencies are better situated than courts to manage complex public programs such as Medicare and Medicaid managed care efficiently and effectively. An additional reason to prefer a regulatory strategy that centers on proactive monitoring by agencies rather than remedial action by courts is that litigation relating to deficiencies in public managed care programs may, for a number of reasons, be difficult for beneficiaries to bring and win.

Barriers to Class Action Litigation

Frew v. Gilbert is a Medicaid plaintiffs' success story: Skilled and energetic legal advocates championed a suit on behalf of an entire class of beneficiaries, achieving near-total vindication. However, the victory is something of an aberration, attributable to the commitment of the attorneys involved and, critically, to the fact that the case was heard by one of the country's most activist judges.

Other plaintiffs and would-be plaintiffs have found the barriers to a successful suit against a Medicaid or Medicare HMO intractable. A threshold problem is that these beneficiaries' socioeconomic position makes them particularly indisposed to press claims on their own behalf. Medicare beneficiaries may be very elderly, frail, ill, and lack social support; Medicaid enrollees tend to be poorly educated and many are non-English-speaking. Additionally, many beneficiaries are uninformed about their right to appeal denials of coverage (Bernstein and Stevens 1999). In one study, 27 percent of Medicare HMO enrollees and 35 percent of disenrollees did not know that they had appeal rights (Office of the Inspector General, HHS 1998). The oldest elderly and those in poor health are particularly likely to report problems in appealing HMO decisions (Nelson et al. 1997).

Even if fully informed, beneficiaries may choose not to pursue an appeal because of the amount of time and effort involved. Unless the individual's health condition falls within the narrow category qualifying for expedited review, he or she must pursue a multistage grievance and appeal process that typically takes several months. Before a Medicare beneficiary has the right to bring litigation against the HMO, he or she must exhaust four alternative avenues for relief: the HMO's internal grievance system, review by an external review organization with which CMS contracts, a hearing before an administrative law judge, and review by the departmental appeals board. As one commentator has remarked, beneficiaries "often lack the resources, the stamina, or the inclination" to navigate this lengthy process (Rodwin 1996: 1347). In contrast, the federal courts have not required the exhaustion of administrative remedies in order to bring suit against a state Medicaid agency (see Tallahassee Mem'l Reg'l Med. Ctr. v. Cook, 109 F.3d 693 [11th Cir. 1997]). However, the litigation process is still lengthy and potentially intimidating to Medicaid beneficiaries.

Another legal barrier is Eleventh Amendment restrictions on suits against state governments. The Eleventh Amendment prohibits suits

against state governments in federal court (see Seminole Tribe of Florida v. Florida, 517 U.S. 44 [1996]) or state court (see Alden v. Maine, 527 U.S. 706 [1999]) by a state's own citizens or citizens of other states. The Supreme Court has carved out narrow exceptions to this prohibition for suits against state officers for declaratory and injunctive relief (see Edelman v. Jordan, 415 U.S. 651 [1974]; Ex Parte Young, 209 U.S. 123 [1908]). Thus, citizens may file a suit seeking to compel state officials to implement, or refrain from implementing, policies prospectively, but they cannot seek retrospective relief in the form of money damages. This, of course, explains private attorneys' lack of interest in litigating against state Medicaid agencies.

Beneficiaries may also be pessimistic about their prospects for legal recovery because of their status as poor persons. Such pessimism is not groundless: Empirical research has shown that "haves" tend to be more successful in litigation than "have-nots," both at the trial court level (Galanter 1974; Wanner 1975) and the appellate level (Songer and Sheehan 1992). So-called "underdogs"—individuals who are below the poverty line or members of racial minority groups—fare worst, especially when their cases are heard by conservative judges (Ulmer 1978; Rowland and Todd 1991). The effect is most pronounced when underdogs go up against federal or state government units (Songer and Sheehan 1992), as is the case in litigation against Medicaid and Medicare administrators. In such cases, the government's superior litigation resources and accumulated wisdom gleaned from its repeat-player status in the courts leave poor litigators outgunned and outmatched (ibid.: 254–255).

Finally, beneficiaries who do bring a class action suit relating to procedural abuses by a Medicare or Medicaid HMO may find that their possibilities for recovery are limited as a matter of law. This has become a particular problem for cases challenging violations of beneficiaries' grievance and appeal rights. The usual form that such actions take is a suit against the secretary of the Department of Health and Human Services (if a Medicare HMO is involved) or against the state-level counterpart (if brought by a Medicaid HMO beneficiary). Claims are brought under the due process provisions of the Fifth or Fourteenth Amendment and the federal Medicare and Medicaid statutes and applicable regulations. A 1999 U.S. Supreme Court decision, however, suggests that constitutional claims may no longer be available to Medicare and Medicaid HMO enrollees.

