The Implications of Privatization on Low-Income People
Public Health and Private Profit: A Witch’s Brew

By Manjusha P. Kulkarni, Susan Fendell, and Erica Berry

This Comprehensive Resource Can Help You Learn How to Win, Manage and Profit from Medicare and Medicaid Contracts.

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A bottom-line emphasis on corporate profitability as the central value underlying the private sector component of our health care reimbursement system undermines the efforts of practitioners to provide human welfare-centered health care services.

Joseph S. Bak and Robert H. Weiner

While privatization of the delivery of government benefits may be a relatively new phenomenon in cash assistance programs such as Temporary Assistance for Needy Families, it has been used for quite some time in the field of health care delivery. The marriage of corporate interests and health care services is not often an easy one. In this article we survey some results of privatization in three separate contexts: administration of the eligibility and initial appeals process in California’s State Children’s Health Insurance Program; mental health managed care for Medicaid recipients in Massachusetts; and the conversion of public hospitals into private, sometimes for-profit, entities. While the details vary among the examples, the common themes that emerge are an inherent tension between profit and service, and unnecessary complexity engendered by efforts to address that tension.

I. Privatized Administration of the Healthy Families Program in California

California’s State Children’s Health Insurance Program, called Healthy Families, is separate from its Medicaid program, which is known as Medi-Cal. A quasi-governmental agency, the Managed Risk Medical Insurance Board, administers Healthy Families. Since the inception of Healthy Families, the board has contracted with a private company, Electronic Data Systems, to make eligibility deter-

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3 In establishing State Children’s Health Insurance Programs (SCHIP), states were allowed to expand their existing Medicaid programs, create separate SCHIP programs, or do a combination of the two. California chose to do both. California expanded Medi-Cal’s federal poverty level programs to adolescents between ages 16 and 19. It also created the Healthy Families program for all uninsured children with family incomes up to 250 percent of the federal poverty level.

For the note on the authors, see p. 647.
minations and administer the initial level of the appeals process. Experience with this system indicates that, whatever the virtues of privatization, mixing profit motivation with the administration of public benefits programs raises a number of thorny issues that may prove difficult to address even if the state agency’s intentions are good. This may be particularly true with regard to ensuring adequate review of privatized eligibility decisions.

The federal statute and regulations for the State Children’s Health Insurance Program require that states give to each applicant or enrollee a written notice of any decision on an application. Federal law also requires that states ensure that an applicant or enrollee has an opportunity to review eligibility denials, failures to make timely eligibility determinations, and suspensions or disenrollments. Electronic Data Systems is responsible in Healthy Families for the initial notification of decision. The first step in the Healthy Families appeals process requires Electronic Data Systems to determine whether the appeal request involves a question of eligibility for the program or one of benefits coverage. If Electronic Data Systems concludes that the request involves a benefits coverage issue, Electronic Data Systems forwards the matter to the Managed Risk Medical Insurance Board for program review. Any decision that the board renders on a benefits coverage issue may not be taken to an administrative hearing. If, on the other hand, Electronic Data Systems decides that the request concerns eligibility, the matter enters the appeal track, with Electronic Data Systems conducting the initial review of the case.

If Electronic Data Systems determines that its original decision was correct, it notifies the applicant that the applicant may appeal the decision to a second level of review. At the second level the executive director of the Managed Risk Medical Insurance Board reviews the case within thirty days. If the applicant is not satisfied after the executive director makes a determination, the applicant finally may request an administrative hearing.

The Healthy Families appeals process stands in sharp contrast to the Medi-Cal process. In Medi-Cal, receipt of a notice

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4 A state is required to designate a single state agency to administer its Medicaid program. 42 C.F.R. § 431.10(b)(1) (2001). While the state agency may delegate its authority to make Medicaid eligibility determinations to local governments, it may not, with some exceptions, ordinarily allow private contractors to make Medicaid eligibility determinations. Id. § 431.10(e); 42 U.S.C. § 1396a(a)(55), 1396r-1a(b)(3)(A)(i) (1999). However, the SCHIP program has no such restriction.

5 42 C.F.R. § 457.340(e) (2001). If the application is approved, denied, suspended, or terminated, the notice must include information on the enrollee’s rights and responsibilities, including the right to review. Id. § 457.340(e)(1). If eligibility is suspended or terminated, the child’s parent or caretaker must receive sufficient notice to take appropriate actions to allow coverage to continue without interruption pending an appeal. Id. § 457.340(e)(2).

6 Id. § 457.1130(a).


8 See CAL. INS. CODE § 12693.87 (West 2001) for information about the Healthy Families appeals process. Note that the statute has no provision for individuals to challenge Electronic Data Systems’ decision that the matter is not one entitled to an appeal.

9 Recent Bush administration changes in 42 C.F.R. § 457.1120 permit states to create a specific review process for SCHIP that comports with the minimal requirements of the SCHIP regulations, or to adopt existing grievance and appeal requirements applicable to all health insurance issuers in the state, or use the Medicaid fair hearing process. This flexibility itself reflects a conceptual shift toward a private model of service delivery and dispute resolution in the SCHIP statutes and regulations. States have modeled their separate SCHIP program after private insurance systems. Designing SCHIP programs in this way ignores the needs—which are markedly different from those of consumers of private insurance—of those receiving public benefits. Although we do not discuss it here, the use of private insurance systems as benchmarks for the SCHIP program reflects a definitive move toward privatization in public benefit programs.

10 If the original denial is deemed incorrect, the applicant is enrolled in the program.
of action or discovery of an adverse decision triggers participants’ rights to a hearing. Individuals are granted an administrative hearing upon filing a request. No intermediate internal review is required, as it is in Healthy Families.

California advocates whose clients have applied for Healthy Families have identified a number of problems with the application and appeals processes. The problems stem in whole or in part from Electronic Data System’s involvement. First, advocates complain that the Healthy Families appeals process is dysfunctional: since the inception of the program in 1998, not a single administrative hearing request on Healthy Families has been filed. Managed Risk Medical Insurance Board staff claim that there have been no fair hearings because Electronic Data Systems or the board has rectified all problems before they reach the hearing stage.

Data from the board suggest otherwise. According to the agency’s own numbers, approximately 135,000 children were disenrolled from Healthy Families between November 2000 and October 2001. Of these, the board reported, over 94,000 children were terminated for a “possibly avoidable disenrollment reason.” That all of these families decided to forgo appeals because they no longer wanted the health coverage strains credulity.

Advocates suspect that the labyrinthine nature of the Healthy Families appeals process partially explains the total absence of requests for fair hearings. The process is so complicated, with so many levels of review, that only those with remarkable persistence could likely negotiate it fully. But that cannot be the full explanation. Health coverage is such an important commodity that at least some families could be expected to attempt the gauntlet. The very fact that so many thousands of children were terminated from Healthy Families without a single request for an administrative hearing indicates that families are somehow prevented or discouraged from requesting or pursuing appeals.

