NEW YORK MEDICAID: NEVER CAN SAY GOODBYE

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As controversy swirls over continually rising health costs sapping valuable resources from our economy,[1] relatively little consideration is given to reducing the disproportionately high costs dedicated to often marginally beneficial life prolongation. It is incumbent to assess how we allocate our medical resources. Reform measures for Medicaid, a government health insurance program for the poor, typically focus upon reducing the numbers of people covered by the program,[2] the scope of entitlements to receive certain drugs or procedures,[3] the short-term cost savings of negotiating drug prescription reductions,[4] or fraud.[5] However, the tendency for the government to devote hi-tech, high cost procedures to preserve the lives of the terminally ill for a marginally longer time while ignoring more efficient methods of improving aggregate lifetime health of the poor and needy are serious cost drains on an endemically flawed health insurance system.[6]

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[1] National health care spending is approximately $1.9 trillion, 16% of the national economy, a record high. In 2004, Medicaid spending was $290.9 billion, increasing at an annual rate of 7.9%, the same rate as for total health care spending. Robert Pear, *Growth of National Health Spending Slows Along With Drug Sales*, N.Y. TIMES, Jan. 10, 2006, at A15.

[2] *See* Richard L. Kaplan, *Crowding Out: Estate Tax Reform and the Elder Law Policy Agenda*, 10 ELDER L.J. 15, 31–32 (2002) (noting, in the context of obtaining long-term nursing care, that drawbacks to qualifying for Medicaid include impoverishing oneself, and that, due to the cost-cutting trends of Medicaid to pay below-market rates for health care, many health service providers no longer accept Medicaid recipients, or severely limit the number of Medicaid recipients that they do accept, sharply proscribing health care options for Medicaid patients).

[3] N.Y. PUB. HEALTH LAW § 2807 (2005) (hospital reimbursement provisions limiting the amount which hospital service corporations, including health maintenance organizations, may pay hospitals on behalf of its subscribers).

[4] *See, e.g.*, David Glendinning, *Medicaid Panel Eyes Restrictions on Drugs Physicians Prescribe*, AM. MED. NEWS, Sept. 12, 2005, at 1–2 (discussing a set of recommendations that a panel convened by the Department of Health and Human Services made on how to cut about $11 billion from the federal Medicaid budget, including allowing states to negotiate drug medication discounts, allowing managed care programs to access rebates, charging beneficiaries for "non-preferred" drugs, restricting applicant entry into Medicaid through asset transfers, and prohibiting states from taxing Medicaid managed care organizations to gain federal matching funds).

[5] Clifford J. Levy & Michael Luo, *New York Medicaid Fraud May Reach into Billions*, N.Y. TIMES, July 18, 2005, at A1; *see also* Mark Johnson, *Pirro, Cuomo Differ on Medicaid*, N.Y. SUN, Oct. 9, 2006, *available at* http://www.nysun.com/article/41187.

[6] *See* Joanne Lynn et al., *Financing of Care for Fatal Chronic Disease: Opportunities for Medicare Reform*, 175 W. J. MED. 299 (2001) (arguing that it is often cheaper for Medicare social security insurance to allow families to provide their dying relatives with home care, but that the system creates financial incentives for insurance providers to encourage the use of expensive hospital services, including intensive care unit stays, instead).

A government-run health insurance program should clearly differ from a private insurance scheme. The government is obligated to cover the necessary medical expenses of all qualifying beneficiaries, healthy and sick alike, often for the remainder of their lives.[7] Therefore, public Medicaid should have far greater incentive than private insurance companies to invest in the future health of its beneficiaries by spending more on preventive care. The government should offer health care providers higher reimbursement rates for care like basic doctor visits and long-term, non-acute treatment regimes, including smoking cessation programs, nutrition clinics, and specialized rehabilitation treatment for chronically ill persons. By preventing or delaying the onset of serious medical complications, the government can help make the poor healthier and more productive while reducing the long-term costs of their medical treatment. Back on their feet, many of the temporarily impoverished children and young adults on Medicaid will be more physically capable of contributing to society rather than continuing to burden taxpayers at the federal, state, and local levels.

This Note will argue that New York's Medicaid program should reduce spending on terminal patient life sustenance and other acute illness care and should increase spending on preventive care. Part I discusses the basic structure of the Medicaid welfare health insurance program. Part II describes, in closer detail, New York Medicaid, the most expensive state Medicaid program in the country, and suggests that New York Medicaid is failing to properly promote the health of its poor. Part III introduces a concept for measuring the Medicaid program's effectiveness according to the personal health outcomes of the program's participants. Part IV analyzes recent trends in the Medicaid regime across the nation, according to Part III's mode of analysis, and concludes that New York must avoid continuing to delegate responsibility over Medicaid to private managed care providers who confuse and discourage the Medicaid-eligible population regarding Medicaid system utilization. Part V discusses recent reform efforts in New York, which at best amount to marginal improvements. Part VI proposes further reform measures meant to provide incentives for Medicaid participants to lead healthier lifestyles and to utilize more beneficial health care resources at lower costs.

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[7] *See* Beal v. Doe, 432 U.S. 438, 444 (1977) (a physician must provide a qualifying Medicaid patient with all medically necessary care); *see also* Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1539 (1996) (arguing the "medically necessary" standard of care encourages overuse of expensive treatment).

I. MEDICAID OVERVIEW

A. A FEDERAL AND STATE GOVERNMENT COOPERATIVE VENTURE TO TREAT THE "NEEDY"

Medicaid is a means-tested, fee-for-service insurance reimbursement plan designed to provide medical assistance to persons unable to meet the costs of medically necessary care and services.[8] Medicaid is fundamentally a welfare program, generally requiring its beneficiaries to be otherwise impoverished and therefore unable to pay for necessary medical care.[9] The federal government shares Medicaid costs with states that elect to participate in the plan (which all do), and, in return, participating states must comply with the requirements that Medicaid statutes and the Secretary of Health and Human Services (HHS) impose.[10] A state Medicaid plan must cover the "categorically needy," persons eligible under strict financial means tests under the now-repealed Aid to Families with Dependent Children (AFDC)[11] or certain impoverished individuals who qualify through Supplemental Security Income (SSI).[12] A state may, at its option, cover the "medically needy," those applicants who meet non-financial requirements but whose income or resources exceed the financial requirements of the program.[13] New York covers the "medically needy," bringing in nearly two million people under this heading, far more than any other state, and making medical necessity the most common grounds by which people qualify for New York Medicaid.[14]

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8 42 U.S.C. § 1396 (2005); Atkins v. Rivera, 477 U.S. 154, 156 (1986).

9 42 U.S.C. §§ 1396, 1396a (2005); Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 724–27 (1991) (arguing that impoverishment is a prerequisite for Medicaid coverage, including for middle-class nursing home residents who may "spend down" their assets and income to qualify for Medicaid long-term care benefits, typically to cover nursing home costs).

10 42 U.S.C. § 1396; *Atkins*, 477 U.S. at 156–57.

11 Persons who would have been eligible for AFDC under AFDC requirements in effect on July 16, 1996 are eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. §§ 601–615 (2005).

12 Social Security Act, Title XVI §§ 1601, 1602, 1611, 1619(b), 1634, 42 U.S.C. §§ 1381–1383c (2005) (§ 1619(b) grants continued Medicaid benefits for SSI recipients who go back to work).

13 42 U.S.C. § 1396a(a)(10)(A); *see also* 42 U.S.C. § 1396a(a)(17) (delegating broad authority to the HHS to set standards for determining the financial eligibility of Medicaid applicants).

14 CTRS. FOR MEDICARE & MEDICAID SERVICES, MEDICAID AT-A-GLANCE 2005: A MEDICAL INFORMATION SOURCE 2 (2005), *available at* http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf [hereinafter MEDICAID AT-A-GLANCE 2005]. For nationwide enrollment levels, see HOW MEDICAID WORKS: PROGRAM BASICS 13 (Congressional Research Service) (last updated Mar. 16, 2005) (Figure 1. Medicaid Enrollees by Basis of Eligibility, FY2002 & Medicaid Enrollees by Maintenance Assistance Status, FY 2002), *available at* http://kuhl.house.gov/UploadedFiles/medicaidworks.pdf.

When Medicaid patients are young and healthy there is little incentive for physicians and other health care providers to treat them, or spend much time with them if they do. Reimbursements are too low.[15]

Conversely, Medicaid provides large incentive for health care providers to treat critically ill patients of any age, who need expensive medical intervention.[16] Although the federal government sometimes grants states waivers from Medicaid regulations, the courts find that a health plan administrator commits illegal discrimination against the disabled by taking into account any differing capacity to benefit from health care other than a different probability of avoiding death.[17] Courts recoil at determining the patient's best interests by weighing the financial costs of prolonging the life of a terminally ill patient in end-of-life treatment decisions[18] against the likelihood of cure, ability to pay, and reason for the medical condition, despite the inescapable reality that the scarcity of resources could not possibly allow heroic medical attempts to be made for every dying publicly-insured patient.[19] Courts thus discourage rational cost-benefit trade-offs in Medicaid.

A Medicaid-eligible patient is entitled to any necessary and appropriate medical service, with virtually no limits.[20] Unfortunately, this system rewards health care providers for increasing the costs of services they provide, which are passed on to the government. Medicaid law requires a physician treating a Medicaid patient provide all "necessary medical services" for the patient.[21] Such a "medically necessary" standard of care eliminates potential conflicts that might otherwise arise through rational cost-benefit analysis between patient incentives to re-

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15 Richard Perez-Pena, *At Bronx Clinic, High Hurdles for Medicaid Care*, N.Y. TIMES, Oct. 17, 2005, at A1, *available at* http://www.nytimes.com/2005/10/17/nyregion/nyregionspecial4/17clinic.html; *see also* Kaiser State Health Facts, Medicaid & SCHIP—New York, http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=51&rgn=34 (last visited Mar. 9, 2008) (listing New York Medicaid's physician fees for all services as being 70% of the national average for Medicaid fees in Medicaid Physician Fee Index, 2003 chart).

16 Elhauge, *supra* note 7, at 1539.

17 Beal v. Doe, 432 U.S. 438, 444 (1977); Elhauge, *supra* note 7, at 1557.

18 *See, e.g.*, *In re* Doe, 583 N.E.2d 1263, 1269 n.15 (Mass. 1992) ("The cost of care in human or financial terms is irrelevant to the substituted judgment analysis" in end-of-life decisions).

19 *See, e.g.*, Peter A. Singer & Frederick H. Lowy, *Commentary—Rationing, Patient Preferences, and the Cost of Care at the End of Life*, 152 ARCHIVES INTERNAL MED. 478, 479 (1992). This article includes the debatable estimate that $109 billion was spent in 1990 on patients who would decline death-prolonging treatment if asked and argues for greater use of advance Do Not Resuscitate Orders.