Grijalva v. Shalala addressed the question of whether private HMOs

that contract with federal and state agencies to care for Medicare and Medicaid beneficiaries are "state actors." That determination is important because the Fifth and Fourteenth Amendments' mandate that a person may not be deprived of life, liberty, or property without due process of law only applies to the government and those private actors who are so closely linked to the government that their conduct can be deemed state action. Under traditional fee-for-service Medicare and Medicaid, when the government denied a beneficiary coverage for a particular service and failed to provide her with proper notice of the denial and information about her appeal rights, the beneficiary could sue the agency for violating her constitutional due process rights. The question presented in *Grijalva* was whether the beneficiary retained this cause of action when she moved into a Medicare HMO. In other words, is a private Medicare managed care contractor's denial of services to a Medicare beneficiary state action?

The trial court and the Ninth Circuit Court of Appeals answered in the affirmative, holding that "HMOs and the federal government are essentially engaged as joint participants to provide Medicare services such that the actions of HMOs in denying medical services to Medicare beneficiaries and in failing to provide adequate notice may fairly be attributed to the federal government" (see Grijalva v. Shalala, 152 F.3d 1115, 1120 [9th Cir. 1998]). On appeal, however, the Supreme Court appeared to take a different view: In May 1999, the justices remanded the case back to the Ninth Circuit for reconsideration in light of their newly minted decision in *American Manufacturers Mutual Insurance Co. v. Sullivan* (526 U.S. 40 [1999]) and a series of reforms to the Medicare grievance and appeal process passed as part of the BBA 1997.

The meaning of the Court's two-sentence remand in *Grijalva* is unclear. One issue is whether the plaintiffs' appeal was rendered moot by the BBA 1997 reforms, which introduced additional protections for Medicare and Medicaid HMO enrollees contesting denials of care. Among the BBA's provisions relating to grievances and appeals are the following: requirements concerning the timing and content of notices of denials or terminations of services; requirements that HMOs establish internal grievance and appeals procedures, including a 72-hour expedited appeal process for emergent cases, and inform beneficiaries of the availability of these processes; requirements that Medicare HMOs give beneficiaries access to an independent external review and administrative law judge hearing if their initial grievances and appeals are not resolved in their favor; and time limits for Medicare and Medicaid HMOs to make

initial coverage decisions and reconsideration decisions (see 42 U.S.C. Sections 1395w-21-28, 1396u-2; 42 C.F.R. Section 422.400–.426, .560-.622). In requesting a remand in *Grijalva*, the government argued that the new protections rectified all of the problems that originally gave rise to the plaintiffs' claims. The plaintiffs responded that the reforms were insufficient to satisfy the order issued by the Ninth Circuit Court of Appeals. The new procedures did not, for example, implement a five-day turnaround time for written denial notices or provide for external review of expedited cases (McKee 1999).

A second issue is whether Medicare HMOs are state actors after *American Manufacturers Mutual Insurance Co. v. Sullivan*. In *American Manufacturers*, the Supreme Court held that medical payment decisions made by private workers' compensation insurers do not constitute state action. While reasonable lawyers may disagree about the meaning of the Supreme Court's mandate that the lower courts reconsider *Grijalva* in light of this decision, certainly it raises the suspicion that the Court views Medicare HMOs as similar to workers' compensation insurers in terms of their relationship to the state. The underlying reasoning in the *American Manufacturers* opinion—that extensive government regulation of private conduct, without more, does not create a sufficient nexus with the state to make the private party's conduct state action—arguably is equally applicable to HMO contractors.

Because the parties to *Grijalva* settled the case in August 2000 before the lower courts had a chance to review it, the state actor question and the mootness questions have not been resolved. There has been only one published opinion in which the courts have taken up the state actor question as it relates to HMOs, and it does not provide a definitive answer. In *Hyden v. New Mexico Human Services Department* (2000 WL 1873805 [N.M. App. Nov. 22, 2000]), a New Mexico state district court dismissed a Medicaid HMO beneficiary's appeal of her health plan's denial of coverage for treatment by an out-of-network provider. The dismissal was based on the court's conclusion that, under *Grijalva* and *American Manufacturers*, a Medicaid HMO "is not a 'state actor' when it makes medical review decisions." On appeal, the New Mexico Court of Appeals decided the case on state law grounds and explicitly declined to adjudicate the state actor question.