The lack of informal mechanisms for applicants to resolve disputes with Electronic Data Systems exacerbates the problem. On each notice of action the Medi-Cal program gives the name and phone number of the eligibility worker. Healthy Families, on the other hand, offers no opportunity outside the appeals process to discuss a determination and seek resolution. When a Medi-Cal worker miscalculates family income, for example, advocates or their clients can call the eligibility worker and potentially correct the problem. When advocates call Electronic Data Systems, however, rarely are they able to speak to the employee who made the eligibility decision. In cases where advocates do speak with the decision maker, they say they are told that the employee’s hands are tied even if the employee admits to the miscalculation. According to advocates, Electronic Data Systems employees have recommended that clients file a first-level appeal or submit a new application to obtain eligibility.

Because the appeals process is so complicated and time-consuming, many families undoubtedly opt to reapply. This approach has significant disadvantages. Unlike Medicaid, the State Children’s Health Insurance Program does not provide for retroactive coverage. Indeed, coverage begins only after the eligibility determination has been made, not on the date of application. This means that even if a child’s second Healthy Families appli-

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12 For detailed information about the administrative hearing process, see Cal. Welf. & Inst. Code § 10950 (West 2001).
13 Conversation between Manjusha P. Kulkarni and Ernesto Sanchez, contract and marketing manager, Managed Risk Medical Insurance Board (Oct. 12, 2001).
15 Id. at 9.
cation is accepted after the first one was incorrectly rejected, the child will not obtain coverage for any medical care provided during the time it took to correct the initial error. As a result, this scenario can leave a family with substantial medical bills.17

Electronic Data Systems’ failure to supply the names and phone numbers of staff members means that there is little accountability within Electronic Data Systems for the decisions employees make. Unlike Medi-Cal workers, Electronic Data Systems employees who routinely make mistakes are protected by their anonymity from challenge by advocates and their clients.

Despite its public position that the application and appeals system is working well, the Managed Risk Medical Insurance Board recently took action that suggests it suspects otherwise. The most recent contract between the state and Electronic Data Systems contains a new term: if Electronic Data Systems makes an error that results in delay or denial of an applicant’s eligibility for Healthy Families, Electronic Data Systems may be held financially responsible for any uncovered health, dental, and vision expenses the applicant incurred.18

While this addition to the contract demonstrates positive efforts by the agency to encourage Electronic Data Systems to make correct eligibility determinations, the inherent pressures within the company to make a profit may render the provision much less effective than the state might have hoped and indeed could exacerbate the problem that the board apparently was trying to address.19

Under the terms of the provision, Electronic Data Systems faces financial exposure for incurred medical expenses when the company’s mistakes come to the attention of the board; this would happen most frequently through the appeals process. On the positive side, the new contract language should encourage Electronic Data Systems to evaluate cases more carefully and maybe even err slightly on the side of granting eligibility more often at the initial application stage. It might also motivate the company to make first-level appeal decisions more quickly, so that it can correct any of its mistakes before the applicant has had an opportunity to incur much in the way of medical expenses that Electronic Data Systems might have to pay.

On the other hand, the provision might create an even greater incentive for Electronic Data Systems to minimize the number of appeals that are taken from any of its decisions. The fewer people who appeal to the board, the lower will be Electronic Data Systems’ potential financial exposure for incorrect decisions. While this equation could lead the company to avoid appeals to the board by issuing a greater number of favorable first-level appeal decisions, it might just as easily induce the company to discourage applicants from appealing at all, or at least from appealing to the board.

The above possibilities demonstrate some of the difficulties inherent in having a for-profit entity administer a government benefit program. The Managed Risk Medical Insurance Board certainly inserted the new contract provision to encourage more accurate decision making on the part of its contractor. Electronic Data Systems, as a for-profit company, just as certainly wishes to avoid as much financial exposure as possible. From its perspective, an appeal of one of its eligibility decisions, at least past the first level in-house review, can never help its bottom line and could well harm it. Given advocates’ reports that Electronic Data Systems often encouraged clients to reapply rather than appeal even before it faced

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17 If the error is detected in the appeals process, Electronic Data Systems or the Managed Risk Medical Insurance Board may have to pay the medical expenses. We discuss this possibility further below.
18 Agreement No. 97MHF043 between Managed Risk Medical Insurance Board and Electronic Data Systems Corporation, amend. 6 at 31–32 (June 15, 2001) (on file with Manjusha P. Kulkarni).
19 Electronic Data Systems’ total financial exposure from all eligibility errors is limited to $50,000 per fiscal year. Id.
financial liability for incorrect decisions, the new contract provision may further impede implementation of a meaningful appeals process.

The addition of such a provision demonstrates how difficult it is to devise a fair appeals process that a for-profit entity administers. The Managed Risk Medical Insurance Board drafted the new provision in order to use Electronic Data Systems’ profit motive to ensure more accurate and fair application and appeals processes. The provision, with its added layers of incentives, made the appeals process more complex. Had the board simply delegated responsibility for the application and appeals processes to a state agency rather than a private company, the unnecessary complexity could have been avoided. Ultimately attempts such as this one to ensure fairness through financial penalties in the profit-making arrangement only complicate the process and do very little to further individuals’ due process rights.

The current system poses significant barriers to applicants and enrollees. The system is more opaque to clients and their advocates than is the state-run Medicaid program. Electronic Data Systems’ failure to identify individual decision makers insulates them from accountability and prevents clients and their advocates from serving as an external source of quality control information. The total absence of any administrative appeals in the face of over 100,000 terminations from Healthy Families demonstrates that something is clearly amiss with the appeals process. The state’s recent actions to address these issues are just as likely to exacerbate the problem and demonstrate the unnecessary complexity of designing a fair system when a private company is asked to serve both the needs of a target population and its own profit imperative.

II. The Privatization of Medicaid Mental Health Services in Massachusetts

Massachusetts is often touted as an example of the benefits of privatizing management of Medicaid health care services. Privatization proponents point to innovative services, the lack of appeals, and performance standards as proof that the system works. However, data analysis and appraisal of contractual provisions suggest a different story. For example, the private Medicaid managed care organiza-
tion in Massachusetts initiated community support services, a flexible form of care that recipients and clinicians lauded, for persons who have serious mental illness and need assistance addressing basic needs (such as food, housing, and medical care), resolving crises, and linking with community resources. However, very few people have been able to access this community support program. Claims data show that in September 1995 only 19 of 373,000 Medicaid recipients covered by the behavioral health “carveout” used community support services. In September 1998 only 109 of 488,000 covered recipients were able to do so.

A. Brief History

In 1992 Massachusetts implemented mental health managed care for Medicaid recipients. The program was based on capitation: the commonwealth would pay the managed care organization a flat rate per month for each eligible recipient. This is in contrast to fee-for-service arrangements, in which the provision of a service triggers payment. Capitation creates direct financial pressures on a for-profit managed care organization. The company seeks to limit or reduce costs because payment is preset and does not vary with the extent to which an individual uses its services.