20 Elhauge, *supra* note 7, at 1538–39. One arbitrary limit on spending, a limit that arguably cuts against the principle of furnishing Medicaid-eligible patients with all medically necessary care, is that New York Medicaid will pay for only one patient service per day. *See* Ian Urbina, *In the Treatment of Diabetes, Success Often Does Not Pay*, N.Y. TIMES, Jan. 11, 2006, at A1.

21 *See Beal*, 432 U.S. at 444.

ceive any beneficial care and professional norms of providing any beneficial service.[22] In New York, Medicaid pays for hospital care, physician services, prescription medication, nursing home care or home care for bouts of acute illness, and hospice care.[23]

B. SHIFTING COSTS AND RESPONSIBILITY TO THE PRIVATE INSURANCE PLANS

In order to contain costs and shift responsibility for management, more than 70% of New York Medicaid enrollees now receive their health care through health management organizations (HMOs) operating under government contracts that pay out flat annual fees.[24] Across the nation, state Medicaid programs are shifting most beneficiaries to intermediary insurers like HMOs in an attempt to contain costs.[25] Unfortunately, Medicaid's partial privatization does not address the underlying problem of systemic ignorance of cost-benefit trade-offs in healthcare decisions. Rather, these decisions are still driven by incentives to ignore early preventive measures along with the later desire to preserve life as long as possible by any "medically necessary" beneficial care.[26]

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22 Elhauge, *supra* note 7, at 1539. What the Health Care Financing Administration, the federal agency vested with the authority to administer the Medicaid program and to interpret Medicaid regulations, considers "medically necessary" is an easy target for criticism. The agency previously mandated that Viagra be covered under state Medicaid programs, viewing Viagra as "medically necessary" to treat male impotence. 49 Fed. Reg. 35,247, 35,249(K) (Sept. 6, 1984). Medicaid no longer covers male impotence drugs. Pub. L. No. 109-91, 119 Stat. 2091 (2005).

23 *See* New York Department of Health Website, http://www.health.state.ny.us/health_care/medicaid/index.htm#services. For an overview of Medicaid eligibility and covered medical services in each state, see generally MEDICAID AT-A-GLANCE 2005, *supra* note 14.

24 Urbina, *supra* note 20, at A1.

25 Of the more than 44 million total Medicaid population in 2004, over 60% were enrolled in a managed care plan, up from 40% in 1996. *See* CTRS. FOR MEDICARE & MEDICAID SERVICES, FINANCE SYSTEMS AND BUDGET GROUP 2005, at 18 (Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2005), *available at* http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.pdf (demonstrating the shift in the national Medicaid population towards managed care enrollment). An example of the trend in Medicaid administration towards the use of managed care is Florida's recent plan to shift its Medicaid program from a "defined benefit" plan to a "defined contribution" plan, to be administered by private managed care programs setting spending caps for each recipient. *See* Robert Pear, *U.S. Gives Florida a Sweeping Right to Curb Medicaid*, N.Y. TIMES, Oct. 20, 2005, at A1. Due to the federal government freeing states to alter their Medicaid programs to cover more uninsured and in light of a slight decrease in Medicaid spending in the first nine months of 2006, which is at least partially attributable to shifting some medication costs to the Medicare prescription drug benefit, many states are planning on expanding health care coverage. *See* Dennis Cauchon, *States to Expand Health Coverage*, USA TODAY, Jan. 8, 2007, at 1A.

26 *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (reviewing denial of welfare medical benefits under ERISA by the plan administrator under an arbitrary and capricious standard); Elhauge, *supra* note 7, at 1550–52 (describing how under this standard of review, the professional standard of providing any beneficial care dominates judicial decisions,

Private insurance plans, which typically take the form of managed care entities like HMOs within the Medicaid program, are driven by profit motive to offer plans that attract the healthy, but not the sick or high-risk enrollees, away from competing health plans.[27] Further, American private health insurance plans have little incentive to cover much in preventive care or basic care for the chronically ill, which tend to be relatively low-cost but labor-intensive.[28] Private insurers are fiscally wise to minimize coverage of preventive care. Money invested into protecting a patient's health is often of no benefit to the current insurer, because most insurance subscribers will change plans before the eventual serious health complications crop up, and the insurer might make a calculated gamble on this reasonable assumption by not covering much preventive care.[29]

Similarly, private insurers do not want to offer too much coverage for drug benefits or easier access to specialists that would attract the sick, chronically ill, or high-risk population to subscribe to their plan. Many insurers assume that chronic illness complications will occur so far into the future that many people will change jobs, switch insurers, or die before those complications arise. Thus, most savings from preventive measures will only be realized by the competition, particularly where people now generally change health insurance every six years.[30] The insurers, however, are often legally obligated to provide medically beneficial care to current subscribers for high-cost acute care, including terminal illness treatment.[31]

II. NEW YORK MEDICAID

A. THE FINANCIAL INCENTIVES TO OVERUSE EXPENSIVE COURSES OF TREATMENT

In New York, most doctors and many hospitals have little financial incentive to treat Medicaid patients. New York ranks near the bottom of the nation in physician reimbursement. For example, as of 2004, Medicaid in New York paid a physician $24 for a moderately complex office consultation, compared to the $91 national average, whereas the same visits can bring in hundreds of dollars under Medicare or private insurance.[32] Further, this $24 payment would take no account of the com-

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which tend to resolve ambiguities in favor of coverage for beneficiaries who are denied benefits).

27 *See* Urbina, *supra* note 20, at A1.

28 *Id.*

29 *Id.*

30 *Id.*

31 *Id.*

32 Perez-Pena, *supra* note 15, at A1.

plexity of the problem or the skill of the doctor and would apply to all visits, whether simple or complex, for general internists and specialists alike.[33] As a result, many specialists refuse to treat Medicaid patients, severely restricting the supply of specialist care available to these patients.[34] Hospitals that do participate in certain Medicaid plans often schedule Medicaid patients with less-experienced interns or medical residents or allocate shorter examination periods for these patients, resulting in too little time per visit to be thorough.[35]

Likewise, managed care entities, with their lump sums of effectively do-with-this-what-you-will state money, do not offer high enough physician reimbursement to attract many specialists into participating in their Medicaid plans. In New York City, for instance, most participating specialists do business with only two or three of the twenty Medicaid HMOs there, leaving a gaping shortage of specialists to provide necessary care to the suffering poor.[36] Meanwhile, New York continues to spend about double the national average per patient, due to higher reimbursements for services such as hospital care, nursing homes, and mental health facilities.[37]

New York thus provides nursing home owners, managers of care facilities for the functionally and developmentally disabled, drug pharmacies, and health plan executives with high reimbursement rates for their care of the elderly, disabled, and helpless. Meanwhile, the children and potentially healthy and capable young adults are left to wander the Medicaid labyrinth, given little guidance regarding their health management needs and consigned to a do-with-me-what-you-will fatalism.[38]

The New York Medicaid program places the general problem of our incoherent health insurance system in stark relief, as its beneficiaries and health care providers have perverse incentives to run up medical costs at the later stages of life. New York, home to the most expensive state Medicaid system, finds itself strapped for resources as its system's costs spiral upward.[39] New York is trying to reduce costs through short-term measures, including shifting administrative costs to local authorities and

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33 *Id.*

34 *Id.*

35 Richard Perez-Pena, *Trying to Get, and Keep, Care Under Medicaid: Navigating System Takes More Persistence than Many Clients Have*, N.Y. TIMES, Oct. 18, 2005, at B1, *available at* http://www.nytimes.com/2005/10/18/nyregion/nyregionspecial4/18jennifer.html.

36 Perez-Pena, *supra* note 15, at A1.

37 *Id.*

38 *See, e.g.*, Perez-Pena, *supra* note 15, at A1; Perez-Pena, *supra* note 35, at B1.

39 Howard F. Angione, *When the Baby Boom Boomerangs: Elder Law Section Publishes Long-Term Care Report*, 77 N.Y. ST. B.J. 28, 29 (2005); Candice Choi, *N.Y. Medicaid Spends More than Rest of U.S.*, THE CORNING LEADER, Dec. 22, 2005, at 7A.

privatized managed care[40] and cutting certain medications and procedures, while seemingly paying little mind to long-term reform to alter the incentives its system creates.[41]

New York's effort to treat Medicaid patients amounts to pushing aside problems until they are no longer correctable.[42] If a patient is poor, sick, malnourished, and ill-informed regarding lifestyle choices, diet, and exercise risks and rewards, the state policy does not provide for incentives to make positive lifestyle changes that would improve overall health. New York wants Medicaid patients to stop flooding emergency rooms with non-emergent problems,[43] though this perceived result likely flows in part from the state's decision to cut reimbursements to Medicaid beneficiaries enrolled in managed care plans.[44] The state all too often passively affirms a Medicaid beneficiary's choice to abuse his health by not discouraging him from consuming soda, beer, chips, liquor, tobacco, and other harmful products, but asks that the patient, in effect, leave the state alone until he—or at least the corporeal he—wants nothing more than to be left in peace. Then, when his body gives out and wants nothing more than to unburden itself from the torment, the pain, the withering abuses of stinging stimulants, flagging depressants, the prior warnings, complaints, and crises left unresolved—from the unremitting toll of living—when all that his body asks and nature demands is that it be mercifully lain to rest, that is when New York declares: "Stay with us, hold out a little longer. This is life, and must be preserved at all costs!"[45]

In 2001, the 3.6% of enrollees with annual spending exceeding $25,000 accounted for 48.8% of all Medicaid spending.[46] From 2002–2005, New York, like every other state, reduced medical care pro-

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40 *See, e.g.*, Brooke J. Sherman, *Company Has Idea to Reform Medicaid*, ELMIRA STAR GAZETTE, Sept. 10, 2005, at 6C.

41 *See* Kaplan, *supra* note 2, at 33–34 (proposing that Congress standardize the long-term insurance product market).

42 *See* Urbina, *supra* note 20, at A1.

43 *See* Ruth E. Malone, *Whither the Almshouse? Overutilization and the Role of the Emergency Department*, 23 J. HEALTH POL. POL'Y & L. 795, 796 (1998).

44 *See* Elhauge, *supra* note 7, at 1615–16 (explaining that when Medicaid limited reimbursement for prescription drugs, Medicaid hospital admissions increased).

45 *See, e.g.*, Urbina, *supra* note 20, at A1 ("[New York City diabetes treatment centers] did not shut down because they had failed their patients. They closed because they had failed to make money. They were victims of the Byzantine world of American health care, in which the real profit is made not by controlling chronic diseases like diabetes but by treating their many complications.").