The Supreme Court's decision in *Brentwood Academy v. Tennessee Secondary Schools Athletic Association* (121 S. Ct. 924 [2001]) has muddied the field further by suggesting a private organization may be a state actor even where crucial elements of traditional state-action analysis,

such as the public function test, are not satisfied if the degree of "entwinement" with the state is "pervasive." Although the Court provided some guidance as to what such "entwinement" might consist of, pointing to whether the private organization was set up by the state and whether the organization was predominantly composed of state institutions, it is entirely unclear whether Medicaid and Medicare HMOs would satisfy this test. No lower court has yet taken up the question.

Thus, it remains uncertain whether Medicare and Medicaid HMOs are state actors that can be sued for deprivations of constitutional due process. Legal commentary on the *Grijalva* remand has been extremely sparse, and no consensus has emerged among commentators about the implications of the case for future litigation. This uncertainty about the meaning of *Grijalva* raises two problems. One is that to the extent that attorneys read the remand as closing the door on constitutional due process claims for Medicare and Medicaid managed care enrollees, the decision may have a chilling effect on future lawsuits. One of the plaintiffs' attorneys in *Grijalva*, for instance, described the remand as "a setback" for plaintiffs in that type of litigation (McKee 1999). The second problem is that the Supreme Court has left lower court judges without guidance as to how to handle this litigation. Inconsistency in rulings, borne of differences in judges' ideologies of due process and judicial restraint, is the inevitable result.

If future cases do establish that *American Manufacturers* and *Grijalva* preclude constitutional claims, an important avenue for regulating Medicare and Medicaid HMOs will have been eliminated. It would still be possible to sue the government for violations of the grievance and appeal procedures set forth in the federal Medicare and Medicaid statutes and regulations. Such challenges may be quite effective in rectifying abuses of existing regulations. However, they cannot achieve what constitutional claims can: the imposition, by judicial mandate, of additional procedural safeguards beyond what are already established in the statutes and regulations.

In a constitutional due process claim, the plaintiff is able to propose new procedural protections, and the court will use the balancing test of *Mathews v. Eldridge* (424 U.S. 319 [1976]) to determine whether the importance of the interest served and the value of the proposed safeguard in protecting that interest outweigh the increased burden on the state associated with implementing the safeguard. In contrast, in a case brought under the Medicare or Medicaid statutes and regulations, the court undertakes only a limited inquiry into whether the secretary's fail-

ure to enforce the procedural protections for beneficiaries set forth in the statutes and regulations constitutes an abuse of discretion "so extreme as to be an abdication of statutory responsibility" (see Grijalva v. Shalala, 946 F. Supp. 747, 761 [D. Ariz. 1996]). The Supreme Court has shown particular deference to state agencies' interpretations of the Medicaid statute, in part because the statute explicitly delegates to states the authority to interpret the statute through regulations (Kinney 1991). Medicare cases, too, have more often than not been resolved in the government's favor, particularly in recent years. Timothy Jost's (1999) review of 278 cases contesting HCFA's interpretation or application of the Medicare statute or regulations determined that the government prevailed 62 percent of the time and did particularly well at the appellate court level and in cases brought since 1985. Thus, from a plaintiff's perspective, it is desirable to press constitutional claims in addition to statutory claims.

If the *Grijalva* remand is read as foreclosing due process claims against Medicaid and Medicare contractors, broader implications ensue: It would raise a question as to whether the government, in delegating some of its responsibilities under the Medicare and Medicaid programs to HMOs, may effectively be contracting away beneficiaries' constitutional due process rights (Gilman 2001). The government may assign the right to make medical necessity and other coverage decisions to private entities, this reading of the decision suggests, but the due process obligations that are constitutionally incumbent upon the state may not flow to the private actor. Beneficiaries will only have as much protection as the government explicitly provides by statute or contract. If this is the case, then careful contract drafting and vigilant enforcement of contractual obligations by CMS and state Medicaid agencies assume new importance.

The contracting away of constitutional rights is a particular concern when one considers that many HMOs that contract with the government to provide comprehensive services to Medicare or Medicaid beneficiaries themselves delegate some of those responsibilities to subcontractors. A prominent example is the subcontracting of children's mental health services in the Medicaid program, which has resulted in the gross underprovision of care and violations of grievance and appeal rights in some states. The state of Connecticut recently settled a $4 million lawsuit against one of its Medicaid mental health contractors, Healthright, Inc., relating to "improper and unconscionable" denials of care by the subcontractor that Healthright engaged to handle its Medicaid contract

(Hamilton 2000). Subcontractors are two steps removed from the state's constitutional due process obligations, so their actions have some insulation from legal challenge by beneficiaries. Although both state Medicaid agencies and primary HMO contractors are responsible for monitoring the conduct of subcontractors, this does not always occur, as the Healthright case demonstrates.