Mental Health Management of America, a Tennessee-based company, managed the mental health care of most welfare and Supplemental Security Income recipients from July 1992 through June 1996. In July 1996 the Massachusetts Behavioral Health Partnership began managing the same population and soon thereafter began handling the acute care services for the Massachusetts Department of Mental Health. Massachusetts Behavioral Health Partnership underbid its

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20 Behavioral health services may be managed in two ways: they may be managed in conjunction with physical health services, as most health maintenance organizations did in the past, or they may be “carved out” and managed by a company that exclusively manages behavioral health services. Behavioral health care of most Medicaid recipients in Massachusetts is managed by a “carveout”; a much smaller number of recipients are enrolled in health maintenance organizations. Information in this section concerning claims data comes from expenditure and utilization reports of the relevant managed care organizations contracting with the Division of Medical Assistance and from division enrollment reports. The Division of Medical Assistance supplied the reports to Susan Fendell pursuant to formal and informal requests. Unless otherwise noted, statistics refer to the period from July 1997 through February 2001. Mental Health Mgmt. of Am., Mental Health/Substance Abuse Program Enrollment July 1992 to December 1993 (undated) (internal data); id., Mental Health/Substance Abuse Program 1994 (Dec. 14, 1994) (unpublished report); id., Expenditure Report Based on Date of Service (Dec. 31, 1996) (internal data); id., Expenditure Reports (undated) (internal data); Mass. Behavioral Health P’ship, Monthly Utilization Cost Report (undated) (internal data); id., Enrollment Days per Reconciliation Reports (Jan. 3, 2000); Div. of Med. Assistance, Managed Care Reimbursement Unit, Managed-Care Eligibles by Rating Category for Massachusetts Behavioral Health Partnership (undated) (supplied to Susan Fendell Oct. 1, 2001). All reports are on file with Susan Fendell.

21 During fiscal year 1999, approximately 7,300 persons were hospitalized and another 3,500 admitted to 24-hour care for mental illness. Just 705 persons—about 6 percent of persons experiencing acute episodes of serious illness and less than 1 percent of all persons utilizing behavioral health services—received community support services during that same period.

22 The U.S. General Accounting Office noted that capitation created the risk that the managed care organization might inadequately address the health problems of Medicaid beneficiaries in order to contain costs or increase profits and that this result was particularly problematic for those persons needing mental health services. U.S. GEN. ACCOUNTING OFFICE, MEDICAID MANAGED CARE: FOUR STATES’ EXPERIENCES WITH MENTAL HEALTH CARVEOUT PROGRAMS 2 (1999)

23 Most managed care organizations that bid for Medicaid contracts are private corporations with a national base. E.g., Massachusetts Behavioral Health Partnership was originally a joint venture of FHC Options and Value Behavioral Health, which covered more than 28 million persons. Value, which managed the mental health coverage of such giants as General Motors and Sears, was purchased first by Columbia/HCA and later sold to FHC Options. Partnership No More, ADVISOR, Fall-Winter 1997, at 21.
competition with respect to proposed expenditures for Medicaid services even though it had higher administrative costs than other bidders.24

The Massachusetts Division of Medical Assistance for its part sought to expand the use of health maintenance organizations that integrate physical and mental health care. It recently contracted with six private health plans for such services.

B. The Effect on Claims

Since the beginning of the managed care program in July 1992, total expenditures for services have kept largely in lockstep with total enrollment.25 Disabled persons’ access to expensive inpatient service has decreased by over 30 percent under Massachusetts Behavioral Health Partnership, and all adults’ access to inpatient hospitalization has decreased by over 10 percent.26 Access as measured by the percentage of recipients using family counseling, partial hospitalization, acute residential treatment, and holding-bed services has also decreased.27 Use of psychological testing has dramatically decreased: access to psychological testing has dropped more than 40 percent since Massachusetts Behavioral Health Partnership began managing the program, and the amount of testing the partnership authorized also dropped significantly.28

C. The Effect on Counseling

One of the initial promises of privatization was that savings in inpatient expenditures would be used to bolster outpatient services, thereby allowing more recipients to stay in the community. But expenditures on outpatient services did not increase if one controlled for the dramatic increase in the use of medication.29 Instead of an increase in outpatient services to compensate for the decrease in inpatient care, between July 1992 and June 1996 expenditures per recipient for outpatient therapy decreased 27 percent.30 The percentage of recipients who received outpatient therapy remained relatively steady.

D. The Effect on Medication

Statistics suggest that the Massachusetts mental health managed care system relies heavily on medication as treatment for mental illness, despite the recognized need for caution in this area.31

24 The bid evaluation process was effectively closed to the public. The advisory committee for the Division of Medical Assistance and Department of Mental Health included no consumers and only one consumer family member, who was not then involved with any of the family groups active on mental health issues. The division released portions of the bid responses to one consumer group, but neither that group nor the official advisory committee was permitted to see the financial heart of the responses: the proposed capitation rates.

25 Following a series of provider rate increases that began in February 2000, the ratio of expenses to enrollees increased slightly. Enrollment of high-cost populations—disabled and basic (formerly emergency assistance) enrollees—has increased at a more rapid pace than enrollment of recipients of aid for nondisabled families, thereby increasing overall expenses in relation to overall enrollment. The percentage of basic enrollees using services is about twice that of nondisabled families, and the average monthly expenditure per basic user as of February 2001 was over $500 as compared to approximately $300 for a nondisabled family user. Mass. Behavioral Health P’ship, Monthly Utilization Cost Report, supra note 20.

26 Id.; Div. of Med. Assistance, supra note 20.

27 See supra note 26.

28 Id. Access is a measure of the percentage of enrollees using the service.


31 See Peter Breggin, TOXIC PSYCHIATRY (1991) (describing the negative and sometimes irreversible side effects associated with drugs used to treat the symptoms of mental illness).
In the first two years of privatized managed care under Mental Health Management of America, the number of recipients using mental health clinic medication increased by 38 percent, and total medication expenditures by 81 percent. Yet the number of recipients enrolled in the program increased by only 5 percent during this same period.32 The number of recipients using medication and the expenditures for medication services have continued to rise. During Massachusetts Behavioral Health Partnership management, the number of enrollees using medication services increased 30 percent.33

E. The Effect on Rates and Protocols

Changes in treatment protocols and the rates paid to providers are two subtle devices managed care organizations often use to alter treatment patterns.34 From the managed care organization’s perspective, they are preferable to the crude tool of utilization review, which may be subject to appeal procedures.35 In April 1995 Mental Health Management of America signaled its preference for medication, and aversion to therapy, by increasing the rate it paid clinics for medication services from $24.27 to $37.50 for each fifteen-minute unit.36 Moreover, Mental Health Management increased the outpatient protocol for medication by six hours. In contrast, it limited the protocol for outpatient maintenance services for all diagnoses, to twenty-six hours in fifty-two weeks.37 Outpatient maintenance had been permitted on an indefinite basis.