46 Issue Paper, Anna Sommers & Mindy Cohen, Kaiser Commission on Medicaid & the Uninsured, Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending? (Mar. 2006), *available at* http://www.kff.org/medicaid/upload/7490.pdf (also providing federal fiscal year 2001 data showing that 1.1% of enrollees accounted for 25.7% of all Medicaid spending, that 7.6% of enrollees accounted for 65.3% of spending, and that the cohort of the elderly living in institutions, 2.7% of all Medicaid enrollees, accounted for 20.6% of all Medicaid expenditures).

vider rates and introduced drug prescription cost controls.[47] These efforts have done little to address the astounding costs of "acute care services," provided where serious medical problems already exist, and which account for 58% of total Medicaid costs nationwide.[48] Virtually all spending for children and young, non-disabled adults, the groups that have the greatest potential to benefit from educational and preventive care before acute care is necessary, is included in these "acute care services," meaning only a very small portion of total spending goes towards treatment of non-acute health care needs of the young and non-disabled.[49] Yet, while children and able-bodied adults, mostly women, constitute about three-quarters of New York's Medicaid population, only about one-quarter of spending goes toward their care.[50] By comparison, more than 70% of spending goes toward caring for disabled and elderly patients.[51]

The bulk of the remainder of Medicaid spending goes towards "long-term care" spending, with half of that spending being for nursing facility costs.[52] About 42% of Medicaid dollars were previously being spent on low-income "dual eligible" Medicare beneficiaries, who were also enrolled in Medicaid to pay for long-term nursing care and prescription drugs that Medicare does not cover.[53] Some of this spending was shuffled off the Medicaid books and onto the Social Security Medicare ledger on January 1, 2006, when dual eligibles lost Medicaid prescription drug coverage and were instead offered drug coverage under private insurance plans that contract with Medicare.[54]

By best accounts, about 10 to 12% of total health care resources, public and private, are used for the care of persons in their last year of life.[55] Medicaid and the Social Security Insurance health care program, Medicare, spend an even higher share of their financial resources on end-

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47 KAISER FAMILY FOUNDATION, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (2006) [hereinafter MEDICAID AND THE UNINSURED 2006], *available at* http://www.kff.org/medicaid/upload/7235.pdf; *see also* Kaiser State Health Facts, Total Medicaid Spending, FY 2006, http://www.statehealthfacts.org/comparetable.jsp?ind=177&cat=4 (last visited Mar. 9, 2008) (showing updated data on state-by-state Medicaid spending).

48 MEDICAID AND THE UNINSURED 2006, *supra* note 47.

49 *Id.*

50 Perez-Pena, *supra* note 15, at A1.

51 *Id.*

52 MEDICAID AND THE UNINSURED 2006, *supra* note 47.

53 *Id.*

54 Richard L. Kravitz & Sophia Chang, *Medicare Drug Benefit: Promise and Perils for Patients and Physicians*, 353 NEW ENG. J. MED. 2735, 2736 (2005), *available at* http://content.nejm.org/cgi/content/full/353/26/2735.

55 *See* Ezekiel J. Emanuel, *Cost Savings at the End of Life: What do the Data Show?*, 275 JAMA 1907, 1907 (1996); Steven H. Miles et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 W. J. MED. 302, 302 (1995), *available at* http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1303057.

of-life care: one-quarter of total combined Medicaid and Medicare expenditures each year are for the approximately 5% of beneficiaries who die during that year, with most of that disbursement in the last month of life for acute hospitalizations.[56]

Unfortunately, encouraging profligate consumption of the worst cut of life's offerings by vigorously treating irreversible illness complications and prolonging terminal illness, is no way to treat our citizens. Life and its battles are not won at the margins.[57] They are won in those seemingly fat and easy stages, where margins for error are widest and indiscretions might pass with little immediate consequence. When the lungs don't burn, the joints don't creek, and nachos with beer followed by a smoke seems to pass as a meal with no immediate adverse effects, the state does not encourage the consumer, the medical supplier, nor the insurers to pay notice to the harm being done. Yet, it is during these prime cuts of life that people can best accrue and secure good health. New York should expend more of its technological, medical, and financial capital on educating and encouraging the blooming living to treat their bodies well, while accepting the fate of the dying, and furnishing them with a comfortable avenue through which to pass into the ether.[58]

B. NEW YORK'S MISALLOCATION OF ITS GREEN TO PUT ITS POOR IN THE PINK

New York is not necessarily more generous to its poor than are other states simply because it spends more on Medicaid. It may simply provide the most systematically inefficient Medicaid program in the United States. In 2003, New York spent more than $38 billion for Medicaid, more than any state.[59] By 2005, New York's Medicaid program

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[56] Susan C. Miller et al., *Government Expenditures at the End-of-Life for Short- and Long-Stay Nursing Home Residents: Differences by Hospice Enrollment Status*, 52 J. OF THE AM. GERIATRICS SOC'Y 1284, 1284 (2004) (finding that government expenditures for Medicare- and Medicaid-eligible (dual eligible) nursing home patients in the last month of life were significantly less for hospice than for non-hospice short-term residents).

[57] *See* Michael D. Cantor, *Making Tough Choices*, 2004 U. ILL. L. REV. 183, 184–88 (2004) (discussing three typical courses of death, which have in recent times displaced the sudden, at-home death brought on by infectious disease or cancer as the paradigm for dying in America, in order of most to least predictable: 1) rapid deterioration, as typified by lung cancer patients, 2) cyclical chronic disease, such as congestive heart failure, and 3) steady deterioration, exemplified by dementia). These death trajectories present concerns not with getting the patient well in any permanent sense, but simply with providing care to ease patient and family suffering. *Id.*

[58] *See id.* at 194–96.

[59] *See* Kaiser Family Foundation, Raw Data Download, http://www.statehealthfacts.org/rawdata.jsp (click on "Medicaid & SCHIP" and download file) (last visited Apr. 8, 2008). In 2006, California, the next highest spender at about $34.3 billion, had 10.6 million recipients, compared with New York's 5.1 million. Kaiser Family Foundation, State Medical Fact Sheet: New York & California, http://www.statehealthfacts.org/mfs.jsp?rgn=34&rgn=6&x=10&y=8 (last visited Apr. 8, 2008).

cost a nation-leading $44.5 billion, covering 21% of doctor and medical bills, the largest share amongst the most populous states and more than double the national average of 9.3%.[60] New York's mean Medicaid outlay per patient in fiscal year 2005 was $7,733, the highest for any state in the nation.[61] The mean outlay for an "aged," over 65 years old, Medicaid recipient in fiscal year 2005 was $21,223.[62] New York also spends more Medicaid dollars for nursing home and other institutional care than any other state, nearly double that of Pennsylvania, the next highest-spending state.[63] Still growing, New York's Medicaid spending for fiscal year 2006 was approximately $44.7 billion.[64]

Data collected for New York's Department of Health weave a consistent story of how New York expends tremendous financial resources on its elderly Medicaid population as compared to its young Medicaid recipients. Statewide, and within New York City and in almost every county, there are many more recipients age 20 or younger than recipients age 65 and over—a young-to-old recipient ratio of a little over 4:1—and yet much less money is spent on the younger population—a young-to-old spending ratio of about 1:2.[65] Even considering that the elderly population files far more claims per recipient, which is not surprising given that people tend to have more health problems when they get older, the spending per claim for the elderly is much higher, indicating that the elderly Medicaid recipients not only demand far more medical attention, but demand costlier day-to-day attention as well.[66] This can be largely explained by the costly nature of the kinds of care the elderly tend to more often demand. For instance, the "aged" Medicaid population con-

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60 Choi, *supra* note 39, at 7A.

61 Only District of Columbia was higher at $7941. *See* Kaiser Family Foundation, Medicaid Payments per Enrollee, FY2005, http://www.kff.org/mfs/hl.jsp (last visited Apr. 8, 2008).

62 *Id.*

63 In fiscal year 2006, New York's Medicaid program spent over $6.9 billion on institutional care for nursing home care and institutional care facilities for the developmentally disabled and the mentally retarded. Kaiser Family Foundation, State Medical Fact Sheet: Distribution on Medicaid Spending on Long Term Care, FY 2006, http://www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4&sub=47&yr=29&typ=4&sort=202 (last visited Apr. 8, 2008). New York Medicaid spent another $8.5 billion on various types of home care such as personal and home health services, private duty nursing, and hospice programs. *Id.*

64 Kaiser Family Foundation, State Medical Fact Sheet: State Lows and Highs, http://www.kff.org/mfs/hl.jsp (last visited Apr. 8, 2008).

65 New York State Department of Health Office of Medical Management, *Fiscal Financial Year 2002–2003 Reference File* (Microsoft Excel Document on file with author), at COREF 03 (listing statewide aid for 1,864,088 recipients aged 0–20 at slightly under $5.5 billion on about 40 million individual claims, as compared with about $10.55 billion for the 449,832 recipients aged 65 and over on about 63.6 million individual claims).

66 Total cost for recipients aged 65+ of $10.55 billion for 63.575 million claims, or about $166 per claim; total cost of $5.496 billion for recipients aged 0–20 for 40.006 million claims, or about $137 per claim; total cost of $17.853 billion for recipients aged 21–64 for 93.801 million claims, or about $190 per claim. *Id.*

sumed more than three-quarters of the over $6 billion spent on long term care.[67] "Institutional long term care," generally nursing home service provided as a mandatory benefit under Medicaid, tolled almost $50,000 per recipient at $183 per day of care in fiscal year 2002-2003.[68]

By contrast, the state only spent an average of $18 per day on child care, $14 per claim for podiatrist care, and $56 per claim for non-clinical dental care, all of which are "optional" categories of service that New York chooses to cover.[69] About $117 million was spent on general childcare; more than ten times that amount was spent on care facilities for the developmentally disabled.[70] In considering which health care providers currently benefit from Medicaid, note that less than $400 million was spent on physician reimbursement, while $4.17 billion went to pharmacies, over $3.2 billion more went to HMOs, and over $2.7 billion to Community and Rehabilitation Services to care for the disabled at a cost of about $360 per day.[71]

New York spends a higher proportion of its Medicaid dollars on the disabled and a far lower proportion on children than does the nation as a whole.[72] These numbers are consistent with the notion that New York Medicaid costs are inflating because it reimburses at very high rates for the kinds of care that cost a lot, either through long-term accrual or by costly acute care procedures, creating financial incentives for health providers and patients to overuse the more expensive kinds of health care.

C. THE PRESCRIPTION FOR IMPROVING THE HEALTH OF THE POOR

Faced with how to provide optimal health care for an aging population, New York Medicaid must, perhaps counter-intuitively, direct more of its attention to the care of its young. The state should exercise its discretion in shaping its Medicaid program to form a coherent plan that encourages healthy living, responsibility, and better basic, non-acute care

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67 Aged 65+ long term care cost over $4.8 billion of the more than $6 billion total for long term care costs, with similarly high proportional spending on the elderly for each subcategories of institutional and non-institutional long term care, as well as for home care, personal care, assisted living, and hospice. *Id.*

68 *Id.* at COREF 03, P Long Term Care.

69 *Id.* at P HMO CC, P Foot Eye Dental.

70 *Id.* (listing fiscal year 2002–2003 spending for child care as $116.9 million and spending for Independent Care Facilities for the Developmentally Disabled (ICF-DD) at $1.191 billion).