What Role Litigation?

The foregoing has highlighted several shortcomings of litigation as a means of rectifying procedural and substantive deficiencies in Medicare and Medicaid managed care. Several structural factors constrain the courts' ability to manage public programs. There are concerns about the impact on the judiciary's institutional legitimacy when they attempt to do so. And in the post-*Grijalva* legal landscape, the outlook for ameliorating procedural due process abuses by Medicare and Medicaid HMOs through litigation by beneficiaries has become uncertain. All of these factors suggest that high hopes cannot be pinned on the courts to regulate the quality of care provided by Medicare and Medicaid HMOs. As has been observed in relation to the litigation against tobacco manufacturers, "Litigation may be a complement to the more traditional apparatus of policy making and implementation, but it seems destined to fail as an alternative" (Jacobson and Warner 1999: 798). Instead, the focus should be on what state and federal agencies need to do to manage these programs effectively, given the lack of judicial oversight.

To say that litigation cannot be the dominant pillar of the regulatory scheme for public managed care programs, however, is not to say that there is no meaningful role for it to play. Litigation may make a valuable contribution to a regulatory regime that relies primarily on administrative agencies. Two functions—a signaling function and a bypass function—might be posited.

The signaling model envisions a regulatory environment in which agencies generally act in good faith on behalf of beneficiaries in their administration of public managed care programs but may require nudging to make needed reforms. In this view, administrators fail to rectify problems in their programs because they lack some critical resource, such as information, a sense of urgency, or financial resources. Litigation fills this gap, energizing administrators to respond to the problems identified or to seek the needed resources from the legislature.

Even if plaintiffs ultimately do not prevail in their lawsuits, the very

fact that the claims are filed, publicized, and investigated may put the government on notice of particular problems with Medicare and Medicare managed care. Eleanor Kinney (1991: 789), describing the role of judicial review in shaping Medicare and Medicaid policy in the era prior to the expansion of managed care contracting, expressed this notion as follows:

> This use of judicial review can perhaps best be understood in the negative. If program constituencies do not sue, then the agency may be tempted to exercise its discretion quite broadly to accomplish policy goals that are not consistent with the perceived interests of the constituency. In such cases, judicial challenge may be important simply to indicate that the affected constituency believes a particular policy issue is important and that the agency's policy or its implementation is detrimental to the constituency's legitimate interest.

In this model, agencies may misunderstand beneficiaries' needs and interests or may be unaware of how a particular rule or procedure negatively impacts beneficiaries. Litigation, especially class action litigation, clarifies these matters and calls for an agency response. Judicial review can also keep agencies attentive to the wishes of the legislature, a function that assumes particular importance during periods of divided government (Melnick 1994: 270).

In addition to getting the attention of agencies, litigation can be used to help agencies get the attention of the legislature. Program administrators may, in some cases, welcome litigation because it allows them to go to the legislature with a powerful argument for additional resources. In recounting litigation brought in the early 1970s over the adequacy of public education for special-needs students, for example, Donald Horowitz (1977: 258–259) explains that the District of Columbia school system was willing to enter into a consent decree, acknowledging that it had provided substandard education and providing a remedy, because it hoped to obtain an expansion of its budget in order to meet the requirements of the decree. In that case, the school system did not get its budget increase, but there is evidence from other contexts—for example, prison reform litigation—that judicial decisions often do result in augmentation of agency budgets (Harriman and Straussman 1983).

Significantly, the same structural factors that make courts poor managers of public programs give them the means to excel in the signaling role. Their detachment and insulation from politics makes them more likely than legislatures to rectify violations of individual rights when

strong majoritarian pressures militate against action. Their ad hoc approach to problem resolution leads to decisions that vindicate rights in a specific, authoritative way (Horowitz 1977: 22), sending a very clear signal to legislators. And judges' lack of specialized knowledge and relative ignorance about social context may allow them to escape from the limited vision and commitment to a single policy that characterize many administrators (Horowitz 1977: 31).