Managed care organizations use reimbursement rates to encourage clinics to recommend group rather than individual counseling. Massachusetts Behavioral Health Partnership currently reimburses individual therapy at $66 per hour. It reimburses group therapy at $23 per recipient per sixty to ninety minutes. Thus an eight-person group session can gain the clinic $184 per hour, almost three times the amount of an individual session.

32 Mental Health Mgmt. of Am., Expenditure Reports, supra note 20.
33 Mass. Behavioral Health P’ship, Monthly Utilization Cost Report, supra note 20; Div. of Med. Assistance, supra note 20. Expenditures per user of services increased by only 1 percent. Id.
34 Treatment protocols may designate the frequency or length of treatment recommended for particular diagnoses. E.g., Mental Health Management of America initially set a guideline of twelve therapy sessions in a four-week period for a person in the acute stage of anxiety disorder, twenty-six sessions in a twenty-six-week period for a person in the active stage, and once a month thereafter. Mental Health Mgmt. of Am., Letter to Outpatient Providers, app. B (June 24, 1993) (on file with Susan Fendell). Massachusetts Behavioral Health Partnership’s protocols did not designate stages of the disorder but set a range of twelve to twenty-nine therapy sessions over a period of six months for an adult experiencing anxiety disorder, overall a lower amount than the prior Medicaid contractor. Mass. Behavioral Health P’ship, Outpatient Treatment Authorization Parameters (May 20, 1997) (on file with Susan Fendell).
35 Utilization review is a process by which the managed care company exerts direct control on its expenditures. The company scrutinizes services—either prospectively or retroactively—and decides whether to authorize or pay for the services requested. A denial of care usually is subject to internal appeal procedures and sometimes, as in the case of Medicaid managed care, external appeal options.
36 The managed care organization was financially responsible for medication monitoring and prescribing, not the medications themselves. Thus the units used to measure medication services reflect the time spent with enrollees. Memorandum from Mental Health Management of America to Mental Health Corporation of Massachusetts Members (Nov. 15, 1994) (on file with Susan Fendell); Memorandum from Mental Health Management of America to Susan Fendell, Mental Health Legal Advisors Committee (Mar. 23, 1995) (on file with Fendell).
The use of protocols to determine appropriate outpatient care is a concern to some mental health professionals. Providers sometimes strictly apply these protocols in determining the treatment plans for which they request prior authorization. This is particularly true if the managed care organization has warned providers, as has happened in Massachusetts, that it will subject to close scrutiny cases that do not follow the protocols and terminate outpatient-service providers from the network if they resist requests to bring their patterns of care within acceptable limits.

F. Interactive Voice Response System

In April 1997 Massachusetts Behavioral Health Partnership implemented an automated system for prior authorization of outpatient services. The system was appealing to many providers—dialing into a computer and entering the recipient’s identification number, effective date of service, number of sessions requested, and diagnostic code—rather than filling out paperwork or attempting to access a utilization reviewer and explain a patient’s care.

When Massachusetts Behavioral Health Partnership began its automated pilot, however, the main response of providers was concern about how the data from this computerized system would be used. Providers were concerned that decisions regarding their inclusion in the provider network would be based on meeting the guidelines, and indeed reviews are performed on cases seeking authorization for treatments outside the protocols. The partnership has made clear that falling within their treatment norms “indicates provider readiness for self-management” that will result in “less concentrated network management intervention” (i.e., case reviews) for the provider. Thus, regardless of a client’s individual needs, providers are encouraged to register or seek authorization for the treatment norm as the managed care organization defines it.

The automated system of prior authorization of outpatient services, an otherwise useful tool to eliminate burdensome paperwork for providers, has been manipulated to encourage providers to seek lower levels of care for their enrollees than they might otherwise deem appropriate. The automation allows the managed care organization to monitor a standard and usual amount of treatment for each diagnosis, which itself may be an average of that requested via the system. The managed care company then warns providers that if the care they request does not fall within this standard, they will be subject to time-consuming telephone reviews or paperwork and may even suffer exclusion from the provider network.

G. Appeals and the Fair Hearing Process

When a federally qualified health maintenance organization provides managed care, federal law requires the organization to provide “meaningful procedures for hearing and resolving grievances.” Further, federal law requires all health maintenance organizations participating in Medicaid to have internal grievance procedures to appeal referral denials. State law and regulations may also require the organizations to develop grievance proce-

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38 Mental Health Management of America outlined protocols based on groupings of diagnoses in its October 1992 plan for procurement of outpatient services. These protocols specified the expected length and “intensity” of service during active treatment, rehabilitation, and maintenance, if any. Mental Health Mgmt. of Am., A Plan for the Procurement of Outpatient Services for the Medicaid Mental Health and Substance Abuse Managed Care Program, app. A (Oct. 1, 1992) (on file with Susan Fendell).

39 See, e.g., Letter from Massachusetts Behavioral Health Partnership to William Taylor, chief executive officer of advocates (July 9, 1999) (describing fiscal year 2000 Utilization Management Initiative based on reviewing cases outside the protocols).

40 Id.

41 42 U.S.C. § 300e(c)(5) (1999); see also 42 C.F.R. § 417.124(g) (1999).

dures. Massachusetts requires that each insured household receive “a description of
the carrier’s method for resolving insured complaints, including a description of the
formal internal grievance process.” While organization policies differ to some extent,
most have a two- or three-step process: a complaint to member services, a paper
review, and an opportunity to present the case to an appeals committee. Complain-
ants who are not satisfied with the internal appeal determination may appeal
to the Division of Medical Assistance. Some providers require that complainants par-
ticipate in binding arbitration (precluding litigation) if they cannot resolve their dis-
putes through internal processes.

Recipients enrolled in a MassHealth managed care plan are entitled to a fair
hearing before the division’s board of hearings to appeal (1) the requirement to enroll
in a managed care plan; (2) the denial of a prior authorization; (3) the denial of ser-
vices from an out-of-area managed care provider; and (4) the disenrollment or
denial of transfer from a MassHealth managed care provider. However, the divi-
sion’s hearing regulations define an “appealable action” as “an action by the
Division to deny, reduce, suspend, terminate, or restrict assistance to an individu-
al receiving or seeking such assistance. No action by a provider shall constitute an
appealable action, except as otherwise pro-
vided herein with regard to a transfer or discharge by a nursing facility.”

Consider the following scenario: A doctor calls the managed care organiza-
tion requesting prior authorization for admission of a patient to a day treatment
program. The managed care organization refuses authorization for the day program,
but agrees to authorize six hours of out-
patient treatment. The doctor accedes to
the company’s position. Does the patient
get notice of this denial of her doctor’s
original request?