71 *Id.* at COREF 03.

72 For fiscal year 2005, 29.1% of New York's Medicaid spending was on elderly enrollees, 42.5% on disabled enrollees, and 10.7% on children. Kaiser Family Foundation, State Medical Fact Sheets: Distribution of Medicaid Payments by Enrollment Group, FY 2005, http://www.statehealthfacts.org/comparetable.jsp?ind=182&cat=4. The national averages are 26.1%, 40.8%, and 17.3%, respectively. *Id.*

for its poor, while discouraging wasteful and harmful behavior that leads to grave health outcomes later in life.[73] Currently, New York provides very generous reimbursement rates for services like nursing homes, home care, and hospitals while offering very little reimbursement for basic doctor visits.[74]

The government should not regard the issue of rising health care costs for the poor as the result of mere political or bureaucratic hurdles obstructing the ameliorating force of the free market that managed care privatization of Medicaid seems to promise.[75] Even with the increasing use of managed care plans to serve the Medicaid population, Medicaid spending continues to increase.[76] Rather than improving, or at least maintaining, health care provisions for the poor and disabled while cutting unnecessary public spending, managed care's typical cost containment strategy of cost capitations often merely serves to divert patients back to the traditional health care safety net, the emergency room, while reducing the quality and scope of Medicaid coverage to beneficiaries prior to the onset of serious health complications.[77] The failure of New York's privatization and localization efforts in curbing the excesses of Medicaid spending should come as no surprise.[78] Managed care complicates the Medicaid program and hinders the public delivery of health care.

III. REDEFINING NEW YORK MEDICAID'S PURPOSE

A. A CALL FOR GOVERNMENT REFORM

New York Medicaid must heal itself. As long as the state thinks only in terms of patching its own systemic problems through shortsighted corrections, it makes no real progress.[79] When the state does not institute accountability for poor long-term health choices, it merely defers and accrues interest on the payment of future medical bills.[80] Eventually,

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73 *See* Michael S. Sparer, *Medicaid Managed Care and the Health Reform Debate: Lessons from New York and California*, 21 J. HEALTH POL. POL'Y & L. 433, 456 (1996) (commenting on New York's tendency to set policy county-by-county and case-by-case).

74 Perez-Pena, *supra* note 15, at A1 (discussing New York's record of paying less than almost every state to its doctors for treating Medicaid patients, while paying about twice the national average on a per-patient basis).

75 *See* Sparer, *supra* note 73, at 455–56 (expressing cautious optimism at the prospect of competing managed care organizations injecting competition into the Medicaid business and improving care for the poor, particularly in terms of increasing primary care and reducing emergency room use).

76 *See* Pear, *supra* note 1, at A15.

77 *See* Malone, *supra* note 43, at 816–21; Elhauge, *supra* note 7, at 1616.

78 Elhauge, *supra* note 7, at 1616–17; *cf.* Sparer, *supra* note 73, at 455.

79 *See* Elhauge, *supra* note 7, at 1616; *see also* Cantor, *supra* note 57, at 184–88.

80 *See* Perez-Pena, *supra* note 35, at B1 (discussing the confusion of the Medicaid system to its beneficiaries).

poor personal health choices of many Medicaid-eligible citizens will accumulate, leading to the misery of chronic and terminal illnesses, and the expensive tests and treatments that accompany them.[81] Medicaid encourages the poor and otherwise uninsured to demand professional health care and service when they feel ill, but do little to encourage the maintenance of good health.[82] Unless these patients are given a clear financial stake in becoming and remaining as healthy as possible, Medicaid will continue to become increasingly inefficient.

Medicaid's policies do little to encourage healthy lifestyle choices or to discourage unhealthy ones.[83] But the cumulative effect of poor health care decisions becomes more apparent as the patient develops a chronic or terminal illness. For example, a physician might prescribe that a patient cease smoking to alleviate particular symptoms. Medicaid policy, though, allows the patient to continue to smoke, if he so chooses, without any health care benefit or financial penalty. If he does continue to smoke, he can continue to visit the doctor as his symptoms persist and worsen, and the doctor will continue to advise the patient to quit.[84] Even if he continues to smoke, he loses no Medicaid benefits.[85] Eventually, the patient's body will no longer be able to resist the punishment tolling from the harmful effects of smoking, and he will likely contract lung cancer, throat cancer, emphysema, or some other tobacco-related disease. The now-dying patient, probably shorn of a great deal of potential life lost due to tobacco addiction, will likely undergo an expensive battery of tests, procedures, and medical treatments to temporarily stave off the disease's fatal consequences. Finally, the patient may be left to slowly whither in the intensive care unit, continuing the financially, physically, and psychologically expensive death process.[86] Aggregating these recurring, sad situations on a statewide level yields high costs for relatively little benefit.

It is both instructive and disquieting to consider the returns of New York City's attempts to treat Type 2 diabetes, a chronic disease that is often the result of genetics, obesity, and inactivity, at four specialized centers.[87] Even as the number of Type 2 diabetes patients in the city has doubled, three of the four centers created to preventively treat the disease

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81 *See* Urbina, *supra* note 20, at A1.

82 *See* Beal v. Doe, 432 U.S. 438, 444 (1977).

83 *See* Urbina, *supra* note 20, at A1.

84 *See* New York Department of Health Website, *supra* note 23.

85 *See* 42 U.S.C. §§ 601–615 (2005); N.Y. PUB. HEALTH LAW § 2807 (2007).

86 *See* Cantor, *supra* note 57, at 188; Lynn et al., *supra* note 6; Singer & Lowy, *supra* note 19, at 479.

87 Urbina, *supra* note 20, at A1.

have closed.[88] Meanwhile, over 100 kidney dialysis clinics, aimed at managing a complication of late-stage diabetes, have opened.[89]

The general fee-for-service health care regime provides financial incentive for insurers, hospitals, and doctors to neglect or refuse to provide less lucrative preventive treatment to control chronic disease. For example, a $30,000 foot amputation is typically reimbursed through Medicaid, whereas appointments with a podiatrist that might have saved the foot, are not; expensive dialysis treatments for serious diabetes complications are covered, although earlier treatments to visit a nutritionist that could keep the kidneys functioning are not.[90] A chronic condition like Type 2 diabetes is not profitable for providers, pharmaceutical or insurance companies to treat, because diligent treatment is required over a lifetime, rather than through short-term acute care.[91] Insurance companies that oversee many Medicaid plans are under financial pressures to not provide certain benefits, like listing an endocrinologist on the insurance network's primary care physician list, because doing so would attract subscriptions by the chronically ill.[92] Even once enrolled in a plan, care providers profit not from offering time-consuming preventive treatment, but rather from hi-tech procedures, like a quick-fix bariatric stomach-shrinking surgery, which the state will reimburse at a much higher level.[93]

Financial incentives to overtreat acute, life-threatening health problems through hi-tech, high-cost procedures after undertreating early-stage, low-cost problems represent an endemic flaw in the American health care system.[94] Managed care profiteers, with myopic views on how to accrue the most reimbursement money while minimizing revenue sharing with hospitals and physicians, only serve to perpetuate this sorry situation. If Medicaid policy does not change, miserable outcomes will inexorably result, given our aging population.[95] Insurers will continue to

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88 *Id.*

89 *Id.*

90 *Id.*

91 *Id.*

92 *Id.*

93 *Id.*

94 *See id.*; *see also* David Glendinning, *Financial Trouble Predicted for Medicare*, AM. MED. NEWS, Jan. 2/9, 2006, *available at* http://www.ama-assn.org/amednews/2006/01/02/gvsc0102.htm (reporting on outgoing Federal Reserve Board Chair Alan Greenspan's warning that modern advances in prescription medicines and technological innovations that lead to doctors over-prescribing certain treatments are major potential sources of health care cost increases that place the financial health of the Medicare program in dire peril).

95 *The Cost and Financing of Long-Term Care Services: Hearing Before the Subcomm. on Health of H. Comm. on Ways & Means*, 109th Cong. 1–15 (2005) (statement of Douglas Holtz-Eakin, Director, Cong. Budget Office) [hereinafter *Long-Term Care Hearing*], *available at* http://www.cbo.gov/ftpdocs/63xx/doc6316/04-27-LongTermCare_testimony.pdf (arguing

deter high-risk patient enrollment.[96] Enrollees will be left ignorant as to the cause of their ailments and the inexpensive ameliorative courses of action they can take to prevent worsening health.[97] Medicaid administrators will continue to disallow long-term preventive care as not being "medically necessary."[98] Short-term, life preservation care will unquestionably be insured and reimbursed.[99] The cycle of irrational spending will continue to spin out wider orbits, with no measures of cost accounting or delegations of managerial authority capable of masking the rising debts that our bent-backward health care system reveals in rising costs, lost life, and added misery.

B. ACCEPTING THE LIMITS OF HUMAN HEALTH AND AFFIRMING THE VALUE OF INFORMED PERSONAL CHOICE OVER HEALTH CARE DECISIONS

Rest assured: the one certainty with which we are blessed is our mortality. Each person has limited time in which to reap some kind of value during life. Once squandered, no technology can ever restore this lost opportunity. Yet, to demand any beneficial care that might prolong life regardless of costs, as Medicaid laws and regulations seem to do,[100] can only rest upon a flawed notion of the capacity for human health treatment. The ability to prolong the death process does not necessarily create an increase in net health, and in many cases may entail a net reduction in the quality of life. The much-publicized assisted suicide scenarios are merely the marginal cases, over which much blood, sweat, and tears are wrung in trying to arrive at a solution to the ineluctable mystery of life, and over who finally decides what is in the patient's best interests.[101] Regardless of where the answer may lie in deciding when to

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demand for long-term care services for the elderly is increasing, with the current health insurance regime discouraging the purchase of private insurance to pay for these future expenses).

96 Perez-Pena, *supra* note 15, at A1.

97 Urbina, *supra* note 20, at A1.

98 *See* Perez-Pena, *supra* note 15, at A1 (illustrating through the story of young Angel Perez, a boy born with a hand deformity and misshapen ears, who needs strong, persistent advocacy to obtain insurance and proper specialist care to reconstruct his hand and ears, largely because so few proper specialists will participate in Medicaid plans that reimburse them so little for their services).

99 *See* Urbina, *supra* note 20, at A1 ("By the time a situation is acute, when dialysis and amputations are necessary, the insurer, which has been gambling on never being asked to cover procedures that far down the road, has little choice but to cover them, if only to avoid lawsuits, analysts said.").

100 *See* 42 U.S.C. §§ 1396, 1396a (2005); Atkins v. Rivera, 477 U.S. 154, (1986).