The signaling model thus envisions an interactive environment in which litigants nudge administrators, who nudge legislatures. Litigation is a relatively routine part of regulation and does not necessarily put litigants and program administrators in a harshly adversarial position. It has been suggested that Congress has made a deliberate and rational choice to rely on signals such as litigation as a means of monitoring public programs. Mathew McCubbins and Thomas Schwartz (1984) argue that Congress considered two possible oversight strategies, "police-patrol" oversight and "fire-alarm" oversight. The former consists of active and direct program monitoring in which Congress audits a sample of agency activities with the aim of detecting and remedying violations of legislative intent. The latter consists of establishing procedural and structural mechanisms to detect problems without congressional involvement and bring the violations to Congress's attention. Congress has chosen the fire-alarm model, McCubbins and Schwartz explain, because it is less costly and time consuming for legislators and more effective in detecting violations. Among the enabling mechanisms Congress has set up as part of the fire-alarm system are formal grievance procedures for program beneficiaries to challenge agency actions and funding for legal aid organizations to represent disenfranchised beneficiaries in litigation against the government.

Many litigators involved in class action suits against Medicare and Medicaid agencies would, no doubt, quarrel with the optimistic view of agency-litigant interaction posited by the signaling model. They might suggest a competing model in which litigation is a beneficiary's desperate attempt to resolve a problem that the agency has refused to recognize despite repeated complaints. In this bypass model, litigation enables the beneficiary to circumvent the unresponsive agency and seek relief in the form of a judicial order. While complaints made by Medicare and Medicaid beneficiaries through nonjudicial channels may be ignored, lawsuits cannot be. Administrators are forced to investigate the issue and respond in some way. Often, the response is to propose administrative measures to resolve the problem and terminate the litigation.

The bypass model does not view agencies as good-faith regulators in beneficiaries' interest, at least not in all cases. Rather, it recognizes a range of pressures and constraints that may keep agencies from being responsive to public concerns. Financial and personnel limitations are obvious problems, but there are also more subtle inhibitory forces in bureaucracies: administrators' personal reluctance to acknowledge problems with systems under their command, political pressure to defend the system (as was, perhaps, the case in *Frew*), agency capture, red tape and poor communication in multilayered bureaucratic structures, and simple inertia. Litigation is a means of making an end run around these barriers to administrative reform. It is a remedy in those cases in which the failures of the administrators to whom public programs are entrusted have become so grave that resorting to a third party is necessary. The bypass model best captures the dynamics of the tobacco litigation: there, courts have forced action where the legislature and regulatory agencies have failed, perhaps due to capture by the industry (Jacobson and Warner 1999: 793).

In the bypass model, courts may respond to beneficiaries' unmet needs in two ways. They may impose far-reaching program reforms and oversee their implementation, essentially taking over the agency's responsibilities for program administration. Alternatively, they may establish legal standards and norms, the violation of which can give rise to an award of damages. For instance, cases such as *Grijalva* may establish explicit due process standards, and a beneficiary whose HMO does not meet those standards can sue for damages. The impact of this remedy is, however, circumscribed by the legal doctrines that insulate government agencies and HMOs from such liability—the Eleventh Amendment and, on one reading of *Grijalva*, the state action doctrine.

It is unclear whether the signaling model or the bypass model more accurately describes agency monitoring of Medicare and Medicaid managed care. Seemingly, there have been cases in which each has been applicable. The BBA 1997 reforms to the Medicare grievance and appeal process, for example, were passed as a direct response to the district court order in *Grijalva* (see Grijalva v. Shalala, 946 F. Supp. 747 [D. Ariz. 1996]). There, litigation sent an unambiguous signal to the legislature that its existing scheme for protecting due process rights was inadequate. In contrast, the *Frew* litigation cleaves closer to the bypass model: the lawsuit was initially prompted by legislative and executive inaction to improve Texas's EPSDT services and renewed when the state Medicaid agency had to be further coerced into honoring its obligations under the consent decree.

Conclusions

Both the signaling and the bypass functions of litigation are likely to remain important in the years to come. It might be argued that the signaling function has become relatively less salient because CMS and state Medicaid agencies now seem to be acutely aware that stronger oversight of their managed care programs is needed. Numerous studies and reports by academic researchers and the federal government have sent them very clear signals that they need to step up their quality control efforts.

Many state Medicaid agencies have made significant efforts to improve both the quality and the quantity of monitoring their HMO contractors. Recent surveys have detailed a wide array of quality improvement initiatives under way in different states, including improving the collection and use of encounter data, clarifying managed care plans' responsibilities to provide EPSDT services, increasing provider reimbursement and providing financial incentives to comply with EPSDT obligations, and improving beneficiary outreach and education (GAO 2001; Landon, Tobias, and Epstein 1998). Further, some of the more activist state attorneys general, such as Connecticut's Richard Blumenthal, have demonstrated a willingness to take the ultimate step of terminating the contracts of persistently noncompliant HMOs and suing them for fraud and breach of contract (Anonymous 1999).