The answer is no. The Division of
Medical Assistance considers the action of the managed care organization to be an
action of the provider, rather than an
action of the division that would trigger
notice. This policy is at best troubling,
given the financial interest of the mental
health practitioner in pleasing the man-
aged care company in order to remain in
its provider network (and to reduce un-
paid paperwork). Since a managed care
organization can exclude any particular
provider from its network, and limit refer-
als to an included provider, providers
not surprisingly express concern over
appealing managed care organization
decisions.

Besides the threat of exclusion from
the network, providers face the increasing
use of so-called subcapitation, wherein
insurers attempt to control costs and share

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43 See, e.g., MASS. GEN. LAWS ch. 1760, § 13 (2001); MASS. REGS. CODE tit. 211, §§ 45.04(1)(e)(6),
.07(4) (1999).
44 MASS. GEN. LAWS ch. 1760, § 6 (2001).
45 See id. at 54; see also Toney v. U.S. Healthcare Inc., 37 F.3d 1489 (3d Cir. 1994).
47 Id. § 610.004 (emphasis added); see also 42 U.S.C. § 1396(a)(3) (1999); 42 C.F.R.
§ 431.201 (1999). A recipient who loses before the Board of Hearings may seek rehear-
ing or judicial review.
48 Telephone Interview with Richard Sherman, director of public policy, Massachusetts
Chapter of the National Association of Social Workers (Nov. 26, 2001); see also Richard
H. Beinecke & Sylvia B. Perlman, The Impact of the Massachusetts Managed Mental
Health/Substance Abuse Program on Outpatient Mental Health Clinics 8 (1995) (on file
with Susan Fendell) (“Since the [managed care organization] has both the privilege and
the obligation of maintaining its own network, each provider always feels at risk of
being excluded from that network.”) Indeed, one managed care company executive
counseled providers: “[S]top thinking of yourself as a provider, as an agency.
[Community Mental Health Centers] and providers have to start thinking of themselves
as companies.” One can only imagine the more stringent limits on care under a subcapi-
tated system (see discussion infra) if advice like this is given without subcapitation.
financial risk with providers by paying providers a set fee for each insured regardless of the amount of services the clinician provides to that individual.\textsuperscript{50} Although subcapitation may prove cost-effective by putting the provider in the role of gatekeeper, it further strains the traditional patient-doctor relationship. Providers are pressed to offer low rates to please insurers and managed care organizations and to squeeze care even further to meet their own bottom lines.

Consequently the consumer, who is the only one in the system committed solely to the consumer’s own best interests, receives no notice of the process or of the consumer’s right to appeal the ultimate decision. Even if the consumer did have notice, the consumer likely would be hard-pressed to find a provider to support the appeal.

In fact, there has been a paucity of appeals to date. Since the inception of the mental health managed care program in April 1992, only one Medicaid recipient had requested a fair hearing before the Division of Medical Assistance as of July 2001. Rather, what little review exists consists of doctor-to-doctor reviews—what the division and the managed care organizations call reconsiderations. In the fourth quarter of fiscal year 2001, there were 318 doctor-to-doctor reviews. Of those, over 55 percent resulted in a denial or modification of the provider’s request for services. Yet those decisions resulted in only 24 appeals that trigger notice to recipients.

There are many possible explanations for these numbers, some more plausible than others. As noted above, the appeals process never begins if the clinician does not stick to her guns. Recipients requesting mental health services may not have the emotional wherewithal to fight a faceless corporation or a government agency. Recipients—aware that persons with mental illnesses often are stigmatized—may be loath to expose their need for mental health services.\textsuperscript{51}

H. Administrative Costs and Profits

Allocation of risk, administrative payments, and permissible earnings are all important items that transfer public monies to private coffers, lessening the amounts available for public services. While a state will often negotiate detailed contracts covering these issues when privatizing a service, contract terms often go unobserved.

In Massachusetts the managed care organization originally stood to profit or lose money primarily based on whether it over- or underspent the capitation payments for covered services. However, this equation has since been altered in ways that increasingly diminish the financial risk to the Massachusetts Behavioral Health Partnership and the potential savings to the state. Between fiscal years 1997 and 2002, the risk to the partnership from overspending the capitation rate has decreased, thus undercutting the primary cost-containment argument supporting managed care. During the same period Massachusetts increased the amount of money that the partnership could earn from underspending the capitated rate, thereby putting additional pressure to eliminate or limit the provision of services in general and expensive services in particular.

Massachusetts Behavioral Health Partnership and the state seem to have concluded that further profit from under-spending could not be achieved without cutting services to the bone. Consequently, in the past several years, the partnership has been able to earn significantly more money from meeting certain “performance standards” built into the contract than from underspending the amounts received from the state for mental health services. The Division of

\textsuperscript{50} See Charles Stein, \textit{And the Last Shall Be First}, BOSTON GLOBE, Feb. 20, 1994, at A1, A3.

\textsuperscript{51} “Because of depression, anxiety, humiliation and the stigma of being in mental health treatment, most patients will not be their own advocates on this subject publicly or privately.” Joyce Edward & Karen Shore, \textit{The Trauma of Managed Mental Health Care}, N.Y. TIMES, Feb. 15, 1993, at A14.
Medical Assistance has acknowledged that these performance bonuses are intended to compensate for the loss of potential earnings from underspending following the year-one contract. The state paid almost $11.7 million to Mental Health Management of America for administrative expenses for fiscal year 1993 and almost $2 million to another company to process Medicaid payments to Mental Health Management and providers. Massachusetts Behavioral Health Partnership’s administrative budget increased from $15.4 million in year one to slightly over $19.5 million in year five. The reported jump in administrative earnings, from 12 to 18 percent of the total earnings, does not include the potential administrative subsidies (totaling almost $1 million in fiscal year 2001) that were part of the performance standards. Nor does it include slightly over $1 million for managing the acute care of Department of Mental Health clients. And none of these amounts takes into account the substantial administrative costs the Division of Medical Assistance still incurs directly.

I. Performance Standards

The performance standards and other sanctions or bonuses included in the contract for the benefit of the managed care organization are poor cousins called on to control the inherent economic imperative of their more powerful relations, the basic financial incentives underlying capitation and for-profit management of services.

The Massachusetts Behavioral Health Partnership’s performance standards in fiscal year 1997, its first year, mostly dealt with provider relations (prior approval decisions and claims processing), a sore subject for the previous contractor, Mental Health Management. By contrast, the performance standards in the partnership’s fiscal year 2000 contract—for which the partnership could potentially be paid several million dollars—generally consisted of specific small-scale work products. These included thirty consumer satisfaction reports, two statewide conferences, one training video, three provider training courses, development of two protocols, identification of resources, seventy-five treatment plans (on behalf of over 400,000 enrollees that the partnership covered), and one Web site. The two standards that actually required a quantitative improvement over the prior year’s performance—medication monitoring and seven-day aftercare—reflected the fact that the partnership failed to meet them in fiscal year 1999, although even here the requirements were ratcheted down from

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52 See Susan Fendell, Fiscal Year 99 Performance Standards: DMA Fails Contract Negotiating 101, ADVISOR, Spring–Winter 1999, at 6. The increase in amounts that Massachusetts Behavioral Health Partnership could earn from performance standards was far greater than the decrease in earning potential from underspending capitation payments. See, e.g., Standard Contract Between the Commonwealth of Massachusetts Executive Office of Health and Human Services DMA and the Massachusetts Behavioral Health Partnership, amend. 4 at 12 (June 28, 1999) (on file with Susan Fendell).