101 *See, e.g.*, Thomas E. Quill & Diane E. Meier, *The Big Chill—Inserting the DEA into End-of-Life Care*, 354 NEW ENG. J. MED. 1–3 (2006), *available at* http://content.nejm.org/cgi/content/short/354/1/1; *see also* William Saletan, *Alternative Sentence: A Counterproposal to Assisted Suicide*, SLATE, Mar. 4, 2005, http://www.slate.com/id/2114344/ (foreseeing the legalized assisted suicide debate as playing out in a manner somewhat parallel to the legalized abortion debate).

pull the plug, tuck the eyelids, and turn off the lights, there still remains the matter of the bill. The potential for reversing the patient's fate in terms of improving life outcomes, and doing so at a much lower cost, is decided long before the patient reposes in a death bed. For our youth, the time is now; for our dying, that time has passed.

For Medicaid recipients, there is no health bill collector arriving at the door on the first of the month. Medicaid recipients' personal choices over their lifestyles are left unchecked by appropriate messages from their ultimate health care provider, the government. Regretfully, many recipients also must confront the powerful and sometimes imperceptible forces of physical decay as accelerated by personal neglect.[102] Of course, many Medicaid recipients are responsible, health conscious, and follow their doctor's orders.[103] But without the government signaling to Medicaid recipients that they must demonstrate personal responsibility to be entitled to health care above the level provided,[104] personal neglect is left to work its deleterious effects on those who are ignorant or indifferent to the physical signals or medical professionals' warnings of long-term damage. New York should proclaim that medical health insurance protection is to be the haven of the personally accountable, the achievable goal of the willing, and the removable luxury of the irresponsible.

However, many Medicaid beneficiaries, no matter how hard they may try to follow a prescribed course of treatment, will simply be in poor health, and in need of regular medical care. If Medicaid is to be a social safety net, it should be a well structured one, woven taut, with strong fabric, no holes, and little embroidery. The state cannot be stingy with its dollars for the truly needy.

Nor should it be obtuse in setting the rules of realizing and maintaining Medicaid benefits, leaving dependents unsure of where they stand and where they must go to stay on sure footing with the state in terms of their eligibility, provider plan's benefit coverage, and application paperwork satisfaction.[105] People's lives are at stake, and concentrating on marginal issues about who constitutes the acceptable beneficiary class through rules that appear fickle to its players is an unworthy and ineffi-

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102 *See* Perez-Pena, *supra* note 15, at A1 (describing physical suffering that patients have suffered as a result of ignoring the administrative requirements of Medicaid).

103 *See, e.g.*, Urbina, *supra* note 20, at A1 (discussing success stories of diligently treated diabetes patients insured by Medicaid).

104 It is no coincidence that there are so many Medicare recipients who achieve dual eligible status to realize the much more generous prescription drug and nursing care benefits traditionally provided by Medicaid or that Medicaid fraud is a constant worry of government. *See* Kapp, *supra* note 9, at 724–26. It is a generous insurance program in many respects besides its vast spending on clear end-of-life situations. *See* Angione, *supra* note 39, at 29–30.

105 *See* Perez-Pena, *supra* note 35, at B1 ("New York's vast, generous, but disturbingly imperfect Medicaid program . . . seems to offer great largess with one hand, and chip away at it with the other.").

cient exercise of state authority.[106] Furthermore, privatizing Medicaid risks, changing the very aim of the health insurance welfare system from a program meant to promote health to a cost account meant to limit public financial costs in times of personal crisis. Cutting health care spending ought not be the primary factor determining the success of Medicaid reform. Rather, health care spending is itself merely a means to the end of improving the health of those who cannot afford to pay for the necessary care to achieve that end.

Unfortunately, New York is casting its lot more with managed care, hoping market competition will contain financial costs, at the risk of casting bare the fates of the impoverished to some hybrid free-market and spending apportionment system.[107] Human health is too capricious at the individual level for strict rationing of health care. Still, clear trends on how certain lifestyles translate into certain health outcomes suggests that encouraging modifications of personal health care behavior may not prove futile. Only clear guidance to Medicaid recipients on the health lifestyle directions they should follow to maintain Medicaid eligibility will effect any real improvement in our poor and disabled population's quality of health.

IV. ALTERNATIVE APPROACHES TO MEDICAID

A. THE FLORIDA PILOT PROGRAM AND THE FOLLY OF MANAGED CARE PRIVATIZATION

The government's main response to curbing the costs of Medicaid in recent years has been to shift the administration of the program from a joint federal-state government venture to a more localized and privatized regime.[108] Florida is beginning a pilot program that carries this process to its next logical progression, transferring responsibility for Medicaid patients' health care to private insurance entities, like health maintenance organizations and physician-hospital provider service networks.[109] The state pays the private managed care entrepreneurs a risk-adjusted premium and leaves it at the discretion of those private entities to determine the amount, scope, and duration of covered benefits for Medicaid patients.[110] The new system effectively replaces beneficiaries' "defined benefit" package with a "defined contribution" package, an allocation of

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106 *See id.*

107 *See* Sparer, *supra* note 73, at 444–45, 455; *see also supra* notes 24–31 and accompanying text.

108 *See* Sparer, *supra* note 73, at 433–35.

109 Amy Snow Landa, *Florida Doctors Wary of Medicaid Overhaul*, AM. MED. NEWS, Jan. 2/9, 2006, at 5–6, *available at* http://www.ama-assn.org/amednews/2006/01/02/gvsb0102.htm.

110 *Id.* at 5.

money to purchase a defined set of services.[111] Florida's program caps spending per patient and delegates administrative decision-making to for-profit insurance plans, which need not adhere to federal mandatory standards under a waiver that the federal Human and Health Services agency provided to Florida.[112] Medicaid recipients who require more funds than is allocated in their annual allotment are supposed to be covered by the health plans administering the benefits, thus providing an economic incentive for health plans to find ways to minimize spending.[113]

Florida's pilot program has significant pitfalls. Granted, this plan does hint at the proper acknowledgment that spending money in one area is often an implicit choice not to spend in another. It also requires Florida to deposit money into accounts for recipients who enroll in programs to help them lose weight or stop smoking, thus providing an economic incentive to live healthier.[114] However, Florida is likely dooming its program to failure by grounding it upon seriously flawed assumptions. First, by setting a price ceiling on spending per patient, Florida places in jeopardy the primary benefit of insurance—pooled risks—if profit-seeking private entities prove stingier or more confusing to consumers than the government has been in covering the unfortunate.[115] While group health risks may be predicted within a reasonable degree of certainty, each individual's year-to-year health and concomitant health costs can be highly volatile. Under the Florida program, the state will not reimburse the managed care providers for health catastrophes unanticipated by the state, leaving it to the managed care provider to pay these costs.[116] Second, the program apparently sets aside money, enrollee-by-enrollee, according to his or her historic medical conditions and use of health care.[117] This means that those who tended to abuse the system in the past by disregarding their health or the costs of care they place on the public tab will be rewarded with greater future defined contributions from the state.[118] Third, the program deranges the very purpose of Medicaid to now be "to bring predictability to Medicaid spending and to re-

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111 Pear, *supra* note 25, at A1.

112 *Id.*

113 *See id.*

114 *Id.*; *see also Kaiser Daily Health Policy Report Highlights News of Recent State Medicaid Developments*, KAISER DAILY REPORTS., Sept. 28, 2006, *at* http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=40109 ("Florida . . . allows beneficiaries who engage in certain healthy behaviors to receive up to $125 which can be used toward medical expenses.").

115 *See* Sparer, *supra* note 73, at 435–36 (stating concerns of safety net providers such as hospital and community health centers that have traditionally served the uninsured and indigent patient populations).

116 *See* Pear, *supra* note 25, at A1.

117 *Id.*

118 *See id.*

duce Medicaid's rate of growth."[119] But profit motive will not impart upon managed care organizations the power to divine the health outcomes of Medicaid enrollees. If managed care should improve cost predictability, it will do so through stricter denials of coverage, the costs of which will be shifted to other sources, such as the public safety net of emergency rooms and community health centers, absent statewide coordination of health care delivery.[120] Florida's new program is best explained as a product of defeatism by a state that regards its Medicaid program as a sunk cost, to be controlled for each patient on a yearly basis.

Florida effectively admits that it cannot manage its own welfare health insurance program. Instead, it entrusts a private managed care system to deal with the problems of Medicaid, hoping that profit motive will minimize spending and abandoning the overriding concern for health outcomes. New York should not follow this path, but should instead regard Medicaid as a means of protecting from physical catastrophe the population of people unable to pay for health care and as an opportunity to encourage healthier habits, with the hope that many Medicaid enrollees will provide future contributions as productive members of society.

B. THE VERMONT ELDER CARE PLAN

A truer measure of choice is injected into the lives of Medicaid seniors by a plan like that beginning in Vermont, where Medicaid-eligible seniors may choose among nursing homes, residential care facilities, and their own homes as their place of care.[121] Although Vermont touts the program as a great future-cost-saver, whether the money and resources, direct and hidden, to be spent on increased home care will outpace that previously spent on institutional care remains to be seen.[122] New York should carefully monitor Vermont's success with home and assisted living care, as New York itself appears poised to implement a similar pro-

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119 *Id.* (statement provided by federal officials as to why Florida obtained a waiver of federal mandates).

120 Elhauge, *supra* note 7, at 1616; Sparer, *supra* note 73, at 456–58 (arguing that managed care of Medicaid may serve to reduce costs, but its success as good public policy will likely depend on a host of variables centering on coordinated state-wide activity of health care providers, and that otherwise managed care effectively serves as a cost-shifting mechanism).

121 Sarah Miller Llana, *A Push for Stay-at-Home Healthcare*, CHRISTIAN SCI. MONITOR, Jan. 3, 2006, at 3, *available at* http://www.csmonitor.com/2006/0103/p03s03-ussc.html.

122 *See id.* (explaining that Vermont will set aside the money it spent previously on Medicaid seniors under the new beneficiary waiver option of institutional care plan, but perhaps without accounting for greater hidden costs like greater family member contributions to care maintenance).

gram.[123] This is especially important because Medicaid covers more than half of all elderly nursing home residents.[124]

C. THE SALUTARY INJECTION OF CHOICE INTO HEALTH CARE

Whether or not a reform like Vermont's will improve Medicaid elder care efficiency, it seems to point in the proper direction of thinking about health care insurance, whether for the poor or the affluent, as a consumer good.[125] Viewed as a consumer good, health care can be helpful where the government and health care providers properly inform the poor of their individual health care concerns, and provide them with a suitable array of choices regarding the allocation of time and resources to manage their health. The best way to spend resources to help the poor would be decided by how a well-informed consumer population would prioritize spending and set individual preferences. For example, since critical life support ventilators are targeted to specific individuals rather than the public good, it is entirely rational to allow poor people who collect government subsidized benefits to choose benefits of higher personal priority like primary care physician appointments or easier access to appropriate medications.[126]

Medicaid currently provides its recipients with full benefit coverage for critical life support, which is a tremendous financial drain on the system. In recent years, many people, realizing the futility of "heroic

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123 Candice Choi, *Nursing Home Availability Varies,* ROCHESTER DEM. & CHRON., Jan. 23, 2006, at 5B (discussing a New York State panel that is targeting counties that may have an excess of nursing home beds with an eye towards closing nursing homes and potentially increasing assisted living care, which the Health Department estimates to be a less expensive alternative).