HCFA/CMS also has shown a substantial institutional commitment to rectifying the shortcomings in monitoring that existed in the early years of Medicare managed care. The BBA regulations are a major step forward as was the adoption in 1994 of a range of intermediate sanctions for noncompliant HMOs (though these new sanctions have rarely, if ever, been used). Several of HCFA's 2000 work projects related to managed care quality monitoring, including evaluations of access to emergency care in Medicare and Medicaid HMOs, evaluations of states' outreach efforts for Medicaid-eligible children, and investigations of how HEDIS data might be put to better use (Office of the Inspector General, HHS 2000).

These efforts, however, may be attenuated in the Bush administration. In January 2001 HCFA introduced an initiative to broaden the agency's role in monitoring Medicaid EPSDT programs (GAO 2001: 23), but in August CMS retreated from this position, saying that it was important to let states retain control of their programs (HHS 2001).

Rolling back federal agency oversight of public managed care at this juncture is difficult to justify. As *Frew* demonstrates, abuses by managed

care contractors remain commonplace. As *Grijalva* suggests, litigation may be an unreliable means of correcting them. Agencies are able to accomplish things that courts cannot, such as the development of better ways of collecting and using data on care processes in Medicare and Medicaid HMOs. The monitoring capabilities of many state agencies, however, remain limited. This is particularly true of those states who are newcomers to Medicaid managed care. It is important that CMS support states by providing increased technical assistance to state monitors, for instance, in the area of developing performance benchmarks (Landon, Tobias, and Epstein 1998).

In closing, managed care is still something of an experiment in the Medicaid and Medicare programs. We continue to seek answers to basic questions about the quality of care in Medicare and Medicaid HMOs, cost savings associated with public contracting with HMOs, and the financial ability of HMOs to care for the Medicare and Medicaid populations at current reimbursement rates. Although this investigation is pending, the government has an obligation to ensure that the experiment is accompanied by heightened protection for the individuals—poor, elderly, disabled, and vulnerable—who serve as its subjects.

References

Aberbach, J. D., and B. A. Rockman. 2000. *In the Web of Politics: Three Decades of the U.S. Federal Executive*. Washington, DC: Brookings Institution.

Anonymous. 1999. Connecticut Drops Healthright from Medicaid Program. *Mealey's Managed Care Liability Reporter*, 13 January, 18.

———. 2000. Grievance Systems Inconsistent in State Medicaid Contracts. *Inside Health Care Reform*, 1 September 2000, WL 11695481.

Bernstein, J., and R. Stevens. 1999. Public Opinion, Knowledge, and Medicare Reform. *Health Affairs* 18:180–193.

Bickel, A., and H. Wellington. 1957. Legislative Purpose and the Judicial Process: The Lincoln Mills Case. *Harvard Law Review* 71:1–39.

Bonnyman, G., and M. Johnson. 1998. Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs. *Tennessee Law Review* 65:359–387.

Butler, S. M., P. M. Danzon, B. Gradison, R. Helms, M. Moon, J. P. Newhouse, M. V. Pauly, M. Phillips, U. E. Reinhardt, R. D. Reischauer, W. L. Roper, J. Rother, L. D. Schaeffer, and G. R. Wilensky. 1999. Crisis Facing HCFA and Millions of Americans. *Health Affairs* 18:8–9.

Dallek, G., C. Jimenez, and M. Schwartz. 1995. *Consumer Protections in State HMO*

Laws. Volume 1: Analysis and Recommendations. Los Angeles: Center for Health Care Rights.

Donabedian, A. 1988. The Quality of Care: How Can It Be Assessed? *Journal of the American Medical Association* 260:1743–1748.

Epstein, A. 1997. Medicaid Managed Care and High Quality: Can We Have Both? *Journal of the American Medical Association* 278:1617–1621.

Fletcher, W. 1982. The Discretionary Constitution: Institutional Remedies and Judicial Legitimacy. *Yale Law Journal* 91:635–697.

Fossett, J. W., M. Goggin, J. S. Hall, J. Johnston, L. C. Plein, R. Roper, and C. Weissert. 2000. Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers? *Health Affairs* 19:36–49.

Freeman, J. 2000. The Private Role in Public Governance. *New York University Law Review* 75:543–675.

Galanter, M. 1974. Why the Haves Come Out Ahead: Speculations on the Limits of Social Change. *Law and Society Review* 9:95–160.

Gilles, M. E. 2000. Reinventing Structural Reform Litigation: Deputizing Private Citizens in the Enforcement of Civil Rights. *Columbia Law Review* 100:1384–1453.