53 Some of the money earmarked for administration goes to profit. According to Mental Health Management’s bid, 15 percent of its administrative budget was for profit and another 26 percent was to go to its parent company. First Mental Health Inc. d.b.a. Mental Health Mgmt. of Am., Proposal to Provide Services for the Mental Health/Substance Abuse Program: Reimbursement Proposal (Nov. 14, 1995) (on file with Susan Fendell).

54 In fiscal year 2000 the maximum potential administrative subsidies associated with performance standards totaled $700,000. Richard Sheola, Memorandum to Behavioral Health Advisory Committee Members (Nov. 11, 1999) (on file with Susan Fendell). The author uses the term “subsidies” because, in its bid for the contract, Massachusetts Behavioral Health Partnership promised to incorporate many of the same types of activities into its management of services at no additional cost.

55 The fiscal year 2002 contract provides for $18.5 million for administration and $400,000 for managing Department of Mental Health acute care services. However, the performance standards are primarily for training and surveys, which involve mostly administrative costs. Massachusetts Behavioral Health Partnership can earn $3.75 million for completing these tasks.
the earlier standards. The parties deleted performance standards measured by quantitative improvements from the fiscal year 2001 contract, and by fiscal year 2002 all penalties for failure to meet performance standards were removed.

The dubious value of these performance standards is magnified if one compares the items for which Massachusetts Behavioral Health Partnership could receive bonuses with the promises the partnership made in its original bid for the commonwealth contract:

1. [The partnership] will solicit consumer feedback through satisfaction surveys to assure that the [behavioral health program] is meeting the needs of the members. Peer/ Family Counselors will administer the surveys directly to members who have accessed services.

2. Over the course of the contract period, [the partnership] will provide technical assistance to those providers to empower them to develop the appropriate services.

3. [W]e will develop programs aimed at strengthening the family unity.

Massachusetts Behavioral Health Partnership received a bonus for accomplishing each of the above items. When a bid is awarded on the basis of a bidder’s representations of services to be rendered, those services should be incorporated in the contract without additional compensation. If not, one may conclude that the bidding process lacks credibility, that bidders frequently make bloated representations to obtain contracts, or that Division of Medical Assistance staff, consciously or through inattention, negotiated contractual terms that compensate the partnership for services already promised as an inherent part of its management.

Even as Massachusetts expands the population that its experiment in privately managed care covers, it does not know the impact of such privatization on the mental health care available to its low-income citizens. Data across contractors are not comparable, and the amount of information available from the current managed care company, and from the Division of Medical Assistance, is far too limited to allow healthy public debate about the wisdom of the program.56

Specific changes in expenditures for mental health care may be beneficial or disastrous for Medicaid recipients and Department of Mental Health clients, but, without ample information on all expenditures, we have no way to analyze how the mental health care system is being managed.

Massachusetts’ inability to monitor a massive program in which a private entity controls the data necessary for meaningful oversight leads to the conclusion that management of mental health care should be the work of a publicly accountable agency.

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56 Massachusetts Behavioral Health Partnership breaks down its expenditures into categories different from those used by Mental Health Management of America. Regardless of the validity of the new presentation of data, the lack of consistent categories impairs the ability of the commonwealth and other reviewers to monitor the changes that the new managed care organization wrought. This is another reason that control over information systems—and indeed the management of services—should rest with the commonwealth. Control of the raw data allows the data to be recombined, broken down, and presented in whatever fashion is appropriate for monitoring patterns of care. When a private company is involved, the commonwealth must negotiate for information and for each slightly different iteration of the data. Failure to supply information to the public was at one point so flagrant that the state legislature has required the Division of Medical Assistance and the Department of Mental Health to submit quarterly reports to the ways and means committee on Massachusetts Behavioral Health Partnership’s performance, including utilization trends, quality of care, and type of care purchased. Unfortunately those reports are merely copies of the unrevealing reports the managed care organization furnished, and do not include any governmental analysis of the information.
reorganized. For example, decreased hospitalization, a goal sought by many consumers, is beneficial only if alternatives such as crisis stabilization beds and outpatient therapy are sufficiently funded and accessible. Furthermore, whether the alleged savings from privately managed care are being funneled back into scarce community resources (e.g., supported housing) is not clear. 57

In reviewing the Massachusetts experience with two managed care providers, one must question the wisdom and the conceptual underpinnings of privatizing the management of mental health care. One of the main reasons for concern about the private management of health care systems is the inherent incentive to distort care decisions to meet bottom-line goals. 58 Promised program savings that never materialize or are short-lived, increased expenditures for administration, and cuts in services all caution against the private management of care as a panacea for Medicaid’s fiscal woes. Massachusetts’ inability to monitor a massive program in which a private entity controls the data necessary for meaningful oversight leads to the conclusion that management of mental health care should be the work of a publicly accountable agency. 59

If the goal is to provide quality mental health care to indigent citizens, then we should almost certainly abandon the road of private management of that system. The Division of Medical Assistance can manage a quality mental health system if given the same resources currently afforded the private corporation Massachusetts has hired.

III. Privatization and Public Hospitals

As health care costs continue to rise and the number of uninsured Americans remains largely unchanged, public hospitals struggle to provide quality health care services to indigent populations. 60 This struggle has led some public hospitals either to close completely or to convert to private ownership in order to gain possible strategic, managerial, and financial advantages not commonly available to public hospitals. Although there may be some potential gains from the privatization of public hospitals, the conversion may diminish the availability and quality of traditional hospital services for low-income patients.

57 One notable source of savings has little to do with managed care but instead with a change in the method by which hospitals are reimbursed. Mental Health Management of America reversed the 1991 Medicaid decision to reimburse hospitals on a per-discharge basis rather than a per diem rate. According to the Brandeis report, supra note 29, changes in the method of reimbursement accounted for 24 percent of the savings in expenditures for twenty-four-hour care. However, Mental Health Management was able to negotiate lower contract rates with hospitals than the Division of Medical Assistance could because the process was more insulated from politics than previously.

58 See, e.g., the allegations of the plaintiffs in a suit against eight private insurers. Milt Freudenheim, 3 State Groups Join Doctors In Insurer Suit, N.Y. TIMES, Mar. 27, 2001, at C1.

59 As noted earlier, data from Mental Health Management of America and Massachusetts Behavioral Health Partnership are not directly comparable. Furthermore, the Division of Medical Assistance has failed to produce, or request the managed care organizations to produce, trended data on service utilization. Thus, while the Division of Medical Assistance is given raw claims data, it has not analyzed this information in a manner that shows the impact of privately managed care on the utilization of individual services and client populations. We speculate that this failure reflects both a lack of interest on the part of administrations supportive of the perceived cost-cutting potential of privatization and the related lack of adequate division staff to perform such an evaluation.