124 *See Long-Term Care Hearing, supra* note 95, at 8. The Congressional Budget Office endorses the idea of reducing Medicaid long-term care spending by strengthening rules to reduce Medicaid estate planning through disposition of assets or "spending down" into Medicaid eligibility, while acknowledging that such measures would do little to contain total costs. *See id.* at 11.

125 *See* Daniel Gross, *Low Co-Pays Everyday: Could Wal-Mart Solve America's Health Care Crisis?,* SLATE, Jan. 5, 2006, http://www.slate.com/id/2133840/ (arguing that Wal-Mart is well-positioned to promote the idea to the public that health-care is a consumer good, which may come as a welcomed development, where "low-income consumers of preventive health care and low-end insurance are underserved in many parts of the country, in much the same way lower-income rural retail consumers were underserved when Sam Walton built his first Wal-Mart in the 1960's."). State or municipal governments may eventually force Wal-Mart and other large, generally low-wage employers to spend a base level on employee health insurance to unburden the states from uninsured employees on Medicaid rolls. *See, e.g.,* Michael Barbaro, *Maryland Sets a Health Cost for Wal-Mart,* N.Y. TIMES, Jan. 12, 2006, at E1.

126 *See* Steven E. Landsburg, *Do the Poor Deserve Life Support?,* SLATE, Jan. 3, 2006, http://www.slate.com/id/2133518/ (arguing against criticism of the Baylor Regional Medical Center's decision to remove a 27-year-old terminal cancer patient from her ventilator for failure to pay her medical bills, resulting in her quick death, asking the critics to first address the attractiveness of the underlying public choice of spending less on goods poor people value the most in consideration of giving every poor person ventilator insurance).

efforts" to prolong life (or death, if you will) of terminally ill individuals, have preemptively signed "living wills," with clear directives that often avoid such futile efforts.[127] Mandating living wills specifying advance directives for Medicaid enrollees could remove some confusion in end-of-life decision-making and their attendant high costs.[128]

Throughout the swirl of life's many stages, we all eventually face choices. The hand of the state may intervene, as a guiding force, the blind prophet with its hand at the beggar's back. The runny-nosed baby, sorrily clad in a well-worn knit-sweater hood, absolved of choice, save which finger to cling upon, lives in ignorance and uncertainty. The schoolchild, brain sweltering with ideas, terrible violence curdling within expanding limbs, id flowing through innocent fingers, knows only that which she sees, touches, smells, hears, fears, and screams. The teenager-cum-independent, grasping at strings and gasping in fumes, huffs an intoxicating aroma, and drowns out the voices, dulling the fire, quelling the mob, stifling the train of thought, losing sight of a bastion of hope. She tears asunder her life's cradle, the possibilities draining, unrealized. The woman, bringing up baby, numb to the papers, dumb in her capers, ignorant of the big hand, claws through quicksand, with gritty dirt where fingernails ought to be. She consumes the black spirit and exhales the cinders through her exfoliating balloon-lungs, the sands of time dripping Kool, but all too fast.

If Medicaid recipients were given the opportunity to choose whether they prefer critical life support, should they become terminally ill, or the equivalent cost-value of other goods, such as basic medical examinations, most would probably choose the basic care.[129] However, before society can justifiably attribute the causes of poor health outcomes to the sick themselves, these Medicaid patients must be given the opportunity to make an informed choice between long-term consequences and short-term enjoyment. If our government wishes to delegate further decision-making, administration, and oversight of Medicaid to the local and private spheres, it should take the further step of delegating responsibility down the chain of authority, and imbue the clay figure beneficiaries with the rosy hue of free will in their health care decisions. The integrity of Medicaid must ultimately be measured by how well it serves to improve life. Those Medicaid recipients, whose lives are meant to be improved by the program, ought to be best situated to determine their own self interests, but this is only so if the recipients are empowered with infor-

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127 M. Gregg Bloche, *Managing Conflict at the End of Life*, 352 NEW ENG. J. MED.2371, 2371–73 (2005).

128 Singer & Lowy, *supra* note 19, at 479.

129 *See* Landsburg, *supra* note 126.

mation regarding their health and the rules of the insurance game.[130] Therefore, Medicaid recipients must be given the power, incentive, and responsibility to chart their own course within the Medicaid system.

V. RECENT NEW YORK REFORM EFFORTS

Although New York has recently taken some initial steps to reform Medicaid, it has yet to address the fundamental problems inherent in its fee-for-service reimbursement system and the lack of patient accountability. Further, New York continues to move towards privatizing Medicaid and to focus its enforcement oversight more on improper beneficiary enrollment than on improper provider billing and fraud schemes. By allocating funding responsibility and control to local counties, while simultaneously delegating authority to determine individual health plans to for-profit managed care organizations, New York is relinquishing its opportunity to fundamentally reform its Medicaid program for the long-term benefit of its citizenry.

A. DRUG PRESCRIPTION SPENDING CONTROL

To begin with, New York must make basic reforms to reduce wasteful prescription drug spending. In 2005, New York spent $3.8 billion, more than any other state on prescription drugs for Medicaid patients.[131] Still, New York lagged behind more than 30 other states in finally implementing the basic cost control of a "preferred drug list" selected by a committee of doctors and pharmacists for each class of treatment.[132] This list restricts the use of costlier name brand drugs where generic drugs would be similarly effective, and creates bargaining leverage for a state's Medicaid agency to negotiate lower medication prices with manufacturers.[133] Perhaps much of the cost saving potential has been lost, given how medication costs have inflated, and some of New York Medicaid's drug bargaining power has been lost to the Medicare Plan D shift of dual eligible enrollees, a major former source of Medicaid beneficiary drug consumption.[134] Also problematically, New York seems wedded to reimbursing drug-dispensing pharmacies based on "average wholesale price" figures provided by drug manufacturers rather than by actual cost.[135]

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130 *See id.*

131 Michael Luo, *Drug Costs Run Free Under New York Medicaid*, N.Y. TIMES, Nov. 23, 2005, at A1.

132 *Id.*

133 *Id.* (noting that doctors must file for and receive State approval to prescribe drugs to Medicaid patients that are not on the preferred list).

134 *Id.*; Kravitz & Chang, *supra* note 54, at 2736.

135 Luo, *supra* note 131, at A1.

B. HEALTH CARE PROVIDER FRAUD PREVENTION

Another basic flaw New York Medicaid is just beginning to address and must correct is its enforcement policies to reduce health service and insurance provider fraud. A New York Times computer analysis of public records revealed wide-ranging indications of extensive Medicaid fraud in New York State.[136] Examples of possible Medicaid fraud included: doctors prescribing to AIDS patients unnecessary and extraordinarily expensive muscle-building drugs that were later diverted to bodybuilders; dentists billing the state for phantom fillings and improper procedures; school districts receiving over $1 billion in questionable payments for speech therapy sessions without the required evaluations; medical ambulette transportation services charging the state for rides to many people able to walk on their own and for rides that likely never took place; and nursing home operators collecting high-income salaries from Medicaid payments while providing substandard care for their nursing home residents.[137] A former chief state investigator of Medicaid fraud and abuse estimated that at least 10% of state Medicaid dollars were paid out on fraudulent claims and that another 20 to 30% were based on unnecessary spending.[138]

Whatever the precise numbers may be, a significant portion of the approximately $10,600 that the government now spends per each of the 4.2 million New York Medicaid recipients is almost surely now being devoted to making ostensible health care providers and insurance plan managers rich, rather than to improving the welfare of the poor and disabled.[139] Yet, New York has maintained an uncoordinated auditing and policing system with diminishing resources and diminishing returns in recent years, even as New York Medicaid has grown in size.[140] Early returns on New York's supposedly reinvigorated commitment to prosecute fraud and abuse by allowing some counties to flag questionable spending in their systems are promising, with Rockland County quickly uncovering millions of dollars worth of questionable billing that state officials will investigate and prosecute.[141]

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136 Levy & Luo, *supra* note 5, at A1.

137 *Id.*

138 *Id.*

139 *Id.*

140 *See* Clifford J. Levy & Michael Luo, *Governor Adds Muscle to Curb Medicaid Fraud*, N.Y. TIMES, July 20, 2005, at A1 (citing a 70% drop in fraud and abuse recoveries by the State Department of Health since 2000 and explaining how New York's policing resources were disjointed and lagging technologically, missing even clear indications of billing improprieties, likes spikes in billing claims).

141 Richard Perez-Pena, *Officials in Rockland Question Medicaid Billings of $13 Billion*, N.Y. TIMES, Jan 6, 2006, at B1.

Encouragingly, at least basic reforms of the New York Medicaid system are on the horizon. Cheats and crooks have long followed the Medicaid money, creating fraudulent schemes and crime rings, scraping tax dollars off the unassuming backs of taxpayers, and swiping vigorish from the gambling insurers by lopping off chunks of the state's lump sum disbursements earmarked for patient care. Until recently, Albany seemed to regard the situation with sardonic disinterest.[142] Now, the state government has at least mustered perturbation at the prospect of the widespread bilking and created a new Inspector General's office to centralize, expand, and reinvigorate the policing of fraud by health care providers.[143] Similarly, New York State now offers a bounty reward to Medicaid fraud whistleblowers, something previously offered by other states and the federal government.[144] Also, New York State will implement a Preferred Drug List, asking pharmaceutical companies to provide the state with rebates, and requiring them to pay to get their drugs on the list from which doctors can prescribe without gaining authorization from the Health Department.[145] Other cost saving measures include eliminating coverage for government employees, increasing co-payments for certain medications, and adjusting premium rates for the working poor under New York's Family Health Plus Plan.[146] The state budget estimates $1.4 billion in savings from the more than $44.5 billion in annual Medicaid costs.[147]

C. EASING NEW YORK MEDICAID'S UNIQUE BURDEN ON LOCAL GOVERNMENTS

Facing down a financial crisis, Chemung County Executive Tom Santulli is trying to overhaul his County's Medicaid program. Mr. Santulli's efforts provide some hope that New York may soon find a starting model for conscientious and compassionate Medicaid reform efforts. New York has approved Mr. Santulli's plan to designate an independent agency to administer Chemung County's Medicaid services.[148] Case managers are expected to monitor patients to ensure they show up for appointments, see appropriate medical professionals, and receive proper

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142 *See* Levy & Luo, *supra* note 140, at A1.

143 Clifford J. Levy, *Governor Plans Agency to Fight Medicaid Fraud*, N.Y. TIMES, Jan. 14, 2006, at A1.

144 New York will allow citizens suing on behalf of the government to recover a percentage of the public funds recovered. Candice Choi, *Medicaid Reforms Attack Fraud, Waste*, ASSOCIATED PRESS, Jan. 7, 2006.