Gilman, M. E. 2001. Legal Accountability in an Era of Privatized Welfare. *California Law Review* 89:569–642.

Goldstein, A. 2001. Medicaid Rights Will Be Deferred; States Lobbied Bush on Clinton Rules. *Washington Post*, 16 August, A1.

———. 1999. Medicaid HMOs Fail Audit of Service. *Washington Post*, 13 January, B8.

Gormley Jr., W. T. 1996. Accountability Battles in State Administration. In *The State of the States*, 3d ed., ed. C. E. Van Horn. Washington, DC: CQ Press.

Graglia, L. 1976. *Disaster by Decree: The Supreme Court Decisions on Race and the Schools*. Ithaca, NY: Cornell University Press.

Hamilton, E. 2000. Firm to Pay $4 Million in Kids' Mental Health Care. *Hartford Courant*, 12 May, A1.

Hammond, T. H., and J. H. Knott. 1996. Who Controls the Bureaucracy? Presidential Power, Congressional Dominance, Legal Constraints, and Bureaucratic Autonomy in a Model of Multiinstitutional Policy Making. *Journal of Law, Economics, and Organization* 12:119–163.

Harriman, L., and J. Straussman. 1983. Do Judges Determine Budget Decisions? *Public Administration Review* 43:343–351.

Hill, L. B. 1995. Is American Bureaucracy an Immobilized Gulliver or a Regenerative Phoenix? Reconsidering the Alleged Demise of Federal Bureaucratic Power. *Administration and Society* 27:322–360.

Horowitz, D. 1977. *The Courts and Social Policy*. Washington, DC: Brookings Institution.

Jacobson, P. D., and K. E. Warner. 1999. Litigation and Public Health Policy Making: The Case of Tobacco Control. *Journal of Health Politics, Policy and Law* 24:769–804.

Jost, T. S. 1999. Governing Medicare. *Administrative Law Review* 51:39–116.

Justice, W. 1992. The Two Faces of Judicial Activism. *George Washington Law Review* 61:1–12.

Kemerer, F. 1991. *William Wayne Justice: A Judicial Biography*. Austin: University of Texas Press.

Kiewiet, D. R., and M. D. McCubbins. 1991. *The Logic of Delegation: Congressional Parties and the Appropriations Process*. Chicago: University of Chicago Press.

Kinney, E. D. 1991. The Role of Judicial Review Regarding Medicare and Medicaid Program Policy: Past Experience and Future Expectations. *Saint Louis University Law Journal* 35:759–792.

Kramarow, E., H. Lentzner, R. Rooks, J. Weeks, and S. Saydah. 1999. *Health, United States, 1999 with Health and Aging Chartbook*. DHHS Pub. No. (PHS) 99-1232. Hyattsville, MD: National Center for Health Statistics.

Landon, B. E., C. Tobias, and A. M. Epstein. 1998. Quality Management by State Medicaid Agencies Converting to Managed Care: Plans and Current Practice. *Journal of the American Medical Association* 279:211–216.

Legislative Analyst's Office, State of California. 1998. Reviews of Medi-Cal Managed Care Plans Show Disappointing Results. *California Update*, August. Available on-line at http://www.lao.ca.gov/cal_update/aug_98_update. html.

Long, N. 1949. Power and Administration. *Public Administration Review* 9:257–264.

Mabin, C. 2000. Bush Defends Texas Health Care. *AP Online*, 1 September 2000, WL 25992863.

McCubbins, M. D., and T. Schwartz. 1984. Congressional Oversight Overlooked: Police Patrols versus Fire Alarms. *American Journal of Political Science* 28:165–179.

McKee, M. 1999. An HMO Showdown. *Recorder*, 15 September, 1.

Meckler, L. 2000. Texas Is Shorting Medicaid Kids, Court Rules. Bush Administration Is Ordered to Find Solution by October. *Seattle Times*, 31 August, A6.

Melnick, R. S. 1994. *Between the Lines: Interpreting Welfare Rights*. Washington, DC: Brookings Institution.

Mishkin, P. J. 1978. Federal Courts as State Reformers. *Washington and Lee Law Review* 35:949–976.

Moe, T. M. 1982. Regulatory Performance and Presidential Administration. *American Journal of Political Science* 26:197–224.

———. 1989. The Politics of Bureaucratic Structure. In *Can the Government Govern?*, ed. J. E. Chubb and P. E. Peterson. Washington, DC: Brookings Institution.

———. 1990. The Politics of Structural Choice: Toward a Theory of Public Bureaucracy. In *Organization Theory: From Chester Barnard to the Present and Beyond*, ed. O. E. Williamson. New York: Oxford University Press.