60 See Robert J. Mills, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS: HEALTH INSURANCE COVERAGE: 2000 (2001). The Henry J. Kaiser Family Foundation defines public hospitals to include hospitals that a city, county, or state owns; district hospitals that a state taxing district owns and operates; and public-sector academic medical centers, defined as teaching hospitals, that public universities operate. See Mark Legnini et al., Econ. & Soc. Research Inst., Privatization of Public Hospitals (1999). See also Phyllis E. Bernard, Privatization of Rural Public Hospitals: Implications for Access and Indigent Care, 47 Mercer L. Rev. 991 (1996) (stating that public hospitals are typically created for the purpose of providing medical care to community residents regardless of the ability to pay).
Public hospitals traditionally are key providers in a community’s health care safety net. They are the providers of last resort for the poor and uninsured. Often public hospitals are a crucial link in a health care delivery system that includes both public health department clinics and community health centers. These safety-net providers ensure that people without health insurance have access to at least basic health care services, including hospitalization. Public hospitals often provide—in addition to general hospital services—emergency services, urgent care, and ancillary services such as translators and even primary care through outpatient clinics.61

However, as the Medicaid program continues to shift to a managed care delivery system, which often sends Medicaid patients to other facilities, public hospitals face a bleak future. Public hospitals find themselves competing with private hospitals for Medicaid clients because managed care plans have drastically reduced hospital admissions for their privately insured enrollees, thereby attracting private hospitals to Medicaid clients and their federal funding. Each of these circumstances, along with the high cost associated with caring for uninsured patients with poor health, has hurt public hospitals financially and caused local governments to look for solutions to their economic struggles.

Since 1979, the number of public hospitals and public beds has declined tremendously. In 1979 there were 211 public hospitals. That number dropped to 139 hospitals in 1998.62 More than one-third of all public hospital beds have been lost over the same period.63 The Henry J. Kaiser Family Foundation summarized this trend as follows: for every 100 public hospitals, 1 closes and 2 convert to private ownership or management annually.64

A public hospital can convert to private status by several means. The term “conversion” or “privatization” encompasses several different restructuring activities, including but not limited to leases, asset sales, mergers, closures, and affiliations.65 The final entity can be “private, such as a nonprofit or for-profit corporation; quasi-public, such as a hospital authority, public benefit corporation, or hospital taxing district; or a public-private partnership, which can result from affiliations and joint-ventures.”66

One of the key concerns that arise upon the conversion of a public hospital to nonpublic status is the hospital’s continued commitment to serve medically needy populations. However, health law advocates and legal services attorneys must closely examine other issues that may directly affect legal services clients. Let us look at two particular issues that health advocates may encounter and how to address them. The first is the possible threat to women’s reproductive health services. The second is access to hospital records and documents.

A. The Threat to Women’s Reproductive Health Services

As mentioned earlier, a public hospital may be converted to a private entity through an affiliation or merger with a nonpublic entity. If the nonpublic entity is a religious health care provider, such

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61 Randall Bovbjerg et al., Health Care for the Poor and Uninsured after a Public Hospital’s Closure or Conversion, in ASSESSING THE NEW FEDERALISM (Urban Inst., Occasional Paper No. 36, Sept. 2000).
62 Id. These declines reflect both closures and shifts from public to private status.
63 Id.
64 LEGNINI ET AL., supra note 60.
65 Id. For a detailed description of these conversion types, see id. See also Bernard, supra note 60; Eleanor Hamburger et al., The Pot of Gold: Monitoring Health Care Conversions Can Yield Billions of Dollars for Health Care, 29 CLEARINGHOUSE REV. 473 (Aug.–Sept. 1995).
66 LEGNINI ET AL., supra note 60, at 8.
as a Catholic hospital, the religious institution may impose its religious restrictions on its new partner (the public hospital). Such restrictions can strongly inhibit access to reproductive health care services for low-income women.67

As noted in a National Women’s Law Center report, many secular hospitals, including public hospitals, have charitable missions.68 They may prescribe that the facility deliver a certain level of indigent or uncompensated care to individuals within the facility’s community. Similarly many religious institutions have charitable missions, for which they receive special tax benefits, but their missions may be quite different from those of a public hospital. Consequently an affiliation between a public hospital and a religious institution can sometimes limit the public hospital’s mission by imposing an overlay of a particular religion’s beliefs on the only care available to certain segments of the community.69

B. Access to Records and Documents

Another issue facing health care advocates once a public hospital converts to private status is the availability of hospital records and documents. Most of the records that a public hospital as a public entity maintains are subject to state public disclosure or public record statutes. Whether these records are available for public viewing once the public hospital converts to private status is not clear. Therefore, if one were trying to determine the amount of charitable care a hospital delivered in a specified time period, one may have more difficulty obtaining this information from a converted hospital if the state legislature or courts determine that the hospital’s private status exempts it from public disclosure laws.

All fifty states and the District of Columbia have some form of public disclosure statute, but these statutes do not take into account the current trend in government to privatize traditional government services, such as health care delivery. Interpreting statutory provisions and developing standards that lend themselves to fairness and justice amid bureaucratic change has been the responsibility of state courts. In thirty-four states courts have addressed the issue of access to “public records” when a governmental entity privatizes some type of public service.70 These decisions determine whether the private entity is a “public agency” or whether certain of the entity’s records are “agency records.” The courts have considered several factors, and their interpretations of the right to access have ranged from flexible to restrictive.71

67 ELENA COHEN & JILL MORRISON, NAT’L WOMEN’S LAW CTR., HOSPITAL MERGERS AND THE THREAT TO WOMEN’S REPRODUCTIVE HEALTH SERVICES: USING CHARITABLE ASSETS LAWS TO FIGHT BACK (2001); see also Susan Berke Fogel & Lourdes Rivera, Merger Mania: Religious Mergers and Access to Reproductive Health Services, 33 CLEARINGHOUSE REV. 30 (May–June 1999).

68 COHEN & MORRISON, supra note 67.

69 The transfer of a public hospital’s duties to a sectarian, private entity is not always problematic. In one case the court found that the lease executed between a public hospital and a private, nonprofit corporation, the Sisters of St. Joseph of Newark, was valid because the lease “adequately recognize[d] and protec[t] the public interest.” See Bernard, supra note 60, at 1012 (quoting O.M. Lien v. City of Ketchikan, 383 P.2d 721 (Alaska 1963)). In City of Ketchikan the court determined that the lease was valid because no evidence showed the Sisters to have operated the hospital in a way that promoted their religious beliefs. The nonprofit corporation “had met all the needs which one reasonably could impose upon a private entity now serving a public role.”