145 *Id.*

146 *Id.*

147 *Id.*

148 *See* Salle E. Richards, *State Approves Medicaid Reform*, ELMIRA STAR-GAZETTE, Dec. 29, 2006, at 1C.

medications.[149] The County will also offer patients the opportunity to learn preventive health skills, including proper diet.[150]

Though undesirable, the need for greater county participation in the administering and policing of New York Medicaid has rapidly increased in recent years. New York is the only state that imposes a large portion of the financial responsibility for Medicaid's cost on local governments.[151] In 2005, New York State paid about $6.6 billion for Medicaid, which is 15% of the state's entire Medicaid budget.[152] Unfortunately, Upstate New York has recently encountered a financial crisis in meeting its financial obligations to the Medicaid program. Recently, much of Upstate New York dipped into a prolonged recession while New York expanded Medicaid enrollment.[153] For example, over the past five years in Chemung County, Medicaid rolls have increased by 50%, while employer-provided health insurance decreased.[154]

Combining rapidly increasing heath care costs with more enrollees, Chemung County's Medicaid costs practically doubled in five years to $18.5 million in 2005, consuming one-fifth of the total County budget and virtually all of the property tax revenue.[155] With the tax revenue base shrinking and the option of increasing property and sales taxes already stretched to their limits, Chemung County's government has been forced to cannibalize itself, cutting public employment and services and leasing the local landfill to a private contractor, with permission to expand the waste dump.[156] Neighboring Steuben County's local share of Medicaid costs for 2006 is estimated to be $19 million, delaying County highway repair and development programs.[157] The state has relieved some of the financial burden by capping the growth of the local Medicaid costs.[158] Still, this may not be enough because many county governments are being held hostage by Medicaid burdens.

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149 Mary Perham, *Pataki's Proposed Budget Could Include Medicaid*, THE CORNING LEADER, Jan. 14, 2006, at 3A.

150 *Id.*

151 Richard Perez-Pena & Michael Luo, *As New York Medicaid Grows, Swelling Costs Take Local Toll*, N.Y. TIMES, Dec. 23, 2005, at A1, *available at* http://www.nytimes.com/2005/12/23/nyregion/nyregionspecial2/34medicaid.html.

152 *Id.*

153 *Id.*

154 *Id.*

155 *Id.*

156 *See id.*

157 *See* Mary Perham, *Better Roads Among Legislature's Goals*, THE CORNING LEADER, Jan. 8, 2006, at 3A.

158 Jay Gallagher, *N.Y. to Pay $1.1B for Medicaid Cap*, ELMIRA STAR-GAZETTE, Jan. 14, 2006, at 1C (explaining that according to the estimated $46.5 billion cost estimates for New York Medicaid in fiscal year 2005–2006, the 3.5% cap on Medicaid spending by counties and New York City was expected to shift $1.1 billion to the state government that would otherwise be paid by local governments, including $4.07 million by Chemung County and $4.93 million by Steuben County).

D. SYSTEMIC PROBLEMS LINGER

While the recent reforms are important and some may prove helpful, they should mark just the beginning of a realization of a rational, cohesive plan to insure the poor and the disabled. New York spent about $3.8 billion of its Medicaid dollars on prescription drugs in 2004[159] and allocated up to 10% of total Medicaid spending towards fraudulent claims.[160] Policing fraud at the health provider level is particularly encouraging, since New York is renowned for being lax in detecting Medicaid crime by unethical insurance plan managers and doctors.[161] However, even ideal oversight and enforcement in these trouble areas would leave New York with the most expensive Medicaid program. The twin demands of a renewed commitment to devoting greater attention to the care and guidance of the younger Medicaid enrollees and containing spending on irretrievably ill individuals remain as pertinent as ever. Basic reforms to drug coverage and fraud-policing will help slow the acceleration of cost increases. Still, New York must make more extensive changes to preserve the viability of Medicaid. Otherwise, New York will be, at best, pennywise and pound-foolish.

VI. PROPOSALS FOR CHANGE

New York must make fundamental structural changes to its Medicaid program, and soon. For instance, New York Medicaid should obtain a waiver from the federal government regarding certain "medically necessary" mandatory care items that it could instead provide on a conditional basis, connected to recipients' choices following medically prescribed plans.[162] For physically capable applicants and recipients, participation in smoking cessation, weight loss, or other wellness programs should be prerequisites in obtaining certain welfare health benefits. Further, patients who keep their appointments with medical professionals and other responsible behavior ought to be able to earn good behavior credits, strengthening their entitlement claims to more beneficial public health insurance plans.[163]

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159 Luo, *supra* note 131, at A1.

160 Levy & Luo, *supra* note 5, at A1.

161 *See id.*

162 For an overview of the waiver requirements the Social Security Act authorizes states to use in operating their Medicaid programs, see Centers for Medicare and Medicaid Serives, Overview of Medicaid State Wavier Program Demonstration Projects, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp#TopOfPage (last visited Sept. 8, 2007).

163 West Virginia has already received federal approval to embark on a plan to reward with added benefits its "responsible" Medicaid patients who sign and abide by a pledge to attend health improvement programs, checkups, screenings and appointments as directed, while limiting non-abiding patients to only federally required basic services. Potential obstacles to this program's success, however, include the patient population's lack of information regarding the new plan and their difficulties in obtaining access to the preventive medicine

Currently, our government runs a deficit in understanding the more fundamental problems with our health insurance system.[164] "It's almost as though the system encourages people to get sick and then people get paid to treat them,"[165] while "[o]ur national unwillingness to acknowledge the conflict between efforts to limit medical spending and insistence on all possibly beneficial care worsens this toxicity."[166] New York Medicaid must be willing to modify its delivery of health care.

Much of the targeted Medicaid population, the poor, tends to be an irresponsible and undisciplined group as compared to the population at large.[167] Doctors commonly complain that Medicaid patients are highly unreliable; they walk in without appointments and regularly miss appointments that they do schedule.[168] Medicaid enrollees, however, also comprise about one-fifth of New York's total population,[169] and constitute a diverse group of people, many of whom are capable of making healthier lifestyle choices that better suit the new demands that the government might place upon them.[170]

A. INFORMING THE MEDICAID POPULATION

Information is power. The more Medicaid patients are taught about their health and the courses of recommended treatment, the more likely they will be to comply with their treatment. Early intervention and prevention of health problems creates greater opportunities to effectively

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West Virginia means to promote. *See* Erik Eckholm, *Medicaid Plan Prods Patients Toward Health*, N.Y. TIMES, Dec. 1, 2006, at A1, A29.

164 *See, e.g.*, *National Governors Association Meeting Addresses Recent Medicaid Revisions*, KAISER DAILY HEALTH POL'Y REP., Feb. 28, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=35677 (noting that a congregation of state governors in Washington, D.C. "expressed guarded optimism" that a recent federal budget reconciliation law proposal to cut Medicaid entitlement benefits could help curb Medicaid costs, but failing to reach any consensus on how to reform Medicaid other than to oppose the reconciliation law proposal to pare federal funding to states by limiting states' use of certain accounting techniques and changing the drug reimbursement formula).

165 Urbina, *supra* note 20, at A1 (quoting Dr. Mathew E. Fink, a former president of Beth Israel Hospital in New York City, which previously operated a diabetes center until the reality of losing money on every diabetes patient it treated through comprehensive chronic care forced the center to close).

166 Bloche, *supra* note 127 (explaining why our national debate about how to medically treat patients in a vegetative state will not be resolved without a fuller accounting of the cost considerations that attach to end-of-life decisions).

167 *See* Perez-Pena, *supra* note 15, at A1.

168 *Id.* (explaining the most common reason doctors cite for refusing to see Medicaid patients, however, is probably still the low Medicaid reimbursement rates).

169 *Id.*

170 *See, e.g.*, Urbina, *supra* note 20, at A1 (illustrating how a committed preventive medicine clinics to treat diabetes patients, many of whom are on Medicaid, can successfully improve patient awareness and understanding of their disease, which leads to improved disease maintenance through more diligent self-administered blood-sugar level testing, and improved diet and exercise).

minimize serious complications and negative outcomes. Educating patients will create a sense of responsibility and control over their well being, which the current system does not foster. Left blind to the cause and effect of their own courses of action, many Medicaid patients will continue to wallow in an acquired pit of fatalism.[171]

Left to neglect, disease will fester. Much of the Medicaid population's apparent indifference to their own health and welfare, marked by inattention to doctor appointments, ignorance as to their insurance status, and inability to recognize their poor health habits and symptoms, leaves their physicians and caseworkers cold.[172] Ignorance reigns. Defeatism abounds. Government administrators, marking off Medicaid recipients as hopeless cases and sunk costs, pass the buck. Private health plans siphon off any profit they can from monthly block grants, offering as little coverage for preventive care as they can "manage."[173]

B. SIMPLIFYING THE ENROLLMENT PROCESS AND DEMANDING BENEFICIARY RESPONSIBILITY

The Medicaid enrollment process should be simplified. In order to conserve administrative costs and reduce confusion amongst Medicaid-eligibles, insurance administrators, and health care providers, New York should reduce the paperwork and proof necessary to apply for and maintain Medicaid coverage. Currently, New York's Medicaid renewal process is possibly the most complex in the nation, entailing six pages of forms to fill, six more pages to read, and duplicative proofs of information such as income and citizenship status.[174]

This front-end filtering of consumer fraud, meant to prevent undeserving people from receiving Medicaid benefits through improper enrollment or renewal, saves little money but places a heavy administrative burden on the state. According to federal regulators, care for ineligible patients account for less than two-percent of Medicaid costs in every state.[175] In terms of defrauding the program, the real cost drain comes at the provider level, not at the consumer level.[176] Yet, largely due to a daunting enrollment and renewal process, an estimated one million eligi-

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171 *Id.*

172 *Id.*

173 Medicaid HMOs operating in Broward County, Florida, site of part of the Florida Medicaid privatization pilot program, have recently operated at an 18.6% average profit rate. Landa, *supra* note 109, at 7.

174 *See* Perez-Pena, *supra* note 15, at A1.

175 *Id.*

176 *See id.* (quoting Robert Goldberg, a senior fellow at the Manhattan Institute, as saying, "I don't think there's any question that most of the fraud is provider-driven, not patient-driven.").

ble New Yorkers are not in the Medicaid program.[177] This number will likely grow if New York loses its federal waiver, which permits the state to implement its "facilitated enrollment" program, allowing HMO's, community groups, and health clinics to assist people in filling out their Medicaid applications.[178]

Clearly, those Medicaid enrollees who are not capable of helping themselves should not be punished for reasons beyond their control. Children, the disabled, and many other Medicaid-eligible citizens must not slip through the cracks of the system. If anything, the government should encourage more facilitated enrollment to ensure that such people receive the welfare health insurance to which they are legally entitled.