Moe, T. M., and S. A. Wilson. 1994. Presidents and the Politics of Structure. *Law and Contemporary Problems* 47:1–44.

Nelson, L., R. Brown, M. Gold, A. Ciemnecki, and E. Docteur. 1997. Access to Care in Medicare HMOs 1996. *Health Affairs* 16:148–156.

Office of the Inspector General, U.S. Department of Health and Human Services (HHS). 1998. *Beneficiary Perspectives of Medicare Risk HMOs: 1996*. OEI-06-95-00430. Washington, DC: U.S. Government Printing Office.

———. 2000. Work Plan: Fiscal Year 2000: Health Care Financing Administration Projects. Available on-line at http://www.hhs.gov/oig/wrkpln/2000/ hcfa.pdf.

Perkins, J., and K. Olson. 2000. *Medicaid Managed Care and Due Process*. Lawrenceville, NJ: Center for Health Care Strategies.

Perkins, J., K. Olson, L. Rivera, and J. Skatrud. 1996. *Making The Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction*. Chapel Hill, NC: National Health Law Program.

Rodwin, M. 1996. Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs. *Houston Law Review* 32:1319–1380.

Rosenbaum, S. 1998. Negotiating the New Health System: Purchasing Publicly Accountable Managed Care. *American Journal of Preventive Medicine* 14:67–71.

Rosenbaum, S., and J. Darnell. 1997. An Analysis of Medicaid Section 1115 Statewide Medicaid Managed Care Demonstrations: Implications for Federal Policy. Washington, DC: Kaiser Commission on the Future of Medicaid.

Rosenbaum, S., C. A. Sonosky, K. Shaw, and M. H. Zakheim. 1999. Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts. 3d ed. Available on-line at http://www.gwu.edu/~chsrp/ MANGA/chapterette6.htm.

Rowland, C. K., and B. J. Todd. 1991. Where You Stand Depends on Who Sits: Platform Promises and Judicial Gatekeeping in the Federal District Courts. *Journal of Politics* 53:175–185.

Rudenstine, D. 1986. Judicially Ordered Social Reform: Neofederalism and Neonationalism and the Debate over Political Structure. *Southern California Law Review* 59:449–494.

Scanlon, W. J. 2001. *Medicare Management: Current and Future Issues. Testimony Before the Committee on Finance, United States Senate*. GAO-01-8787. Washington, DC: U.S. Government Printing Office.

Shannon, K. 2000. Judge's Landmark Rules Impact Texas. *AP Online*, 31 August 2000, WL 25992381.

Shuman, D. W. 1993. The Psychology of Deterrence in Tort Law. *University of Kansas Law Review* 42:115–168.

Songer, D. R., and R. S. Sheehan. 1992. Who Wins on Appeal? Upperdogs and Underdogs in the United States Courts of Appeals. *American Journal of Political Science* 36:235–258.

Ulmer, S. 1978. Selecting Cases for Supreme Court Review: An Underdog Model. *American Political Science Review* 72:902–910.

U.S. Department of Health and Human Services (HHS). 2001. HHS Proposes New Medicaid Managed Care Regulation to Ensure Patient Rights Protections for Beneficiaries. Press release, 16 August. Available on-line at http://www.hhs.gov/ news/press/2001pres/ 20010816.html.

U.S. General Accounting Office (GAO). 1995a. *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care*. GAO/HEHS-95-155. Washington, DC: U.S. Government Printing Office.

———. 1995b. *Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan*. GAO/HEHS-95-87. Washington, DC: U.S. Government Printing Office.

———. 1997. *Medicaid Managed Care: Challenge of Holding Plans Accountable*

Requires Greater State Effort. GAO/HEHS-97-86. Washington, DC: U.S. Government Printing Office.

———. 1999. *Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights*. GAO/HEHS-99-68. Washington, DC: U.S. Government Printing Office.

———. 2000. *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings*. GAO/HEHS-00-183. Washington, DC: U.S. Government Printing Office.

———. 2001. *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*. GAO-01-749. Washington, DC: U.S. Government Printing Office.

Wanner, C. 1975. The Public Ordering of Private Relationship. Part 1: Initiating Civil Cases in Urban Trial Courts. *Law and Society Review* 8:421.

Waterman, R. W. 1989. Presidential Influence and the Administrative State. Knoxville: University of Tennessee Press.

Wildavsky, A. 1964. *The Politics of the Budgetary Process*. Boston: Little, Brown.

Wilson, J. Q. 1989. *Bureaucracy: What Government Agencies Do and Why They Do It*. New York: Basic Books.