Some of the factors considered are the funding sources and the level of public funding, the function of the private entity, and the beneficiaries of the private entity’s actions. The “totality of factors” test weighs these and other factors together. Ten state courts use the “public function” approach. This approach “focuses less on a factorial test and more on whether an entity is performing a public function.” These courts do not concern themselves with the level of funding or the type of control a public entity exerts over the private entity. Courts in six states use the “nature of records” approach. This approach examines the characteristics of the records or documents in question and does not concern itself with the attributes of the private entity. These three approaches allow a fair degree of flexibility in the level of access to “public records.”

Some courts have taken a more restrictive approach and allow access only to certain documents if specific criteria or standards are met. These restrictive approaches include the “public funds” approach (Arkansas, Indiana, Michigan, North Dakota, South Carolina, and Texas), the “prior legal determination” approach (New Jersey, Pennsylvania, Tennessee, and West Virginia), the “possession” approach (Iowa), and the “public control” approach (Illinois). Each of these approaches makes it very difficult for a hospital patient or the patient’s attorney to obtain certain hospital records because generally the courts in those states look at only one factor to determine whether a private entity should be subject to public scrutiny.

An affiliation between a public hospital and a religious institution can sometimes limit the public hospital’s mission by imposing an overlay of a particular religion’s beliefs on the only care available to certain segments of the community.

C. Ways to Protect the Interests of the Low-Income Community

If one becomes aware that a public hospital in the community is converting to private status, one may take some precautionary measures to help ensure that services are still delivered to the uninsured and underinsured. First, health advocates (or client groups in Legal Services Corporation-funded programs) can lobby the state legislature to enact measures to ensure that the private hospital provides full access to health care services for the indigent at the same level that the public hospital did. For example, in 1996 Boston City Hospital, a public teaching hospital; Boston Specialty and Rehabilitation Hospital, a public long-term care hospital; and Boston University Medical Center Hospital, a private, nonprofit teaching hospital consolidated their operations to form Boston Medical Center, a private, nonprofit entity. Patient advocacy groups lobbied every individual who had influence on the consolidation process to ensure that the Massachusetts legislature approved legislation that considered the needs of the indigent population.

Second, health advocates may seek to influence or indirectly participate in

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73 Georgia, New York, Ohio, California, Louisiana, Missouri, Utah, Kentucky, Delaware, and New Hampshire.

74 Feiser, supra note 70, at 844.

75 Colorado, Maine, Minnesota, Montana, Washington, and Wisconsin.

76 For a more detailed discussion of case law and how these standards were applied in various government privatizations, see Feiser, supra note 70, at 853–60.

77 See LEGNINI ET AL. supra note 60, at 43.
negotiations between the public hospital and the private entity in a manner that encourages the prospective partners to consider cost-effective means of providing indigent care. Advocates may urge the partners to improve primary care services for the indigent population through outpatient clinics or mobile medical facilities. The contract that carries out the privatization of the hospital should provide for a certain level of indigent care to be delivered within the community. The contract should include an assessment or evaluation scheme to give community activists and health advocates a means to ensure compliance with the indigent care requirements.

Third, health advocates may be able to invoke a state’s charitable asset laws to require that the nonprofit corporation provide a certain level of indigent care within the community. For example, Brackenridge Hospital and Children’s Hospital in Austin, Texas, were leased to Seton Healthcare Network, which is affiliated with the Catholic Church. Pursuant to the leasing agreement, Seton had to provide charity care at a level equal to 4 percent of its net patient revenues, the level of care that the nonprofit organization requires. By urging state attorneys general to uphold the public’s interest and ensure that nonprofit entities comply with charitable asset laws, health advocates may be able to maintain the current level of indigent care being delivered in their community.

And, fourth, health advocates must attempt to ensure that the government maintains some form of control or presence in the newly formed health facility. If this can be accomplished, there is a greater probability that the private hospital will be subject to the state’s public disclosure provisions and that any future community concerns can be addressed. The government may exert some control by having an ex officio seat on the hospital’s board of directors.

Health advocates must be mindful that public hospital conversions are largely a political process because most require approval from state or local governments. Hospital officials are aware of this, and in order to have the conversion proceed successfully they may be induced to negotiate with or at least take into account the interests of those who are likely to be adversely affected by the conversion. Health advocates should use this to their advantage.

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78 See Bernard, supra note 60, at 1043.
79 Id.
80 Charitable asset laws or nonprofit incorporation laws are “statutes, cases, or other legal authority requiring that a charitable or non-profit institution use their assets to fulfill their charitable missions.” Cohen & Morrison, supra note 67, app. A, at 39. This requirement is imposed on nonprofit institutions because they receive numerous benefits, including tax breaks, from their nonprofit status. In order to maintain its special status, the nonprofit institution must adhere to the standards delineated in the charitable assets or nonprofit incorporation laws.
81 See Legnini et al., supra note 60, at 62. Community advocates favored the use of a lease agreement in order to “protect the [hospital] as a public asset and to ensure that Seton continued [Austin’s] commitment to charity care.” Id. at 60. If Seton did not comply with the agreement, the city would be able to take back the hospital operations. As in the Boston case, advocates participated in the public hearings and meetings, which allowed them to ensure that their clients’ interests were fairly represented in the lease agreement. See also Tex. Health & Safety Code Ann. § 311.045(b)(1)(C) (stating that a nonprofit hospital providing community benefits must provide “charity care and government-sponsored indigent health care . . . in an amount equal to at least four percent of net patient revenue.” If a nonprofit hospital does not meet this standard, it loses its tax-exempt status. See Cohen & Morrison, supra note 67, at 1; see also Hamburger et al., supra note 65.
82 See Bernard, supra note 60, at 1043-44. See also Palm Beach County Health Care Dist. v. Everglades Mem’l Hosp., 658 So. 2d 577 (Fla. Dist. Ct. App. 1995). In Palm Beach the interlocking board of directors, linking Everglades Memorial Hospital and the hospital district, was the only mechanism to ensure that the private entity’s obligations to the public were met.
advantage and play an active part in seeing that any restructured health care system continues to address the needs of indigent populations.

IV. Conclusion

Certain problems inherent to privatization should give public officials pause before they rush headlong into the process. One must consider whether the state itself administering health programs is ultimately more efficient, both in terms of administrative costs and quality of service. Taxpayers should question increasing investments in private companies when those same investments could be used to support a public health system that would continue to protect the public for years to come. Public management provides greater accessibility to comparable data over time, affords more accountability to the public, and places public values ahead of the profit-making concerns of private corporations. A public system is also more easily mustered to a common cause or calling, such as responding en masse to an ongoing biological or chemical threat.

When a government chooses to spend its public dollars on private health care administrators, advocates should seek to ensure that the public retains sufficient access to information to allow it to monitor and influence expenditures, the quality of care being provided, and the nature of the review process afforded to those involved in disputes with the private entity administering the program in question. Without these safeguards, and perhaps even with them, both the quality of care and the accessibility of health services for the poor predictably will suffer under the profit pressures of a privatized delivery system.