Medicaid reform must reflect informed, rational policy choices that discourage public expenditures on life support and costly acute care procedures, while creating incentives for Medicaid recipients to lead healthy lifestyles. To achieve these ends, New York must accept that forces of nature conspire to weaken and destroy human life, but steadfastly affirm that the government is itself capable of improving Medicaid. New York must also accord greater respect to its Medicaid population, whose lives the state now seems to regard as a source of burden, except at those end-stages when human life tends to quickly diminish in force and capability, when any beneficial care is deemed not only desirable, but "medically necessary."[179]

New York should not try to curb Medicaid costs by merely cutting benefits and welfare rolls, by further routinizing and limiting methods of medical diagnosis and prescription of Medicaid patients or by delegating authority to private entities to administer Medicaid.[180] Instead, New York should allow for greater physician autonomy in prescribing individual courses of treatment for patients, with strong financial incentives for the promotion of preventive medicine and a measure of financial disincentive for Medicaid patients to be kept alive for the sake of prolonging the death process.

The state should empower the poor with the responsibility of making intelligent health care decisions. Medicaid patients and their health

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177 *Id.*

178 Richard Perez-Pena, *For Medicaid Clients, New Hurdle Looms*, N.Y. TIMES, Nov. 21, 2005, at B3, *available at* http://www.nytimes.com/2005/11/21/nyregion/21medicaid.html (explaining arguments in favor of "facilitated enrollment" include keeping up enrollment, saving pointless trouble in re-enrolling people incorrectly dropped from the program, and avoiding the forcing of such people to emergency room care for non-emergent health problems. Arguments against facilitated enrollment include the encouragement of HMO's to spend too much on advertising and unscrupulously signing people up to their plans, and the risk of placing some ineligible people onto Medicaid).

179 *See supra* notes 15–26 and accompanying text.

180 *See supra* notes 2–5 (typical reform measures) and notes 108–20 (privatization) and accompanying text.

care providers should clearly understand that it is in their best interests to anticipate future illness and to treat potential problems sooner rather than later through diligent patient practices of proper diet, exercise, and long-term medical professional guidance.[181] Early recognition and treatment of health problems results in better health outcomes.[182] Young or old, patients often benefit from the same tenets of care; prevention and early recognition and treatment of deteriorating conditions.[183] A system of incentives for "good" behavior and long-term financial disincentives for "bad" behavior should be incorporated into the Medicaid system.

Patients are already, in effect, forced to work for their benefits in an unproductive way that doubles as an eligibility screen—the confounding enrollment process.[184] Making patients work for benefits in a more straightforward and potentially helpful manner—a financial incentive scheme—is a more rational way to guide behavior. The state should shift the administrative focus of the yearly Medicaid application and renewal process from a background check for proof of pedigree and placement in one of a coterie of private and public health plans, to an evaluation of the enrollee's needs as well as compliance in following medical directives.[185] Entry into the program should not be burdensome. Exit from Medicaid ought to be based upon either change of financial circumstance removing need or failure to follow doctor or caseworker prescriptions. However, keeping Medicaid eligibles off the rolls should not result from failure to comprehend a difficult and shifting insurance scheme, such as that which currently exists.

Medicaid must place some responsibility on its enrollees in return for government benefits. The paradigm should shift to Medicaid recipients signing "contracts" for care, with built-in provisions for maintaining individual responsibilities.[186] One line of questioning should regard the

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181 Urbina, *supra* note 20, at A1 (illustrating how the chronically ill poor particularly demand steady reminders of how to keep up habits of appropriate diet and exercise and regular personal health monitoring).

182 *See, e.g.*, Vinay M. Nadkarni, et. al., *First Documented Rhythm and Clinical Outcome from In-Hospital Cardiac Arrest Among Children and Adults*, 295 JAMA 50, 56 (2006) (concluding that children survived to hospital discharge following in-hospital cardiac arrest more often than adults did, primarily because of better outcomes following loss of pulse, and suggesting that "an early aggressive approach to pediatric resuscitation may have contributed to better outcomes.").

183 *See, e.g.*, Linda Quan, *Adult and Pediatric Resuscitation: Finding Common Ground*, 295 JAMA 96, 96–97 (2006).

184 *See* Perez-Pena, *supra* note 15, at A1.

185 *Cf.* Perez-Pena, *supra* note 35, at B1; Perez-Pena, *supra* note 15, at A1 (describing current process).

186 West Virginia's pilot program that asks beneficiaries to sign pledges to do their best to remain healthy and to attend health improvement programs as directed, with built-in incentives for compliance, would seem a potentially useful natural experiment for testing the efficacy of this model. Still, early indications that beneficiaries do not understand the pledge or the program in general, as well as inadequate transportation facilities to service much of the rural

patient's record of keeping medical appointments. For example, a Medicaid patient could be dropped from a more generous public Medicaid plan for failing to show up for three different appointments with a doctor or for some high no-show rate. Also, patients could have their Medicaid benefit coverage significantly reduced for failing to comply with physician orders, like not attending smoking cessation clinics, failing a nicotine urinalysis, or not meeting with other medical professionals referred to for treatment.

Irresponsible patients, rather than being fully covered and reimbursed for all beneficial care, would only be entitled to coverage for basic doctor visits with a primary care physician and certain preventive medical programs. Emergency care and life preservation measures must also be provided. In terminal cases, perhaps comfort care, rather than expensive treatments, could be administered, with the state legislature and federal administrators to provide the necessary planning details. However, New York State should not continue to spend its most expensive welfare resources on those people who do not prove themselves responsible or accountable for their actions. Nothing alerts a previously irresponsible patient's senses quite like some brush with her own mortality. It is fitting, then, that such a patient accepts some personal responsibility for her own health care.

C. IMPROVING ACCESS TO MEDICAL CARE FOR MEDICAID PATIENTS

On the medical provider side, New York State should address the lack of specialist care for Medicaid patients by increasing doctor reimbursement and by requiring that all physicians and hospitals accept Medicaid patients. First, New York must change its Medicaid reimbursement scheme to pay more for basic doctor visits and even more for specialist consultations. As noted earlier, New York Medicaid languishes near the bottom of the nation in reimbursing its physicians, and makes little distinction between simple and more complicated treatments.[187] Since most specialists choose not to treat Medicaid patients and health clinics designed to treat chronic illnesses tend to be unprofitable ventures, many Medicaid patients have to travel long distances to find a physician.[188] New York must reimburse physicians enough that they actually profit, or at the very least break even from treating Medi-

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areas covered by the program may portend difficulties in the program's effective application. *See* Eckholm, *supra* note 163, at A1.

187 Perez-Pena, *supra* note 15, at A1. New York does plan to increase its Medicaid reimbursement rates to doctors for 2007. Doug Trapp, *Medicaid Payment Inching up*, AM. MED. NEWS, Nov. 6, 2006, at 1. Still, reimbursement levels are expected to remain well below treatment expenses. *Id.* at 2.

188 *See* Perez-Pena, *supra* note 15, at A1; Eckholm, *supra* note 163, at A1. *See generally*, Urbina, supra note 20.

caid patients.[189] Second, New York should require all physicians to accept some number of Medicaid patients as a condition for retaining their license to practice medicine in the state. Doing so will ensure the supply of able physicians available to the needy and infuse a sense of common ownership of the Medicaid program throughout the medical profession.

If New York State sufficiently raised Medicaid physician reimbursement levels, doctors would not incur a financial penalty each time they treat a Medicaid patient.[190] With better reimbursement rates for comprehensive preventive care for Medicaid enrollees, health clinics primarily created for Medicaid enrollees can finally become financially viable enterprises.[191] Physicians who grow frustrated with patients who act irresponsibly can alert program administrators to the patient's poor medical attendance and compliance record, requesting that the patient no longer be referred to that physician, and that the state remove certain Medicaid coverage for the patient.

D. ENCOURAGING PREVENTIVE CARE AND DISCOURAGING BEHAVIOR DETRIMENTAL TO HEALTH

A system of incentives and disincentives should be infused into the welfare health insurance provisions. For instance, through "good" behavior, an enrollee may earn a generous Medicaid plan, one that includes not only free tobacco cessation programs, obesity treatment, and other preventive medicine programs, but the promise to fully pay for all care in treating chronic illnesses like diabetes, cancer, and AIDS, as well as other hospital care, physician services, prescription medication, nursing home care or home care for bouts of acute illness, and hospice care. In other words, that enrollee keeps what New York Medicaid already provides, with the added benefit of increased availability of medical providers and treatment programs, adding particular value to younger Medicaid beneficiaries. Those who fail to follow physician orders, and give other indicators of personal neglect or abuse, would receive a reduction in their public health insurance entitlement package.

The benefits of these changes outweigh the costs. Granted, such a program constrains certain freedoms of choice for patients and physicians alike. Patients who lose certain benefits for previously accepted irresponsible behavior, like failing to keep scheduled doctor appointments and continuing to overeat and not exercise, may feel wronged, especially if they have never been held accountable for these behaviors before.[192] Doctors and hospitals who do not wish to participate in treat-

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189 *Cf.* Urbina, *supra* note 20, at A1.

190 *Id.*

191 *Id.*

192 *Cf.* Perez-Pena, *supra* note 15, at A1.

ing those sometimes irresponsible and relatively non-lucrative Medicaid consumers may resent the state ordering them to see these patients. However, as a matter of equity, all physicians should offer services to Medicaid patients to match supply to public demand for providing the needy with more preventive care and chronic illness maintenance. Both higher physician reimbursement and mandatory physician participation, along with strict enforcement of compliance codes to minimize fraud, should become mandatory state policy. For the sake of rewarding the responsible, health care providers should be paid more, and treated patients should be paid in kind, for facing their health problems earlier on and learning how to manage those problems on a long-term basis. Patients could finally find the specialist care they need early enough to effectively treat their health problems and physicians who do treat them would receive profitable reimbursement fees for every Medicaid patient they treat.[193] Health care choices would often be made and courses of treatment would begin before it would be too late to restore health, and Medicaid would not have to spend a large portion of its budget on expensive tests and treatments for irretrievably dying patients.

E. CONCLUSION

The government must take back control of Medicaid and use the program as a valuable tool in a broader effort to reform the health care profession. Medicaid presents an opportunity to inform and guide the public. If the poor and disabled are informed of the health risks that their lifestyles create, and are given the power and incentive to alter their behavior, the focus of health insurance may shift back to its proper plane, that of improving health, by moving away from the market-driven incentives that lead to substandard preventive care and overemphasized acute care. The government, with the available economic advantage of monopoly control of the Medicaid program, and the financial tools of defining eligibility requirements, benefit entitlements, and reimbursement levels, is in the unique position of being able to provide comprehensive health care insurance for all its "categorically" and "medically" needy citizens. Medicaid has the potential to create a model of efficiency combined with compassion that private insurers lack. New York State should reclaim its ambitious welfare program as its own beacon of hope for its sick and impoverished citizens.

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193 *See* Urbina, *supra* note 20, at A1 (contending that under the current Medicaid reimbursement scheme, every basic Medicaid patient visit represents a financial loss for the treating physician and the hospital).